Healthy Connections

PROVIDER MANUAL

Physicians, Laboratories, and Other Medical Professionals

Established February 1, 2005
Updated May 1, 2019

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections
MEDICAID

South Carolina
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Post Office Box 8206
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MEDICAID BULLETIN

CHIR	*05-01*	*PHY-MSP-HBP*	*05-01*
LAB-IND	*05-01*	*PHY-OPHT*	*05-01*
MC-ASC	*05-01*	*PHY-PATH*	*05-01*
MC-FFHC	*05-01*	*PHY-PC-FP/GP*	*05-01*
MC-FQHC	*05-01*	*PHY-PC-GER*	*05-01*
MC-RHC	*05-01*	*PHY-PC-INT*	*05-01*
OMP-CRNA	*05-01*	*PHY-PC-NEO*	*05-01*
OMP-NM	*05-01*	*PHY-PC-OG*	*05-01*
OMP-NP	*05-01*	*PHY-PC-PED*	*05-01*
OMP-NPS	*05-01*	*PHY-PC-PED-SUB*	*05-01*
OMP-PSY	*05-01*	*PHY-PS*	*05-01*
PHY-ALG	*05-01*	*PHY-RAD*	*05-01*
PHY-ANES	*05-01*	*PHY-S*	*05-01*
PHY-CARD	*05-01*	*PH-SPEC*	*05-01*
PHY-DERM	*05-01*	*PHY-SURG*	*05-01*
PHY-ENT	*05-01*	*POD*	*05-01*
PHY-ER	*05-01*	*VIS*	*05-01*
PHY-MSP-CBP	*05-01*	*XRAY-IND*	*05-01*

TO: **Physicians, Laboratories and Other Medical Professional Providers**

SUBJECT: **Medicaid Policy Manual for Physicians, Laboratories and Other Medical Professionals**

The enclosed revised Division of Physician Services Medicaid Provider Manual is effective February 1, 2005 and includes all previous HIPAA changes and Medicaid policy bulletins.

This manual is to be used for program information and requirements, billing procedures, and provider services guidelines. **Due to several substantial changes in policy, providers are urged to carefully review this revision.**

In addition to inclusion of policy changes specific to the Physician Services program, the new provider manuals for all Medicaid programs have been reformatted to give them a more consistent, standardized layout and to improve navigation and readability. Headings for each subsection appear on the left side of the page, with the corresponding information on the right. "Chapters" are now called "sections," and the numbering system has been simplified.

The revised manual is organized as follows, with each section having its own table of contents:

Section 1, **General Information and Administration,** contains an overview of the South Carolina Medicaid program, as well as information about record retention, documentation requirements, utilization review, program integrity, and other general Medicaid policies.

Section 2, **Policies and Procedures,** describes policies and procedures specific to the Physician Services program.

Section 3, **Billing Procedures,** contains billing information that is common to all South Carolina Medicaid programs, as well as program-specific guidelines for claim filing and processing.

Section 4, **Procedure Codes**, contains procedure codes, fee schedules, and other approval codes and modifiers.

Section 5, **Administrative Services,** contains contact information for DHHS state and county offices, examples of all forms referenced throughout the manual (as well as some generic forms), and contacts for claim form suppliers/vendors.

The **appendices** include the following:

- Edit Codes, Claim Adjustment Reason Codes (CARCs) & Remittance Advice Remark Codes (RARCs), and Resolutions
- Carrier Codes
- Schedule of Copayments

The enclosed compact disc contains a copy of the manual in Portable Document Format (pdf). To access the file, you will need Adobe Acrobat Reader software, which is pre-installed on most computers and also available for free download at **www.adobe.com/support**. The manual is also available on the DHHS Web site.

The policy manual and fee schedule are not subject to copyright regulations and may be reproduced in their entirety.

If you have any questions regarding this provider manual and fee schedule, please contact your program coordinator in the Division of Physician Services at (803) 898-2660. Thank you for your continued support of the South Carolina Medicaid program.

Robert M. Kerr
Director

RMK/bgaw

Enclosures

NOTE: To receive Medicaid bulletins by email or to sign up for Electronic Funds Transfer of your Medicaid payment, please go to the following link for instructions: http://www.dhhs.state.sc.us/ResourceLibrary/E-Bulletins.htm

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SECTION 6 BIO OUTCOMES INITIATIVE

FORMS

APPENDICES

SUPPLEMENTS

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
05-01-19	Forms	-	Replaced Consent for Sterilization form with 04/30/2022 version
04-01-19	1	35	Updated Prepayment Reviews
04-01-19	Forms	-	Replaced Consent for Sterilization form with April 2019 version
04-01-19	Appendix 1	56	Updated edit codes 906 and 907
04-01-19	Webpage	-	Updated Surgical Package Codes
03-01-19	2	75 77	• Updated Services Covered under EPSDT • Updated Enrollment Prerequisites
03-01-19	4	39	Updated Family Planning CPT/HCPCS Services to add procedure code 87140
03-01-19	Forms	-	Replaced Consent for Sterilization form with March 2019 version
03-01-19	Appendix 2	-	Updated carrier codes
02-01-19	2	85	Updated “Buy and Bill” Prior Authorization Request
02-01-19	4	23-24	Updated J-Codes Requiring Prior Authorization
02-01-19	Forms	-	Replaced Consent for Sterilization form with new version (#0937-0166 Expiration 02/28/19
01-15-19	Change Control Record	1	Changed the date for Sections 2, 4 and Web Page from 01-09-19 to 01-10-19
01-10-19	2	13 20 36 40 62 63 64 69	Updated the following subsections: • After Hour Services • Supplies • Covered Services, Telemedicine • Non-Covered Services, Unusual Travel • Newborns Stabilized for Transport • Neonatal Intensive Care Codes • Additional Services, Neonatology • FFS Children’s Nutritional Counseling Program

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		85 161-162 163 165 166 176-177 179 186-189 203 204 251-253 299	• "Buy and Bill" Prior Authorization Request • Psychological Testing • Psychotherapy with Medical Evaluation and Management Services • Psychotherapy for Crisis • Non-Covered Psychiatric Services • Covered Services, Part II - Diagnostic • Special Ophthalmology Services • Tuberculosis Policy (TB) • Covered Services, Chiropractic Services • Radiologic Examination • Lab Procedures • RHC Children's Nutritional Counseling Program
01-10-19	4	 23 27-29 36-39, 45-47 57-58 72	Updated the following tables: • J-Codes Requiring Prior Authorization • CPT Codes (PT, OT, SP) Requiring Prior Authorization Review • Family Planning CPT/HCPCS Services • Procedure Codes for Vision • Children's Nutritional Counseling HCPCS Codes
01-10-19	Web Page	-	Updated Surgical Package Codes
01-03-19	Forms	-	Replaced Consent for Sterilization form
12-01-18	2	58 275	• Updated Immunizations for Children • Updated Billing Requirements, FQHC Adult Nutritional Counseling Program
12-01-18	4	24	Updated J-Codes Requiring Prior Authorization
12-01-18	Appendix 2	-	Updated carrier codes
11-01-18	2	112 185-187 237	• Updated Perinatal Care • Updated Tuberculosis Policy (TB) • Updated Pathology and Laboratory Services
11-01-18	Forms	-	Updated Claim Reconsideration Form

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
11-01-18	Appendix 1	55-56	Updated edit codes 906 and 907
10-01-18	4	1 71-72 77	• Updated Assistant Surgeon Codes to remove codes to the Physicians Manual webpage • Updated Adult Nutritional Counseling ICD-10-CM Diagnosis Codes • Updated FQHC Wrap Payment Methodology
10-01-18	6	9-57	Updated ICD-10-CM Diagnosis Codes
10-01-18	Appendix 1	44, 55-56, 64-65	Updated edit codes 820, 906, 907, and 977
10-01-18	Webpage	-	• Added Assistant Surgeon Codes • Updated ICD-10-PCS Surgical Codes and CPT Codes for October 1, 2018
08-06-18	1	25	Updated Premium Payment Project
08-06-18	TPL Supplement	17-18	Updated TPL Resources
08-01-18	4	11 79	• Updated ICD-10-PCS Surgical Codes and CPT Codes Requiring Supporting Documentation, October 2017 Update • Updated Adult Nutritional Counseling ICD-10-CM Diagnosis Codes
08-01-18	Appendix 2	-	Updated carrier codes
08-01-18	Managed Care Supplement	-	Updated entire section
07-01-18	2	78 105-106 112 284 312	• Updated the following sections: o Reimbursement for EPSDT Services o Best Practice Guidelines for Perinatal Care (Replaces High Risk Channeling Project – HRCP) Best Practice o 17 Alpha Hydroxyprogesterone Caproate (Makena™and 17P) o Special Clinic Services for FQHCs o Special Clinic Services for RHCs

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
07-01-18	3	39-40 40	• Updated Retro Health Insurance • Updated Retro Medicare
07-01-18	4	83	Added RHC Wrap Payment Methodology
07-01-18	Appendix 1	3, 37, 42, 45, 52-57, 70, 73 48 66-67	• Updated CARC and RARC for edit codes 059, 710, 738, 739, 757, 820, 821, 837, 838, 839, 843, 844, 912, 914, 928, 934, and 952 • Updated CARC for 786 • Updated Resolution for 906 and 907
07-01-18	TPL Supplement	15-16 17	• Updated Retro Health and Pay & Chase • Updated TPL Resources
06-01-18	2	36	Updated Covered Services
05-01-18	2	61 220 23, 29 71-82 143 265 266 277 299	• Removed ICD-9 codes from the following sections and referred providers to the Physicians Services Provider Manual webpage: o Cancer Screening o Hospital Acquired Conditions (HACs) • Updated the following sections: o Convenient Care Clinics o Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) o Department of Health and Environmental Control o Excision of Nail o Routine Foot Care o Psychiatry and Counseling Encounter – T1015 (With HE Modifier), FQHC Encounter and Ancillary Service Coding o Psychiatry and Counseling Encounter – T1015 (With HE Modifier), RHC Encounter and Ancillary Service Coding
05-01-18	4	11, 33, 43, 65, 83, 88	Removed ICD-9 codes and referred providers to the Physicians Services Provider Manual webpage
05-01-18	6	8	Removed ICD-9-CM diagnosis codes and referred providers to the Physicians Services Provider Manual webpage

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
05-01-18	Forms	-	Updated Claim Reconsideration Form
05-01-18	Appendix 2	-	Updated carrier codes
05-01-18	Webpage	-	Added ICD-9 codes
04-01-18	2	4 63-68 78-80 247	• Added Dietitian section • Updated the following sections: o FFS Adult Nutritional Counseling Program o FFS Children's Nutritional Counseling Program o Evaluation and Management (E/M) Visits
04-01-18	4	 1-8 52 83 84-85 86-87 88 88 88-89	Updated the following sections: • Assistant Surgeon Codes • Family Planning CPT/HCPCS Services • Adult Nutritional Counseling ICD-9-CM Diagnosis Codes • Adult Nutritional Counseling ICD-10-CM Diagnosis Codes • Adult Nutritional Counseling HCPCS Codes • Children's Nutritional Counseling ICD-9-CM Diagnosis Code • Children's Nutritional Counseling ICD-10-CM Diagnosis Code • Children's Nutritional Counseling HCPCS Codes
02-01-18	Forms	-	Updated Health Insurance Information Referral Form (DHHS Form 931)
02-01-18	Appendix 2	-	Updated carrier codes
01-01-18	2	 35, 137 45 47 122-123 197 291 324 326-327	Updated the following sections: • Biennial Physical Examination • Referring Sites, Telemedicine • Reimbursement for Professional Services • 17 Alpha Hydroxyprogesterone Caproate (Makena™ and 17P) • Tuberculosis Policy (TB) • Biennial Physical Encounter • Special Clinic Services, Non-Covered Services • Pediatric Anesthesia Services

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
01-01-18	4	1-8 28 37 38-41 42 48-49, 56, 61 69-77	Updated the following tables: • Assistant Surgeon Codes • CPT Codes Requiring Supporting Documentation for KEPRO • CPT Codes Requiring Prior Authorization Review • CPT Codes (PT, OT, SP) Requiring Prior Authorization Review • Transplant Codes Requiring Prior Authorization by KEPRO • Family Planning CPT/HCPCS Services • Procedure Codes for Anesthesia
01-01-18	5	1	Updated Correspondence and Inquiries
01-01-18	Webpage	-	Updated Surgical Package Codes
12-01-17	4	62	Updated Family Planning CPT/HCPCS Services
12-01-17	Forms	-	Updated Claim Reconsideration Form
11-01-17	2	68-69 70-72 295 297	• Added Immunization section • Updated Pediatrics And Neonatology • Deleted FQHC Specials Services heading • Updated Special Services
11-01-17	4	47 89	• Updated Family Planning CPT/HCPCS Services • Add Wrap Payment Methodology
11-01-17	Appendix 2	-	Updated carrier codes
10-01-17	4	11-18 82-85 Webpage	• Updated Procedure Codes Requiring Supporting Documentation - ICD-10-PCS Surgical Code and CPT Codes • Updated Adult Nutritional Counseling ICD-10-CM Diagnosis Codes • Updated ICD-10 Antepartum Visits and ICD-10-PCS Surgical Codes and CPT codes
10-01-17	Appendix 1	3	Added new edit code 063
09-01-17	Forms	-	Updated Claims Reconsideration, Duplicate Remittance Advice Request, and Electronic Funds Transfer (EFT) Authorization Agreement forms

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
08-01-17	Forms	-	• Updated the Table of Contents revision date for DHHS Pediatric Sub-Specialists Certification • Updated Surgical Justification Review for Hysterectomy • Updated Request for Prior Approval Review
08-01-17	Appendix 2	-	Updated carrier codes
07-01-17	6	-	Corrected formatting
07-17-17	Forms	-	Replaced DHHS Pediatric Sub-Specialists Certification Form
07-01-17	2	 27,28 29 31 32-38 38,39 39 39 39 39 39,40 50,51 51 52-54 54 55 85 85 86 103,104, 106 108 110 113-116	Updated the following Program Services sections: • Convenient Care Clinics o Required Services • Immunizations o Reimbursement Policies o Immunizations o Pneumonia Vaccine o Influenza Vaccine o Monovalent Vaccine o Hepatitis Vaccine o Meningococcal Vaccine o Rabies Vaccine and Immune Globulin • Long Acting Reversible Contraceptives (LARCs) • Covered Medication • Tobacco Cessation • Tobacco Cessation for Pregnant Women • South Carolina Tobacco Quitline • Immunizations For Children • Respiratory Syncytial Virus Immune Globulin (Synagis®) • Adult Immunizations • Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) o Required Services o Immunizations o Reimbursement Policies o Resources • Tamper Resistant Prescription Pads

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		117 129 131 132 168,169 175 175 176 177-180 317 317 330 331 338 339 339 354,355	o Prior Authorization • Tobacco Cessation • Tobacco Cessation for Pregnant Women • South Carolina Tobacco Quitline • Long Acting Reversible Contraceptives (LARCs) • Sterilization o Non-Covered Services o Family Planning o Covered Services o Family Planning Visits • Immunizations • Influenza Vaccine • Covered Contraceptive Supplies and Services • Special Clinic Services • Synagis Vaccine • Pneumococcal Vaccine • Influenza Vaccine • Long Acting Reversible Contraceptives (LARCs)
07-01-17	6	3	Added Coverage for Centering Pregnancy Group Prenatal Care language
06-01-17	2	11 152 162, 163 168 174	• Updated Primary Care Services section • Updated the Consent for Sterilization Form number reference in the following sections o Hysterectomies o Sterilization o Covered Service o Definitions (as stated in the Code of Federal Regulations; 42.CFR441.251)
06-01-17	3	11	Updated Modifiers
06-01-17	Forms	-	• Updated Claim Reconsideration Form • Updated DHHS Form 687, formerly DHHS Form 1723 (Consent for Sterilization)
06-01-17	Appendix 2	-	Updated carrier codes
05-01-17	Appendix 1	-	Updated Provider Service Center Hours of Operation
04-01-17	4	1 61	• Updated Assistant Surgeon Codes • Updated Procedures for Anesthesia

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Date	Section	Page(s)	Change
04-01-17	Forms	-	Updated DHHS Pediatric Sub-Specialists Certification Form Updated BOI Universal Screening Tool
03-01-17	2	25, 26 85 88 89 94-96 102 276	Updated the following Program Services sections: • Convenient Care Clinics o Required Services • Pediatrics and Neonatology o Initial Comprehensive Assessments o Additional Services o Extracorporeal Membrane Oxygenation Support (ECMO) o Billing Requirements o Required Services • Pathology and Laboratory Services
03-01-17	Forms	-	Updated Claim Reconsideration Form
02-01-17	Appendix 2	-	Updated carrier codes
02-01-17	2	14 30, 38 56 79 88 93 114 142 145 151 152 173 207 208,209, 212 217 218,223	Updated the following Program Services sections: • Ambulatory Care Visit Guidelines • Convenient Care Clinics o Billing o Immunizations o Covered Services o Immunization • Neonatology o Additional Services • FFS Children's Nutritional Counseling Program • "Buy and Bill" Prior Authorization Request • 17 Alpha Hydroxyprogesterone Caproate (Makena™and 17P) • Emergency Deliveries • Pulse Oximetry Policy • Depo-Provera for Other than Contraceptive Purposes • Elective Sterilization • Part III Ocular Surgery • Use of Modifiers With Procedure Codes • Pulmonary Medicine • Tuberculosis Policy • Allergy and Immunotherapy

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Date	Section	Page(s)	Change
		231 262 266 272 282 349	• Radiologic Examination (X-ray) • Modifiers of Anesthesia Services • Postoperative Pain Management • Clinical Pathology Services • Lab Procedures • Pediatric Anesthesia Services
02-01-17	3	9-12	Updated Claim Filing Options section
02-01-17	4	 1-8 24-25 26, 29, 31, 35 48, 55 63, 64	Updated the following tables: • Assistant Surgeon Codes • Procedure Codes Requiring Prior Authorization By ICORE • Procedure Codes Requiring Prior Authorization By KEPRO • Procedure Codes for Family Planning • Procedure Codes For Anesthesia
01-01-17	2	 25 39 44 56 71 81, 82 85 99 156 192 193 208 263 264 266 310	Updated the following Program Services sections: • Required Services • Meningococcal Vaccine • Biennial Physical Examination • Covered Services • Cancer Screening Services • Meningococcal Vaccine • Initial Comprehensive Assessments • Required Services • Biennial Physical Examination • Psychotherapy • Family Psychotherapy • Special Ophthalmological Services • Spine and Spinal Cord Puncture for Injection • Laboring Epidural • Postoperative Pain Management • Biennial Physical Examination
01-01-17	4	 1-8 28 29 30	Updated the following tables: • Assistant Surgeon Codes • CPT Codes Requiring Prior Authorization Review • Procedure Codes Requiring Prior Authorization by KEPRO • CPT Codes (PT, OT, SP) Requiring Prior Authorization Review

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		41, 53 65	• Family Planning CPT/HCPCS Services • Procedure Codes for Vision
12-01-16	3	9 12 21	• Updated Diagnostic Codes • Updated Place of Service Key • Updated CMS-1500 Instructions, field 24D
12-01-16	4	75, 76, 78	Updated Nutritional Counseling Codes
12-01-16	Forms	-	Updated Claim Reconsideration Form
11-01-16	2	24-25 64 64 98-99	• Updated Convenient Care Clinics, Required Services • Updated Botox® (JO585, Injection, Onabotulinumtoxina, 1 Unit), Dysport ™ (J0586, 5 Units), Myobloc ® (J0587, Injection Rimabotulinumtoxinb, 100 Units), and Xeomin (J0587, Injection, Incobotulinumtoxina, 1 Unit) • Updated Xolair® (Omalizumab) • Updated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Required Services
11-01-16	Appendix 2	-	Updated carrier codes
10-01-16	1	5-6	Deleted SC Healthy Connections Checkup Program language and moved sample Checkup card to South Carolina Healthy Connections Medicaid Card section
10-01-16	2	42-52,	Updated the following sections related to Family Planning: • Family Planning Services o Covered Services o Examinations/Visits o Biennial Physical Examination o Annual Family Planning Evaluation/Management Visits o Periodic Visits o Family Planning Counseling Visits o Referral Instructions o Covered Contraceptive Supplies and Services o Long Acting Reversible Contraceptives (LARCs)

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Date	Section	Page(s)	Change
			○ Covered Screenings and Testing ○ Covered Medications
		155-163,	• Family Planning Services ○ Covered Services ○ Examinations/Visits ○ Biennial Physical Examination ○ Annual Family Planning Evaluation/Management Visits ○ Periodic Visits ○ Family Planning Counseling Visits ○ Referral Instructions ○ Covered Contraceptive Supplies and Services ○ Long Acting Reversible Contraceptives (LARCs) ○ Covered Screenings and Testing ○ Covered Medications ○ Non-Covered Services
		169 295	Radiology and Nuclear Medicine
		309-315,	• Encounter and Ancillary Service Coding ○ Family Planning ○ Covered Services ○ Encounters ○ Biennial Physical Encounters ○ Annual Family Planning Evaluation/Management Encounters ○ Periodic Visits ○ Family Planning Counseling Encounters ○ FQHC Reporting Positive Screens ○ Covered Medication ○ Covered Contraceptive Supplies and Services ○ Covered Screenings and Testing ○ Non-Covered Services
		333-339,	• Family Planning ○ Covered Services ○ Examinations/Visits ○ Biennial Physical Examination ○ Annual Family Planning Evaluation/Management Visit Encounters ○ Periodic Revisit Encounter ○ Family Planning Visits Encounter

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Date	Section	Page(s)	Change
		345	o RHC Reporting Positive Screens o Covered Contraceptive Supplies and Services o Long Acting Reversible Contraceptives (LARCs) o Covered Screenings and Testing o Covered Medications o Non-Covered Services
10-01-16	3	11	Updated Modifiers for Family Planning
10-01-16	4	35-56 36-37	• Updated Family Planning • Update Family Planning ICD-10-CM Diagnosis Codes
10-01-16	6	12-90	Updated ICD-10-CM Diagnosis Codes
09-01-16	2	56 123-214	• Updated Telemedicine, Covered Services • Alcohol and Drug Testing Policy
09-01-16	Appendix 1	67	Updated edit code 979
09-01-16	Appendix 2	-	Updated carrier codes
08-01-16	1	2, 4, 5, 24, 27	Updated to reflect Medicaid Bulletin dated July 11, 2016 – New Medicaid Cards
08-01-16	2	25 55	• Updated Required Services - Lead Screening • Updated Telemedicine Providers
08-01-16	Appendix 1	22, 23, 66	Updated edit codes 527, 532, and 965
07-01-16	2	72 227 253 300 322	Updated the following sections to reflect Medicaid Bulletin dated June 9, 2016 – Coverage of Bariatric Surgery: • FFS Adult Nutritional Counseling Program • Bariatric Surgery (formerly Gastric Bypass Surgery/Vertical-Banded Gastroplasty[(Gastric Stapling]) • Gastric Bypass • FQHC Adult Nutritional Counseling Program • RHC Adult Nutritional Counseling Program
07-01-16	3	-	Updated generic language throughout the section

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Date	Section	Page(s)	Change
06-01-16	Appendix 1	3, 65	Updated edit codes 062 and 974
06-01-16	4	38-54 -	• Updated Checkup and Family Planning CPT/HCPCS Services • Updated KEPRO branding
06-01-16	5	- 1 3	• Updated hyperlinks throughout section • Updated Administration section • Updated Procurement of Forms section
06-01-16	Appendix 1	44 3, 14, 29, 30, 63	Added new edit codes 801 and 802 Updated CARC for edit codes 079, 356, 357, 605, 693, and 958
05-01-16	Appendix 1	6, 63, 67	Updated edit codes 150, 953, 989, 990
05-01-16	Appendix 2	-	Updated carrier codes
04-01-16	2	113 38, 80, 300, 321 50-51, 161-162, 336-337 151 151 313 313-314 315-316 345	• Added South Carolina Reporting and Identification Prescription Tracking System (SCRIPTS) • Updated the following sections: o Pneumonia Vaccine o Long Acting Reversible Contraceptives (LARCs) o Levonorgestrel-Releasing Intrauterine System (Mirena®) Coverage o Etonogestrel Implant (Implanon®) Coverage o Covered Contraceptive Supplies and Services o Special Clinic Services
04-01-16	Managed Care Supplement	18-19	Replaced sample MCO cards
03-01-15	2	123, 124	Updated Alcohol and Drug Testing Policy
03-01-16	Appendix 1	19, 23	Added edit codes 450 and 532
02-01-16	1	-	Updated the following sections to reflect Medicaid Bulletin dated January 26, 2016 – Updates to Section 1

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
			– All Provider Manuals: • South Carolina Medicaid Program o Program Description o SC Healthy Connections Medicaid Card(s) • Records/Documentation Requirements o General Information o Signature Policy • Medicaid Program Integrity o Program Integrity • Appeals
01-01-16	1	19	Updated to reflect Medicaid Bulletin dated December 9, 2015 - Charge Limits
01-01-16	2	38, 79 213-214	• Updated the following sections: o Immunizations - VFC Vaccine CPT codes o Tuberculosis (TB) Policy, Subsequent Nursing Services
01-01-16	Appendix 1	21	Added edit code 527
12-01-15	Cover	-	December 1, 2015 - Replaced manual cover
12-01-15	2	3 25, 26 99, 100, 104 322	• Updated the following the following sections: o Physician's Assistant o Convenient Care Clinics, Required Services o EPSDT Standards, Required Services o Application of Fluoride Varnish
11-01-15	2	39, 80 152	• Updated the following sections: o Immunizations - VFC Vaccine CPT codes o Pessary
11-01-15	Appendix 1	19, 44-47	• Revised edit code 507, 821, 837, 838, 839
10-01-15	1	7 10	• Updated to add SCDHHS alerts • Updated Provider Participation
10-01-15	2	113-114 76 223	• Updated Pharmacy Services • Updated Billing Requirements • Updated Dermatology
10-01-15	6	20-21	• Revised BOI ICD-10 diagnosis codes

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
10-01-15	Appendix 1	1 1 All 4, 20, 23, 27, 43	• Updated general instructions • Updated the following to reflect Medicaid Bulletin dated June 1, 2015—ICD-10 Clinical Modification/ Procedure Coding System o Added note to general instructions o Replaced ICD-9 with ICD-CM throughout section • Deleted edit codes 102-109, 112-116, 503, 527, 566, 791, 792
09-01-15	4	 72 73, 75-76,	• Updated formatting throughout the section • Updated Adult Nutritional Counseling ICD-10-CM Diagnosis Codes • Added Nutritional Counseling HCPCS codes
09-01-15	6	12-58	• Updated BOI ICD-10 diagnosis codes
09-01-15	2	172-76, 92-94, 304-311, 326-334 All	• Updated to reflect Medicaid Bulletin dated July 2, 2015 – Nutritional Counseling and Dietitian Enrollment • Updated to reflect Medicaid Bulletin dated June 1, 2015—ICD-10 Clinical Modification/Procedure Coding System
09-01-15	3	 4-5 8-9 18-19 27-28	• Updated the following sections to reflect Medicaid Bulletin dated June 1, 2015—ICD-10 Clinical Modification/ Procedure Coding System: o Claims Filed via the Web Tool: Use of Emergency Indicator o Diagnostic Codes o CMS-1500 Claim From Completion Instructions, field 21 • Updated SC Medicaid Web-based Claims Submission Tool to reflect Medicaid Bulletin dated June 19, 2015—Claim Submission Web Portal (Webtool) Enhancement SC Medicaid Web-based Claims Submission Tool
09-01-15	4	45-48 11-20, 28,	• Added Nutritional Counseling procedure codes to reflect Medicaid Bulletin dated July 2, 2015 – Nutritional Counseling and Dietitian Enrollment • Updated to reflect Medicaid Bulletin dated June 1,

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		36-37,56-58, 65-70	2015—ICD-10 Clinical Modification/Procedure Coding System
09-01-15	6	7-57	Updated o reflect Medicaid Bulletin dated June 1, 2015—ICD-10 Clinical Modification/Procedure Coding System
09-01-15	Appendix 1	5, 14	• Added edit codes 270 and 271 and updated edit code 110 to reflect Medicaid Bulletin dated June 1, 2015—ICD-10 Clinical Modification/Procedure Coding System
08-01-15	2	72-76, 92-94, 304-311, 326-334	Updated to reflect Medicaid Bulletin dated July 2, 2015 – Nutritional Counseling and Dietitian Enrollment
08-01-15	4	45-48	Added Nutritional Counseling procedure codes to reflect Medicaid Bulletin dated July 2, 2015 – Nutritional Counseling and Dietitian Enrollment
07-01-15	2	29-30 95 305 307 312 327-328	Updated the following sections: • Convenient Care Clinics, Required Services • EPSDT Standards, Required Services • Preventive Services • Provider Enrollment – Medicaid • Application of Fluoride Varnish • Special Clinic Services
07-01-15	Appendix 3	1-2	Updated Copayment Schedule
06-01-15	2	46-47 47-48 168-170 330 330 213	Updated the following sections: • Annual Family Planning Evaluation/Management Visits • Periodic Revisit • Family Planning Visits • The Pediatric Sub-Specialist Program • Pediatric Sub-Specialist Program Participation Requirements Replace procedure code 96367 with 96368
	3	6-7	Updated Diagnostic Codes

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
	Forms		Updated DHHS Pediatric Sub-Specialist Certification Form
04-03-15	2	26 89 110	• Updated the following policies to reflect Medicaid Bulletin dated March 31, 2015: o Convenient Care Clinics, Required Services o EPSDT, Required Services • Deleted procedure code J9355
	4	15	Deleted procedure code J9355
03-13-15	3	15-16 25	• Updated CMS-1500 Claim Form Completion Instructions • Updated SC Medicaid Web-based Claims Submission Tool (Web Tool)
03-09-15	2	78	Updated Newborn Care Billing Notes
03-01-15	2	18 30 45-46 225 296 308 323	Updated the following policies: • Ambulatory Care Visit Guidelines • Required Services • Biennial Physical Examination • Chiropractic Services • Covered Services • Biennial Physical Encounter • Application of Fluoride Varnish • Special Clinic Services
03-01-15	4	28 38	• Added procedure code 45378 • Updated procedure code 88305
03-01-15	Appendix 2		Updated carrier codes
02-01-15	2	4 307 322	• Updated the following policies: o Certified Registered Nurse Anesthetist (CRNA) o Application of Fluoride Varnish o Special Clinic Services
01-01-15	Forms		Updated Claim Reconsideration form
12-01-14	1	9, 10	Updated Provider Participation to reflect Medicaid Bulletin dated October 31, 2014 – Update to Section 1 of All Provider Manuals

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
12-01-14	2	256 304	• Updated Modifiers of Anesthesia Services • Added Provider Enrollment - Medicaid
12-01-14	3	3-4 29-30	• Updated Copayment policy • Added Claim Reconsideration policy
12-01-14	Forms		Added Claim Reconsideration form
12-01-14	Appendix 1	6, 50	Updated edit codes 121 and 839
12-01-14	Appendix 3	1-2	Updated Copayment Schedule
12-01-14	Managed Care Supplement	2	Updated Managed Care Organizations (MCOs) to reflect Medicaid Bulletin dated October 31, 2014 – Update to Section 1 of All Provider Manuals
11-01-14	2	74-75 110 206-211 211-217 44-45 301 204-206	• Added the following policies: o Tetanus, Diptheria, and Pertussis (Tdap) Vaccine o Special Billing Instructions for J1442/J9035 o Tuberculosis (TB) o Allergy and Immunotherapy • Updated the following sections: o Biennial Physical Examination o Special Clinic Services • Deleted Allergen and Clinical Immunology
11-01-14	Forms		Revised DHHS Pediatric Sub-Specialist Certification form
11-01-14	Appendix 1	70	Updated edit code 989
10-01-14	1	33-34	Updated Medicaid Beneficiary Lock-In Program
10-01-14	Appendix 1	3, 31, 36, 48-49, 61 46	• Updated edit code 079, 637, 719, 820, 821, 908, 909 • Added new edit code 790
09-11-14	2	298-299	Removed procedures codes and modifiers from FQHC USPSTF Grade A & B Recommendations table
09-01-14	2	106	Replaced J3592 with J9354

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
09-01-14	4	16	Replaced J3592 with J9354
08-14-14	2	43-51 151, 285, 299 275	• Added Checkup policy for Convenient Care Clinics • Corrected procedure code for Lung Cancer Screening of Smokers • Updated Radiology and Nuclear Medicine
08-06-14	2	143	Corrected procedure code for Lung Cancer Screening of Smokers
08-01-14	1	6	Updated to reflect Medicaid Bulletin dated July 22, 2014 – Coverage of New Screening Services for Healthy Connections Checkup
08-01-14	2	140-154, 275-281, 289-301	Updated to reflect Medicaid Bulletin dated July 22, 2014 – Coverage of New Screening Services for Healthy Connections Checkup
08-01-14	3	8	Updated to reflect Medicaid Bulletin dated July 22, 2014 – Coverage of New Screening Services for Healthy Connections Checkup
08-01-14	4	27-45	Updated to reflect Medicaid Bulletin dated July 22, 2014 – Coverage of New Screening Services for Healthy Connections Checkup
08-01-14	Appendix 1	51, 69 24, 48-51, 58	• Deleted edit codes 845 and 969 • Updated edit codes 537, 837-839, 843, 844, and 892
07-01-14	2	 104 104 124 126 138-139 155-169 288-289 202-203	• Updated the following sections: o Additional CLTC Services o Incontinence Products o Screening Brief Intervention and Referral to Treatment Initiative o Maternal Fetal Medicine Physician Ultrasound Override o Pulse Oximetry Policy o Psychiatric and Counseling Services o Screening Brief Intervention and Referral to Treatment Initiative • Added Hospital Acquired Conditions (HACs) in

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
			accordance with Medicaid Bulletin dated May 23, 2014
07-01-14	Appendix 1	15	Updated resolution for edit code 349, 369, 509
06-11-14	Change Control Record	1	Corrected typo in Forms entry for 06-01-14
06-01-14	2	4 16 22 47 76 80 101 106 201 228 245, 253 246 250-251 251 254 256	Updated the following sections: • Certified Registered Nurse Anesthetist (CRNA) • Ambulatory Care Visit Guidelines • Convenient Care Clinics • Telemedicine Providers, Covered Services • Forensic Medical Evaluations • EPSDT Standards, Required Services • ICORE Prior Authorization Request • Initial Medical Assessment and Referral • Instructions for Obtaining Prior Approval • Out-of-**S**tate (OOS) Services, Prior Approval • Encounter and Ancillary Service Coding, Cancer Treatment and HIV/AIDS Encounter – T1015 (With P4 Modifier) • Federally Qualified Health Center Services, Special Clinic Services • Rural Health Clinics (RHC), Screening Brief Intervention and Referral to Treatment Initiative • Rural Health Clinics (RHC), Services and Supplies • Synagis Vaccine • Rural Health Clinics (RHC), Special Clinic Services • Pediatric Anesthesia Services
06-01-14	Forms		Updated Out-of-State Referral Package
06-01-14	Appendix 1	3, 12	Updated resolutions for edit codes 079, 227, and 239
06-01-14	Appendix 2	All	Updated carrier codes
05-06-14	2	121-122	Added Transportation of Self-Administered Oxygen Dependent Beneficiaries section to reflect Medicaid Bulletin dated May 1, 2014

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
05-01-14	General Table of Contents	1	Removed DHHS county office listing
05-01-14	5	1 5	• Replaced reference to county office listing with the Where To Go for Help web address • Removed DHHS county office listing
05-01-14	Appendix 1	1, 2, 4, 45, 46, 62, 64, 92, 93	Updated edit codes 007, 052, 079, 715, 719, 837, 839, 977, 984
04-01-14	1	6, 23, 25 29-31 32 33 37 39 41-44	• Updated the following sections to reflect Medicaid Bulletin dated December 3, 2013 – Discontinuation of Edit Correction Form • Updated the following sections: o Program Integrity o Recovery Audit Contractor o Beneficiary Oversight o Fraud o Referrals to the Medicaid Fraud Control Unit o Updated acronym for U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG)
04-01-14	2	4, 6, 48, 57, 153, 159, 162, 214, 217, 256 7, 18, 53, 112, 153, 183, 186, 192 64 101 115 139-140 157	• Updated section to include the web address for fee schedules • Updated section to reflect Medicaid Bulletin dated December 3, 2013 – Discontinuation of Edit Correction Form • Updated the following sections: o Immunizations – added procedure code 90672 to VFC Vaccine CPT Codes o ICORE Prior Authorization Request – deleted J1440 and J1441and added J1442 o Tobacco Cessation for Pregnant Women o Family Planning, Covered Services o Exam and Glasses for Birth to Age 21 – added

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Date	Section	Page(s)	Change
		158 160 163 177	codes V2020 and V2025 o Guidelines for Lenses and Frames – added pricing for V2020 and V2025 o Optician – added pricing for V2020 and V2025 o Part III - Ocular Surgery o Chiropractic Services
04-01-14	3	1-31 5- 23 23 25-26	• Updated to reflect Medicaid Bulletin dated December 3, 2013 – Discontinuation of Edit Correction Form • Updated to reflect Medicaid Bulletin dated November 30, 2013 – Transition to the CMS-1500 Health Insurance Claim Forms (02/12) version • Updated Trading Partner Agreement • Updated SC Medicaid Web-based Claims Submission Tool (Web Tool)
04-01-14	4	15	• Added procedure code J1442 • Deleted procedure codes J1440 and J1441
04-01-14	5	12	Updated Horry County address
04-01-14	Forms		• Updated Reasonable Effort Documentation and Duplicate Remittance Advice Request forms • Removed not on CMS-1500 (02/12) version claim form • Removed CMS-1500 (08/05) version claim form • Removed Sample Edit Correction Form • Updated Sample Remittance Advice
04-01-14	Appendix 1	35 -	• Added edit code 527 • Entire section: o Updated to reflect Medicaid Bulletin dated December 3, 2013 – Discontinuation of Edit Correction Form o Updated to reflect Medicaid Bulletin dated November 30, 2013 – Transition to the CMS-1500 Health Insurance Claim Forms (02/12) version
04-01-14	TPL Supplement		• Updated the following sections to reflect Medicaid Bulletin dated December 3, 2013 – Discontinuation of Edit Correction Form:

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		5 6-8 9-10 10-11 13-14 15-16 22-23 30-31	o Timely Filing Requirements o Reasonable Effort o Nursing Facility Claims o Professional, Institutional, and Dental Claims o Rejected Claims o Recovery o Sample Forms – Reasonable Effort o Sample Forms – ECF (deleted)
03-01-14	General Table of Contents	2	Removed fee schedules
03-01-14	2	228-238	Updated Radiology and Nuclear Medicine
03-01-14	4	26 52	• Removed High Tech Radiology procedure codes in accordance with Medicaid Bulletin dated February 19, 2014 – High Tech Radiology Services • Added V2784 to Procedure Codes for Vision
03-01-14	Fee Schedules	-	Removed fee schedules from the manual
02-01-14	Cover	-	January 1, 2014 - Replaced manual cover
02-01-14	2	 39 63 157 159	Updated the following sections: • Immunizations • Immunizations • Guidelines for Lenses and Frames • Optician
02-01-14	4	53-56	Added Procedure Codes for Vision section
02-01-14	5	9	Updated Florence County office telephone number
01-01-14	Change Control Record	1	Add Depo-Provera procedure code change to section 2 for revision date 10-09-13
	2	101 247 249, 250	• Added ICORE Prior Authorization Request section • Changed Depo-Provera procedure code from J1055 to J1050 • Updated to reflect Medicaid Bulletin for Managed

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		7, 18, 54, 113, 154, 185 -	Care Organization Changes dated 11/15/13 • Updated to reflect Medicaid Bulletin for Discontinuation of the Edit Correction Form dated 12/3/13 • Changed PA to prior authorization throughout document
01-01-14	3	-	Updated entire section to reflect the following bulletins: • Discontinuation of Edit Correction Forms (ECFs)s dated December 3, 2013 • Transition to the CMS-1500 Health Insurance Claim Forms (02/12) version dated November 20, 2014 • Managed Care Organizational Changes dated November 15, 2013
01-01-14	4	15-16	Repositioned ICORE prior authorization section
01-01-14	5	1 3-4	Updated the following sections • Correspondence and Inquiries • Procurement of Forms
01-01-14	Forms		• Added CMS-1500 (02/12) version claim form • Added note to CMS-1500 (05/85) version claim form • Updated Duplicate Remittance Advice Request and EFT Authorization Agreement forms • Add SCDHHS Behavioral Health Referral and Feedback Form for LIPS
01-01-14	Appendix 1		Updated to reflect the following bulletins: • Discontinuation of Edit Correction Forms (ECFs)s dated December 3, 2013 • Transition to the CMS-1500 Health Insurance Claim Forms (02/12) version dated November 20, 2014 • Managed Care Organizational Changes dated November 15, 2013
01-01-14	Managed Care Supplement		Updated to reflect bulletin Managed Care Organizational Changes dated November 15, 2013

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Date	Section	Page(s)	Change
01-01-14	TPL Supplement		• Updated to reflect bulletin Transition to the CMS-1500 Health Insurance Claim Forms (02/12) version dated November 20, 2014
12-20-13	2	127 154-163	Updated 17 Alpha Hydroxyprogesterone Caproate section to include Makena™ Updated Ophthalmology and Optometry and Vision Care sections
12-20-13	Forms	-	Added Universal 17-P Authorization Form
12-01-13	2	175-176	Updated Physical Medicine and Therapy
12-01-13	4	20-23	Added CPT Codes (PT,OT, SP) Requiring Prior Authorization Review
12-01-13	5	15	Updated Orangeburg mailing address zip codes
11-06-13	2	 39 39-40 88 140	Updated the following sections: • Immunizations • Influenza Vaccine • Reimbursement Policies • Non-Covered Services
11-01-13	5	17	Updated York County mailing address
11-01-13	MC Supplement	18	Replaced BlueChoice MCO Medicaid card
10-09-13	2	129 254	• Updated Uncomplicated (Routine) Deliveries • Changed Depo-Provera procedure code from J1055 to J1050
10-09-13	4	39	Changed Depo-Provera procedure code from J1055 to J1050
10-01-13	Change Control Record	1	Revision date for section 4 change on 09-01-13 should be 11-01-12
10-01-13	2	13	Updated hyperlink for Primary Care Physician Attestation form
10-01-13	5	15	• Updated Orangeburg office and mailing address

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Date	Section	Page(s)	Change
		17	• Updated York County office address
10-01-13	Forms	-	Updated Mental Health Form
10-01-13	Appendix 1	- 5, 39 69 37, 42, 44	• Updated CARCs/RARCs throughout section • Added edit codes 110 and 725 • Deleted edit code 961 • Revised edit codes 720, 749, 750, 758, and 759
10-01-13	MC Supplement	20	• Added WellCare MCO Medicaid card and contact information
09-01-13	Change Control Record	5	• Date 11-01-13, Section 4— deleted edit code should be J3488
09-01-13	2	22 52 54-55 124 255	• Revised and moved Convenient Care Clinics language • Deleted Home Services language • Updated the following language: o Botox® (JO585, Injection, Onabotulinumtoxina, 1 Unit), Dysport ™ (J0586, 5 Units), Myobloc ® (J0587, Injection Rimabotulinumtoxinb, 100 Units), and Xeomin (J0587, Injection, Incobotulinumtoxina, 1 Unit) o Screening Brief Intervention and Referral to Treatment Initiative o Special Clinics Services
09-01-13	4	11 13 18 20	• Updated Procedure Codes Requiring Support Documentation • Updated CPT Codes Requiring Support Documentation for SCDHHS • Updated CPT Codes Requiring Prior Authorization Review • Updated CPT Codes Requiring SCDHHS Prior Authorization Review
09-01-13	5	8 11 13	• Updated Darlington County zip code • Updated Laurens County phone number • Updated York County office address

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Date	Section	Page(s)	Change
09-01-13	Forms	-	• Updated Allied Professional Supervision Form • Replaced Paraprofessional Update form with Allied Professional Update Form
08-01-13	5	14	• Updated York County physical address
08-01-13	Appendix 1	1 50, 51 72	• Updated resolution for edit code 007 • Updated RARC and resolution for edit codes 820 and 821 • Deleted edit codes 954, 955, and 956
08-01-13	Appendix 2	All	Updated carrier codes
07-01-13	5	8 12	• Updated Colleton County office telephone number • Deleted Newberry County PO Box address
06-01-13	5	12	• Updated Richland county office telephone number
06-01-13	Appendix 1	5, 11, 15, 33, 40 30	• Updated resolutions for edit codes 107, 219, 339 673, 720 • Deleted edit code 577
04-01-13	1	6	Corrected the URL for MedicaideLearning.com
04-01-13	2	15 151	• Added After Hour Services section • Updated Gastroenterology section
04-01-13	Appendix 1	2 20, 25, 28 4, 39, 52, 53, 57, 59 73 50, 51 67, 69	• Changed edit code description reference DMR and MR/RD to ID/RD for edit code 052 • Updated CARCs for edit codes 460, 544, 569 • Updated resolutions for edit codes 079, 722, 837, 838, 855, 865, 960 • Added edit codes 820, 821 • Updated edit code 935, 938, 939
04-01-13	Appendix 2	-	Updated carrier code list
04-01-13	Fee Schedules	-	Updated all fee schedules to reflect January 1, 2013 procedure codes
03-01-13	2	17 73	• Changed Mentally Retarded to Intellectually Disabled • Changed MR/RD to ID/RD

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Date	Section	Page(s)	Change
		197	• Changed Mental retardation to Intellectual disabilities
03-01-13	3	4 10	• Changed ICF/MR ICF/IID • Changed Mentally Retarded to Intellectually Disabled
03-01-13	5	10	Deleted Jasper County PO Box address
03-01-13	Appendix 1	i 2, 38, 70 38, 54, 70	• Deleted Change Log • Changed edit code description reference to DMR and MR/RD to ID/RD for edit codes 052, 053, 712, and 953 • Updated resolutions for edit codes 714, 851, and 953
03-01-13	Managed Care Supplement	7	Deleted the Department of Alcohol and Other Drug Abuse from agencies exempt from prior authorizations
02-01-13	1	18	Updated URL address for the National Correct Coding Initiative (NCCI)
02-01-13	2	17 42 152-153	Updated the following sections • Ambulatory Care Visit Guidelines – Changed patient to provider as the responsible party for and Edit 977 exam charge • Influenza Vaccine – Added edit code 90656 • Physical Medicine and Therapy – revised language
02-01-13	4	22	Deleted PT/OT/ST CPT codes requiring prior authorization by KePRO
01-01-13	2	 13 28 44 62 65 120 134 139	Updated the following sections • Primary Care Services • Preventive/Rehabilitative Services for Primary Care Enhancement (P/RSPCE) • Diabetes Patient Education • Screening Frequency • Reimbursement Policies • Department of Health and Environmental Control • Dispensing Codes for Contact Lenses and Glasses • Covered Services

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Date	Section	Page(s)	Change
		216	• Enrollment
01-01-13	4	20 44	• Updated CPT Codes Requiring SCDHHS Prior Authorization Review • Changed Family Planning Waiver to Family Planning program
01-01-13	5	7 9	• Added Chester county Zip+4 code • Updated Greenville PO Box address
01-01-13	Appendix 1	-	Added Change Log for section changes
12-03-12	1	6 7-8 27-32 33-41	• Updated web addresses for provider information and provider training • Revised heading and language to reflect new provider enrollment requirements • Updated Program Integrity language (entire section) • Revised heading and language for Medicaid Anti-Fraud Provisions/Payment Suspension/Provider Exclusions/Terminations (entire section)
12-03-12	3	11 15 23, 38, 41 29-30	• Updated National Provider Identifier and Medicaid Provider Number • Updated fields 17, 17b to add requirement for referring or ordering provider NPI • Updated provider information web addresses • Updated Electronic Funds Transfer (EFT)
12-01-12	5	6 21	• Updated URL for provider information • Updated McCormick county office telephone number
12-01-12	App**e**ndix 1	24, 26, 27, 32, 33 19, 27, 40, 44, 45, 47, 49, 50, 55, 56, 57, 59, 60, 61,	• Updated CARCs for edit codes 538, 552, 555, 561, 562, 563, 636, 637, 690 • Updated resolutions for edit codes 402, 561, 562, 563, 721, 722, 748, 749, 752, 753, 769, 791, 795, 852, 853, 856, 860, 884, 887, 892, 897, 925, 926

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Date	Section	Page(s)	Change
12-01-12	TPL Supplement	8, 9, 17	Updated web addresses for provider information and provider training
11-01-12	2	6-7 15 30 35 39 43 51-52 90-91 93 100 146 181 183 32-33 33-34 73-74 106	• Updated the following sections: o Co-signatures o Ambulatory Care Visits Guidelines o Botox® (JO585, Injection, onabotulinumtoxinA, 1 unit), Dysport ™ (J0586, 5 units), Myobloc ® (J0587, Injection rimabotulinumtoxinB, 100 units), and Xeomin (J0587, Injection, incobotulinumtoxinA, 1 unit) o Synagis® (Palivizumab) 90378 o Adult Physical Exams o Rabies Vaccine and Immune Globulin o Forensic Medical Evaluations o Rebated Tobacco Cessation and Nicotine Replacement Therapy (NRT) Products o Hospice o Screening Brief Intervention and Referral to Treatment Initiative o Allergen Immunotherapy o 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 o Modifiers of Anesthesia Services • Added the following new headings: o National Drug Code (NDC) Billing Requirements for Drug-Related HCPCS Codes o Physicians Administered Injection Drug Reimbursement Methodology o Tamper-Resistant Prescription Pads o Delivery in Cases of Prolonged Labor
11-01-12	4	20	CPT Codes Requiring SCDHHS Prior Authorization Review: • Added code J0897 • Deleted codes J1453 and J4388
11-01-12	5	1	Updated Allendale county office address

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Date	Section	Page(s)	Change
11-01-12	6	-	Corrected headers and page numbering
11-01-12	Forms	-	Added BOI Universal Screening Tool
11-01-12	Appendix 2	-	Updated carrier code list
10-05-12	Change Control Record	3	Remove Forms section entry for 07/01/12
10-05-12	Forms	-	Updated Duplicate Remittance Advice Request Form
10-01-12	Change Control Record	42	Changed July 6, 2012 date to July 9, 2012
10-01-12	1	4	Replaced back of Healthy Connections Medicaid card
10-01-12	2	177 41-42 88-89 89-90 231-232 30-31 91 99 102-104 149-150 178 40 41 61 110 122	• Deleted Retrospective Review section • Added the following sections: o Rabies Vaccine and immune Globulin o Tobacco Cessation o Tobacco Cessation for Pregnant Women o Convenient Care Clinics – Place of Service 17 • Updated the following sections to revise language from multiple bulletins: o Botox® (JO585, Injection, onabotulinumtoxinA, 5 units), Xeomin (Q2040, Injection, incobotulinumtoxinB, 100 units) o Hospice o Ultrasounds o Uncomplicated (Routine) Deliveries o Physical Medicine and Therapy o Corneal Transplantation (Keratoplasty) • Updated the following sections: o Influenza Vaccine o Respiratory Syncytial Virus Immune Globulin (Synagis®) o Screening Frequency o Birthing Center, Newborn Exam o Billing Notes for Sterilization and Other Related Procedures, Essure Sterilization Procedures

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Date	Section	Page(s)	Change
		178 223 230 231	o Kidney Transplantation o Special Clinic Services, FQHC o Special Clinic Services, RHC o Wrap-Around Payment Methodology
10-01-12	6	1 -	• Added background section • Corrected BIO to BOI throughout document
10-01-12	Appendix 1	-	Updated edit code information through document
08-29-12	2	1 99	• Corrected heading • Added 17 Alpha Hydroxyprogesterone Caproate (Makena™)
08-29-12	4	20	• CPT Codes Requiring SCDHHS Prior Authorization Review: o Added fax number and contact o Added procedure code J1725
08-14-12	Fee Schedule	-	Updated Injectable Fee Schedule to reflect July 2012 procedure codes
08-01-12	1	2, 8, 9, 12, 13, 15, 25, 34	Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012
08-01-12	2	- -	• Corrected KePRO acronym • Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012
08-01-12	3	1, 28, 38, 41 11, 2, 29	• Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012 • Updated hyperlinks
08-01-12	5	1 5 7	• Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012 • Removed fax request information for SCDHHS forms • Added SCDHHS forms online order information • Updated telephone number for Greenville county office
08-01-12	Forms	-	• Deleted forms 140 and 142

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Date	Section	Page(s)	Change
			• Updated Duplicate Remittance Advice Request Form, OOS Referral Package, Transplant Prior Authorization Request Form and Instructions
08-01-12	Appendix 1	- 1, 24, 60, 65, 66-67,70-72 15, 31, 69 8, 10, 29, 31 10, 11, 14, 34, 48	• Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012 • Replaced CARC 141 or CARC A1 for edit codes 52, 053, 517, 600, 924-926, 929, 954, 961, 964, 966, 967, 969, 980, 985-987 • Added edit codes 349, 590, 978, 990, 991-995 • Deleted edit codes 166, 205, 573, 574, 593, 596 • Updated resolution for edit codes 170-172, 171, 174, 210, 321, 711, 798
08-01-12	Managed Care Supplement	1-2 7 11 17 19	• Changed Division of Care Management to Bureau of Managed Care • Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012 • Removed language limiting enrollment to 2500 members • Update contact information for Palmetto Physician Connections • Added to “Medicaid” to BlueChoice HealthPlan
08-01-12	TPL Supplement	5, 6, 10,17, 24	Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012
07-09-12	2	68	Updated EPDST schedule to reflect Medicaid Bulletin dated June 14, 2012
07-09-12	6	-	New section for Birth Outcomes Initiative (reference Medicaid Bulletin dated July 9, 2012
07-01-12	Appendix 1	16, 48 45	• Deleted edit codes 386 and 868 • Added edit codes 837, 838, 839
07-01-12	Appendix 2	-	Updated carrier codes
07-01-12	CCR	5	• Added section 2 update to Psychiatric and Counseling Services for July 1, 2011
06-01-12	2	1, 174	• Removed reference to IVRS

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		107,108, 120, 146, 166, 167, 171-177, 107 135 146-147 165 166 170 171 173 174 182 200-201	• Updated document to reflect Medicaid Bulletin dated May 15, 2012 replacing Alliant Health Solutions with Keystone Peer Review Organization, Inc. (KePRO) • Updated language in the following sections: o Hysterectomies o Part III – Ocular Surgery o Physical Medicine and Therapy o Cosmetic Procedures o Prior Authorization for Mammaplasty and Mastectomy and Reconstructive Procedures o Male Genital System o Prior Approval for Hysterectomy o Points of Emphasis for Prior Authorization o Organ Transplantation o Spinal Cord Neurostimulators Ancillary and Other OOS Services
06-01-12	4	12, 18, 13 18 20	• Updated document to reflect Medicaid Bulletin dated May 15, 2012 replacing Alliant Health Solutions with Keystone Peer Review Organization, Inc. (KePRO) • Deleted code 21899 and 22899 • Updated CPT Codes Requiring Prior Authorization Review • Updated CPT Codes Requiring SCDHHS Prior Authorization Review • Added new sections for PT/OT/ST CPT codes transplant code requiring Prior Authorization by KePRO and Transplant
06-01-12	Forms	-	• Deleted DHHS 1729, Hysterectomy Acknowledge (form, instructions and sample) • Updated the following forms to reflect Medicaid Bulletin dated May 15, 2012 replacing Alliant Health Solutions with Keystone Peer Review Organization, Inc. (KePRO): o Surgical Justification Review for Hysterectomy (form and sample) o Transplant Prior Authorization Request (form and instructions) o Mental Health Form o Psychiatric Prior Authorization Form -

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
			Inpatient
05-01-12	3	8-9	Updated place of service keys
05-01-12	Appendix 1	62	Updated edit code 975
04-01-12	1	4	Replaced South Carolina Healthy Connections card
04-01-12	5	11	• Updated address for Marion County • Updated phone number for Newberry County
04-01-12	Fee Schedules	-	Updated all fee schedules except Physicians & Family Practice
02-07-12	Cover	-	Manual cover updated January 1, 2012
02-07-12	Appendix 1	18 24 30	• Updated edit code 402 • Updated edit code 544 • Updated edit code 636, 637, and 642
02-01-12	3	24, 26	• Added a note regarding The Web Tool • Updated the Remittance Advice -835 Transaction
02-01-12	5	9	Updated the Fairfield county office number
02-01-12	Appendix 1	18 30 42 49	• Updated edit code 402 • Updated edit code 636, 637, and 642 • Updated edit code 766 • Updated edit code 867
01-01-12	1	2-5, 20, 24	Deleted IVRS Information per “Retirement of Toll Free Eligibility Verification Line” bulletin released 11-18-11
01-01-12	2	4, 16, 128	Deleted IVRS Information per “Retirement of Toll Free Eligibility Verification Line” bulletin released 11-18-11
01-01-12	3	- 27	• Updated hyperlinks throughout section • Updated EFT information
01-01-12	5	1	Deleted IVRS Information per “Retirement of Toll Free Eligibility Verification Line” bulletin released 11-18-11

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Date	Section	Page(s)	Change
01-01-12	Appendix 1	62 -	• Deleted IVRS Information per "Retirement of Toll Free Eligibility Verification Line" bulletin released 11-18-11 • Updated CARCs and RARCs throughout the document
01-01-12	Managed Care Supplement	9	Deleted IVRS Information per "Retirement of Toll Free Eligibility Verification Line" bulletin released 11-18-11
01-01-12	TPL Supplement	2	Deleted IVRS Information per "Retirement of Toll Free Eligibility Verification Line" bulletin released 11-18-11
12-01-11	2	70 85	• Updated Prescription policy • Added Alcohol and Drug Testing policy to reflect Medicaid Bulletin dated November 3, 2011
12-01-11	4	12 18	• Deleted codes 22551 and 22552 • Added codes 22551 and 22552
11-10-11	2	36	Deleted reference to Q0091 in first paragraph
11-04-11	2	30 41 55 63 105 147 220 227	Updated the following policies • Xolair • Botox • VAFAC • Developmental Screening • Reimbursement Policy codes • Birthing Centers • Chiropractic services • Synagis Vaccine • FQHC Rate • Division of Ancillary Reimbursement
11-04-11	4	6 12 20 30	• Deleted code 47719 • Updated codes 22551 and 22552 • Updated Med Solutions Policy • Updated Prior Authorization Review
11-01-11	1	24	Updated TPL contact information
11-01-11	3	35, 38,	Updated TPL contact information

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		45, 46	
11-01-11	TPL Supplement	6, 15 12 3, 17, 19	• Changed Medicare timely filing requirement to two years and six months • Deleted policy to use Medicaid legacy provider number on the same line as the Medicaid carrier code • Deleted sample legacy number from UB-04 TPL Fields table • Updated TPL contact information
10-01-11	2	21 36, 94	• Deleted Telepsychiatry section and added Telemedicine policies • Deleted policies for Q0091
10-01-11	4	38	Deleted procedure code Q0091 from Family Planning codes
10-01-11	Fee Schedule	5	Deleted procedure code Q0091
10-01-11	Appendix 1	14, 29 47	• Added edit codes 334 and 584 • Updated edit code 845
09-01-11	Fee Schedules		Updated the fee schedules for the 07/11/2011 effective date, by categorizing them into the following four documents: • Family Practice • OB/GYN • Other • Injectables
09-01-11	1	19	Deleted information regarding National Correct Coding Initiative
09-01-11	5	12	Updated zip code for Spartanburg County office
09-01-11	Appendix 1	15, 29, 30	Added edit code 361, 591, 596 and 605
08-01-11	3	-	Updated language throughout section to reflect the current billing policies including claim processing, claim submission, and copayments
08-01-11	Appendix 1	8	Updated edit codes 165 and 166

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
08-01-11	Appendix 3	1	Updated the copayment schedule per the bulletin effective July 11, 2011
08-01-11	Managed Care Supplement	1, 5	Updated to reflect the new beneficiary copayment requirements in accordance with Public Notice posted July 8, 2011
07-01-11	2	89 115 195- 214-219 220 220-221	• Deleted Laboring Services • Updated Psychiatric and Counseling Services • Updated Radiology and Nuclear Medicine • Updated, added, and deleted language to Rural Health Clinics (RHC) • Updated RHC Reimbursement Methodology • Wrap-Around Payment Methodology
07-01-11	4	20	Updated to reflect Medicaid Bulletin dated May 17, 2011 – Prior Authorization (PA) for High-Tech Radiology Service
07-01-11	5	12	Deleted PO Box address for the Spartanburg County Office
07-01-11	Forms	-	• Updated Mental Health Form
07-01-11	Appendix 1	12 43 56	• Updated resolution for edit code 300 • Added edit codes 840 and 841 • Updated Provider Enrollment Contact information in edit codes 941 and 944
07-01-11	Appendix 3	1	Updated the copayment schedule per the bulletin effective July 8, 2011
06-15-11	4	21	• Change Family Planning Waiver Diagnosis Codes heading to Family Planning Eligibility Category Diagnosis Codes
06-01-11	2	35-36	• Updated the following sections to reflect Medicaid Bulletin dated February 18, 2011- Assurance for All Children (VAFAC) Program Revised Billing Procedures for Vaccine: o Immunization o Influenza Vaccine • Updated the following sections to reflect Medicaid

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		106-107 112 202 205	Bulletin dated March 25, 2011 – State Eligibility Option for Family Planning Services: o Family Planning Eligibility Category Only (formerly Family Planning Waiver) o Billing Note for Sterilization and Other Related Procedures o Billing and Coding Requirements o Billing Notes
06-01-11	4	1, 3-8 19 41, 43 52-53	• Assistant Surgeon Codes: o Added 15847, 19303, 19304, 19305, 19306, 19307, 33254, 33255, 33256, 35302, 35303, 35304, 35305, 35306, 35537, 35538, 35539, 35540, 35637, 35638, 47719, 48105, 48548, 49203, 49204, 49205, 51102, 55875, 58957, 57958, 67041, 67041, 67043 o Deleted 19180.19182, 19200, 19220, 19240, 33253, 35381, 35507, 35541, 35546, 35641, 44152, 44153, 47716, 48005, 48180, 49200, 49201, 51010, 55859, 67038 • Deleted the following CPT Codes that require SCDHHS prior authorization review: A9605, J0128, J1785 • Procedure Codes for Anesthesia: o Changed anesthesia procedure code 00797 units from 11 to 8 o Deleted code 01905 o Added codes 01935 and 01936 • Deleted codes D0120-D7510 from Surgical Package Codes – Covered Class "S"
06-01-11	5	5	Corrected Abbeville County PO Box Zip+4 Code
05-01-11	1	8, 11	Added language prohibiting payment to institutions or entities located outside of the United States
05-01-11	2	7 66	• Added new section – Services Outside of the Country • Updated prescription copayment language
05-01-11	Appendix 1	43	Updated edit code 796
04-11-11	Fee	-	Updated fee schedules to reflect Medicaid Bulletin

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
	Schedules		dated April 7, 2011 – Medicaid Rate Reduction
04-01-11	3	3, 4	Updated Copayment Policy to reflect bulletin dated 3-16-11
04-01-11	5	6	Updated telephone number for Beaufort County
04-01-11	Forms	-	• Updated Electronic Funds Transfer Form • Added Circumcision Prior Authorization Form
04-01-11	Appendix 3	-	Updated copay amounts to reflect bulletin dated 3-16-11
03-16-11	2	35 36, 227, 232, 235, 239 38, 183 137-140 222	• Added VAFAC Vaccine CPT Codes • Updated Influenza vaccine codes • Updated routine newborn circumcision policy • Updated vision services policies • Updated pediatric services for beneficiaries over 21
03-16-11	4	3-8 20	• Deleted Assistant Surgeon codes 33861, 35454, 35456, 35459, 39502, 39520, 39530, 39531, 43324, 43326, 64573, 93510, 93511, 93514, 93524, 93526, 93528, 93529, 93539, and 93540 • Added CPT codes 54150, 54160, and 54161
03-01-11	1	7, 9	Updated to reflect Medicaid Bulletin dated February 9, 2011 – Provider Service Center
03-01-11	2	6, 16, 204, 216, 220	Updated to reflect Medicaid Bulletin dated February 9, 2011 – Provider Service Center
03-01-11	3	22, 27, 28	Updated to reflect Medicaid Bulletin dated February 9, 2011 – Provider Service Center
03-01-11	5	4 5	Updated to reflect Medicaid Bulletin dated February 9, 2011 – Provider Service Center Added toll free number for Aiken County
03-01-11	Appendix 1	-	Added SCDHHS Medicaid Provider Service Center (PSC) information at top of each page in header

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		67	section Made change to Edit Code 990 description
03-01-11	Appendix 2	-	Updated alpha and numeric carrier code lists to reflect Web site update on 12/14/10
03-01-11	TPL Supplement	17 24, 25	• Changed the name of the Provider Outreach Web site to Provider Enrollment and Education • Updated the descriptions for Form130s
02-01-11	Appendix 1	3	Added edit codes 079 and 080
01-01-11	1	7 19-20	• Updated the South Carolina Medicaid Web-based Claims Submission Tool section • Updated to reflect Medicaid Bulletin dated December 8, 2010 – Information on NCCI Edits
01-01-11	2	35 83 111-112 129 156 180, 200, 231, 238 198 199	• Added VAFAC Vaccine CPT code 90650 • Removed reference to PAID Spin Off Program from the Hospital-Salaried or Hospital-Based ER Physicians section • Added CPT codes 58700 and 58720 under the Billing Notes for Sterilization and Other Related Procedures section • Removed code 90889 from the Additional Billable codes section • Updated the diagnostic procedure codes for gastroenterology • Changed references to 2004 CPT coding to CPT in the Splints, Special Clinic Services, and Reimbursement Policy sections • Added code 80047 to list o automated multi-channel chemistry test • Updated the CPT-approved code range for organ and disease-oriented panels to
01-01-11	3	22, 25, 26 28, 29 19, 34 26	• Updated electronic remittance package information • Updated to reflect Medicaid Bulletin dated December 10, 2010 – Reporting Patient Liability on Claims • Updated to reflect Medicaid Bulletin dated December 10, 2010 – Requests for Duplicate Remittance Package

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
01-01-11	4	22-38	Updated Family Planning Waiver CPT codes chart
01-01-11	5	12	Added toll-free telephone number for Saluda county
01-01-11	Forms	-	Added Duplicate Remittance Request Form Updated the Psychiatric Prior Authorization Form
01-01-11	Appendix 1	9	Added edit codes 165 and 166
01-01-11	TPL Supplement	8, 10 8 10 13 15 15	• Removed references to Dental claims • Removed language to contact program areas for missing carrier codes • Added reference to CMS-1500 for correcting edit code 151 on the ECF • Added edit code 165 to other TPL-related insurance edit codes list • Updated Retro Medicare section to include the following: o Changed the timely filing requirement from 90 days of the invoice to 30 days o Added SCDHHS TPL recovery language • Updated the Retro Health and Pay & Chase section
01-01-11	Fee Schedules	-	Removed the Laboratory Fee Schedule
12-01-10	Cover	-	Replaced “Medicaid Provider Manual” with “South Carolina Healthy Connections (Medicaid)”
12-01-10	4	45-83 21	• Surgical Package Codes: Deleted S/F, Description, Effective Date, and Class Code columns • Updated Family Planning Waiver Diagnosis Codes
12-01-10	Appendices	-	Replaced “South Carolina Medicaid” with “South Carolina Healthy Connections (Medicaid)” in the headers
12-01-10	Supplements	-	Replaced “South Carolina Medicaid” with “South Carolina Healthy Connections (Medicaid)” in the headers
11-01-10	Fee Schedules	-	• Added the Injectable Drug Fee Schedule • Updated the Physicians Fee Schedule

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Date	Section	Page(s)	Change
11-01-10	Appendix 1	8 16 32 51 52	• Edit code 202: added information to Resolution section • Edit codes 421 and 424 deleted • Edit code 733 information updated in Resolution section: "Adjust the net charge in field" changed from 26 to 29 • Deleted edit code 959 • Deleted edit codes 962 and 963
11-01-10	TPL Supplement	3, 8, 13-14, 18-19 6, 15-17	• Updated to reflect Medicaid Bulletin dated July 8, 2010 – Transfer of the Dental Program Administration to DentaQuest • Updated to reflect Medicaid Bulletin dated September 13, 2010 – Changes to the Third Party Liability Medicare Recovery Cycle
10-01-10	1	- 1 7 10	• Removed all reference to the SCHIP program to reflect Medicaid Bulletin dated August 19, 2010 – Changes to the Healthy Connections Kids (HCK) Program • Updated Program Description section • Updated the SC Medicaid Web-Based Claims Submission Tool section to reflect Medicaid Bulletin dated July 8, 2010-Transfer of the Dental Program Administration to DentaQuest • Updated Freedom of Choice section
10-01-10	5	11	Correct McCormick county office street address
10-01-10	Forms	-	Enlarged Consent for Sterilization form
10-01-10	Managed Care Supplement	- 1 2 3 4 5 6 13	• Removed all references to the SCHIP program to reflect Medicaid Bulletin dated August 19, 2010 – Changes to the Healthy Connections Kids (HCK) Program • Updated Managed Care Overview • Updated Managed Care Organizations and Core Benefits paragraphs • Updated MCO Program ID card paragraph • Updated MHN Program ID card paragraph • Updated Core Benefits • Updated Exempt Services • Updated Overview

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Date	Section	Page(s)	Change
		17	• Deleted "Medicaid Managed" from "Current Medicaid Managed Care Organizations" heading and following paragraph
09-01-10	2	5 6, 7 34-36 62-64 65 68 70 78 79-82 102 112 115 121-126 122 124 126 127 128-129 129 129, 131 132 133 134	• Updated Paramedical Providers bullets • Updated Certified Nurse Practitioner and Clinical Nurse Specialist sections • Updated table • Replaced 0-6, 7-18, and Catchup Immunization Charts • Updated Prescriptions • Updated Prior Authorization • Deleted information on pharmaceutical information to treat erectile dysfunction (ED) • Changed code W0051 to 90801 • Replaced list of Alcohol and Drug Centers • Added "submit to Alliant Health Solutions via facsimile to 803-255-8260" • Updated Sterilization Consent Form Parts I-IV titles • Updated information for Essure Procedure • Added "submit to Alliant Health Solutions via facsimile to 803-255-8260" • Changed word "physician" to "clinician" in indicated places • Moved "Providers Qualified to Prescribe Services" section to page 121 and added third bullet listing "Psychiatric Nurse Practitioner" • Updated Providers Eligible to Bill for Services • Added third bullet under "Psychiatric Diagnostic Interview Examination" • Changed word "physician" to "Clinician" as indicated • Updated Psychological Testing section • Changed "physician" to "Clinician" as indicated • Updated Environmental Intervention for Medical Management and Individual Psychotherapy bullets • Updated Family Psychotherapy • Updated Group Psychotherapy section and changed "Physician" to "Clinician" as indicated • Updated Pharmacological Management section • Updated Additional Billable Codes and

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Date	Section	Page(s)	Change
			Counseling Services sections
		136	• Added "submit to Alliant Health Solutions via facsimile to 803-255-8260"
		137	• Updated Counseling Services section
		163	• Updated Billing Notes
		181	• Added "submit to Alliant Health Solutions via facsimile to 803-255-8260"
		190-194	• Updated QIO information replacing Qualis with Alliant Health Solutions
		218, 236	• Added DentaQuest phone number 888-307-6553
09-01-10	3		Updated the following sections to reflect Medicaid Bulletin dated July 8, 2010 – Transfer of the Dental Program Administration to DentaQuest:
		22	• Companion Guides
		23	• South Carolina Medicaid Web-based Claims Submission Tool
		40	• Claim-Level Adjustments
09-01-10	4	11, 12, 15, 18	• Changed Qualis Health to Alliant Health Solutions • Updated codes
		13	• Added fax # for Alliant Health; removed duplicate code #s 22830, 43845, 58956, and 63660
		18	• Added the following codes: 1920, 11921, 93750, A9604, J0598, J0894, J1680, J9033, J9226, 33975, 33976, 33977, 33978, 33979, 33980, 33981, 33982, 33983, 33999, 54240, 54250
		19	• Updated mailing address as indicated
		39	• Inserted Approved STI Drug List and STI Diagnosis codes
09-01-10	5	5	• Removed County Commissioner's Building from the Aiken County address
		8	• Deleted Dorchester County physical address telephone number
		11	• Removed Highway 28 N from the McCormick County address
09-01-10	Forms	-	• Updated the following forms to replace the prior approval review fax information: o Request for Prior Approval Review • Surgical Justification Review for Hysterectomy

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
09-01-10	Appendix 1	9 -	• Added edit code 225 • Removed all references to the ADA Claim in the Resolution column
09-01-10	TPL Supplement	12 13 18	• Updated the Dental Paper Claims section to delete paper claims submission instructions and added the DentaQuest contact information • Updated the Web-Submitted Claims section with the exception to Dental claims • Updated the TPL Resources section to include the DentaQuest contact information for TPL questions
08-04-10	2	27,66,67, 68,69, 70	• Corrected spelling of word “Medicaid”
08-01-10	5	5, 9, 11-13 6	• Updated the zip codes for Aiken, Edgefield, McCormick, Newberry, and Saluda counties • Updated the address for Barnwell County • Updated the telephone number for Beaufort County
08-01-10	Appendix 1	20 51, 52 59	• Deleted edit code 520 • Deleted Provider Enrollment e-mail address from codes 941 and 944 • Changed resolution for edit code 994
07-01-10	Change Control Record	1	Added entry for updating the Physicians Fee Schedule on 06-28-10
07-01-10	2	27, 42, 66-70	Changed First Health to Magellan Medicaid Administration
07-01-10	5	-	Updated telephone numbers and zip codes for multiple county offices
07-01-10	Appendix 1	32 35	• Updated edit code 714 • Updated edit code 738
07-01-10	Appendix 2	21, 22, 25, 63, 89	Changed First Health to Magellan Medicaid Administration
06-28-10	Forms	-	Updated the following forms:

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
			• DHHS Form 1723, Consent for Sterilization • Surgical Justification Review for Hysterectomy • Request for Prior Approval Review
06-28-10	Fee Schedule	-	Updated Physicians Fee Schedule
06-01-10	2	112 149 200 242	• Updated language regarding essure sterilization under Billing Notes for Sterilizations and other Related Procedures • Removed 92250 Fundus photography with interpretation and report • Under Reimbursement Methodology removed referral to DEFRA mandates • Corrected CPT code 09124 to 01924
06-01-10	4	19	Added CPT Code 93750
06-01-10	Managed Care Supplement	1 3 17 20, 23, 25	• Updated Managed Care Overview section • Updated Manage Care Organization (MCO), Core Benefits section • Updated the Managed Care Disenrollment Process, Overview section • Updated to reflect Medicaid Bulletin dated March 18, 2010—Managed Care Organizational Change
05-05-10	2	197	Updated the Reimbursement Methodology section to remove language limiting the amount carriers, providers, or private pay patients can bill Medicaid
05-04-10	2	196	Updated the Reimbursement Methodology section
05-01-10	5	1	• Removed reference to sample form at the end of this section • Replaced reference to sample form in the Forms section of this manual
03-01-10	Cover	-	Replaced the manual cover
03-01-10	Change Control Record	1	Added Time Limit for Submitting Claims Medicaid Bulletin date to sections1 and section 3 entries dated 12-01-09
03-01-10	2	12	• Replaced CMS Web site address for CCI Edit

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Date	Section	Page(s)	Change
		91	information • Updated to reflect 17 Alpha Hydroxyprogesterone Caproate policy in accordance with Medicaid Bulletin dated January 26, 2010
03-01-10	3	5, 23	Removed modem as an electronic claims transmission method
03-01-10	4	13 18 21-37	• Updated the following charts in accordance with Medicaid Bulletin dated January 29, 2010 o CPT Codes Requiring SCDHHS Support Documentation – Added A9604, J0598, J0718, J1680, J9155 o CPT Codes Requiring Prior Authorization – Added 63661, 63662, 63663, 63664 • Replaced Family Planning Waiver Diagnosis Codes and Family Planning CPT Codes charts
02-01-10	Appendix 1	13 36	• Added New Edit Codes 356,357 and 358 • Updated Edit Code 738
02-01-10	Appendix 2	All	Updated Carrier Code List
01-01-10	2	6 15 47 158 173	• Added new Direct Physician Supervision subsection • Updated to reflect co-signature policy in accordance with Medicaid bulletin dated December 17, 2009 • Under Ambulatory Care Visit Guidelines, changed eligibility inquiries to unlimited for the number of calls to the IVRS and the number of transactions per call • Updated to reflect the Visual Evoked Potential (VEP) testing policy in accordance with Medicaid bulletin dated December 21, 2009 • Updated the number of allowable chiropractic visits per year to 8 visits • Updated the Lesion Removal subsection
01-01-10	4	21	Added Family Planning codes 73830, 78656, 78657
01-01-10	5	5	• Updated Physical Address for Allendale County Office

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		10 12	• Replaced Jasper County DSS with Jasper County DHHS • Replaced Orangeburg County DSS with Orangeburg County DHHS
01-01-10	Appendix 1	49	Updated edit code 932
12-01-09	1	8 25	• Updated policy to reflect Medicaid Bulletin dated November 13, 2009 – Electronic Remittance Package • Updated Timely Filing for Submitting Claims section to reflect Medicaid Bulletin dated November 24, 2009
12-01-09	2	86 99 172 208	• Updated Ultrasound subsection • Updated Family Planning subsection • Added new Keloid/Scar Conditions subsection • Updated Retroactive Eligibility subsection
12-01-09	3	1-2 21-28	• Updated Claim Filing Timeliness section to reflect Medicaid Bulletin dated November 24, 2009 • Updated policy to reflect Medicaid Bulletin dated November 13, 2009 – Electronic Remittance Package
12-01-09	4	21	Family Planning CPT Codes list: • Added code 96372 • Deleted code 99384
12-01-09	5	8	Updated the Dorchester County office street address
12-01-09	Appendix 1	- - 18, 19 20	• Replaced CARC 17 with CARC 16 • Updated CARC A1 • Updated codes 509 and 510 • Added code 533
11-01-09	2	3	Updated policies to reflect Medicaid Bulletin dated October 12, 2009 – Qualified Medicare Beneficiaries and Physician Assistants
11-01-09	4	13, 19	Moved code J1453 to CPT codes that require SCDHHS prior authorization
11-01-09	Appendix 2	All	Updated carrier code list

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
11-01-09	Fee Schedule	-	Updated Physicians Fee Schedule
10-01-09	1	3-4 4-6 26	• Updated the Medicare/Medicaid Eligibility section to include Qualified Medicare Beneficiaries (QMBs) • Updated SC Medicaid Healthy Connections language throughout section • Updated South Carolina Medicaid Bulletins and Newsletters • Changed heading to Medicare Cost Sharing
10-01-09	2	155	Under Chiropractic Services, Covered Services, changed 12 maximum visits to 8 maximum visits
10-01-09	4	47-256	Revised the Support Documentation sections
10-01-09	5	10 11 12	• Updated physical address for Jasper County office • Updated telephone number for Lexington County office • Updated zip codes for Orangeburg County office
10-01-09	Appendix 1	3 60	• Updated edit code 065 • Updated edit code 852
09-08-09	Managed Care Supplement	20	Replaced the Absolute Total Care Medicaid beneficiary card sample
09-01-09	2	147 156	• Updated code for Cardiac Magnetic Resonance Imaging (MRI) of the Heart • Under Chiropractic Services, Covered Services, changed 12 maximum visits to 8 maximum visits
09-01-09	4	11 14 15, 16, 17	• Supporting Documentation ICD-9 Surgical Code and CPT Code list • Added code J0453 to the CPT Code Requiring Support Documentation for SCDHHS • Prior Authorization ICD-9 Surgical Codes and CPT Codes list: o Added code 03.99 o Changed code 85.60 to 85.6 o Removed code 85

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		18 19	• CPT Codes Requiring Qualis Health Prior Authorization Review list: o Added codes19316, 22899, and 69714 o Removed codes 15831 and 19140 • Added codes J9207, J9330, and Q4100 to the CPT Codes Requiring SCDHHS Review list
09-01-09	Managed Care Supplement	21 20, 25	• Removed all references to CHCcares to reflect Medicaid Bulletin dated August 3, 2009 • Updated Absolute Total Care entries as following: o Changed the company's name to Absolute Total Care o Replaced the beneficiary card samples o Corrected contact information
08-01-09	3	ii	Corrected Table of Contents formatting
08-01-09	5	14	Updated telephone number for York County office
08-01-09	Appendix 1	3	Updated edit code 062
08-01-09	Appendix 2	-	Updated carrier code list
07-08-09	2	129	Updated policies to reflect Medicaid Bulletin dated March 11, 2009 – Psychiatric and Counseling Services
07-08-09	4	18	Added procedure code 19316 to the CPT Code Requiring Qualis Health Prior Authorization Review list
07-08-09	Forms	-	Added new Psychiatric Prior Authorization Form – Inpatient
07-01-09	2	43 54-55 111-112, 121, 125, 222, 229 155	• Added notes to the Forensic Medical Evaluations HCPCS chart • Updated administration fee to $13.00 for CPT codes 90473 and 90474 • Updated policies to reflect Medicaid Bulletin dated June 5, 2009 – Modification to Psychiatric and Counseling Services • Updated policies to reflect Medicaid Bulletin dated June 5, 2009 – Modification to Chiropractic Services

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
07-01-09	4	18	Added procedure code 19340 to CPT Codes Requiring Qualis Health Prior Authorization Review list
07-01-09	5	6, 12 8 9	Updated address for Bamberg and Orangeburg County offices • Updated office zip code for Darlington County • Updated telephone number for Fairfield County office
07-01-09	Forms	-	Updated Mental Health Form
06-01-09	2	43 86	• Updated the Forensic Medical Evaluations subsection • Added Laboring Services subsection
06-01-09	TPL Supplement	19	Updated Department of Insurance Web site address
05-01-09	1	1-6, 11 2 3 5 28-33	• Updated to reflect managed care policies and procedures effective May 1, 2009 • Updated the Eligibility subsection • Added the beneficiary contact telephone number to the South Carolina Healthy Connections Medicaid Card subsection • Removed the program start date from the SC Healthy Connections Kids SCHIP Dental Coverage subsection • Updated the Medicaid Program Integrity subsection
05-01-09	2	1-2, 109, 154, 177, 180, 206 35, 36, 38-42, 94 129	• Updated to reflect managed care policies and procedures effective May 1, 2009 • Replaced the following Pediatrics and Neonatal procedures codes: 99293-99296, 99431 - 99435, 99440 • Deleted the following Pediatrics and Neonatal procedures codes: 90918-90921 and 90922-90925
05-01-09	5	14	Updated telephone number for Union County office
05-01-09	Appendix 1	43	Deleted edit code 694

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
05-01-09	Appendix 2	-	Updated list of carrier codes
05-01-09	Managed Care Supplement	-	Updated supplement to include general policies and procedures effective May 1, 2009
04-01-09	1	2, 3, 8	Updated hyperlinks
04-01-09	2	31 42-43 111-112, 121, 125, 222-225, 230-233	• Updated policies to reflect Medicaid Bulletin dated March 4, 2009 – Medicaid Eligibility and Services Updates • Updated Forensic Medical Evaluations subsection • Updated policies to reflect Medicaid Bulletin dated March 4, 2009 - Psychiatric and Counseling Services
04-01-09	3	4, 6, 7, 10, 21, 22, 27, 35, 38	Updated hyperlinks
04-01-09	4	11-12 15-16	• Replaced “Supporting Documentation Diagnosis Codes” heading with “Supporting Documentation ICD-9 Surgical Codes and CPT Codes” • Replaced “Prior Authorization Diagnostic Codes” heading with “Prior Authorization ICD-9 Surgical Codes and CPT Codes”
04-01-09	5	11	Updated telephone number for Lexington County office
04-01-09	Forms	-	Added Mental Health Form
03-06-09	4	13, 18, 15	Corrected the following Qualis Health Prior Authorization lists: • Qualis Health Support Documentation o Added codes 54235, 54240, 57292, and 63650 • ICD-9 Qualis Health Prior Authorization Review o Added code 03.09 o Changed code 71.90 to 71.9 o Added code 03.09 • Qualis Health Prior Authorization Review

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
			o Changed code 52435 to 54235 o Added codes 54240, 57292 o Removed duplicate code 63170
03-01-09	2	43 180, 182	• Updated Forensic Medical Evaluations subsection to reflect Medicaid Bulletin dated February 13, 2009 • Updated Organ Transportation subsection to reflect Medicaid Bulletin dated February 18, 2009
03-01-09	5	4 8 5, 11-13	• Updated hyperlink • Corrected Dorchester County's Orangeburg Road telephone number • Change DSS to DHHS in addresses for Abbeville, McCormick, Newberry, and Saluda counties
03-01-09	Forms	-	• Added new Transplant Prior Authorization Form • Removed outdated Out-of-Service Referral Form to reflect Medicaid Bulletin dated February 18, 2009
03-01-09	Appendix 1	43 72	• Added new edit codes 693 and 694 • Changed edit code 945 Resolution to input "26"modifier in field 18
03-01-09	Managed Care Supplement	1, 7, 10, 17, 23, 25-30, 35	Updated hyperlinks
03-01-09	TPL Supplement	8, 9, 19	Updated hyperlinks
02-04-09	2	5 12-15 24, 26, 33, 34, 87 42-43 130 131 134-138	• Changed Medicaid ID number to NPI number • Updated Ambulatory Care Visit Guidelines • Changed code 90772 to 96372 • Added Forensic Medical Evaluations subsection • Updated Ophthalmology and Optometry subsection • Updated Exam and Glasses for Beneficiaries Age 21 and Over subsection to reflect verbiage change for post-surgical lens and medical necessity • Updated vision policy to reflect Medicaid Bulletin

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		224	dated December 19, 2008 • Changed Dental program manager telephone number
02-04-09	4	15-18	Updated Qualis Prior Authorization codes to reflect Medicaid bulletin dated January 15, 2009
02-04-09	5	5	Updated Allendale County office PO Box zip code
02-04-09	Forms	-	Updated Authorization Agreement for Electronic Funds Transfer (EFT) form
02-04-09	Appendix 2	-	Updated list of carrier codes revised 02/01/09
01-01-09	1	8	Updated hyperlink for bulletin.scdhhs.gov
01-01-09	2	30, 219, 225 219, 225	• Changed adult physical exam frequency from every two years to every five years • Changed code range for adult physical exam from 99391-99394 to 99391-99395
01-01-09	4	18	Added procedure codes 19342 and 52435
01-01-09	5	11	Updated Lee County office address
12-01-08	2	94, 149, 150, 168, 169, 170, 175-179, 187	Made revisions to reflect InterQual information
12-01-08	4	-	Added and deleted various codes in the Prior Authorization and Supporting Documentation from Qualis Health procedure code and diagnosis codes sections.
11-01-08	1	8	Added e-bulletin information to reflect Medicaid Bulletin dated August 26, 2008
11-01-08	2	-	Removed codes S4989 and 90657
11-01-08	2	118-120 208	• Revised verbiage for Psychiatric Counseling Services section • Out-of-state services – revised address and

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Date	Section	Page(s)	Change
		209	verbiage • Revised verbiage and added chart for Ancillary and Other OOS Services section
11-01-08	3	25, 27	Added EFT information to reflect Medicaid Bulletin dated August 26, 2008
11-01-08	4	19	Removed code S4989
11-01-08	Forms	-	Added the Out-of-State Referral Form
10-01-08	3	29	Changed ECF field 1 to Prov/Xwalk ID
10-01-08	4	17	Added procedure codes 58570, 58571, 58572, 58573
10-01-08	5	9, 13	• Updated address for Lake City • Updated phone number for Sumter County office
10-01-08	Forms	-	• Revised ECF example to show update for field 1 • Revised the DHHS Pediatric Sub-Specialist Certification Form
10-01-08	Appendix 1	-	Updated edit codes 007, 059, 112, 219, 308, 339, 386, 403, 710, 722, 786, 798, 799, 843, 844, 845, 912, 914, 928, 941, 942, 943, 945, 952
09-01-08	2	4 89 92 93 105 225 231 232	• Revised definition of Licensed Midwife • Deleted Birthing Centers section • Added 59409 with TC modifier and Observation for Maternity/Labor information • Added Mirena J7302 coverage information • Changed Essure Sterilization BMI to 35 • Added code J7307 • Added code J7307 • Added Pediatric Anesthesia Services section
09-01-08	4	13-14 17	• Deleted 36 Support Documentation procedure codes • Deleted 3 Prior Authorization procedure codes
09-01-08	5	6	Updated phone number for Berkeley County office
09-01-08	5	10	Updated phone number for Kershaw County office

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Date	Section	Page(s)	Change
09-01-08	Forms	-	Added revised Pediatric Sub-specialist Certification form
09-01-08	Appendix 1	17	Added Edit Code 318
08-01-08	2	- 108	• Corrected document formatting • Added Psychiatric and Counseling Services Information
08-01-08	5	7	Deleted PO Box for Chester County
08-01-08	Appendix 1	3	Updated Edit Code 062
07-01-08	5	11	Deleted PO Box for Lancaster County
07-01-08	Managed Care Supplement	27	Replaced Web site address for BlueChoice
06-01-08	3	10, 18, 20, 21, 27	Updated NPI policy and form instructions to reflect May 23, 2008, deadline requiring NPI only on claims for typical providers
06-01-08	5	12	Updated telephone number for Orangeburg county office
06-01-08	Forms	-	Updated the following forms to reflect May 23, 2008, deadline requiring NPI only: • Pediatric Sub-Specialist Certification • Request for Prior Approval Review • Surgical Justification Review for Hysterectomy
06-01-08	Appendix 1	30, 39, 42	• Added new edit code 529 • Deleted NPI warning edits 578, 579, 580, 581, 582, 583, 692
06-01-08	TPL Supplement	-	Updated Example Dental Claim Form Reporting Third-Party for Medicare Information to show NPI only; change/removed sample entries for fields 8, 15, 23, and 49; and added a tooth number to line 4
05-01-08	Managed Care	-	Revised supplement to include general policies and procedures effective May 1, 2008 and updated the

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
	Supplement		SCDHHS-approved MCO contractors section
04-01-08	2	14	• Updated Medical Necessity Guidelines for ambulatory care visits
		17	• Updated Exceptions to the 977 Edit section
		22	• Deleted Case Management Services section
		29	• Added instructions for faxing prior approval requests for Boxtox® (JO585, Botulinum Toxin Type A) and Myobloc® (Botulinum Toxin Type A)
		37	• Changed adult physical exam frequency from every five years to every two years
		43	• Deleted code 99501 for Newborn Care Billing Notes
		48	• Deleted code X0401 for additional neonatology services
		51	• Changed reference section from “EPSDT Resources” to “Reimbursement Policies”
		59	• Added oral health training module Web sites to EPSDT Required Services section
		83	• Deleted Telephone Referral section from Alcohol and Drug Abuse Rehabilitation Services section
		94	• Changed code range for administrative days from 99304-99340 to 99304-99337
		109	• Changed HCPCS code from S0180 to J7307 for Etonogestrel Implant (Implanon™) Coverage
		112-118	• Updated Family Planning section
		134	• Deleted verbiage and description for CPT code 99371, supervising allied professionals
		134, 136	• Added physical location requirement for physicians (including physicians not specializing in psychiatric care) who supervise allied professionals
		146	• Prescription Request section: o Changed address for Robertson Optical Lab o Updated Prescription Request Form instructions
		165	• Added adult age limit for reimbursement of Physical Medicine and Therapy services
		253	• Changed adult physical exam frequency from every five years to every two years
04-01-08	4	1-3	• Deleted Injection Code and Chemotherapy Code

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Date	Section	Page(s)	Change
		14 18	lists • Updated the CPT Codes Requiring Support Documentation for SCDHHS list • Replaced the CPT Codes Requiring SCDHHS Prior Approval Review list
04-01-08	5	8	Updated address and phone number for Dorchester County office
04-01-08	Appendix 1	4, 13, 20, 33	Added new edit codes 062, 219, 339, 528
04-01-08	TPL Supplement	2 3, 8, 15 12 29	• Updated reference to Medicaid card name • Changed references to location of forms from Section 5 to Forms section • Updated field numbers for occurrence codes on UB-04 • Replaced sample ADA form with more attractive version
03-01-08	1	3-5 7	• Replaced sample Partners for Health Medicaid card with new Healthy Connections card and updated card information. • Deleted information about location of supervising entities – requirements will be included in Section 2 where applicable
03-01-08	3	10-22 All	• Updated NPI policy and form instructions to reflect March 1, 2008, deadline requiring NPI on claims for typical providers (with or without Medicaid legacy number). • Standardized formatting
03-01-08	Forms	-	Replaced Form 931 with new version dated January 2008
03-01-08	Appendix 1	59 70	• Added edit code 808 • Revised edit code 943 description and status (from warning to active)
03-01-08	TPL Supplement	9 21-22	• Added information on carrier code “CAS” for open casualty cases • Replaced Form 931 samples with new versions

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
02-01-08	3	13 31, 34 47	• Corrected instructions for field 10b • Standardized references to six-character legacy Medicaid provider number • Corrected mailing address for refunds
02-01-08	5	1	Removed "including Partners for Health" from first paragraph
02-01-08	Forms	-	• Updated bookmarks for forms • Updated mailing address for Medicaid Refunds Form 205
01-01-08	5	10	Updated address for Lancaster County office
01-01-08	Managed Care Supplement	1 3	• Removed PhyTrust from the list of MHNs • Added Carolina Crescent to the list of MCOs
12-01-07	5	8, 10, 12	• Updated addresses for Edgefield, Lancaster and Oconee County offices • Updated zip code for Kershaw county
11-01-07	2	15-16, 37, 51, 53-54, 61-62, 122	Updated policies to reflect Medicaid Bulletin dated October 10, 2007
11-01-07	4	5-34	Separated Covered and Non-Covered Surgical Package procedures and added subheadings to Table of Contents
11-01-07	5	9, 10 10	• Updated telephone numbers for Florence and Kershaw counties • Updated Horry County address to 1601 11th Ave., 1st Floor
11-01-07	Forms	-	Updated DHHS Form 17623, Consent for Sterilization
11-01-07	Change Control Record	1	Added SILVERxCARD deletion to 10-01-07, Section 2 changes
11-01-07	Appendix 1	All	• Corrected ECF field numbers throughout edit resolution instructions

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
			• Added new edit code 107
11-01-07	Appendix 2	All	Updated list of carrier codes
10-01-07	1	1-2 3 4 12 15 25	• Removed PEP information • Added information about managed care enrollment broker and Managed Care Supplement • Removed managed care sample cards (cards and other information will appear in the new Managed Care Supplement). • Clarified that "days" refers to business days • Clarified which sections of manual may contain PA information • Expanded provider list under Program Integrity
10-01-07	2	1-2, 51, 223 70 184 187	• Removed PEP information • Remove reference to SILVERxCARD copayment schedule • Changed Musculoskeletal System to Prior Authorization for Mammaplasty and Mastectomy and Reconstructive Procedures • Inserted Musculoskeletal System subheading after Prior Authorization for Mammaplasty and Mastectomy and Reconstructive Procedures
10-01-07	3	15, 47	• Removed PEP information • Added 90-day time limit for reversing refunds
10-01-07	4	-	Corrected document formatting
10-01-07	Appendix 1	26 38-40, 43, 70	• Corrected description for edit code 502 • Added NPI warning edits 578-583, 692, 943
10-01-07	-	-	Added Managed Care Supplement
10-01-07	TPL Supplement	15-17	• Added 90-day time limit for reversing refunds • Added information on Part B timely filing schedule to explain which claims are pulled into Retro Medicare
09-01-07	2	17	• Under Ambulatory Care Visit Guidelines, removed

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
			"office" from consultation examination
		29	• Under Nursing Home/Rest Home Facility Services, Visit Guidelines, changed CPT codes
		38	• Under Cancer Screening Services, add code G0121 for low-risk clients
		60	• Updated policy on fluoride varnish treatment to reflect Medicaid Bulletin dated July 16, 2007
		129	• Under Psychiatry, removed code 90802 from Note
			• Under Medicare/Medicaid – Dual Eligibility, changed the program manager telephone number
		137 192	• Under Urinary System (50010 – 53899), changed WJ modifier to 99 modifier
		201	• Updated policy on the cost of corneal tissue to reflect Medicaid Bulletin dated June 25, 2007
		202	• Updated policy on Group II transplants to reflect Medicaid Bulletin dated June 27, 2007
		220	• Under Billing and Coding Requirements, changed WJ modifier to 99 modifier
		260	• Updated policy on Pediatric Sub-Specialist requirements to reflect Medicaid Bulletin dated July 31, 2007
		261-283	• Updated policy to delete Physicians Enhanced Program (PEP) in accordance with Medicaid Bulletin dated July 13, 2007
09-01-07	4	5	• Updated Surgical Package Codes list
		50-53	• Updated Support Documentation Codes list and added Qualis Health and SCDHHS forwarding addresses
		54-57	• Updated Support Documentation Codes list and added Qualis Health and SCDHHS forwarding addresses
		58	• Under Family Planning Waiver Diagnosis Codes, changed the sterilization diagnosis code
07-01-07	1	-	Revised policies and procedures throughout section
07-01-07	4	41, 43	Inserted updated prior authorization and support documentation ICD-9 and diagnosis codes from Section 2
07-01-07	Forms	-	Updated DHHS Form 205

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Date	Section	Page(s)	Change
07-01-07	Appendix 2	-	Updated list of carrier codes
06-01-07	3	All	• Removed Time Restricted Supplement • Updated form completion instructions for new CMS-1500 and Form 130 versions • Updated ECF and RA descriptions • Added information about National Provider Identifier • Replaced Reference to Forms 110 and 120 with Form 115 • Clarified retroactive eligibility policy • Updated ECF correction instructions • Added CPT and HCPCS ordering information • Made minor editorial changes throughout section
06-01-07	5	3-4 6-8 12 -	• Revised "Procurement of Forms" to address new CMS-1500 and updated vendor information • Added toll-free numbers for Berkeley, Charleston and Dorchester county offices • Updated phone number for Oconee County • Split forms and exhibits from Section 5 to create Forms section
06-01-07	Forms	-	• Updated DHHS forms to add National Provider Identifier field • Updated sample claims to new CMS-1500 version • Updated ECF and remits to new versions • Updated Pediatric Sub-Specialist Certification Form, Request for Prior Approval Review, and Surgical Justification Review for Hysterectomy
06-01-07	Appendix 1	-	Updated list of edit codes
06-01-07	TPL Supplement	All	• Updated all sample forms and claims with new versions • Updated form completion instructions to match new form versions
05-02-07	2	34 38 51	• Updated policies on Synagis® to reflect Medicaid Bulletin dated October 3, 2006 • Changed procedure codes in table for sigmoidoscopy and screening colonoscopy • Deleted Multi Channel Testing—Physician

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Date	Section	Page(s)	Change
			Interpretation
		53	• Removed paragraph on SCDHEC and Child Health Maintenance Course from Enrollment Prerequisites
		61	• Add statement “children under the age of 19” in Immunizations for clarity
		63-65	• Under Reimbursement Policies: o Removed paragraph on vaccine administration and added verbiage including codes 90473 and 90474 to reflect Medicaid Bulletin dated 03/30/07 o Added Indicator “N” under Reimbursement Policies to reflect Medicaid Bulletin dated 03/30/07
		99	• Add verbiage to Ultrasounds to reflect Medicaid Bulletin dated 03/28/07
		113-117	• Complete revision of the Family Planning
		120	• Separated the signature and date requirements under Sterilization Consent Form for clarity
		141	• Removed extra section heading under Exam and Glasses for Age 21 and Over
		142	• Changed Exam and Glasses for Age 21 and Over section heading to Guidelines for Lenses and Frames
		142	• Listed trifocals and executive bifocals separately
		143	• Added new paragraph at the of the Vision Non-Covered Services section for lens replacement of non-Medicaid frames
		163	• Add new section, Gastrostomy Button Device Feeding Tube Kit to reflect Medicaid Bulletin dated 03/30/07
		171	• Replaced verbiage under Neurology section to reflect Medicaid Bulletin 03/30/07
		177	• Added new verbiage at the end of the first paragraph for multiple procedure reduction under Payment Guidelines section
		198	• Removed codes 19301 – 19307 from the CCME prior authorization list
05-02-07	4	1-4	• Reformatted the Injection Code list and Chemotherapy Drug codes list

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Date	Section	Page(s)	Change
		5-28, 41-42 45-46 47-50	• Updated Surgical Package, Support Document, Prior Authorization procedure codes • Added Family Planning CPT and diagnosis codes • Added Anesthesia procedure codes and corresponding base units
05-02-07	Appendix 1	-	Updated list of edit codes
05-02-07	Fee Schedules	All	Replaced the Physicians Fee Schedule for 2007
04-01-07	5	8	Updated phone number for Darlington county office
04-01-07	Appendix 1	-	Updated list of edit codes
04-01-07	Appendix 2	-	Updated list of carrier codes
04-01-07	Time Restricted Supplement	-	Updated date for mandatory use of revised CMS-1500
03-01-07	2	66-67 114 143-144 204 242 261-262	• Updated Children and Adolescents Immunization Schedules • Changed verbiage in Department of Health and Environmental Control and Initial Family Planning and Follow-up Exams sections • Changed “Dispensing Codes and Fees for Contact Lenses” to “Dispensing Codes for Contact Lenses and Glasses” • Added new paragraph in Corneal Transportation section to reflect bulletin dated December 13, 2006 • Added new section: Positron Emission Tomography (PET) Scans to reflect bulletin dated January 19, 2007 • Added new section: Pediatric Sub-Specialist Program Participation Requirements to reflect bulletin dated November 30, 2006
03-01-07	5	6	• Updated Barnwell county office address • Added DHHS Pediatric Sub-Specialists Certification form

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Date	Section	Page(s)	Change
03-01-07	Time Restricted Supplement	All	Removed all references to NDC quantity and unit
03-01-07	Appendix 1	-	Updated list of edit codes
02-01-07	TPL Supplement	31-32	Updated ECF Samples to show third payer line
01-01-07	2	31, 32, 34 37 38 39 79 99 111 112 114, 116, 248, 250, 251, 255, 257, 258 136 155 158 161 182 196	• Updated sections to remove pricing of Botox, Mybloc, Xolair, Synagis • Changed code 76092 with 77057 • Added codes 82271 and 82272 to Hemocult Test • Changed code 76092 with 77057 • Removed "4th Floor" from the address for DME inquiries • Updated venipuncture information to match the system limits • Removed reference to Norplant as no longer covered since 2004 • Changed Family Planning Waiver from 22 months to 10 months • Removed references to Norplant • Changed "Providers must notify the ESRD program manager…" to "Providers must notify their program manager…" • Changed code 95078 to 95075 • Added the following statement to clarify of acne diagnosis code 706.1 documentation: "Support documentation is not required for billing purposes; however, the patient's record must clearly document the condition and medical necessity." • Changed code 15831 to 15830 and added the correct CPT information • Changed code range 17304 – 17310 to range 17311-17315 • Added the Moh's Technique 2007 definitions • Changed code 19140 to range 19300 – 19307 • Deleted code 15831

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Date	Section	Page(s)	Change
		197 265	• Added codes 15830 and 15847 with definitions • Deleted codes 19140 • Added codes 19300 – 19307 • Updated code 19361 • Changed description for procedure code 17000
01-01-07	3	-	Added Time Restricted Supplement
01-01-07	5	-	Added line “03” to sample ECF for the third payer declaration
01-01-07	Appendix 1	9, 14	Added Edit Codes 202, 203, 204, 301
01-01-07	Appendix 2	-	Updated list of carrier codes
11-01-06	2	- - 2 56 201	• Change “S.C. Medicaid” to South Carolina Medicaid • Changed “DHHS” and “DHEC” to SCDHHS and SCDHEC, respectively • Managed Care Overview – Added prior authorization criteria • Changed “12- and 24-months of age” to “9- and 24-months of age” • Points of Emphasis for Prior Authorization o Updated prior authorization criteria o Change “Better Health Plan” to “Unison Health Plan of South Carolina”
11-01-06	2	41-43, 57, 63	Updated policies to reflect Medicaid Bulletins dated September 19, 2006 and October 9, 2006.
11-01-06	5	-	Updated county office addresses
10-01-06	2	6, 18, 37-38, 44, 138, 140, 146, 162-163, 194, 203-204	Updated policies to reflect Medicaid Bulletins dated June 21, 2006; July19, 2006, and July 28, 2006
10-01-06	5	-	Updated county office addresses
10-01-06	Appendix 2	-	Updated list of carrier codes

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Date	Section	Page(s)	Change
09-01-06	5	-	Updated county office addresses
09-01-06	Appendix 1	10, 11, 13 15, 17, 18 22, 23, 24 26, 27, 28 29, 30, 31 32, 35, 36 39, 40, 41 42, 46, 47 48, 49, 50 52, 58, 60 61, 62, 63 66, 67	• Updated CARCs for edit codes 504, 561, 562, 563, 636, 923, 940, 949 • Updated RARCs for edit codes 207, 208, 227, 234, 239, 263, 317, 369, 377, 421, 501, 504, 505, 507, 508, 515, 541, 545, 553, 564, 570, 672, 674, 709, 714, 719, 721, 722, 748, 749 • Updated resolutions for edit codes 761, 764, 765 768, 769, 771, 772, 773, 774 • Added new edit codes 518, 724 • Deleted edit code 777
08-01-06	-	-	Added TPL Supplement
08-01-06	5	-	Updated Reasonable Effort Documentation form
07-01-06	2	65-66 188	• Updated the Children and Adolescents Immunization Schedules • Updated CCME telephone number for prior authorizations
07-01-06	Appendix 1	23, 60, 61	Updated resolution for edit codes 504, 923, 940
07-01-06	Appendix 2	-	Updated list of carrier codes
05-02-06	2	-	Updated policies to reflect bulletin dated May 1, 2006
05-01-06	Appendix 1	52	Updated resolution for edit code 852
04-01-06	2	139-146	• Changed Vision Care Services to Part I • Changed Diagnostic Ophthalmology Services to Part II • Changed Ocular Surgery to Part III
04-01-06	Appendix 1	43	Updated resolution for edit code 735
04-01-06	Appendix 2	-	Updated list of carrier codes
03-01-06	3	4, 18, 19	• Changed the Trading Partner Agreement (TPA) and the Companion Guides Web site references to www.dhhs.state.sc.us

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Date	Section	Page(s)	Change
		20 25 25 40	• Changed the Internet Explorer version required for the Web Tool to 6.0 • Added TPL indicators to the ECF field 4 description • Added Injury Code indicators to the ECF field 5 description • Changed address name for refund checks (Form 205) from Division of Finance to Cash Receipts
03-01-06	5	-	Removed "Sample Only" from Claim Adjustment Form (DHHS Form 130)
03-01-06	Appendix 1	60	Changed resolution for edit code 925
02-01-06	Appendix 1	41	Changed resolution for edit code 721
01-01-06	1	4, 5	Removed SILVERxCARD sample and program description
01-01-06	2	-	Changed "Carolina Medical Review" to "The Carolinas Center for Medical Excellence" throughout manual; updated CCME address, telephone, and fax number.
		17 21 28-29 31 40 54 62 76	Deleted Confirmatory Consultations CPT codes • Corrected Special Services/Visits – Emergency Office Services procedure code • Changed Visit Guidelines CPT code range and deleted the frequency limitations on codes • Corrected Myoblock® spelling; removed statement to bill Myoblock® using J3490 • Changed prior authorization forwarding address, fax, and telephone number to FIRST HEATLH Clinical Call Center • Added reimbursement codes for Influenza Vaccine under the VAFAC program • Added "DHHS will not reimburse for the FlueMIST vaccine product or the administration fee outside of the VAFAC program." • Replaced Lead Screening paragraph • Added Well-child care indicators for field 24H of CMS-1500 • Changed Initial Consultation and Follow-up

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
			Consultation procedure code ranges
		90-91	• Replaced Administrative Days procedure code ranges and deleted Medicaid code limitation statements
		100	• Added to Postpartum Care, "Effective July 1, 2005" and "not" to family planning counseling or instruction
		103	• Deleted requirement to complete DHHS Form 204 for Physician's Backup
		112	• Added to Appropriate Staff, "Effective July 1, 2005" and "not" to family planning counseling or instruction for office visits, an initial family planning exam, or a postpartum exam
		113	• Deleted E/M visit for Family Planning Counseling for Diaphragms (57170) • Added "Effective July 1, 2005" and "in addition to billing for the appropriate E/M office visit code or postpartum visit" for Norplant
		113, 251, 258	• Deleted A4260 for Norplant
		124, 125, 129	• Delete all sections with code 96100, Psychological Testing with interpretation and report • Delete codes 90871, 96115
		126, 137 142	• Added to Exam and Glasses for Beneficiaries Under 21, "Repairs and replacements during the year are not authorized." • Added to Exam and Glasses for Age 21 and over, "detached retina surgery, corneal surgery, or glaucoma surgery. Prior authorization is required for post surgical lenses for recipients age 21 and over."
		154	• Changed CPT code range for Chemotherapy Administered in a Physician's Office • Deleted code 96140
		156	• Changed Billing Notes CPT code range; deleted CPT range 90780-90781
		212	• Changed code for refilling and maintenance of the implantable pump
		216	• Removed Automated Multi-channel Chemistry Tests code 83715
		218	• Changed Pathology Consultations procedure code range

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Date	Section	Page(s)	Change
		226-227 259-263, 271 267 272-273	• Deleted Lab Procedures78160 and 82273 • Deleted Healthy Option Program • Deleted Category 1 Service codes 99201-99215 • Deleted Category 2 Services codes 99301-99313, 99321-99333
01-01-06	5	Exhibits	Changed "Carolina Medical Review" to "The Carolinas Center for Medical Excellence" throughout manual; updated CCME address, phone, and fax number.
01-01-06	5	21	Updated Authorization Agreement for Electronic Funds Transfer
01-01-06	Appendix 1	67	Added edit code 935
01-01-06	Appendix 2	-	Updated list of carrier codes
12-01-05	Appendix 1	70	Added edit code 949
11-01-05	1	6, 7	Removed "HIPAA" from names of S.C. Medicaid Provider Outreach and S.C. Medicaid EDI Support Center
11-01-05	3	6 16	• Changed verb tense under Procedural Coding and Diagnostic Codes • Removed requirement for entering whole numbers for day or units in field 24G
11-01-05	3	4, 20, 34, 35	Changed generic reference for the South Carolina Medicaid Web-based Claims Submission Tool from SCMWBCST to Web Tool
11-01-05	3	4, 18, 19	Changed Web site from www.scdhhshipaa.org to www.scmedicaidprovider.org
11-01-05	5	5-14	Updated list of DHHS county offices
10-01-05	5	5-14	Updated list of DHHS county offices
10-01-05	Appendices	-	Made each appendix a separate file; moved Change Control Record out of appendices to a separate file

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Date	Section	Page(s)	Change
09-01-05	2	18 32 56 62 63 114 203	• Added Provider ID and recipient ID to prior approval statement • Changed zip code from 8602 to 8206 • Added bullet for "No "Lead" for the purchase of mini-blinds • Procedure code 99394 added "This code should be used for both new and established patients." • Deleted Modifiers 1 and 2 for well-child care treatment and referral for treatment for an identified problem • Corrected spelling of IUD • Deleted Cornea telephone number (843) 792-2765
09-01-05	4	-	Corrected CMS-1500 claim form entries
09-01-05	Appendix 2	All	Updated lists of carrier codes
09-01-05	Appendix 1	38 and 64	Added edit codes 577 and 900
09-01-05	Fee Schedules	All	Added the Physicians Fee Schedule and Laboratory Fee Schedule at the end of manual
08-01-05	Appendix 1	62	Added edit code 868
07-01-05	2	44, 45, 94, 95, 106, 252, 259, 281	Deleted information pertaining to Pregnancy/ Newborn Risk Assessments and Form 204 in accordance with Medicaid Bulletin dated June 14, 2005.
07-01-05	3	All	• Added description of new Web Tool features • Removed instruction to attach EOB to paper claims • Change MIVS zip code to 29211-9804 (from 29201)
07-01-05	5	Exhibits	Deleted Pregnancy/Newborn Risk Assessment Form (Form 204)
07-01-05	Appendix 2	All	Updated lists of carrier codes
03-14-05	2	216	Deleted first sentence in second paragraph of General Guidelines Section and added information in accordance with Medicaid Bulletin dated March 1,

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
			2005
03-02-05	5	10, 11	Changed incorrect area codes for county offices in Saluda & Union
03-01-05	Appendices	All	Added new edit codes & changed some resolutions
02-11-05	5	4	Updated manual ordering information under Web Address header

SECTION 1

GENERAL INFORMATION AND ADMINISTRATION

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SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

PROGRAM DESCRIPTION

The Medicaid program, as established by Title XIX of the Social Security Act, as amended, provides quality health care to low income, disabled, and elderly individuals by utilizing state and federal funds to reimburse providers for approved medical services. This care includes the diagnosis, treatment, and management of illnesses and disabilities.

The South Carolina Department of Health and Human Services (SCDHHS) is the single state agency designated to administer the South Carolina Medicaid program in compliance with state and federal laws and regulations and the South Carolina State Plan.

SCDHHS offers a fully capitated Managed Care Program through Managed Care Organizations. A Primary Care Case Management/Medical Home Network model is only available for participants that qualify for the Medically Complex Children's Waiver. For more information regarding this care model, please see the Managed Care Supplement included with this manual.

The Medicaid Managed Care Organization (MCO) program consists of contracted MCOs that, through a developed network of providers, provide, at a minimum, all services outlined in the core benefit package described in the MCO contract and MCO Policies and Procedure guide, for certain eligibility categories. SCDHHS pays MCOs a per member per month capitated rate, primarily according to age, gender, and category of eligibility. Payments for core services provided to MCO members are the responsibility of MCOs, not the Fee-for-Service Medicaid program.

MCOs may elect to provide their members enhanced services beyond what is offered under traditional fee-for-service Medicaid.

ELIGIBILITY DETERMINATION

Applications for Medicaid eligibility may be submitted online at apply.scdhhs.gov. The application is also

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

ELIGIBILITY DETERMINATION (CONT'D.)

available for download on the SCDHHS website at http://www.scdhhs.gov and can be returned by mail, fax, or in person. Individuals can continue to apply for Medicaid at out-stationed locations such as county health departments, some federally qualified health centers, most hospitals, and SCDHHS county eligibility offices.

Individuals who apply for SSI through the Social Security Administration and are determined eligible are automatically eligible for Medicaid.

For certain programs, Medicaid eligibility may be retroactive for a maximum of three months prior to the month of application when the applicant received medical services of the type covered by Medicaid and the applicant would have met all eligibility criteria had the application been filed at the time. A child born to a woman eligible for Medicaid due to pregnancy is automatically entitled to Medicaid benefits for one year provided that the child continues to reside in South Carolina.

Not all Medicaid beneficiaries receive full coverage. Some beneficiaries may qualify under the categories of limited benefits or emergency services only. Questions regarding coverage for these categories should be directed to the SCDHHS Provider Service Center (PSC) at 1-888-289-0709. Providers can also submit an online inquiry at http://scdhhs.gov/contact-us. A provider service representative will then respond to you directly with additional information about these categories.

Providers may verify a beneficiary's eligibility for Medicaid benefits by utilizing the South Carolina Medicaid Web-based Claims Submission Tool or an eligibility verification vendor. Additional information on these options is detailed later in this section.

Certain services will require prior approval and/or coordination through the managed care provider. For questions regarding the Managed Care program, please visit the SCDHHS website at http://scdhhs.gov to view the MCO Policy and Procedure Guide.

More information about managed care can also be found in the Managed Care Supplement included with all provider manuals.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

ENROLLMENT COUNSELING SERVICES

SCDHHS provides enrollment counseling services to Medicaid beneficiaries through a contract with a private vendor. Services are provided under the program name "South Carolina Healthy Connections Choices." The function of the enrollment counselor is to assist Medicaid-eligible members in the selection of the best Medicaid health plan to suit individual/family needs. For additional information, visit http://www.SCchoices.com or contact South Carolina Healthy Connections Choices at (877) 552-4642.

MEDICARE / MEDICAID ELIGIBILITY

Medicaid beneficiaries who are also eligible for Medicare benefits are commonly referred to as "dually eligible." Providers may bill SC Medicaid for Medicare cost sharing for Medicaid-covered services for dually eligible beneficiaries. Some dual eligibles are also Qualified Medicare Beneficiaries (QMB). If the dually eligible beneficiary is also a QMB, providers may bill SC Medicaid for Medicare cost sharing, for services that are covered by Medicare without regard to whether the service is covered by SC Medicaid. Reimbursement for these services will be consistent with the SC State Medicaid Plan.

Please refer to Section 3 of this manual for instructions regarding billing procedures for dually eligible beneficiaries. For instructions on how to access beneficiary information, including QMB status, refer to the Medicaid Web-Based Claims Submission Tool (the Web Tool), explained later in this section.

In the Web Tool, the Eligibility or Beneficiary Information section will indicate "Yes" if the beneficiary is a Qualified Medicare Beneficiary.

Note: Pharmacy providers should refer to Section 2 of the Pharmacy Services Provider Manual for more information on coverage for dually eligible beneficiaries.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

SOUTH CAROLINA HEALTHY CONNECTIONS MEDICAID CARD

Medicaid beneficiaries are issued a plastic South Carolina Healthy Connections Medicaid card. Only one person's name appears on each card. If more than one family member is eligible for Medicaid, the family receives a card for each eligible member. In addition to the member's name, the front of the card includes the member's date of birth and Medicaid Member Number. Possession of the plastic card does not guarantee Medicaid coverage. Failure to verify eligibility prior to providing a service leaves the provider at risk of providing services to an ineligible individual.

As of August 1, 2016, SCDHHS announced the release of a new South Carolina Healthy Connections Medicaid card. The new card will no longer contain a magnetic data strip. The new cards will be issued to newly enrolled beneficiaries and current beneficiaries who request replacement cards. All active beneficiaries prior to August 1, 2016, will continue to use their current Medicaid card until further notice.

Providers shall accept all versions of the existing cards: cards with a magnetic data strip and the blue Healthy Connections Checkup card. All providers are encouraged to use the Web Tool to check eligibility. For additional information about the Web Tool, please refer to South Carolina Medicaid Web-Based Claims Submissions Tool (Web Tool) later in this section.

The following are examples of valid South Carolina Healthy Connections Medicaid cards:

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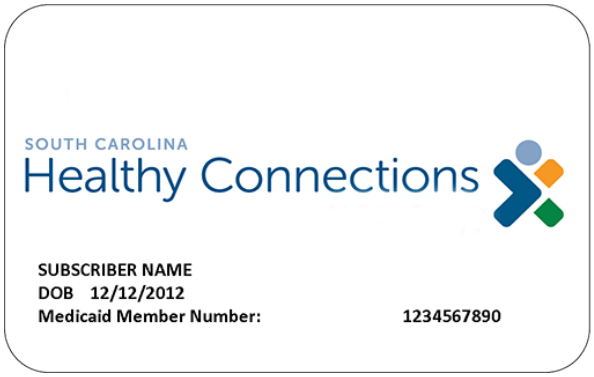
SOUTH CAROLINA MEDICAID PROGRAM



The back of the Healthy Connections Medicaid card includes:

- A toll-free number for providers to contact the PSC for assistance
- A toll-free number for the beneficiary if he or she has questions about enrollment or Medicaid-covered services

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

SOUTH CAROLINA HEALTHY CONNECTIONS MEDICAID CARD (CONT'D.)

- A toll-free number for the beneficiary if he or she has questions regarding pharmacy services

Providers are urged to report inappropriate use of a Medicaid card by a beneficiary (such as abuse, card-sharing, etc.) to the Division of Program Integrity's toll-free Fraud and Abuse Hotline at 1-888-364-3224.

Beneficiaries who are enrolled with a MCO will also be issued an identification card by the MCO. This MCO-issued card contains phone numbers for member services and provider billing issues specific to the managed care plan. Please see the Managed Care Supplement for samples of cards from the various managed care plans.

SOUTH CAROLINA MEDICAID WEB-BASED CLAIMS SUBMISSION TOOL (WEB TOOL)

SCDHHS provides a free tool, accessible through an Internet browser, which allows providers to submit claims (UB and CMS-1500), attach supporting documentation, query Medicaid eligibility, check claim status, offers providers electronic access to their remittance advice, and the ability to change their own passwords.

Providers interested in using this tool must complete a SC Medicaid Trading Partner Agreement (TPA) with SCDHHS and return the signed SC Medicaid TPA Enrollment Form. Once received, the provider will be contacted with the website address and Web Tool User ID(s). If a provider utilizes a billing agent and elects to have the billing agent access their electronic remittance advice, both the provider and the billing agent must have a TPA on file. The provider's TPA must name their billing agent. The billing agent's TPA must include the provider's name and Medicaid number. For more information regarding the TPA, refer to Section 3 of this manual.

To learn more about this tool and how to access it, visit the SC Medicaid Provider Education website at: http://medicaidelearning.com/ or contact the SC Medicaid EDI Support Center via the SCDHHS PSC at 1-888-289-0709. A listing of training opportunities is also located on the website.

Note: Dental claims cannot be submitted on the Web Tool. Please contact the dental services vendor at 1-888-307-6553 for billing instructions.

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SOUTH CAROLINA MEDICAID PROGRAM

SOUTH CAROLINA MEDICAID ALERTS, BULLETINS AND NEWSLETTERS

SCDHHS Medicaid alerts, bulletins and newsletters are distributed electronically through e-mail and are available online at the SCDHHS website.

To ensure that you receive important SC Medicaid information, visit the website at http://www.scdhhs.gov/ and subscribe to alerts, bulletins and newsletters.

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SOUTH CAROLINA MEDICAID PROGRAM

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SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

PROVIDER ENROLLMENT

PROVIDER PARTICIPATION

The Medicaid program administered by the South Carolina Department of Health and Human Services (SCDHHS) is considered to be a covered entity under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191.

Provider participation in the Medicaid program is voluntary. To participate in the Medicaid program, a provider must meet the following requirements:

- Complete an online provider enrollment application and agreement and submit any necessary supporting documentation. Certain provider types, depending on the type of service provided, are required to sign a contractual agreement in addition to the provider enrollment agreement.
- Accept the terms and conditions of the online application by electronic signature, indicating the provider's agreement to the contents of the participation agreement, the Electronic Funds Transfer Agreement, W-9 and Trading Partner Agreement.
- Be licensed by the appropriate licensing body, certified by the standard-setting agency, and/or other pre-contractual approval processes established by SCDHHS.
- If eligible, obtain a National Provider Identifier (NPI) and share it with SCDHHS. Refer to https:// nppes.cms.hhs.gov for additional information about obtaining an NPI.
- Be enrolled in the South Carolina Medicaid program and receive official notification of enrollment. This also applies to providers wanting to contract with one or all of the South Carolina Medicaid MCO.
- Continuously meet South Carolina licensure and/or certification requirements of their respective professions or boards in order to maintain Medicaid enrollment.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

PROVIDER ENROLLMENT

PROVIDER PARTICIPATION (CONT'D.)

- Comply with all federal and state laws and regulations currently in effect as well as all policies, procedures, and standards required by the Medicaid program.
- Medicaid will not provide any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside the United States.

All rendering providers must be enrolled in the Medicaid program. Enrolled providers are prohibited from allowing non-enrolled providers use of their Medicaid ID number/NPI number in order for non-participating providers to be reimbursed for services. Claims for Medicaid reimbursement submitted under a Medicaid ID number or NPI number other than that of the ordering, referring or rendering provider will be considered invalid and may result in a program integrity investigation and/or recoupment of the Medicaid payment. As required by 42 CFR 455.440, all claims submitted for payment for items and services that were ordered or referred must contain the NPI of the physician or other professional who ordered or referred such items or services.

A provider must immediately report any change in enrollment or contractual information (*e.g.*, mailing or payment address, physical location, telephone number, specialty information, change in group affiliation, ownership, etc.) to SCDHHS PSC within 30 days of the change. Failure to report this change of information promptly could result in delay of payment and/or termination of enrollment. Provider Enrollment inquiries to South Carolina Medicaid should be directed as follows:

Mail: Medicaid Provider Enrollment
PO Box 8809
Columbia, SC 29202-8809
Phone: 1-888-289-0709, Option 4
Fax: 803-870-9022

Extent of Provider Participation

Providers have the right to limit the number of Medicaid patients they are willing to treat within their practice; however, providers may not discriminate in selecting the Medicaid beneficiaries they will treat or services they will render. A provider may not refuse to furnish services

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

PROVIDER ENROLLMENT

Extent of Provider Participation (Cont'd.)

covered under Medicaid to an eligible individual because of a third party's potential liability for the service(s). A provider who is not a part of a MCO's network may refuse service to a Medicaid MCO member.

A provider and a beneficiary (or the beneficiary's guardian or representative) should determine before treatment is rendered whether the provider is willing to accept the beneficiary as a Medicaid patient. In an emergency, or if a provider cannot determine that a patient is Medicaid-eligible at the time service is rendered, the provider should meet with the beneficiary (or the beneficiary's legal guardian or representative) at the earliest possible date to determine whether the provider is willing to accept the beneficiary as a Medicaid patient for the previously rendered service. To avoid disputes or misunderstandings, providers are encouraged to document the details of their provider-patient agreement in the patient's record.

In furnishing care to beneficiaries who are participating in a Medicaid managed care option, all providers are required to comply with the benefit requirements specified by the applicable managed care program with respect to issues such as the extent of approvals for referrals, etc. Specific questions may be addressed directly with the MCO.

Once a provider has accepted a beneficiary as a Medicaid patient, it is the responsibility of the provider to deliver all Medicaid-covered services throughout the course of treatment. The policy section of this manual may include clarification of specific program policies.

Non-Discrimination

All Medicaid providers are required to comply with the following laws and regulations:

- Title VI of the Civil Rights Act of 1964 that prohibits any discrimination due to race, color, or national origin (45 CFR Part 80)
- Title V, Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 794 that prohibits discrimination on the basis of handicap (45 CFR Part 84)
- The Americans with Disabilities Act of 1990 that prohibits discrimination on the basis of disability (28 CFR Parts 35 & 36)

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

PROVIDER ENROLLMENT

Non-Discrimination (Cont'd.)

- The Age Discrimination Act of 1975 that prohibits discrimination on the basis of age (45 CFR Parts 90 and 91)

Service Delivery

Freedom of Choice

Except as otherwise specified in this manual, a Medicaid beneficiary has the right to choose any provider who is both a participant in the Medicaid program and willing to accept the beneficiary as a patient.

However, once a beneficiary exercises his or her freedom of choice by enrolling in a Medicaid MCO, the beneficiary is required to follow that MCO's requirements (*e.g.*, use of designated primary and specialist providers, precertification of services, etc.) for the time period during which the beneficiary is enrolled in the MCO.

Medical Necessity

Medicaid will pay for a service when the service is covered under the South Carolina State Plan and is medically necessary. "Medically necessary" means that the service (the provision of which may be limited by specific manual provisions, bulletins, and other directives) is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. A provider's medical records or other appropriate documentation for each beneficiary must substantiate the need for services, must include all findings and information supporting medical necessity and justification for services, and must detail all treatment provided. Medicaid will not provide any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS/ DOCUMENTATION REQUIREMENTS

GENERAL INFORMATION

As a condition of participation in the Medicaid program, providers are required to maintain and provide immediate access to original and electronic medical records, including associated audit trails. Record means any document or electronically stored information including writings, drawings, graphs, charts, photographs, sound recordings, images, and other data or data compilations, stored in any medium from which information can be obtained either directly or, if necessary, after translation by the provider into a reasonably usable form that allows the ability to review the record.

SCDHHS does not have requirements for the media formats for medical records. Providers must have and maintain a medical record system that insures that the record may be accessed and retrieved immediately. That, for the purposes of reviewing, copying, and reproducing documents, access shall be allowed to all records concerning services and payment to SCDHHS, the State Auditor's Office (SAO), the South Carolina Attorney General's Office (SCAG), the United States Department of Health and Human Services (HHS), Government Accountability Office (GAO), and/or their designee during normal business hours.

SCDHHS will accept electronic records and clinical notes in accordance with the Uniform Electronic Transactions Act (S.C. Code Ann. §§ 26-6-10 et seq.) and the Health Insurance Portability and Accountability Act (HIPAA) electronic health record requirements. Furthermore, providers must comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191.

A provider is defined as an individual, firm, corporation, association or institution which is providing, or has been approved to provide, medical assistance to a beneficiary pursuant to the State Medical Assistance Plan and in accord with Title XIX of the Social Security Act of 1932, as amended.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS / DOCUMENTATION REQUIREMENTS

GENERAL INFORMATION (CONT'D.)

Records are considered to be maintained when:

- They fully disclose the medical necessity for treatment and the extent of services provided to Medicaid beneficiaries
- All required documentation is present in beneficiaries' records before the provider files claims for reimbursement, unless program policy otherwise states
- Beneficiary medical, fiscal and other required records and supporting documentation must be legible

A provider record or any part thereof will be considered illegible if at least three (3) medical or other professionals in any combination, who regularly perform post payment reviews, are unable to read the record or determine the extent of services provided. An illegible record will be subject to recoupment.

Medicaid providers must make records immediately accessible and available for review during a provider's normal business hours or as otherwise directed, with or without advance notice by authorized entities and staff as described in this section. An authorized entity may either copy, accept a copy, or may request original records. Any requested record(s) is deemed inaccessible if not immediately available when requested by an authorized entity. Unless otherwise indicated, the medical record shall be accessible at the provider's service address as documented by the SCDHHS provider enrollment record. If the requested records are not available, they must be made available within two (2) hours of the authorized entity's request, or are otherwise deemed inaccessible. It is the responsibility of the provider to transport/send records to the place of service location as documented by the SCDHHS provider enrollment record.

The following requirements apply to retention of records for Medicaid purposes only; other state or federal rules may require longer retention periods. That for Medicaid purposes all fiscal and medical records shall be retained for a minimum period of five (5) years after last payment was made for services rendered, except that hospitals and nursing homes are required to retain such records for six (6) years after last payment was made for services

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS / DOCUMENTATION REQUIREMENTS

General Information (Cont'd.)

rendered. If any litigation, claim, audit, or other action involving the records has been initiated prior to the expiration of the appropriate retention period the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the appropriate retention period, whichever is later.

Providers may contact the PSC or submit an online inquiry at http://scdhhs.gov/contact-us for specific information regarding documentation requirements for services provided.

Signature Policy

For medical review purposes, Medicaid requires that services provided/ordered be authenticated by the author. Medical documentation must be signed by the author of the documentation except when otherwise specified within this policy. The signature may be handwritten, electronic, or digital. Stamped signatures are unacceptable.

Handwritten Signature

A handwritten signature is a mark or sign by an individual on a document signifying knowledge, approval, acceptance or obligation.

- If the signature is illegible, SCDHHS shall consider evidence in a signature log to determine the identity of the author of a medical record entry.
- An order must have a signature which meets the signature requirements outlined in this section. Failure to satisfy these signature requirements will result in denial of related claims.
- A stamped signature is unacceptable.

Signature Log

Providers may include a signature log in the documentation they submit. This log lists the typed or printed name of the author associated with the illegible initials or signature.

Electronic Signatures

Providers using electronic signatures need to realize that there is a potential for misuse with alternative signature methods. The system needs to have software products that are protected against modification and that apply adequate administrative procedures that correspond to recognized standards and laws. The individual whose name is on the alternate signature method and the provider are responsible for the authenticity of the information for which an attestation has been provided.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS / DOCUMENTATION REQUIREMENTS

Electronic Signatures (Cont'd.)

Acceptable Electronic Signature Examples:

- Chart 'Accepted By' with provider's name
- 'Electronically signed by' with provider's name
- 'Verified by' with provider's name
- 'Reviewed by' with provider's name
- 'Released by' with provider's name
- 'Signed by' with provider's name
- 'Signed before import by' with provider's name
- 'Signed: John Smith, M.D.' with provider's name
- Digitized signature: Handwritten and scanned into the computer
- 'This is an electronically verified report by John Smith, M.D.'
- 'Authenticated by John Smith, M.D'
- 'Authorized by: John Smith, M.D'
- 'Digital Signature: John Smith, M.D'
- 'Confirmed by' with provider's name
- 'Closed by' with provider's name
- 'Finalized by' with provider's name
- 'Electronically approved by' with provider's name
- 'Signature Derived from Controlled Access Password'

Date

The signature should be dated. However, for review purposes, if there is sufficient documentation for SCDHHS to determine the date on which the service was performed/ordered then SCDHHS may accept the signature without a date.

The only time it is acceptable for an entry to not be signed at the time of the entry is in the case of medical transcription.

Exceptions

There are some circumstances for which an order does not need to be signed. For example, orders for clinical diagnostic tests are not required to be signed. The rules in 42 CFR 410 and Pub. 100-02, chapter 15, section 80.6.1,

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS / DOCUMENTATION REQUIREMENTS

Exceptions (Cont'd.)

state that if the order for the clinical diagnostic test is unsigned, there must be medical documentation by the treating physician (*e.g.,* a progress note) that he/she intended the clinical diagnostic test be performed. This documentation showing the intent that the test be performed must be authenticated by the author via a handwritten or electronic signature.

DISCLOSURE OF INFORMATION BY PROVIDER

As of April 14, 2003, for most covered entities, health care providers are required to comply with privacy standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, which includes providing all patients and/or clients with a Notice of Privacy Practices. The Notice should include sufficient information to disclose to each Medicaid patient/client the provider's intent to release any medical information necessary for processing claims, including Medicaid claims. Providers who have not issued their patients/clients a Notice of Privacy Practices should obtain authorization to release such information to SCDHHS. The authorization must be signed and dated by the beneficiary and must be maintained in the patient's/client's record.

Once a Notice of Privacy Practices is acknowledged by the Medicaid beneficiary, or the beneficiary's authorization to release information is obtained, a provider who uses hard-copy claim forms that require the patient's signature is no longer required to have each claim form signed by the beneficiary. Providers who file claims electronically are required under their Trading Partner Agreement (TPA) to ensure ready association of electronic claims with an acknowledged Notice of Privacy Practices or a signed statement from the beneficiary consenting to the release of information necessary to process claims.

Certain medical services may be subject to more stringent rules or regulations governing the disclosure of information than others. However, if a provider is unable to release information necessary for Medicaid claims processing due to the lack of proper Notice or authorization from the beneficiary, payment may be denied and/or previous payments may be recouped. Consequently, providers who are concerned about releasing patient information to SCDHHS are advised to obtain specific written authorization from the Medicaid patient/client.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS / DOCUMENTATION REQUIREMENTS

SAFEGUARDING BENEFICIARY INFORMATION

Federal regulations at 42 CFR Part 431, Subpart F, and South Carolina Regulations at Chapter 126, Article 1, Subarticle 4, require that certain information concerning Medicaid applicants and beneficiaries be protected. As a condition of participation in the Medicaid program, all providers must agree to comply with the federal laws and regulations regarding this protection, by execution of either a contract or a provider enrollment agreement. Questions regarding access to protected information should be referred to the PSC. Provider can also submit an online inquiry at http://scdhhs.gov/contact-us to request additional information.

Beneficiary information that must be protected includes but is not limited to the following:

- Name and address
- Medical services provided
- Social and economic circumstances
- Medical data, including diagnosis and past history of disease or disability
- Any information involving the identification of legally liable third-party resources
- Any information verifying income eligibility and the amount of medical assistance payments

This information may generally be used or disclosed only for the following purposes:

- Establishing eligibility
- Determining the amount of medical assistance
- Providing services for beneficiaries
- Assisting in a Medicaid-related investigation, prosecution, or civil or criminal proceeding

Regarding the release of beneficiary information to billing/collection agencies, the Centers for Medicare and Medicaid Services (CMS) has instructed the states that the requirements for the release of beneficiary information should parallel the limitations on payments. Agents to whom payments could be made are allowed to obtain relevant beneficiary information, since the sharing of that information is for a purpose directly connected with Medicaid administration. However, if no payment could be

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS / DOCUMENTATION REQUIREMENTS

SAFEGUARDING BENEFICIARY INFORMATION (CONT'D.)

made to the agent because the agent's compensation is tied to the amount billed or collected, or is dependent upon the collection of the payment, then Medicaid is not allowed to release beneficiary information to that agent.

Note: The manner in which the Medicaid program deals with the agent is determined primarily by the terms of the agent's compensation, not by the designation attributed to the agent by the provider. Agents or providers who furnish inaccurate, incomplete, or misleading information to SCDHHS regarding agent compensation issues may face sanctions.

Confidentiality of Alcohol and Drug Abuse Case Records

Federal law requires providers to observe more stringent rules when disclosing medical information from the records of alcohol and drug abuse patients than when disclosing information concerning other Medicaid beneficiaries. Federal regulations govern the information that must be protected in such cases and the circumstances under which this information may be disclosed. These regulations may be found at 42 CFR Part 2.

SPECIAL / PRIOR AUTHORIZATION

Certain medical services must be authorized by SCDHHS (or its designee) prior to delivery in order to be reimbursable by Medicaid. Some of the services that are specifically subject to prior authorization and approval are as follows:

- Services provided outside of the South Carolina Medicaid Service Area (SCMSA). The SCMSA is South Carolina and adjacent areas within 25 miles of its borders. Providers should contact the PSC or submit an online inquiry for prior authorization guidelines.
- Services not routinely covered by Medicaid, or other services that require prior approval before payment or before service delivery as a matter of policy. Please refer to the appropriate section of this manual, contact the PSC, or submit an online inquiry for prior authorization guidelines.
- Services for which prepayment review is required.

Refer to program-specific sections of this manual for other services that must be authorized prior to delivery.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS / DOCUMENTATION REQUIREMENTS

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SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

CHARGE LIMITS

Except as described below for free care, providers may not charge Medicaid more for services to a beneficiary than they would customarily charge the general public. Providers should bill their usual and customary charges and not the Medicaid reimbursement rate. Retroactive adjustments can only be made up to the billed amount. Medicaid will generally pay the lower of the established Medicaid reimbursement rate or the provider's billed amount. Medicaid reimbursement is available for covered services under the State Medicaid Plan that are provided to Medicaid beneficiaries, regardless of whether there is any charge for the service to the beneficiary or the community at large.

BROKEN, MISSED, OR CANCELLED APPOINTMENTS

CMS prohibits billing Medicaid beneficiaries for broken, missed, or cancelled appointments. Medicaid programs are state-designed and administered with federal policy established by CMS. Federal requirements mandate that providers participating in the Medicaid program must accept the agency's payment as payment in full. Providers cannot bill for scheduling appointments or holding appointment blocks. According to CMS Program Issuance Transmittal Notice MCD-43-94, broken or missed appointments are considered part of the overall cost of doing business.

NATIONAL CORRECT CODING INITIATIVE (NCCI)

The South Carolina Medicaid program utilizes National Correct Coding Initiative (NCCI) edits and its related coding policy to control improper coding.

The CMS developed the NCCI to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. The purpose of the NCCI edits are to prevent improper payment when incorrect code combinations or units of service are reported exceeding what is normally considered to be medically necessary. NCCI edits identify procedures/services performed by the same provider for the same beneficiary on the same date of service.

NCCI consist of two types of edits:

1) NCCI Procedure to Procedure (PTP) edits: These edits define pairs of HCPCS/CPT codes that

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

NATIONAL CORRECT CODING INITIATIVE (NCCI) (CONT'D.)

should not be reported together for a variety of reasons. These edits consist of a column one code and a column two code. If both codes are reported, the column one code is eligible for payment and the column two code is denied. In some instances an appropriate modifier may be added to one or both codes of an edit pair to make the code combination eligible for payment.

2) Medically Unlikely Edits (MUE): These edits define for each HCPCS/CPT code the number of units of service that is unlikely to be correct. The units of service that exceed what is considered medically necessary will be denied.

It is important to understand, however, that the NCCI does not include all possible combinations of correct coding edits or types of unbundling that exist. Providers are obligated to code correctly even if edits do not exist to prevent use of an inappropriate code combination.

Services denied based on NCCI code pair edits or MUEs may not be billed to patients.

The CMS web page https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html provides overview information to providers on Medicaid's NCCI edits and links for additional information.

MEDICAID AS PAYMENT IN FULL

Once a provider has accepted a beneficiary as a Medicaid patient, the provider must accept the amount established and paid by the Medicaid program (or paid by a third party, if equal or greater) as payment in full. Neither the beneficiary, beneficiary's family, guardian, or legal representative may be billed for any difference between the Medicaid allowable amount for a covered service and the provider's actual charge, or for any coinsurance or deductible not paid by a third party. In addition to not charging the patient for any coinsurance or deductible amounts, providers may not charge the patient for the primary insurance carrier's copayment. Only applicable Medicaid copayments and services not covered by Medicaid may be billed to the beneficiary.

For beneficiaries enrolled in a Medicaid managed care option, the managed care entity must accept SCDHHS' capitated payment as payment in full for all services

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

MEDICAID AS PAYMENT IN FULL (CONT'D.)

covered by the capitation arrangement. Managed care network providers must accept their reimbursement from the managed care entity as payment in full. Only services not included in the specified benefits package or not otherwise covered by Medicaid may be billed to a beneficiary enrolled in a managed care option.

PAYMENTS LIMITATION

Medicaid payments may be made only to a provider, to a provider's employer, or to an authorized billing entity. **There is no option for reimbursement to a beneficiary.** Likewise, seeking or receiving payment from a beneficiary pending receipt of payment from the Medicaid program is not allowed, except where a copayment is applicable. By virtue of submitting a claim to Medicaid, a provider is agreeing to accept Medicaid as the payer.

REASSIGNMENT OF CLAIMS

In general, Medicaid payments are to be made only to the enrolled practitioner. However, in certain circumstances payment may be made to the following:

1. The employer of the practitioner, if the practitioner is required as a condition of employment to turn over fees to the employer
2. The facility in which the service is provided, if the practitioner has a contract under which the facility submits the claim
3. A foundation, plan, or similar organization operating an organized health care delivery system, if the practitioner has a contract under which the organization submits the claim
4. A business agent. Regulations found at 42 CFR Part 447, Subpart A, allow Medicaid to make payment for services to a provider's "business agent" such as a billing service or an accounting firm, only if the agent's compensation is:
   a) Related to the cost of processing the billing
   b) Not related on a percentage or other basis to the amount that is billed or collected
   c) Not dependent upon the collection of the payment

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

REASSIGNMENT OF CLAIMS (CONT'D.)

If the agent's compensation is tied to the amount billed or collected or is dependent upon the collection of the payment, Medicaid is not allowed to make payment to the agent. Furthermore, providers are urged to seek advice regarding the HIPAA (Public Law 104-191) provisions when entering into such an agreement.

THIRD-PARTY LIABILITY

As a condition of eligibility for Medicaid, federal regulations at 42 CFR Part 433, Subpart D, require individuals to assign any rights to medical support or other third-party payment to the Medicaid agency (SCDHHS) and cooperate with the agency in obtaining such payments. The South Carolina Code §43-7-420 makes this assignment effective automatically upon application for Medicaid.

Medicaid providers may obtain information regarding third-party resources that are known to SCDHHS by utilizing the South Carolina Medicaid Web-based Claims Submission Tool. Third-party resources include but are not limited to health benefits under commercial health insurance plans, indemnity contracts, school insurance, Workers' Compensation, and other casualty plans that may provide health insurance benefits under automobile or homeowner's coverages.

For Medicaid purposes, third-party resources are divided into two general categories: Health Insurance and Casualty Insurance.

Health Insurance

In general, health insurance may include any individual accident and health policy or group policy that provides payment for health care costs. Unless otherwise permitted, a provider who accepts a Medicaid beneficiary as a patient is required to request payment from all available third-party resources prior to billing Medicaid. All third-party claims filed must be assigned to the provider.

Should the third-party carrier deny payment or reduce payment to less than the Medicaid approved amount, the provider may then submit the claim to Medicaid. The claim filed to Medicaid must be properly completed with all applicable third-party information entered in the appropriate fields (see Section 3 or other appropriate

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

Health Insurance (Cont'd.)

materials for billing instructions). Under the federally mandated Cost Avoidance program, 42 CFR §433.139, claims for certain services to beneficiaries who have health insurance coverage may automatically reject if the third-party carrier has not been billed first.

If a claim is rejected for failure to bill third-party coverage, the provider must submit a new claim with the correctly coded information that documents payment or denial of payment by the third-party carrier.

While most claims are subject to coordination of benefits to ensure Medicaid is the payer of last resort, federal regulations exempt claims submitted for physicians' services under the Early & Periodic Screening, Diagnosis, and Treatment (EPSDT) program, Maternal Health, Title IV – Child Support Enforcement, and certain Department of Health and Environmental Control (DHEC) services under Title V. While providers are encouraged to file with any liable third party for these claim types, if they choose not to do so, SCDHHS will pay the claims and bill liable third parties directly through the Benefit Recovery program.

Premium Payment Project

Through the Premium Payment Project, SCDHHS is able to pay private health insurance premiums for Medicaid beneficiaries who are subject to losing coverage due to non-payment. SCDHHS will pay these premiums when said payment is determined to be cost effective.

Premium payment is usually cost effective for Medicaid beneficiaries with chronic medical conditions requiring long-term treatment such as cancer, end stage renal disease, chronic heart problems, congenital birth defects, and AIDS. Depending on the amount of the premium, the program may also be appropriate for beneficiaries with short-term costly health needs, such as pregnancy.

Providers of services to participating beneficiaries should consider Medicaid the payer of last resort and bill any liable third-party insurance plan prior to billing Medicaid.

Questions regarding the Premium Payment Project or referrals for beneficiary participation in this project should be directed to the Third-Party Liability– Medicaid Insurance Verification Services (MIVS) department by calling 1-888-289-0709 option 5, then option 4.

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Casualty Insurance

Casualty insurance includes policies that provide payment for treatment related to an accident or injury. This type of coverage is most commonly related to incidents such as auto accidents, and in these cases the injured party is frequently represented by an attorney.

Unlike health insurance claims, claims involving casualty insurance are not subject to review under the Cost Avoidance program. The accident questionnaire is the primary referral source and is generated by the Medicaid claims processing system. At times, it is the provider who identifies a potentially liable third party. If there is casualty insurance coverage, the provider may pursue the claim directly with either the beneficiary's attorney or the casualty insurance carrier, or file a claim with Medicaid (provided that the one-year time limit for submission of claims has not been exceeded).

If the provider files a claim with Medicaid and the claim is paid, then SCDHHS will pursue reimbursement from any liable third party.

Provider Responsibilities – TPL

A provider who has been paid by Medicaid and **subsequently** receives reimbursement from a third party must repay to SCDHHS either the full amount paid by Medicaid or the full amount paid by the third party, whichever is less. Some providers may choose to submit a repayment check accompanied by a completed Form for Medicaid Refunds (DHHS Form 205) identifying the third-party payer. Others providers may decide to submit a Claim Adjustment Form 130, which will allow them to void and/or replace a claim that resulted in under or overpayment. Examples of these forms can be found in the Forms section of this manual. For detailed information regarding both of these adjustment processes, please refer to Section 3 of this manual.

The Medicaid program makes payments to providers on behalf of beneficiaries for medical services rendered, but only to the extent that the beneficiary has a legal obligation to pay. If the beneficiary does not have a legal obligation to pay, then Medicaid will not make a payment. This means that if a beneficiary has third party insurance, including Medicare, SCDHHS's payment will be limited to the patient's responsibility (usually the deductible, co-

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

Provider Responsibilities – TPL (Cont'd.)

pay and/or coinsurance.) The Medicaid reimbursement and third party payment cannot exceed the amount the provider has agreed to accept as payment in full from the third party payer. A provider must not bill Medicaid for the difference between the payment received from a third party and the actual charges if the provider's third-party payment was determined under a "preferred provider" agreement. A "preferred provider" agreement is an agreement between the provider and the third party payer that establishes an amount that the provider is agreeing to accept as payment in full on its claims. Where such an agreement exists, Medicaid may only coordinate payment up to the lesser of the Medicaid allowed amount or the amount the provider has agreed to accept as payment in full from the third party payer.

The South Carolina Code §43-7-440(B) requires Medicaid providers to cooperate with SCDHHS in the identification of any third-party resource that may be responsible for payment of all or part of the cost of medical services provided to a Medicaid beneficiary. Upon receiving knowledge of third-party coverage that is not verified via the SCDHHS Web Tool, a provider is encouraged to notify SCDHHS's Division of Third-Party Liability of said coverage. The Health Insurance Information Referral Form may be used for this purpose. This form can be found in the Forms section of this manual.

The Division of Third-Party Liability must also be notified in writing if copies of claims submitted to Medicaid are released to anyone, including the beneficiary or the beneficiary's attorney. Before being released, the documents must clearly indicate that third-party benefits are assigned to SCDHHS pursuant to state law.

Providers should be aware that in no instance will SCDHHS pay any amount that is the responsibility of a third-party resource. If a provider releases copies of claims submitted to Medicaid and the release of those documents results in third-party payment being made to the beneficiary rather than to the provider, SCDHHS will not reimburse the provider for the amount of the third-party payment made to the beneficiary.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

TIME LIMIT FOR SUBMITTING CLAIMS

SCDHHS requires that only "clean" claims received and entered into the claims processing system within one year from the date of service (or date of discharge for hospital claims) be considered for payment. A "clean" claim is one that is edit and error-free and can be processed without obtaining additional information from the provider or from another third party. This time limit will not be extended on the basis of third-party liability requirements. However, the one-year time limit does not apply to Medicare cost sharing claims or to claims involving retroactive eligibility.

Medicare Cost Sharing Claims

Claims for payment of Medicare cost sharing amounts must be received and entered into the claims processing system within two years from the date of service or date of discharge, or up to six months following the date of Medicare payment, whichever is later.

Retroactive Eligibility

Claims involving retroactive eligibility must meet both of the following criteria to be considered for payment:

- Be received and entered into the claims processing system within **six months** of the beneficiary's eligibility being added to the Medicaid eligibility system **AND**
- Be received within **three years** from the date of service or date of discharge (for hospital claims). Claims for dates of service that are more than three years old will not be considered for payment.

To document retroactive eligibility, the provider is responsible for submitting one of the following documents with each claim within the above time frames:

- DHHS Form 945, which is a statement verifying the retroactive determination furnished by the eligibility worker, or
- The computer-generated Medicaid eligibility approval letter notifying the beneficiary that Medicaid benefits have been approved. This can be furnished by the beneficiary or the eligibility worker. (This is different from the Certificate of Creditable Coverage.)

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

Retroactive Eligibility (Cont'd.)

SCDHHS will no longer consider claims that exceed the timely filing limits due to the provider being unaware of the beneficiary's coverage.

Please refer to Section 2 of the provider manual for any additional Retroactive Eligibility criteria that may apply.

Payment Information

SCDHHS establishes reimbursement rates for each Medicaid-covered service. Providers should contact the PSC or submit an online inquiry for additional information.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

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SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID PROGRAM INTEGRITY

The South Carolina Department of Health and Human Services ensures the integrity of the Medicaid Program and seeks to identify and reduce waste, fraud, and abuse in the use of Medicaid funds through the activities carried out by the Division of Program Integrity and the Division of Audits. The purposes of program oversight are to safeguard against unnecessary, inappropriate, and/or fraudulent use of Medicaid services, identify excessive or inaccurate payments to providers, and ensure compliance with the applicable Medicaid laws, regulations, and policies.

PROGRAM INTEGRITY

The Division of Program Integrity conducts post-payment reviews of all health care provider types including but not limited to hospitals (inpatient and outpatient) rural health clinics, Federally-qualified health clinics, pharmacies, ASCs, ESRD clinics, physicians, dentists, other health care professionals, speech, PT and OT therapists, CLTC providers, durable medical equipment providers, transportation providers, and behavioral and mental health care providers. Program Integrity uses several methods to identify areas for review:

- The toll-free Fraud and Abuse Hotline and the Fraud and Abuse email for complaints of provider and beneficiary fraud and abuse. The hotline number is 1-888-364-3224, and the email address is fraudres@scdhhs.gov.
- Each complaint received from the hotline or email is reviewed, and if the complaint is determined to involve either a Medicaid beneficiary or provider, a preliminary investigation is conducted to identify any indications of fraud and abuse.
- Referrals from other sources as well as ongoing provider monitoring that identify aberrant or excessive billing practices.
- The automated Surveillance and Utilization Review System (SURS) to create provider profiles and exception reports that identify excessive or aberrant billing practices.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID PROGRAM INTEGRITY

PROGRAM INTEGRITY (CONT'D.)

A Program Integrity review can cover several years' worth of paid claims data. (See "Records/Documentation Requirements" in this section for the policy on Medicaid record retention.) The Division conducts payment reviews, analysis of provider payments, and review of provider records, using statistical sampling and overpayment estimation when feasible, to determine the following:

- Medical reasonableness and necessity of the service provided
- Indications of fraud or abuse in billing the Medicaid program
- Compliance with Medicaid program coverage and payment policies
- Compliance with state and federal Medicaid laws and regulations
- Compliance with accepted medical coding conventions, procedures, and standards
- Whether the amount, scope, and duration of the services billed to Medicaid are fully documented in the provider's records

The Division of Program Integrity ("Program Integrity") or its authorized entities, as described under Records Documentation/Requirements, General Information of Section 1, conduct both announced and unannounced desk and field reviews, on-site inspections, and/or investigations of providers to determine whether the provider is complying with all applicable laws, rules, regulations, and agreements. Program Integrity may conduct reviews, investigations, or inspections of any current or former enrolled provider, agency-contracted provider, or agent thereof, at any time and/or for any time period. During such reviews, Program Integrity staff will request medical records and related documents ("the documentation"). Record means any document or electronically stored information including writings, drawings, graphs, charts, photographs, sound recordings, images, and other data or data compilations, stored in any medium from which information can be obtained either directly or, if necessary, after translation by the entity into a usable form that allows authorized entities, described under Records Documentation/Requirements, General Information of

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID PROGRAM INTEGRITY

PROGRAM INTEGRITY (CONT'D.)

Section 1, the ability to review the record. Program Integrity or its designee(s) may either copy, accept a copy or may request original records. Program Integrity may evaluate any information relevant to validating that the provider received only those funds to which it is legally entitled. This includes interviewing any person Program Integrity believes has information pertinent to its review, investigation or inspection. Interviews may consist of one or more visits.

Program Integrity staff will thoroughly review the records to determine whether the documentation accurately represents paid claims and rendered services, and whether the provider is in compliance with its obligations to the state Medicaid program. The documentation must sufficiently disclose the extent of services delivered, medical necessity, appropriateness of treatment, quality of care, and the documentation adheres to all applicable policy requirements. The provider, therefore, must submit a copy of all requested records by the date requested by Program Integrity. Providers must not void, replace, or tamper with any claim records or documentation selected for a Program Integrity review activity, until the activity is finalized.

An overpayment arises when Program Integrity denies the appropriateness or accuracy of a claim. Reasons for which Program Integrity may deny a claim include, but are not limited to the following:

- The Program Integrity review finds excessive, improper, or unnecessary payments have been made to a provider
- The Provider fails to provide medical records as requested
- The provider refuses to allow access to records

In each scenario Medicaid must be refunded for the denied claims.

The provider is notified via certified letter of the post-payment review results, including any overpayment findings. If the Provider disagrees with the findings, the provider will have the opportunity to discuss and/or present evidence to Program Integrity to support any disallowed payment amounts. If the parties remain in disagreement

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID PROGRAM INTEGRITY

PROGRAM INTEGRITY (CONT'D.)

following these discussions, the Provider may exercise its right to appeal to the Division of Appeals and Hearings.

If the provider does not contest Program Integrity's finding, or the appeal process has concluded, the provider will be required to refund the overpayment by issuing payment to SCDHHS or by having the overpayment amount deducted from future Medicaid payments. Termination of the provider enrollment agreement or contract with SCDHHS does not absolve the provider of liability for any penalties or overpayments identified by a Program Integrity review or audit.

Sanctions including but not limited to suspension, termination, or exclusion from the Medicaid program may result upon the failure of the provider to:

- Allow immediate access to records
- Repay in full the identified overpayment
- Make arrangements for the repayment of identified overpayments
- Abide by repayment terms
- Make payments which are sufficient to remedy the established overpayment

In addition, failure to provide requested records may result in one or more of the following actions by SCDHHS:

- Immediate suspension of future payments
- Denial of future claims
- Recoupment of previously paid claims

Any provider terminated for cause, suspended, or excluded will be reported to the Centers for Medicare and Medicaid Services (CMS) and U.S. Department of Health and Human (HHS) Office of Inspector General (OIG).

PREPAYMENT REVIEW

In order to ensure that claims presented by a provider for payment meet the requirements of federal and state laws and regulations, a provider may be required to undergo prepayment claims review. Grounds for being placed on prepayment claims review shall include, but shall not be limited to identification of aberrant billing practices as a result of reviews, investigations, or data analysis performed by Program Integrity/SUR, or other grounds as determined by Program Integrity/SUR.

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PREPAYMENT REVIEW (CONT'D.)

Parameters are developed for prepayment review based on the specific areas of concern identified in each case. As part of the prepayment review process, providers may be required to submit paper claims, rather than electronic claims, along with supporting medical record documentation (*e.g.,* clinical notes, progress notes, diagnostic testing results, other reports, superbills, X-rays, and any related medical record documentation) attached to each claim for all services billed. This documentation is used to ascertain that the services billed were billed appropriately, and according to South Carolina Medicaid policies and procedures. Services inconsistent with South Carolina Medicaid policies and procedures are adjudicated accordingly. Claims submitted initially without the supporting medical record documentation will be denied.

Additional medical record documentation submitted by the provider for claims denied as a result of the prepayment review process is not considered at a later time. A provider is removed from prepayment review only when determined appropriate by Program Integrity/SUR. Once removed from prepayment review, a follow-up assessment of the provider's subsequent practice patterns may be performed to monitor and ensure continued appropriate use of resources. Noncompliant providers are subject to administrative sanctions as defined in the rules in South Carolina Regulations at Chapter 126, Article 4, Subarticle 1.

RECOVERY AUDIT CONTRACTOR

The South Carolina Department of Health and Human Services, Division of Program Integrity, has contracted with a Recovery Audit Contractor to assist in identifying and collecting improper payments paid to providers as a result of billing errors as referenced in 42 CFR 476.71. Section 6411(a) of the Affordable Care Act, Expansion of the Recovery Audit Contractor (RAC) Program amends section 1902(a) (42) of the Social Security Act and requires States to establish a RAC program to enable the auditing of claims for services furnished by Medicaid providers. Pursuant to the statute, these Medicaid RACs must: (1) identify overpayments; (2) recoup overpayments; and (3) identify underpayments. The Centers for Medicare & Medicaid Services (CMS) published the final rule implementing this provision, with an effective date of

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MEDICAID PROGRAM INTEGRITY

RECOVERY AUDIT CONTRACTOR (CONT'D.)

January 1, 2012. States are required to contract with Medicaid RACs "in the same manner as the Secretary enters into contracts" with the Medicare Recovery Auditors. For example, the contingency fee paid to the Medicaid RAC may not exceed that of the highest fee paid to a Medicare Recovery Auditor.

Under this rule, State contracts with Medicaid Recovery Audit Contractors must include the following requirements (or the State must obtain an exemption from CMS for the requirement):

- That each Medicaid RAC hires a minimum of 1.0 FTE Contractor Medical Director who is a Doctor of Medicine or Doctor of Osteopathy licensed to practice in that State.

  Note: SCDHHS has an approved State Plan Amendment to allow the RAC to have a part-time, in-state medical director who is also a practicing physician, in lieu of a 1.0 FTE medical director.

- That each Medicaid RAC also hires certified coders (unless the State determines that certified coders are not required for the effective review of Medicaid claims)
- An education and outreach program for providers, including notification of audit policies and protocols
- Minimum customer service measures such as a toll-free telephone number for providers and mandatory acceptance of provider submissions of electronic medical records on CD/DVD or via facsimile at the providers' request
- Notifying providers of overpayment findings within 60 calendar days
- A 3 year maximum claims look-back period and
- A State-established limit on the number and frequency of medical records requested by a RAC.

  Note: SCDHHS has an approved State Plan Amendment to allow the RAC to review claims that are older than three years. The RAC will only be allowed to review claims older than three years upon written permission of the agency.

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MEDICAID PROGRAM INTEGRITY

RECOVERY AUDIT CONTRACTOR (CONT'D.)

HMS (Health Management Systems, Inc.) is the current Recovery Audit Contractor for the SCDHHS Division of Program Integrity.

BENEFICIARY EXPLANATION OF MEDICAL BENEFITS PROGRAM

The Beneficiary Explanation of Medical Benefits Program allows Medicaid beneficiaries the opportunity to participate in the detection of fraud and abuse. Each month the Division of Program Integrity randomly selects several hundred beneficiaries for whom claims for services were paid. These beneficiaries are provided with an Explanation of Medical Benefits that lists all non-confidential services that were billed as having been delivered to them and which were paid during the previous 45-day period. Beneficiaries are requested to verify that they received the services listed. The Division of Program Integrity investigates any provider when the beneficiary denies having received the services.

BENEFICIARY OVERSIGHT

The Division of Program Integrity performs preliminary investigations on allegations of beneficiary fraud and abuse. This includes, but is not limited to, beneficiaries who are alleged to have:

- Submitted a false application for Medicaid
- Provided false or misleading information about family group, income, assets, and/or resources and/or any other information used to determine eligibility for Medicaid benefits
- Shared or lent their Medicaid card to other individuals
- Sold or bought a Medicaid card
- Diverted for re-sale prescription drugs, medical supplies, or other benefits
- Obtained Medicaid benefits that they were not entitled to through other fraudulent means
- Other fraudulent or abusive use of Medicaid services

Program Integrity reviews the initial application and other information used to determine Medicaid eligibility, and makes a fraud referral to the State Attorney General's Office or other law enforcement agencies for investigation

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MEDICAID PROGRAM INTEGRITY

BENEFICIARY OVERSIGHT (CONT'D.)

as appropriate. Beneficiary cases will also be reviewed for periods of ineligibility not due to fraud but which still may result in the unnecessary payment of benefits. In these cases the beneficiary may be required to repay the Medicaid services received during a period of ineligibility.

Complaints pertaining to beneficiaries' misuse of Medicaid services can be reported using the Fraud and Abuse Hotline (1-888-364-3224) or fraud email at fraudres@scdhhs.gov.

MEDICAID BENEFICIARY LOCK-IN PROGRAM

The Division of Program Integrity manages a Beneficiary Lock-In Program that screens all Medicaid members against clinically-vetted criteria designed to identify drug-seeking behavior and inappropriate use of prescription drugs. The Beneficiary Lock-In Program addresses issues such as coordination of care, patient safety, quality of care, improper or excessive utilization of benefits, and potential fraud and abuse associated with the use of multiple pharmacies and prescribers. The policy implements SC Code of Regulations R 126-425. The Division of Program Integrity reviews beneficiary claims data in order to identify patterns of inappropriate, excessive, or duplicative use of pharmacy services. If beneficiaries meet the lock-in criteria established by SCDHHS, they will be placed in the Medicaid Lock-In Program to monitor their drug utilization and to require them to utilize one designated pharmacy. Beneficiaries who are enrolled in the Lock-In Program with an effective date of October 1, 2014 and forward will remain in the program for two years. The beneficiary has the opportunity to select a pharmacy and has the right to appeal. The program also has provisions that allow the beneficiary to obtain emergency medication and/or go to another pharmacy should the first pharmacy provider be unable to provide the needed services.

DIVISION OF AUDITS

Medicaid providers, who contract with SCDHHS for services, including state agencies, may be audited by the SCDHHS Division of Audits. The SCDHHS Division of Audits was formed to assist the agency in the management, assessment, and improvement of agency programs, services, and operations. The Division of Audits accomplishes these goals by reviewing and evaluating programs administered by SCDHHS to determine the extent to which fiscal, administrative, and programmatic objectives are met in a cost-effective manner.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID PROGRAM INTEGRITY

DIVISION OF AUDITS (CONT'D.)

In performing its audits, the Division of Audits follows generally accepted auditing standards (GAGAS). The Division of Audits performs different types of audits of Medicaid providers and programs, including:

- Performance audits that provide an independent assessment of the program outcomes and the management of resources. These audits address the effectiveness, efficiency, and adequacy of program results.
- Audits of contracts with health care providers and other state agencies to ensure compliance with contract terms and conditions for Medicaid service delivery and administration
- Audits to confirm the accuracy and allowability of costs and other financial information reported to SCDHHS.

PAYMENT ERROR RATE MEASUREMENT

The South Carolina Medicaid program, along with the Medicaid programs in other states, is required to comply with the CMS Payment Error Rate Measurement (PERM) program, which was implemented in federal fiscal year 2007. Each state will be reviewed every three years. PERM requires states to submit a statistically valid sample of paid Medicaid claims to a federal contractor, which will review for compliance with payment rates and state Medicaid policies, and will determine whether medical necessity for the service is adequately documented in the medical record. Providers who are chosen for the sample will be required to submit all applicable medical records for review; however, for most providers only one claim will be chosen for the sample. Providers who fail to send in the requested documentation will face recoupment of the Medicaid payment for the claim in question. In addition if the CMS PERM contractor determines that a Medicaid claim was paid in error, SCDHHS will be required to recoup the payment for that claim. PERM will combine the errors found in each state in order to establish a national Medicaid error rate.

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MEDICAID PROGRAM INTEGRITY

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SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSIONS / PROVIDER EXCLUSIONS / TERMINATIONS

FRAUD

The South Carolina Medicaid program operates under the anti-fraud provisions of 42 US Code §1320a-7b. This federal law relates to both fraud and abuse of the program and identifies illegal acts, penalties for violations, and the individuals and/or entities liable under this section.

The Division of Program Integrity carries out SCDHHS responsibilities concerning suspected Medicaid fraud as required by 42 CFR Part 455, Subpart A. Program Integrity will conduct a preliminary investigation and cooperate with the state and federal authorities in the referral, investigation, and prosecution of suspected fraud in the Medicaid program. Suspicion of fraud can arise from any means, including but not limited to fraud hotline tips, provider audits and program integrity reviews, RAC audits, data mining, and other surveillance activities. SCDHHS refers suspected cases of Medicaid fraud by health care providers to the Medicaid Fraud Control Unit (MFCU) of the State Attorney General's Office for investigation and possible prosecution. SCDHHS also makes referrals to the Bureau of Drug Control for suspected misuse or overprescribing of prescription drugs, especially controlled substances. If a provider suspected of fraud or abuse is also enrolled in a Medicaid Managed Care Organization (MCO), Program Integrity will coordinate the investigation with the MCO(s) involved. Suspected Medicaid fraud on the part of a beneficiary is referred to a Medicaid Recipient Fraud Unit in the State Attorney General's Office for investigation.

PAYMENT SUSPENSIONS

Medicaid payments to a provider may be withheld upon credible allegation of fraud, in accordance with the requirements in 42 CFR §455.23.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER EXCLUSIONS /TERMINATIONS

Suspension of Provider Payments for Credible Allegation of Fraud

SCDHHS will suspend payments in cases of a credible allegation of fraud. A "credible allegation of fraud" is an allegation that has been verified by SCDHHS and that comes from any source, including but not limited to the following:

- Fraud hotline complaints
- Claims data mining
- Patterns identified through provider audits, civil false claims cases, and law enforcement investigations

SCDHHS has flexibility in determining what constitutes a "credible allegation of fraud." Allegations are considered to be credible when they have indications of reliability based upon SCDHHS' review of the allegations, facts, and evidence on a case-by-case basis.

Notice of Suspension

SCDHHS will suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity. Payments may be suspended without first notifying the provider of the intention to suspend payments. SCDHHS will send notice of its suspension of program payments within the following timeframes:

- Within five business days of suspending the payment, unless requested in writing by a law enforcement agency to temporarily withhold such notice
- Within 30 calendar days of suspending the payment, if requested by law enforcement in writing to delay sending such notice

The Notice of Payment Suspension will include all information required to be provided in accordance with 42 CFR §455.23.

All suspension of payment actions will be temporary and will not continue after either of the following:

- SCDHHS or the prosecuting authorities determine that there is insufficient evidence of fraud by the provider
- Legal proceedings related to the provider's alleged fraud are completed

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER EXCLUSIONS /TERMINATIONS

Referrals to the Medicaid Fraud Control Unit

Whenever an investigation leads to the initiation of a payment suspension in whole or part, SCDHHS will make a fraud referral to the South Carolina Medicaid Fraud Control Unit.

Good Cause not to Suspend Payments or to Suspend Only in Part

SCDHHS may find that good cause exists not to suspend payments, or not to continue a payment suspension previously imposed on an individual or entity regarding a credible allegation of fraud, if any of the following are applicable:

- Law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation;
- Other available remedies implemented by SCDHHS will more effectively or quickly protect Medicaid funds;
- SCDHHS determines, based upon the submission of written evidence by the individual or entity that is the subject of the payment suspension, that the suspension should be removed;
- SCDHHS determines that beneficiary access to items or services would be jeopardized by a payment suspension for either of the following reasons:
    - An individual or entity is the sole community physician or the sole source of essential specialized services in a community;
    - The individual or entity serves a large number of beneficiaries within a medically underserved area, as designated by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.
- Law enforcement declines to certify that a matter continues to be under investigation;
- SCDHHS determines that payment suspension is not in the best interests of the Medicaid program.

SCDHHS may also find that good cause exists to suspend payments in part, or to convert a payment suspension previously imposed in whole to one only in part, on any

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER EXCLUSIONS /TERMINATIONS

Good Cause not to Suspend Payments or to Suspend Only in Part (Cont'd.)

individual or entity regarding a credible allegation of fraud, if any of the following are applicable:

- SCDHHS determines that beneficiary access to items or services would be jeopardized by a payment suspension for either of the following reasons:
  - An individual or entity is the sole community physician or the sole source of essential specialized services in a community;
  - The individual or entity serves beneficiaries within a medically underserved area, as designated by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.
- SCDHHS determines, based upon the submission of written evidence by the individual or entity that is the subject of a whole payment suspension, that such suspension should be imposed only in part.
- SCDHHS determines the following:
  - The credible allegation focuses solely and definitively on only a specific type of claim or arises from only a specific business unit of a provider; and
  - A payment suspension in part would effectively ensure that potentially fraudulent claims were not continuing to be paid. If this determination is made by SCDHHS, it will be documented in writing.
- Law enforcement declines to certify that a matter continues to be under investigation.
- SCDHHS determines that payment suspension is not in the best interest of the Medicaid program.

Even if SCDHHS exercises the good cause exceptions set forth above, this does not relieve the agency of its obligation to refer a credible allegation of fraud to the Medicaid Fraud Control Unit.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER EXCLUSIONS /TERMINATIONS

PROVIDER EXCLUSIONS

Federal regulations that give States the authority to exclude providers for fraud and abuse in the Medicaid program are found at 42 CFR Part 1002, Subparts A and B. Exclusion means that a health care provider, either an individual practitioner or facility, organization, institution, business, or other type of entity, cannot receive Medicaid payment for any health care services rendered. Exclusions from Medicaid, as well as the State Children's Health Insurance Program (SCHIP), may be the result of:

- Conviction of a criminal offense related to delivery of services in a health care program
- Conviction of health care fraud under either Federal or State laws
- Conviction of the patient neglect or abuse in connection with delivery of health care
- Excessive claims or furnishing of unnecessary or substandard items and services
- Failure to comply with financial responsibilities and obligations
- Adverse action by a licensing board

Exclusions can be initiated by either federal authorities such as the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG) or by the State Medicaid agency. An excluded individual may be a licensed medical professional, such as a physician, dentist, or nurse, but exclusion is not limited to these types of individuals. The ban on Medicaid funding can extend to any individual or entity providing services that are related to and reimbursed, directly or indirectly, by a Medicaid program.

In addition, the HHS-OIG and/or SCDHHS may exclude an entity, including managed care organizations, if someone who is an owner, an officer, an agent, a director, a partner, or a managing employee of the entity has been excluded.

Any medical provider, organization, or entity that accepts Medicaid funding, or that is involved in administering the Medicaid program, should screen all employees and contractors to determine whether any of them have been excluded. Any individual or entity which employs or contracts with an excluded provider cannot claim Medicaid

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER EXCLUSIONS /TERMINATIONS

PROVIDER EXCLUSIONS (CONT'D.)

reimbursement for any items or services furnished, authorized, or prescribed by the excluded provider.

Federal regulations further require that any party who is excluded from participation in Medicare under 42 CFR Part 1001 must also be excluded from the Medicaid program. Medicaid payment is not available for services furnished directly by, or under the supervision of, an excluded party.

The HHS-OIG maintains the LEIE (List of Excluded Individuals and Entities), a database accessible to the general public that provides information about parties excluded from participation in Medicare, Medicaid, and all other Federal health care programs. Visit the HHS-OIG website at http://www.oig.hhs.gov/fraud/exclusions.asp to search and/or download the LEIE.

SCDHHS also maintains its own list of excluded, South Carolina-only Medicaid providers (or those with a South Carolina connection) on our website. Visit the Provider Information page at http://provider.scdhhs.gov for the most current list of individuals or entities excluded from South Carolina Medicaid.

PROVIDER TERMINATIONS

"Termination" means that the SCDHHS has taken an action to revoke a provider's Medicaid billing privileges, the provider has exhausted all applicable appeal rights or the timeline for appeal has expired, and there is no expectation on the part of the provider or SCDHHS that the revocation is temporary. Under Federal regulations established by the Affordable Care Act, SCDHHS has established the reasons under which a provider can be terminated from the Medicaid program "for cause"; see SCDHHS PE Policy-03, Terminations.

ADMINISTRATIVE SANCTIONS

State regulations concerning administrative sanctions in the Medicaid program are found in South Carolina Regulations at Chapter 126, Article 4, Subarticle 1. SCDHHS may impose one or more of the following sanctions against a provider who has been determined to have abused the program:

- Educational intervention
- Post payment review
- Prepayment review

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER EXCLUSIONS /TERMINATIONS

ADMINISTRATIVE SANCTIONS (CONT'D.)

- Peer review
- Financial sanctions, including recoupment of overpayment or inappropriate payment
- Termination or exclusion
- Referral to licensing/certifying boards or agencies

OTHER FINANCIAL PENALTIES

The State Attorney General's Office may also impose financial penalties and damages against a provider who has been determined to be guilty of fraud or convicted of a crime related to participation in the Medicaid or Medicare programs.

The HHS-OIG may also impose civil money penalties and assessments under the provisions of 42 CFR Part 1003.

FAIR HEARINGS

Proposed South Carolina initiated exclusion or termination from the Medicaid program, as well as recoupment of an overpayment identified by Program Integrity, may be appealed within 30 days of imposition of the sanction. (See "Appeals Procedures" elsewhere in this section.)

Any party who has been excluded or terminated from the Medicaid program as a result of a similar action by Medicare may exercise appeal rights as set forth in the written notice from the HHS-OIG. Appeals to the HHS-OIG shall be processed in accordance with 42 CFR 1001.2007. A party so excluded shall have no right to separate appeal before SCDHHS.

REINSTATEMENT

Re-enrollment in Medicaid by formerly excluded providers is not automatic. The CFR [42 CFR 1002.215(a)] gives states the right to review requests for reinstatement and to grant or deny the requests.

Before a request for re-enrollment in Medicaid will be considered, the provider must have an active, valid license to practice and must not be excluded from Medicaid or Medicare by the HHS-OIG.

It is the provider's responsibility to satisfy these requirements. If the individual was excluded by the HHS-OIG, then the individual must first apply to HHS-OIG for reinstatement and follow any federal requirements.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER EXCLUSIONS /TERMINATIONS

REINSTATEMENT (CONT'D.)

SCDHHS may deny reinstatement to the Medicaid program based on, but not limited to, any one or a combination of the following:

1. The likelihood that the events that led to exclusion will re-occur.
2. If, since the date of the original exclusion, the provider has been convicted of fraud related to the delivery of services in a healthcare program, or has been convicted or had his license suspended or revoked due to failure to follow standards of care and/or patient harm or abuse.
3. If new information is provided that such conduct (as described above) occurred prior to the date of the exclusion but was not known to SCDHHS at the time.
4. If the provider has been excluded or had billing privileges terminated from Medicaid and/or Medicare by any state or by the HHS-OIG.
5. Any terms or conditions associated with reinstatement by the appropriate licensing board or regulatory agency, or by the HHS-OIG.
6. Whether all fines, overpayments, or any other debts owed to the Medicaid program have been paid or arrangements have been made to fulfill these obligations.

All requests for re-enrollment in Medicaid will be considered by SCDHHS on an individual basis and on their own merit.

Any appeal of a denial of reinstatement will be in accordance with SCDHHS appeals policies and procedures as provided by South Carolina Code of Laws R. 126-150.

A terminated provider will also be required to reapply and be reenrolled with the Medicaid program if they wish billing privileges to be reinstated.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

APPEALS

SCDHHS maintains procedures ensuring that all Medicaid providers will be granted an opportunity for a fair hearing. These procedures may be found in South Carolina Regulations at Chapter 126, Article 1, Subarticle 3. An appeal hearing may be requested by a provider when a request for payment for services is denied or when the amount of such payment is in controversy.

The South Carolina Medicaid appeals process is not a reconsideration or claims review process. It is a formal process that should be considered as an avenue of last resort to be used in attempting to resolve or settle a dispute(s). Providers should contact the PSC or submit an online inquiry for assistance to resolve or settle a dispute(s) before requesting an administrative hearing.

In accordance with regulations of SCDHHS, a provider wishing to file an appeal must request a hearing in writing and submit a copy of the notice of adverse action or the remittance advice reflecting the denial in question. Appeals may be filed:

Online: www.scdhhs.gov/appeals

By Fax: (803) 255-8206

By Mail to:

Division of Appeals and Hearings
Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

The request for an appeal hearing must be made within 30 days of the date of receipt of the notice of adverse action or 30 days from receipt of the remittance advice reflecting the denial, whichever is later. Hearings will be held in Columbia unless otherwise arranged. The appellant or appellant's representative must be present at the appeal hearing.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

APPEALS

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SECTION 2

POLICIES AND PROCEDURES

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SECTION 2 POLICIES AND PROCEDURES

PROGRAM OVERVIEW

GENERAL INFORMATION

The South Carolina Medicaid program recognizes all medical services that are medically necessary, unless limitations are noted within the policy restrictions of this manual. The South Carolina Medicaid program is restricted to services for eligible beneficiaries that are provided services by enrolled or contracted providers and rendered within the South Carolina service area.

Note: Medicaid beneficiaries enrolled in special programs may have limits and restrictions for Medicaid reimbursable services. For Managed Care program participants, providers should review the Managed Care supplement provided with this manual for health care services. Please confirm eligibility and coverage by checking Medifax or the South Carolina Medicaid Web-based Claims Submission Tool (if provider is a member).

The South Carolina Medicaid program recognizes the services outlined in this manual and will reimburse providers as defined under the heading "Provider Qualifications" below. All other services are considered non-covered services within the South Carolina Medicaid program. The South Carolina service area is usually defined as within twenty-five miles of the state line. Services rendered outside the service area are subject to the outlined prior approval guidelines. All services are subject to the guidelines and limitations established in this manual.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM OVERVIEW

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SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

PROVIDER QUALIFICATIONS

Physician

For Medicaid billing purposes, the term "physician" includes doctors of medicine and osteopathy who are currently licensed in the state in which they are rendering services by that state's Board of Medical Examiners.

Physician Services

Physician services rendered either in the patient's home, a hospital, a skilled nursing facility, a physician's office, a clinic, or elsewhere are defined as those services provided by, or under the personal supervision of, an individual licensed under state law to practice medicine or osteopathy in the state in which he or she is rendering services. When billing for services, the provider of service must be the same as the provider of service noted in the patient's medical record, unless working in an exceptional situation such as supervision, locum tenens, etc. Additionally, Medicaid providers should bill actual charges for their services rather than the anticipated reimbursement. Please refer to Section 3 of this manual, "Billing Procedures," for more detailed Medicaid billing instructions.

Hospital-Based Physician

A hospital-based physician is defined as a physician licensed to practice medicine or osteopathy who is employed by a hospital, and whose payment for services is claimed by the hospital as an allowable cost under the Medicaid program and billed by the contracted hospital.

Physician's Assistant

A physician assistant (PA) may provide medically necessary covered services so long as the services provided are allowed by State law and consistent with the agreement between the PA and the PA's supervising physician. PAs providing services to Healthy Connections beneficiaries must be enrolled as SC Medicaid providers.

Services rendered and billed under the PA's individual NPI number are reimbursed at 80% of the current Medicaid Family and General Practitioners physician's fee schedule for professional services.

Certified Nurse Midwife

A certified nurse midwife (CNM) must be licensed to practice as a registered nurse and as a certified nurse midwife in the state in which he or she is rendering services. Services are provided under the supervision of a physician preceptor according to a mutually agreed-upon protocol. Reimbursement is 100% of the physician rate.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Licensed Midwife

A licensed midwife is defined as a person who is not a medical or nursing professional licensed by the South Carolina Department of Health and Environmental Control (SCDHEC), for the purpose of providing specifically defined prenatal, delivery, and postpartum services to low-risk women. Reimbursement is 65% of the physician rate.

Certified Registered Nurse Anesthetist (CRNA)

A CRNA must be licensed to practice as a registered nurse in the state in which he or she is rendering services **and** currently certified by the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists. A recent graduate is a new graduate of an advanced formal education program for nurse anesthetist accredited by the national accrediting organization who must achieve certification within one year of graduation. Upon obtaining certification, recent graduates must notify Provider Enrollment to continue practicing as a Medicaid provider. CRNAs may work under the medical direction of a surgeon or under the supervision of an anesthesiologist. CRNAs working under the medical direction of a surgeon or under the supervision of an anesthesiologist will be reimbursed at 50% of the physician rate. CRNAs not working under the direction of an anesthesiologist or supervised by a physician will be reimbursed 87% of the physician rate.

Anesthesiologist Assistant (AA)

An Anesthesiologist Assistant (AA) must be licensed to practice as an AA in the state he or she is rendering services. AAs may only work under the supervision of an anesthesiologist.

Dietitian

A dietitian is defined as any individual meeting the licensure and educational requirements in the state of South Carolina and/or the border states of Georgia and North Carolina. All services must be rendered within the South Carolina Medicaid Service Area (SCMSA). The SCMSA is defined as South Carolina and adjacent areas within 25 miles of its borders.

Paramedical Professionals

The following medical professionals may render services to Medicaid patients under the direct supervision of a licensed physician:

- Audiologists
- Speech pathologists
- Physical therapists
- Occupational therapists
- Licensed master social workers

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Paramedical Professionals (Cont'd.)

- Psychiatric nurse practitioners
- X-ray or lab technicians
- Licensed respiratory therapists
- Nurse midwives
- Nurse practitioners (NPs)

Reimbursement will be made to the supervising physician or hospital where the professional is employed, and where the service is rendered, under the restrictions set forth in this manual. If any of these medical professional services are included in a hospital cost report, they cannot also be billed separately as professional services.

CERTIFIED NURSE PRACTITIONER (CNP) AND CLINICAL NURSE SPECIALIST (CNS)

The CNP/CNS may enroll with South Carolina Medicaid and be assigned a Medicaid ID number if he or she meets all of the following criteria:

- Licensed to practice as a registered nurse
- Licensed as a CNS/CNP in the state in which he or she is rendering services
- Practicing under a physician preceptor according to a mutually agreed-upon protocol

CNP/CNSs may bill for services under their physician preceptor's NPI number or under their individual NPI number (NP + 4 digits).

The services they render are limited to those that are allowed under state law and are documented in the approved written protocol.

Delegated acts and protocols that outline the scope of practice guidelines for NPs, CNMs, CNs, or PAs should be current and available in the personnel file of the supervised practitioner. Upon submission of a claim, the rendering physician is attesting that the services have been accurately and fully documented in the medical record and that he or she assumes responsibility for the NP, CNM, CNS, or PA. The claim also confirms that the provider has certified the medical necessity and reasonableness for the service(s) submitted to Medicaid for payment. This policy does not supersede state law, as it relates to requirements, for off-site practice protocols that outline co-signature guidelines for PAs. These requirements can be found in Article 7, Section 40-47-955, of the South Carolina Physician Assistants Practice Act.

Services rendered and billed under the NP individual NPI number are reimbursed at 80% of the physician's fee schedule for evaluation and management codes and all professional codes, and 100% for supplies

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

CERTIFIED NURSE PRACTITIONER (CNP) AND CLINICAL NURSE SPECIALIST (CNS) (CONT'D.)

and pathology services. Fee schedules are located on the SCDHHS website at http://www.scdhhs.gov.

Any CNP/CNS employed by a hospital will be ineligible to submit claims for his or her services, as these services are included in the hospital cost report.

To request a CNP/CNS enrollment form, contact Provider Enrollment at 1-888-289-0709.

Direct Physician Supervision

For Medicaid billing purposes, direct supervision means that the supervising physician is accessible when the services being billed are provided; and, the supervising physician is responsible for all services rendered, fees charged and reimbursements received.

Co-signatures

Effective with dates of service on or after January 1, 2010, SCDHHS will discontinue the requirement of the physician's co-signature in a medical record when services are performed by the following professionals:

- Nurse Practitioner (NP)
- Certified Nurse-Midwife (CNM)
- Certified Nurse Specialist (CNS)
- Physician Assistant (PA)

Delegated acts and protocols that outline the scope of practice guidelines for NP, CNM, CNS, or PA should be current and available in the personnel file of the supervised practitioner. Upon submission of a claim, the rendering physician is attesting that the services were accurately and fully documented in the medical record and that he or she assumes responsibility for the NP, CNM, CNS, or PA. The claim also confirms the provider has certified the medical necessity and reasonableness for the service(s) submitted to Medicaid for payment.

This policy update does not supersede state law as it relates to requirements for off-site practice protocols that outlines when co-signatures are required for PAs. These requirements can be found in Article 7 of the South Carolina Physician Assistants Practice Act section 40-47-955.

Clinics and Ancillary Services

Under the Omnibus Budget Reconciliation Act of 1989 (OBRA '89), several specific types of health professionals and facilities are eligible for enrollment in the South Carolina Medicaid program. Their services are compensable only for beneficiaries with special needs, age 21 and under, and are related to an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) exam.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Clinics and Ancillary Services (Cont'd.)

These providers include physical therapists, occupational therapists, speech therapists, and audiologists. Facilities and private therapists providing rehabilitative services have to meet certain qualifications. Guidelines for these services are outlined in the "Rehabilitative Services Policies and Procedures" manual available online at www.scdhhs.gov.

Federally Qualified Health Centers and Rural Health Clinics are eligible for participation under South Carolina Medicaid. For information and policy guidelines on these clinics, call the SCDHHS Provider Service Center (PSC) at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us.

BILLING REQUIREMENTS/ REIMBURSEMENT

Services Outside of the Country

Medicaid will not provide any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States.

Pre- and Post-Payment Review

All Medicaid claims, including claims for surgery, are paid through an automated claims processing system. These claims are subject to pre-payment edits and may require documentation. If a prepayment edit is received, providers must file a new claim and submit documentation to support medical necessity.

Post-payment reviews are conducted regarding utilization, appropriateness, medical necessity, and other factors.

All claims and reimbursements are subject to post-payment monitoring and recoupment if review indicates a claim was paid inappropriately or incorrectly. Providers are required to maintain and disclose their records consistent with Section 1 of this manual.

SCDHHS reserves the right to request medical records at any time for purposes of medical justification and/or review of billing practices.

Physician's Office Within an Institution

When a physician establishes an office within a nursing home, hospital, or other institution, coverage of services and supplies furnished in the office must be determined in accordance with the "incident to a physician's professional services" criteria as determined by federal regulations. A physician's office within an institution must be confined to a separately identified part of the facility that is used solely as the physician's office and cannot be construed to extend throughout the entire institution. Thus, services performed outside the "office" area will be subject to coverage rules applicable to services furnished outside the office setting (*i.e.*, a technical component that is included in the institutional reimbursement).

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Physician's Office Within an Institution (Cont'd.)

Consideration must be given to the physical proximity of the institution and the physician's office. When his or her office is located within a facility, a physician may not be reimbursed for services, supplies, or use of equipment that falls outside the scope of services "commonly furnished" in physician's offices. Additionally, a distinction must be made between the physician's office practice and the institution, especially when the physician is the administrator or owner of the facility. Thus, for their services to be covered the auxiliary medical personnel must be members of the office staff rather than of the institution's staff, and the cost of supplies must represent an expense of the physician's office practice. Finally, the physician must directly supervise services performed by the employees of the physician outside the "office" area; his or her presence in the facility as a whole is not sufficient.

Teaching Physician Policy: Requirements for Billing

Services provided by residents under the direct supervision of a teaching physician are billable to Medicaid. For Medicaid billing purposes, direct supervision means that the teaching physician is accessible, as defined in Subsection I, when the resident provides the services being billed. The teaching physician is responsible for all services rendered, fees charged, and reimbursements received. The services must be documented, as defined in Subsection II, in the patient's medical record. The supervising physician must sign the patient's medical record, indicating that he or she accepts responsibility for the services rendered.

For the purpose of the policy, the following definitions apply:

- **Resident** – A resident is an individual who participates in an approved graduate medical education (GME) program, or a physician who is not in an approved GME program but who is authorized to practice only in a hospital setting. The term includes interns and fellows in GME programs recognized as approved for purposes of direct GME payments made by the fiscal intermediary.
- **Medical Student** – A medical student is an individual who is enrolled in a program culminating in a degree in medicine. Any contribution of a medical student to the performance of a billable service or procedure must be performed in the physical presence of a teaching physician or jointly with a resident in the course of providing a service meeting the requirements set forth for teaching physician billing.
- **Teaching Physician** – A teaching physician is an individual who, while functioning under the authority and responsibility of a resident program director, involves resident and/or medical students in the care of his or her patients or supervises residents in the care of patients.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

SUBSECTION I: ACCESSIBILITY OF THE TEACHING PHYSICIAN

Accessibility of the teaching physician while the resident is providing a service is defined as follows for particular service types.

Ambulatory Services

Accessibility of the teaching physician for supervision of ambulatory services requires the teaching physician to be present in the clinic or office setting while the resident is treating patients. The physician is thus immediately available to review the patient's history, personally examine the patient if necessary, review the records of the encounter and laboratory tests, confirm or revise the diagnoses, and determine the course of treatment.

Inpatient Services

Accessibility of the teaching physician for supervision of non-procedural inpatient services requires that the teaching physician evaluate the patient within 24 hours of admission and on each day thereafter for which services are billed. The teaching physician must review the patient's history, personally examine the patient as needed; review the records of the encounter and laboratory tests, confirm or revise the diagnoses; and determine the course of treatment.

Procedures

Minor Procedures – For supervision of procedures that take only a few minutes to complete or involve relatively little decision-making once the need for the procedure is determined, accessibility requires that the teaching physician be on the premises and immediately available to provide services during the entire procedure.

All Other Procedures – For supervision of all other procedures, accessibility requires that the teaching physician be physically present during all critical and key portions of the procedure and be immediately available to provide services during the entire procedure.

Subsection II: Documentation of the Teaching Physician

Documentation for services must include a description of the presence and participation of the teaching physician. The resident may document the encounter, to include a note that describes the involvement of the teaching physician. The teaching physician's signature is then adequate to confirm agreement.

Documentation of an encounter by the teaching physician may reference portions of a medical student's notes. The combined entries of the medical student, resident, and teaching physician must be adequate to substantiate the level of service required and billed. Documentation must include the teaching physician's signature for each encounter.

Reciprocal Billing and Locum Tenens Arrangements

Reciprocal Billing

A physician may submit claims and receive payment for covered visit services (including emergency visits and related services) that the physician arranges to be provided by a substitute physician on an occasional reciprocal basis.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Locum Tenens Arrangements

It is a longstanding and widespread practice for physicians to retain substitute physicians to take over their professional practices when the regular physician is absent for reasons such as illness, pregnancy, vacation, or continuing medical education. The regular physician usually bills using his or her Medicaid provider number and receives payment for the substitute physician's services as though the regular physician performed them personally. The regular physician generally pays the substitute physician a fixed amount per diem, with the substitute physician having the status of an independent contractor rather than an employee. These substitute physicians are generally called "locum tenens" physicians.

A physician may submit claims and receive payment for covered visit services (including emergency visits and related services) of a locum tenens physician who is not an employee of the regular physician, and whose services for the regular physician's patients are not restricted to the regular physician's office.

The following requirements must be met for both reciprocal billing and locum tenens arrangements:

- The regular physician must be unavailable to provide the visit services.
- The Medicaid beneficiary must have arranged or be seeking to schedule the visit services from the regular physician.
- The substitute physician must meet the same licensing requirements as required by Medicaid. However, Medicaid enrollment is not required.
- The substitute physician cannot provide the visit services to Medicaid beneficiaries over a continuous period of longer than 60 days.
- Claims should be filed using the regular physician's Medicaid Provider ID or NPI number.

The regular physician's office must keep on file a record of each service provided by the substitute physician and make this record available to Medicaid upon request. "Covered visit services" include those services ordinarily characterized as a covered physician visit, as well as any other covered items and services furnished by the substitute physician or by others as incident to the physician services.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

PROGRAM SERVICES

EVALUATION AND MANAGEMENT SERVICES

Please refer to the Current Procedural Terminology (CPT) when multiple evaluation and management services are provided on the same date of service.

Primary Care Services

Guidelines in this section include South Carolina Medicaid policies for general medical care, such as office exams and hospital or nursing home visits.

These services are predominantly billed to Medicaid by Primary Care Physicians such as family physicians, internists, general practitioners, obstetrician/gynecologists, and pediatricians. However, the guidelines are written for all physicians rendering services to South Carolina citizens who are Medicaid beneficiaries.

SCDHHS will implement 42 CFR Part 438, 441, and 447 for services provided January 1, 2013 through December 31, 2014. This action implements the Affordable Care Act (ACA) requirement that increases payments to physicians with a specialty designation of family medicine, general internal medicine, pediatric medicine, and related subspecialists for specified primary care services and charges for vaccine administration under the Vaccines for Children Program.

To qualify for the enhanced rates, a physician must self-attest to one of the following criteria:

- Board certification in one of the specialty designations by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS) or the American Osteopathic Association (AOA)
- Sixty (60) percent of all Medicaid services billed, or provided in a managed care environment in Calendar Year 2012 (January 1, 2012 to December 31, 2012) were for E& M codes 99201-99499 and vaccine administration codes 90460, 90461, 90471, 90472, 90473 and 90474. (Newly enrolled, non-board certified physicians in one of the designated specialties are eligible if they attest to meeting the 60 percent threshold in the prior month).

For additional information, providers should contact the PSC at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us for more information.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Records and Documentation Requirements

The appropriate medical documentation must appear in the patient's medical record to justify medical necessity for the level of service reimbursed, including the illness, history, physical findings, diagnosis, and prescribed treatment. The record must reflect the level of service billed and must be legible.

Procedural and Diagnostic Coding

For dates of service on or before **September 30, 2015**, Medicaid recognizes the medical terminology as defined in the *Current Procedural Terminology (CPT), Fourth Edition*, published by the American Medical Association; and the diagnosis codes as defined in the *International Classification of Diseases, Ninth Edition (ICD-9),* and provided by the U.S. National Center for Health Statistics.

For dates of service on or after **October 1, 2015**, Medicaid recognizes the medical terminology as defined in the Current Procedural Terminology (CPT), Fourth Edition, published by the American Medical Association; and the diagnosis codes as defined in the International Classification of Diseases, Tenth Edition (ICD-10), and provided by the U.S. National Center for Health Statistics.

In 1996, the Centers for Medicare and Medicaid Services (CMS) implemented the National Correct Coding Initiative (CCI) to control improper coding that leads to inappropriate increased payment for health care services. The South Carolina Medicaid program utilizes Medicare reimbursement principles. Therefore, the agency will use CCI edits to evaluate billing of CPT codes and Healthcare Common Procedure Coding System (HCPCS) codes by Medicaid providers in post-payment review of providers' records. For assistance in billing, providers may access the CCI Edit information online at the CMS website, http://www.cms.hhs.gov/NationalCorrectCodInitEd/.

Office/Outpatient Exams

Definitions

Some phrases commonly used to describe a patient's relationship to a physician or practice group are defined as follows:

- **New Patient** – Medicaid defines a new patient as one visiting the office for the first time. A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years. An exception can be justified if all records are lost or destroyed.
- **Established Patient** – An established patient is one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Definitions (Cont'd.)

The designation of new or established patient does not preclude the use of a specific level of services. Medicaid will reimburse no more than one visit per day unless medically justified. If a second visit is medically necessary, the second visit must be clearly documented in the patient's chart.

In the instance where a physician is on call for or covering for another physician, the patient's encounter is classified as it would have been by the physician who is not available. For example, if the patient is an established patient of the physician who is not available, then the covering physician would also report his or her services as an established patient visit.

After Hour Services

Effective April 1, 2013 CPT codes 99050 and 99051 are covered for Primary Care Providers (Pediatrician's, Family Practice, General Practice, Internal Medicine and OB/GYN). Providers will be able to bill the evaluation and management code that best describes the level of service being rendered.

99050: Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (i.e., holidays, Saturday or Sunday), in addition to basic service.

99051: Services provided in an office during regularly scheduled office hours, evening, weekend, or holiday

The purpose of this coverage is to encourage expanded office hours. SCDHHS defines CPT code 99050 to mean all patients scheduled outside published business hours; this would not include a visit that was scheduled at 4:00 p.m. and the patient was not seen by the physician until 6:30 p.m. For CPT code 99051, SCDHHS defines evening hours to be any time after 6:00 p.m. and before 8:00 a.m. Weekends are defined as Saturday 8:00 a.m. to Monday 8:00 a.m. Providers may only bill for the following holidays, the day of New Year's, Independence, Labor, Thanksgiving and Christmas. Holidays are defined as 8:00 a.m. the morning of the holiday until 8:00 a.m. the following morning. After- hours procedure codes are not covered when the service is provided in a hospital emergency department, an inpatient setting, outpatient setting, or an urgent care facility (place of service codes 20, 21, 22, and 23). The reimbursement for each of these CPT codes will be $12.00. All CPT codes, claims submission and policy will be subject to review by the Department of Program Integrity.

Levels of Service

Medicaid recognizes the terminology in the CPT for the levels of services as established criteria for billing office visits.

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Ambulatory Care Visit Guidelines

Medicaid patients ages 21 and older are allowed 12 ambulatory care visits (ACVs) per year, commencing on July 1st of each year. Beneficiaries under age 21 are exempt from this limitation.

Ambulatory care has been defined as all outpatient examinations, to include paid claims for the following types of examinations:

- Encounter Codes T1015
- Psychiatric Diagnostic Exam 90791, 90792
- Physician Examinations 99201-99205, 99212-99215
- Consultations 99241-99245
- Healthy Adult Physical 99385-99387

The following services **do not** count toward the ACV limit:

- Maternal care codes, including antepartum and postpartum care codes
- Established visit codes 99212 and 99213 billed with a primary or secondary pregnancy diagnosis code
- Family Planning visits when billed with the FP modifier (service provided as part of family planning program) or the family planning codes. Please refer to "Obstetrics and Gynecology" in this section for the codes.
- EPSDT screenings
- Minimal exams performed without a physician's direct involvement for ongoing therapies, blood pressure checks, injections, etc., if billed using CPT code 99211
- Emergency department services
- Ambulatory visits for beneficiaries who are currently being treated for HIV/AIDS. These recipients will be exempt from the ACV limit even if the services being provided are not related to the actual cancer treatment.

  Note: In order to bill for these services, providers must attach the "P4" modifier (a patient with severe systemic disease that is a constant threat to life) to the appropriate Evaluation and Management (E&M) code. All claims will be subject to post-payment review by Program Integrity.
- Ambulatory visits for beneficiaries who are currently being treated for cancer. These recipients will be exempt from the

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PROGRAM SERVICES

Ambulatory Care Visit Guidelines (Cont'd.)

ACV limit even if the services being provided are not related to the actual cancer treatment.

Note: In order to bill for these services, providers must attach the "P4" modifier to the appropriate Evaluation and Management (E&M) code. All claims will be subject to post-payment review by Program Integrity.

- Ambulatory visits medically necessary for patients identified by their physician as having a medical need to exceed the 12 ambulatory visit limits. (Please refer to the "Medical Necessity Guidelines" below for more detail.)

Medical Necessity Guidelines

SCDHHS has modified its policy concerning the potential approval of additional ambulatory care visits. To be reimbursed for additional visits over the 12-visit limit, providers must submit a letter directly to Physicians Services requesting additional visits. The letter must be on office letterhead and include the provider's National Provider Identifier (NPI) number, the patient's name and Medicaid ID number, and the physician's signature. Providers must also provide the medical reasons for the request. SCDHHS Operations and Provider Relations will reply, in writing, with approval or denial and the number of additional visits granted if approved. Prescription or 'fill-in-the-blank' form documents will not be accepted. This process is closely monitored for medical necessity and abuse. Please send all requests to:

Healthy Connections Medicaid
Attn: Ambulatory Care Visit Review
Post Office Box 8206
Columbia, SC 29202-8206

The department's copayment policy will continue with each of the authorized additional visits.

In order to avoid possibly receiving a 977 edit for exceeding the 12 allowable ambulatory visits when filing the claim, providers must attach the letter of approval from the SCDHHS Medical Director to the claim. This letter must accompany each claim in order for it to suspend to the program area for review. Additionally, the letter of approval should be maintained in the patient's medical records in the event of a post payment review. Claims must be submitted within the timely filing guidelines.

All covered ancillary services, including other diagnostic lab and x-ray services, are compensable. Surgical procedures, hospital care, and other medically necessary services will be reimbursed by South Carolina Medicaid, regardless of the number of ambulatory visits used by the patient.

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PROGRAM SERVICES

Ambulatory Care Visit Guidelines (Cont'd.)

Verifying the beneficiary's coverage will reflect the estimated visits remaining at the time of service. The estimated visits only reflect the number of exams paid by Medicaid through the claims processing system (MMIS), and should not be considered a guarantee of payment.

When any services are rendered, providers should always request the beneficiary's Medicaid card and verify coverage. However, possession of the card does not guarantee Medicaid eligibility. Beneficiaries may become ineligible for Medicaid for a given month, only to regain eligibility at a later date. It is possible a beneficiary will present a card during a period of ineligibility. It is very important to verify Medicaid eligibility, coverage, and type prior to providing services.

Medicaid eligibility can be verified through the South Carolina Medicaid Web-Based Claims Submission Tool (Web Tool). Please contact the SCDHHS Medicaid Provider Service Center at 1-888-289-0709 for further information.

All examinations rendered after the patient has exhausted his or her ambulatory care visits will be rejected. **Edit 977 will appear on the rejection notice. The provider is responsible for the exam charge.**

Exceptions to the 977 Edit

Exceptions may be made to this edit under the following criteria:

- SCDHHS has modified the policy regarding Ambulatory Care Visits (ACV) for beneficiaries residing in a nursing home or long-term care facility. Claims with the place of service 31 (Skilled Nursing Facility [SNF]), 32 (Nursing Facility), 33 (Custodial Care Facility), and 54 (Intermediate Care Facility/ Intellectually Disabled) will be exempt from the ACV limit of 12 visits.

  A new claim must be submitted within six months of the rejection with a copy of verification of coverage attached indicating ambulatory visits were available for the date of service being billed. The availability of ambulatory visits must have been verified on the actual date of service being billed or the day before.

- If the visit code was a line item rejection and other services paid on the claim, the provider must file a new claim within six months of the rejection with a copy of verification of coverage indicating ambulatory visits were available for the date of service being billed. The availability of ambulatory visits must have been verified on the actual date of service being billed or the day before.

- All timely filing requirements must be met.

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PROGRAM SERVICES

Exceptions to the 977 Edit (Cont'd.)

A provider has the option to bill the patient for the non-covered office visit only. Medicaid will reimburse lab work, injections, x-rays, etc. done in addition to the office visit.

Another available option is to change the office visit code in field 17 to the minimal established office E/M code, 99211, and accept the lower reimbursement. This code does not count toward the ambulatory visit limit.

Additional Ambulatory Services

Services commonly rendered in addition to an office exam are compensable if medically necessary. Diagnostic procedures such as lab and x-ray are compensable as separate charges.

Laboratory Services

Diagnostic lab services are compensable as separate charges when the provider actually renders the service and CMS's Clinical Laboratory Improvement Amendments (CLIA) certification standards are met. The appropriate lab service must be coded with a CPT code in the 80000 range.

If the provider only extracts the specimen to send to an outside independent laboratory or hospital laboratory, then the physician cannot charge for the lab test. When the specimen is sent to the independent lab or hospital lab, report the patient's Medicaid number and the lab will bill for their service. The physician should send the specimen(s) to Medicaid-enrolled labs or the beneficiary will be responsible for the lab charges and should be informed prior to having the specimen taken.

A handling service is compensable to the physician if the specimen is collected by venipuncture or catheterization. In addition, collection of pap smears may be charged. Please refer to "Initial OB Exam" guidelines in this section for handling service codes for pap smears. Medicaid will not reimburse for special handling of specimens using either procedure code 99000 or 99001.

X-ray and EKG Services

Medicaid will reimburse only one provider for the interpretation of diagnostic x-rays and EKGs. Reinterpretations, after a physician has interpreted and reported the test, are not allowed. Please refer to "Radiology" in this section for guidelines for further details.

If an outside source performed the technical part of an x-ray or EKG, then the physician should bill only the professional component.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Special Services/Visits

Postoperative Follow-up Visit – Procedure code 99024 is non-compensable. Please refer to surgical package guidelines under "General Surgery Guidelines" in this section.

Emergency Office Services – Procedure code 99058 may be billed in addition to the appropriate level office E/M code when office services are provided on an emergency basis (after posted office hours).

Procedure codes 99051 through 99056 are non-compensable.

Supplies

Supplies are reimbursable when provided in the physician's office using the following list of procedure codes **only.** All other supplies are reimbursable through DME providers only.

Major Surgical Tray – Reimbursement may be allowed for a surgical tray when minor surgery is performed in a physician's office that necessitates local anesthesia and other supplies (*i.e.*, gauze, sterile equipment, suturing material, etc.). If the procedure code description includes anesthesia, only the minor surgical tray can be billed. When a major surgical tray is used, local anesthesia cannot be billed separately. Reimbursement will not be provided when a hospital outpatient department or Skilled Nursing Facility supplies the tray.

To report, use supplemental procedure code A4550 for a major surgical tray. A major surgical tray may not be charged for a suture removal tray.

Minor Surgical Tray – A minor surgical tray includes those trays necessary for suture removal, minor debridement, superficial foreign body removal, or incision and drainage of superficial abscess. To report use the supplemental code 99070.

Small Supplies and Materials – Procedure code 99070 is used to bill for supplies provided by the physician (except spectacles), which are over and above those usually included with the office visit or other services rendered. Procedure code 99070 can be used when a starter dose of a one-to-three-day supply purchased by the physician is given to assist in the diagnostic or treatment process. Surgical dressings are compensable if the supplies are medically necessary. Documentation should indicate what supply was used or provided. Charges billed should indicate the actual cost to the physician.

Splints and Casts –- These items are reimbursable only under certain circumstances. For details, refer to the musculoskeletal system under the heading "Surgical Guidelines for Specific Systems" in this section.

The following additional supply codes are listed with a description**:**

A4263 – Lacrimal Puncture Plugs

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PROGRAM SERVICES

Supplies (Cont'd.)

A4340 – Indwelling Catheter

A4357 – Urinary Drainage Bag

A4358 – Urinary Leg Bag

A4550 – Major Surgical Tray (including anesth. inject)

A4570 – Splint

A4580 – Cast Supplies (*e.g.*, plaster)

A4590 – Special Casting Material (*e.g.*, fiberglass)

A4627 – Spacer, bag, or reservoir with/without mask

A9500 – Sestamibi

A9502 – Supply of Radiopharmaceutical (Technetium)

A9503 – Technetium Medronate (up to 30 mCi)

A9505 – Thallous Chloride

A9600 – Strontium

E0112 – Crutches, wooden, pair

J7300 – Paraguard Intrauterine Device (IUD),cost

L0120 – Cervical Collar, flexible, foam

L0150 – Philadelphia Cervical Collar, semi-rigid

L1610 – Pavlik Harness

L1830 – Knee Immobilizer, canvas longitudinal

L3650 – Shoulder Immobilizer

L3660 – Figure 8 Mobilizer

L3670 – Acromioclavicular Brace

A4267 – Family Planning Condoms

A4269 – Contraceptive Supply, Spermicide (*e.g.* vaginal foam/cream, suppositories, contraceptive gel/sponge)

99070 – Minor Surgical Tray

A4614 – Peak Flow Meter

V5264 – Ear Mold, not disposable, any type (use LT or RT modifier)

V5265 – Ear Mold, disposable, any type (use LT or RT modifier)

Q0144 – Zithromax, oral, 1 gram, single dose

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PROGRAM SERVICES

Supplies (Cont'd.)

V2500 – Contact Lens, spherical, per lens

V2501 – Contact Lens, toric/prism ballast, per lens

V2510 – Contacts, gas permeable, spherical, per lens

V2511 – Contacts, gas permeable, toric/prism, per lens

V2520 – Contacts, hydrophilic, spherical, per lens

V2521 – Contacts, hydrophilic, toric/ballast, per lens

V2630 – Anterior Chamber Intraocular Lens

V2632 – Posterior Chamber Intraocular Lens

29105 – Application of Long Arm Splint

29125 – Application of non-moveable, short arm splint (forearm to hand)

29126 – Application of moveable, hinged short arm splint (forearm to hand)

29130 – Application of non-moveable, hinged finger splint

29131 – Application of moveable, hinged finger splint

29445 – Application of Rigid Total Contact Cast

29505 – Application of Long Leg Splint

29515 – Application of Short Leg Splint

99070 – Supplies and Materials

99071 – Educational Supplies

This supply list is not all-inclusive. Some supply codes specific to certain specialties may be listed in those sections.

Convenient Care Clinics

Effective with dates of services on or after August 1, 2012, the SCDHHS will now allow Convenient Care Clinics (CCCs) to enroll as a provider group for billing purposes. CCCs are located in retail stores, supermarkets and pharmacies and are able to treat uncomplicated minor illnesses and provide preventative healthcare services. They are often referred to as retail clinics, retail-based clinics, or walk-in medical clinics.

CCCs must bill Medicaid using Place of Service Code 17 as defined by the American Medical Association's current procedural terminology for a walk-in, retail health clinic. Covered services for this place of service are limited to episodic care and wellness/preventative services. Wellness/preventative services are covered for recipients five years and older.

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PROGRAM SERVICES

Convenient Care Clinics (Cont'd.)

Episodic Care for adults and children is defined as a pattern of medical and nursing care in which services are provided to a person for a particular problem, without an ongoing relationship being established between the patient and the health care professionals. Examples of Episodic Care include, but are not limited to allergies, bronchitis, ear infections, flu-like symptoms, mononucleosis, motion sickness, blisters, minor burns, minor cuts, sprains, and strains. Episodic care (*i.e.*, sick visits) is covered for all ages, subject to the Convenient Care Clinics Internal policies governing initial age for treatment.

CCCs are required to send information regarding a service to the primary care physician (PCP) by facsimile within 24 hours of the visit and maintain confirmation of receipt of the facsimile in the patient's file.

Covered Services

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for this provider type is limited to children five years and older. For additional program billing and reimbursement policy information, please refer to "EPSDT" heading in this section.

Immunizations

Vaccinations are covered as indicated in the "Immunization" heading in this section.

Diabetes Patient Education

Diabetes Management services are medically necessary, comprehensive self-management and counseling services provided by programs enrolled by SCDHHS. Enrolled programs must adhere to the National Standards for Diabetes Self-Management Education and be recognized by the American Diabetes Association, American Association of Diabetes Educators, Indian Health Services, or be managed by a Certified Diabetes Educator. An eligible beneficiary must have a diabetes diagnosis and be referred by their primary care physician. For details on this service, please refer to the Diabetes Management Services Provider Manual. Contact the PSC for a list of recognized programs in your area or information on how to become a provider of diabetes education.

Preventative Services

Preventive measures are defined as any routine service exam for adults or children when the procedures are performed in the absence of an illness or complaint(s). A well visit and a sick visit cannot be billed on the same date of service. Generally, the South Carolina Medicaid program requires that a complaint or illness be recorded before a service is compensable. The exceptions to this policy are the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program and the Healthy Adult Physical Exams program.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Preventative Services (Cont'd.)

The Medicaid program sponsors adult physical exams under the following guidelines:

- The exams are allowed once every two years per patient.
- The patient must be 21 years of age or older
- For dates of service on or before **September 30, 2015**, procedure code 99385-99387 and 99395-99397 for the appropriate age and diagnosis code V70.9 should be used when billing.

  For dates of service on or after **October 1, 2015**, procedure code 99385-99387 and 99395-99397 for the appropriate age and diagnosis code Z00.8 should be used when billing.

  - 99385 – Preventative visit, new, age 18-39
  - 99386 – Preventative visit, new, age 40-64
  - 99387 - Preventative visit, new, age 65+

This exam may also be offered to patients with Medicare and Medicaid (dually eligible or qualified Medicare beneficiary).

- A past history for a new patient or an interval history on an established patient.
- A generalized physical overview of the following organ systems:
  - EENT
  - Lungs
  - Abdomen
  - Skin
  - Breasts (Female)
  - External Genitalia
  - Heart
  - Back
  - Pelvic (Female)
  - Prostate (Male)
  - Rectal
  - Brief Neurological
  - Brief Muscular

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PROGRAM SERVICES

Preventative Services (Cont'd.)

- Brief Skeletal
- Peripheral Vascular

Family planning counseling must be offered if the patient is female within childbearing years or men. (An additional family planning code may be billed for this service when provided. Please refer to "Obstetrics and Gynecology" in this section for the description of codes.)

The following lab procedures are included in the reimbursement for a physical:

- Hemocult
- Urinalysis
- Blood Sugar
- Hemoglobin

Any other lab procedures, x-rays, etc., may be billed separately. Portions of the physical may be omitted if not medically applicable to the patient's condition or if the patient is not cooperative and resists specific system examinations (despite encouragement by the physician, NP or office staff). A note should be written in the record explaining why that part of the exam was omitted.

Note: College physicals, DOT physicals, and administrative physicals are not covered services.

Family Planning Services

Family Planning is a limited benefit program available to men and women who meet the appropriate federal poverty level percentage in order to be eligible. This program provides coverage for physical examinations, Family Planning services, Family Planning-related services, and some preventive health screenings. Services provided to men and women enrolled in Family Planning that are not specifically outlined below are the sole responsibility of the beneficiary.

Note: Not all Family Planning Services can be performed in all Convenient Care Clinics (CCCs) therefore, please review your licensure and requirements from the South Carolina Labor and Licensing Regulatory (SCLLR) authority and Department of Health and Environmental Control (DHEC).

Covered Services

Section 4 of this manual contains the list of procedure codes, diagnosis codes, and an approved drug list for the Family Planning Program. While there are codes that may be considered Family Planning services other than the ones listed, they are not covered for this eligibility group. The lists will be updated periodically as codes are added or deleted. All

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PROGRAM SERVICES

Covered Services (Cont'd.)

services, with the exception of referral codes **S0316** and **S0320**, provided to Family Planning beneficiaries must be billed using a FP modifier and approved family planning diagnosis code.

Examinations/Visits

Four types of visits are covered for beneficiaries enrolled in the Family Planning Program. These visits include biennial (once every two years) physical examinations, annual family planning evaluation/management visits, periodic family planning visits, and contraceptive counseling visits.

Biennial Physical Examination

The Family Planning Program sponsors adult physical examinations under the following guidelines:

- The examinations are allowed once every two years per beneficiary.
- The examinations are preventive visits.
- Procedure code G0438 should be used for new patients and G0439 for established patients.
- A FP modifier must be used when billing these codes for Family Planning beneficiaries.
- For dates of service on or before **September 30, 2015**, diagnosis code V70.0 must be used when billing these codes for Family Planning beneficiaries.

  For dates of service on or after **October 1, 2015**, diagnosis code Z00.00 or Z00.01 must be used when billing these codes for Family Planning beneficiaries.

The examinations can be performed by a nurse practitioner, physician assistant, or physician.

The adult physical examination for Family Planning beneficiaries is a preventive, comprehensive visit and should contain the following components, at a minimum:

- A past family, social, and surgical history for a new patient or an interval history for an established patient
- Height, weight, and BMI
- Blood pressure
- A generalized physical overview of the following organ systems:
  - Abdomen
  - Back
  - Heart
  - Lungs

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Biennial Physical Examination (Cont'd.)

- Breasts (Female)
- Brief Muscular
- Brief neurological
- Brief Skeletal
- EENT
- External Genitalia
- Pelvic (Female)
- Peripheral Vascular
- Prostate (Male)
- Rectal
- Skin

- Age, gender and risk appropriate preventive health screenings, according to the United States Preventive Services Task Force Recommendations (Grade A & B only)

For more information on these recommendations, please visit http://www.uspreventiveservicestaskforce.org.

Screenings

Check Up covers a limited amount of prevention screening. Please refer to the USPSTF Grade A & B recommendations as of August 1, 2014 listed in the chart below.

USPSTF Grade A & B Recommendations as of August 1, 2014

Description	Appropriate for the following Family Planning Beneficiaries	Allowable Codes	Required Modifier	Provider Type Requirements	Notes
Age and Risk-Appropriate Screenings for the Following: • Alcohol Misuse • BRCA Screening Questions • Depression Intimate Partner Violence • Obesity • Tobacco Use Low-Intensity Counseling for the Following: • Healthy Diet • Skin Cancer Prevention	• All adults	96150 96151 96152	FP	NP, PA or Physician	Must occur during physical exam
Cholesterol Abnormalities Screening	• Men ages 35+ • Men ages 20-35 if at increased risk for coronary heart disease • Women ages 20+ if at increased risk for coronary heart disease	80061 82465 83718	FP	NP, PA or Physician	Must occur during physical exam
Diabetes Screening	• Asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg	82947 82950 82951 83036	FP	NP, PA or Physician	Must occur during physical exam
Hepatitis C Virus Infection Screening	• All adults at high risk for virus infection • One-time screening for all adults born between 1945-1965	86803 86804	FP	NP, PA or Physician	Must occur during physical exam

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Description	Appropriate for the following Family Planning Beneficiaries	Allowable Codes	Required Modifier	Provider Type Requirements	Notes
Breast Cancer Screening (Mammography)	• Women ages 50-74	77067 77066	FP	Physician Only	Can occur outside physical exam
Abdominal Aortic Aneurysm Screening	• Men ages 65-75 who have ever smoked	76706	FP	Physician Only	Can occur outside physical exam
Colorectal Cancer Screening	• Men and Women ages 50-75	45331 45378 82270 82274 88305 G0105	FP	Physician Only	Can occur outside physical exam
Lung Cancer Screening for Smokers	• **Adults ages 55 - 80 who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years**	71250	FP	Physician Only	Can occur outside physical exam

The following screenings have age, sex, and/or patient history limitations:

- Breast Cancer Screens (Mammographies) are covered for women ages 50 to 74 years.
- Abdominal Aortic Aneurysm (AAA) screens are limited to men who have had a smoking history and are between the ages of 65 and 75 years.
- Colorectal Cancer screens are covered for both men and women who are between the ages of 50 and 75 years.
- Lung Cancer screens cover both men and women between the ages of 55 and 80 years and meet one or more of the following criteria:
    1. Beneficiary is a current smoker
    2. Beneficiary had a 30 pack-year history
    3. Beneficiary quit smoking within 15 year

Family planning counseling must be offered to Family Planning beneficiaries during the physical examination.

Portions of the physical may be omitted if not medically applicable to the beneficiary's condition or if the beneficiary is not cooperative and resists specific system examinations (despite encouragement by the physician, NP or office staff). A note should be written in the record explaining why that part of the exam was omitted.

Note: If a medical condition and/or problem is identified during the physical examination and the provider is unable to offer free or affordable care based on the individual's income, the provider should refer the beneficiary to a provider who can offer services to uninsured

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Biennial Physical Examination (Cont'd.)

individuals (examples include FQHCs, RHCs, free clinics, etc.). Please refer to "Referral Instructions for Family Planning" in this section for important information about billing for beneficiary referrals.

The following lab procedures are included in the reimbursement for the physical examination:

- Hemocult
- Urinalysis
- Blood Sugar
- Hemoglobin

Note: **College physicals, DOT physicals, and administrative physicals are not covered.**

Annual Family Planning Evaluation/Management Visits

The Family Planning program sponsors annual Family Planning Evaluation/ Management visits. The annual visit is the re-evaluation of an established patient requiring an update to the medical record, interim history, physical examination, appropriate diagnostic laboratory tests and/or procedures, family planning counseling, and adjustment of contraceptive management as indicated. This visit should be billed using the appropriate level of CPT evaluation and management codes **99211 – 99215 with an FP modifier**.

The following services, at a minimum, **must** be provided during the annual visit:

- Medical history
- Sexual health assessment
- Weight
- Blood pressure check
- Symptom appraisal, as needed
- Documentation of any treatment and/or counseling including administration and/or issuance of contraceptive supplies
- Counseling and education, as necessary, regarding pregnancy prevention and/or sexually transmitted diseases
- Breast exam, annually if >19 years of age; then every 3 years if 20-39 years of age
- Cervical Cytology:
    - every 3 years if ≥21 years of age
    - every 5 years if ≥30 years of age

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Annual Family Planning Evaluation/Management Visits (Cont'd.)

- Genital exam, to include inspection of skin, hair and perianal region, as well as, palpation of inguinal nodes, scrotum and penis

The following services**,** at a minimum, **should** be provided during the annual visit:

- Laboratory tests
- Issuance of birth control supplies or prescription

Periodic Revisit

The Family Planning Program sponsors periodic revisits for beneficiaries, as needed. The periodic revisit is a follow-up of an established patient with a new or an existing family planning condition. These visits are available for multiple reasons such as change in contraceptive method due to problems with that particular method (*e.g.*, breakthrough bleeding or the need for additional guidance) or issuance of birth control supplies. This visit should be billed using the appropriate level of CPT evaluation and management codes **99211 – 99215 with an FP modifier**.

For CPT codes 99212-99215, the following services, at a minimum, **must** be provided during the revisit:

- Weight and blood pressure check
- Interim history
- Documentation of any treatment and/or counseling including administration and/or issuance of contraceptive supplies

The following services, at a minimum, **should** be provided during the periodic visit:

- Symptom appraisal, as needed
- Laboratory tests
- Issuance of birth control supplies or prescription

Family Planning Counseling Visits

The Family Planning Program sponsors Family Planning Counseling Visits for beneficiaries. The Family Planning Counseling/Education visit is a separate and distinct service, using the appropriate **CPT codes 99401 or 99402 with an FP modifier**. Family Planning Counseling/Education is a face-to-face interaction to enhance a beneficiary's comprehension of, or compliance with, his or her family planning method of choice. These services are for the expressed purpose of providing education/counseling above and beyond the routine contraceptive counseling that are included in the clinic/office visits.

Note: This service may not be billed on the same day as another visit.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Referral Instructions

Family Planning beneficiaries have Medicaid coverage for a limited set of medical services. Beneficiaries enrolled in Family Planning are covered for preventive physical examinations and preventive health screenings, but do not have full Medicaid coverage for follow-up visits, treatment, or medication (apart from those specifically outlined in the benefit structure).

If a health condition or problem is identified during the physical examination or after the provider receives lab results from a preventive screening that was performed, the provider should refer the patient to a source of free or subsidized care. SCDHHS strongly encourages providers to connect uninsured Family Planning beneficiaries to sources of care such as FQHCs, RHCs, free clinics, subsidized hospital clinics, etc. Providers will be compensated for the administrative costs associated with making referrals for Family Planning beneficiaries.

For more information about where to refer Family Planning patients for follow-up care, please visit the South Carolina Primary Health Care Association website, www.scphca.org/health-centers/health-center-list.aspx, for a listing of all FQHCs in the state or contact the SCDHHS Provider Service Center at (888) 289-0709.

Instructions

Effective with dates of service on or after August 1, 2014, providers that refer uninsured Family Planning beneficiaries for follow-up care or treatment for a problem or condition identified during the physical examination or annual family planning visit can bill for this referral activity. Providers must use the procedural coding and modifiers listed below. These referral codes may only be used in instances when the follow-up care is not covered as a component of the Family Planning program.

Note: At least one of the modifiers listed below is required when billing for referral codes.

Note: Providers should **NOT** use the FP modifier when billing for referral codes.

Providers that refer uninsured Family Planning patients for follow-up care or treatment for any health issue identified during or after (lab results) the physical examination or annual family planning visit may bill for this referral activity using one of the following referral codes:

S0320 – Same Day Referral or Telephone Referral: Utilized when a patient is referred to follow-up care immediately after the physical exam or family planning visit OR if lab results are received after the physical exam or family planning visit and a) results can be explained to the patient by phone and b) referral to follow-up care can occur by phone.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Referral Instructions (Cont'd.)

S0316 – Different Day Referral (In-Person): Utilized when a patient is required to receive lab results in-person, on a different day than the physical exam or family planning visit occurs.

Billing Instructions

1) Providers may include the **S0320 – Same Day Referral or Telephone Referral** on the same claim form as the physical examination or annual family planning visit.

2) For dates of service on or before **September 30, 2015**, providers may also bill for the **S0320 – Same Day Referral or Telephone Referral** on a separate claim form. If submitting a separate claim form, diagnosis code **V70.0** must be used.

   For dates of service on or after **October 1, 2015**, providers may also bill for the S**0320 – Same Day Referral or Telephone Referral** on a separate claim form. If submitting a separate claim form, diagnosis code Z00.00 or Z00.01

3) For dates of service on or before **September 30, 2015**, providers must bill for the **S0316 – In-person, Face-to-Face Referral** on a separate claim form. Diagnosis code **V70.0** must be used.

   For dates of service on or after **October 1, 2015**, providers must bill for the **S0316 – In-person, Face-to-Face Referral** on a separate claim form. Diagnosis code Z00.00 or Z00.01 must be used.

4) Providers must include at least one modifier and up to four modifiers from the list below when billing for both the S0320 and S0316 referral codes.

Modifier Instructions

Providers must use the appropriate modifier from the list below**. Up to 4 modifiers can be used for each referral code** (so if a patient is referred to follow-up care for more than one positive screening, include modifiers for all positive screenings)

1. If referring a patient for a positive **diabetes screen**, use modifier **P1**
2. If referring a patient for a positive **cardiovascular screen**, use modifier **P2**
3. If referring a patient for any **positive cancer screen**, use modifier **P3**
4. If referring a patient for any **mental or behavioral health screens**, use modifier **P4**

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PROGRAM SERVICES

Referral Instructions (Cont'd.)

5. If referring a patient for any **other condition or problem**, use modifier **P5**

Referral Instructions for Family Planning Providers who DO offer free or subsidized care to uninsured individuals (*examples*: FQHCs, hybrid clinics, RHCs, subsidized hospital clinics, etc.)

Providers that offer free or subsidized care to uninsured individuals should schedule follow-up visits with Family Planning beneficiaries when a problem or condition is identified during or after the physical examination or family planning visit. This "self-referral" activity is captured in the Encounter rate for the physical examination or family planning visit. However, for data collection and monitoring purposes, providers who fall into this category should include the referral code and appropriate modifiers listed above as a separate line on the Encounter claim form (these codes will bill to $0.00). The referral codes and accompanying modifiers will provide important data to SCDHHS regarding the utilization of follow-up care among the Family Planning population.

Note: Uninsured Family Planning patients will be responsible for any fees associated with follow-up visits. As Family Planning beneficiaries are considered uninsured for purposes of follow-up care, all visits should follow the provider's established policies and procedures for treating uninsured patients.

Referral Instructions for Family Planning Providers who refer patients for additional, preventive screenings

1. If you are a provider that performs a physical examination for a Family Planning beneficiary and are unable to perform certain preventive health screenings (examples include mammography, colonoscopy, AAA screening, and lung cancer screening using computerized tomography), you should refer the patient to a provider who is able to perform these screenings.
2. Providers are not allowed to submit a referral claim for this type of referral.

Covered Contraceptive Supplies and Services

The Family Planning Program provides coverage for contraceptive supplies (for example, birth control pills or male condoms) and contraceptive services such as an injections, IUD, Essure, or sterilization. Please refer to Section 4 of this manual for an approved list of procedure codes and drugs. When billing for contraceptive services and supplies, all claims must bill using a relevant Family Planning diagnosis code.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Long Acting Reversible Contraceptives (LARCs)

Long Acting Reversible Contraceptives (LARCs) are covered under both the pharmacy benefit and under the medical benefit using the traditional "buy and bill" method. Any LARC billed to Medicaid through the pharmacy benefit will be shipped directly to the provider's office for insertion. Providers must only bill Medicaid for the insertion of the device when it is purchased through the pharmacy.

Note: Pregnancy testing (when the test result is negative) is a reimbursable Family Planning service in two situations:

1. The test is provided at the time family planning services are initiated for an individual.
2. The test is provided after the initiation of family planning services, when the patient may not have used the method properly, or when the patient is having an unusual response to the family planning method.

Covered Screenings and Testing

The Family Planning Program provides coverage for STI screenings including: syphilis, chlamydia, gonorrhea, herpes, candidiasis, trichomoniasis and HIV, when performed at the time of the physical examination, initial or annual family planning visits. Please refer to Section 4 of this manual for an approved list of codes for STI testing. All diagnostic tests will require the FP modifier to be appended to the CPT/HCPCS codes. All claims must contain a relevant Family Planning diagnosis code.

Covered Medication

If, during a physical examination or annual family planning evaluation/management visit, any of six specific STIs are identified, antibiotic treatment will be allowed under the Family Planning Program. The six STIs are: syphilis, chlamydia, gonorrhea, herpes, candidiasis, and trichomoniasis. Beneficiaries are responsible for any copayments. STI testing and treatment are only covered during the beneficiaries' physical examination or annual family planning visit.

Tobacco Cessation

Tobacco use is the leading cause of preventable disease and premature death in South Carolina. SCDHHS provides comprehensive coverage for tobacco cessation treatment through pharmacotherapy and counseling for all full-benefit Medicaid beneficiaries. DHHS also partners with SCDHEC to communicate about programs available to assist Medicaid beneficiaries with quitting tobacco use.

Providers are encouraged to screen beneficiaries for tobacco use during medical encounters and document nicotine dependence using the appropriate diagnosis codes.

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PROGRAM SERVICES

Medication

SCDHHS covers prescriptions for the following tobacco cessation and nicotine replacement therapy (NRT) products:

- Bupropion sustained release (SR) products for tobacco use (Zyban)
- Varenicline (Chantix) tablets
- Nicotine gum
- Nicotine lozenge
- Nicotine nasal spray
- Nicotine inhaler
- Nicotine patch

Tobacco cessation products are exempt from the adult monthly prescription limit, prior authorization, and copayment requirements. There is no limit to the number of quit attempts in a calendar year. The following medically appropriate combination therapies are also covered:

- Long-term nicotine patch + other NRT product (gum or spray)
- Nicotine patch + nicotine inhaler
- Nicotine patch + Bupropion SR

General edits on day supply are based on product dosing in manufacturer package inserts. Prescribers are encouraged to reference the AAFP Pharmacologic Product Guide for FDA-approved medications for smoking cessation for more information on product guidelines.

As with all other pharmaceuticals, SCDHHS reimburses only rebated products (brand or generic) for fee-for-service (FFS) beneficiaries. A beneficiary must provide a prescription to receive any medication, including OTC products. A dual-eligible member can receive OTC products through Medicaid coverage, but the individual's Medicare Part D prescription drug plan must cover prescriptions for legend (non-OTC) tobacco cessation products.

For further questions about this benefit, prescribers should contact the Magellan Medicaid Administration's Clinical Call Center at 866-247-1181.

Counseling

Tobacco cessation counseling in individual and group settings are covered when billed with CPT codes 99406 and 99407. Reimbursement for counseling is limited to four (4) sessions per quit attempt for up to two (2) quit attempts annually. Tobacco cessation counseling may be billed on the same day as an office visit using a 25 modifier.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Counseling (Cont'd.)

SCDHHS policy requires that all tobacco cessation treatment must be ordered by a qualified practitioner defined as a physician, nurse practitioner, certified nurse midwife, or physician assistant. Medical documentation including time spent counseling the patient, treatment plan, and pharmacotherapy records must be maintained in the patient record.

South Carolina Tobacco Quitline

One-on-one telephone counseling with web-based support are available to all South Carolinians without charge through the SC Tobacco Quitline. Participants in the Quitline program are connected with a personal Quit Coach, who helps the participant develop a quit plan and uses cognitive behavioral coaching and motivational interviewing techniques to support the quit process. This evidence-based program has been clinically proven to help participants quit tobacco use, and tailored programs are available for Hispanic, Native American, pregnant and youth callers, and smokeless tobacco users, as well as participants who have chronic medical and mental health conditions.

SCDHHS strongly encourages prescribers and pharmacists to refer patients to the SC Tobacco Quitline at 1-800-QUIT-NOW. Services are available 24 hours a day, seven days a week. Additional information is available at:

http://www.scdhec.gov/Health/TobaccoCessation/HelpYourPatientsQuit/

Telemedicine

Telemedicine is the use of medical information about a patient that is exchanged from one site to another via electronic communications to provide medical care to a patient in circumstances in which face-to-face contact is not necessary. In this instance, a physician or other qualified medical professional has determined that medical care can be provided via electronic communication with no loss in the quality or efficacy of the care. Electronic communication means the use of interactive telecommunication equipment that typically includes audio and video equipment permitting two-way, real-time interactive communication between the patient and the physician or practitioner at the referring site.

Telemedicine includes consultation, diagnostic, and treatment services. Telemedicine as a service delivery option, in some cases, can provide beneficiaries with increased access to specialists, better continuity of care, and eliminate the hardship of traveling extended distances.

Telemedicine services are not an expansion of Medicaid-covered services but an option for the delivery of certain covered services. However, if there are technological difficulties in performing an objective through medical assessment or problems in beneficiaries' understanding of telemedicine, hands-on or direct face-to-face care must

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Telemedicine (Cont'd.)

be provided to the beneficiary instead. Quality of health care must be maintained regardless of the mode of delivery.

Consultant Sites

A consultant site means the site at which the specialty physician or practitioner providing the medical care is located at the time the service is provided via telemedicine. The health professional providing the medical care must be currently and appropriately licensed in South Carolina and located within the South Carolina Medical Service Area (SCMSA), which is defined as the state of South Carolina and areas in North Carolina and Georgia within 25 miles of the South Carolina state border.

Referring Sites

A referring site is the location of an eligible Medicaid beneficiary at the time the service being furnished via a telecommunication system occurs. Medicaid beneficiaries are eligible for telemedicine services only if they are presented from a referring site located in the SCMSA. Referring site presenters may be required to facilitate the delivery of this service. Referring site presenters should be a provider knowledgeable in how the equipment works and can provide the clinical support if needed during a session.

Covered referring sites are:

- The office of a physician or practitioner
- Hospital (Inpatient and Outpatient)
- Rural Health Clinics
- Federally Qualified Health Centers
- Community Mental Health Centers
- Public Schools
- Act 301 Behavioral Health Centers

Telemedicine Providers

Providers who meet the Medicaid credentialing requirements and are currently enrolled with the South Carolina Medicaid program are eligible to bill for telemedicine and telepsychiatry when the service is within the scope of their practice.

The referring provider is the provider who has evaluated the beneficiary, determined the need for a consultation, and has arranged the services of the consulting provider for the purpose of consultation, diagnosis, and/or treatment.

The consulting provider is the provider who evaluates the beneficiary via telemedicine mode of delivery upon the recommendation of the referring provider. Practitioners at the distant site who may furnish and receive payment of covered telemedicine services are:

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Telemedicine Providers (Cont'd.)

- Physicians
- Nurse practitioners
- Physician Assistants

Covered Services

Services that are eligible for reimbursement include consultation, office visits, individual psychotherapy, pharmacologic management, and psychiatric diagnostic interview examinations and testing, delivered via a telecommunication system. A licensed physician and/or nurse practitioner are the only providers of telepsychiatry services. As a condition of reimbursement, an audio and video telecommunication system that is HIPAA compliant must be used that permits interactive communication between the physician or practitioner at the consultant site and the beneficiary at the referring site.

Office and outpatient visits that are conducted via telemedicine are counted towards the applicable benefit limits for these services.

Medicaid covers telemedicine when the service is medically necessary and under the following circumstance:

- The medical care is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's need; and
- The medical care can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide.

The list of Medicaid telemedicine services includes:

- Office or other outpatient visits (CPT codes 99201–99215)
- Inpatient consultation (CPT codes 99251–99255)
- Psychotherapy (CPT codes 90832–90838)
- Psychiatric diagnostic interview examination (CPT codes 90791 and 90792)
- Neurobehavioral status exam (CPT code 96116)
- Electrocardiogram interpretation and report only (CPT code 93010)
- Echocardiography (CPT codes 93307, 93308, 93320, 93321, and 93325)

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Non-Covered Services

The following interactions do not constitute reimbursable telemedicine or telepsychiatry services and will not be reimbursed:

- Telephone conversations
- Email messages
- Video cell phone interactions
- Facsimile transmissions
- Services provided by allied health professionals

Coverage Guidelines

The following conditions apply to all services rendered via telemedicine.

1. The beneficiary must be present and participating in the telemedicine visit.
2. The referring provider must provide pertinent medical information and/or records to the consulting provider via a secure transmission.
3. Interactive audio and video telecommunication must be used; permitting encrypted communication between the distant site physician or practitioner and the Medicaid beneficiary. The telecommunication service must be secure and adequate to protect the confidentiality and integrity of the Telemedicine information transmitted.
4. The telemedicine equipment and transmission speed and image resolution must be technically sufficient to support the service billed. Staff involved in the telemedicine visit must be trained in the use of the telemedicine equipment and competent in its operation.
5. An appropriate certified or licensed health care professional at the referring site is required to present (patient site presenter) the beneficiary to the physician or practitioner at the consulting site and remain available as clinically appropriate.
6. If the beneficiary is a minor child, a parent and/or guardian must present the minor child for telemedicine service unless otherwise exempted by State or Federal law. The parent and/or guardian need not attend the telemedicine session unless attendance is therapeutically appropriate.
7. The beneficiary retains the right to withdraw at any time.
8. All telemedicine activities must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996: Standards for Privacy of individually identifiable Health

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Coverage Guidelines (Cont'd.)

Information and all other applicable state and federal laws and regulations.

9. The beneficiary has access to all transmitted medical information, with the exception of live interactive video, as there is often no stored data in such encounters.
10. There will be no dissemination of any beneficiary's images or information to other entities without written consent from the beneficiary.
11. The provider at the distant site must obtain prior approval for service when services require prior approval, based on service type or diagnosis.

Reimbursement for Professional Services

Reimbursement to the health professional delivering the medical service is the same as the current fee schedule amount for the service provided. Consulting site physicians and practitioners submit claims for telemedicine or telepsychiatry services using the appropriate CPT code for the professional service along with the telemedicine modifier GT, "via interactive audio and video telecommunications system" (*e.g.*, 99213 GT). By coding and billing the "GT" modifier with a covered telemedicine procedure code, the consulting site physician and/or practitioner certifies that the beneficiary was present at originating site when the telemedicine service was furnished. Telemedicine services are subject to copayment requirements. Fee schedule are located on the SCDHHS website at http://www.scdhhs.gov.

Reimbursement for the Originating Site Facility Fee

The **referring site** is only eligible to receive a facility fee for telemedicine services. Claims must be submitted with HCPCS code Q3014 (Telemedicine originating site facility fee).The reimbursement is $14.96 per encounter. If a provider from the referring site performs a separately identifiable service for the beneficiary on the same day as telemedicine, documentation for both services must be clearly and separately identified in the beneficiary's medical record, and both services are eligible for full reimbursement.

Reimbursement for FQHCs and RHCs

Referring Site

RHCs and FQHCs are eligible to receive reimbursement for a facility fee for the telemedicine services when operating as the referring site. Claims must be submitted with HCPCS code Q3014 (Telemedicine originating site facility fee). The reimbursement is $14.96 per encounter. When serving as the referring site, the RHCs and FQHCs cannot bill the encounter T1015 code if these are the only services being rendered.

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PROGRAM SERVICES

Consulting Site

The RHCs and FQHCs would bill a T1015 encounter code when operating as the consulting site. Only one encounter code can be billed for a date of service. Both provider types will use the appropriate encounter code for the service along with the "GT" modifier (via interactive audio and video telecommunications system) indicating interactive communication was used.

Hospital Providers

Hospital providers are eligible to receive reimbursement for a facility fee for telemedicine when operating as the referring site. Claims must be submitted with revenue code 780 (Telemedicine). There is no separate reimbursement for telemedicine services when performed during an inpatient stay, outpatient clinic or emergency room visit, or outpatient surgery, as these are all-inclusive payments.

Documentation

Documentation in the medical records must be maintained at the referring and consulting locations to substantiate the service provided. A request for a telemedicine service from a referring provider and the medical necessity for the telemedicine service must be documented in the beneficiary's medical record. Documentation must indicate the services were rendered via telemedicine. All other Medicaid documentation guidelines apply to the services rendered via telemedicine. Examples include but are not limited to:

- The diagnosis and treatment plan resulting from the telemedicine service and progress note by the health care provider
- The location of the referring site and consulting site
- Documentation supporting the medical necessity of the telemedicine service
- Start and stop times

Unusual Travel

Procedure code 99082 is compensable only when a patient must be transported to a medical facility and is accompanied by a physician because there is no other recourse available based on the necessary medical skills and expertise required for the patient's condition. Documentation must be submitted with the claim. Coverage and reimbursement will be determined on a claim-by-claim basis.

Unlisted Services or Procedures

A service or procedure may be provided that is not listed in the CPT. When reporting such a service; the appropriate "unlisted" procedure code may be used to indicate the service, identifying it by special report.

Appropriate records to justify the use of the unlisted code, the complexity of the service, and the charge must accompany the unlisted procedures. The reimbursement will be directly related to the support documentation submitted with the claim. To ensure proper interpretation

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Unlisted Services or Procedures (Cont'd.)

and payment, a complete description of the performed service is required.

Procedures that are considered an integral part of an examination should not be charged separately (*i.e.*, simple vision test, blood pressure check, ophthalmoscopy, otoscopy). Charges for these services in addition to an E/M visit will be denied.

Non-Covered Services

CPT procedure codes 99075, 99078, and 99080 indicating medical testimony, special reports for insurance, educational services for groups, and data analysis are non-compensable by Medicaid.

Preventive/Rehabilitative Services for Primary Care Enhancement (P/RSPCE)

Preventive/Rehabilitative Services for Primary Care Enhancement (P/RSPCE) are provided to support primary medical care in patients who exhibit risk factors that directly impact their medical status. These services are designed to help the physician maximize the patient's treatment benefits and outcomes by supplementing routine medical care.

These services can be provided by public health nurses, social workers, dietitians, health educators, home economists, and public health assistants who have special training and experience in working in the home or other community setting to assist the client in meeting mutually developed health care objectives.

Following are examples of P/RSPCE:

- Comprehensive assessments/evaluations of a client's medical, nutritional, or psychosocial needs by health professionals
- Home or community follow-up as requested by a Primary Care Physician (PCP) to monitor the medical plan of care, reinforce the treatment regime, counsel, provide anticipatory guidance, and support the client's medical needs. Nurses can apply the nursing process with the overall aim of optimizing the health outcomes of the client.
- Social work assessment, counseling, or anticipatory guidance relative to the medical plan of care
- Medical nutrition therapy for clients with chronic disease, growth problems, medically diagnosed anemias, elevated blood lead, or other nutritional disorders
- Coordination of medical services for clients with multiple providers and/or complex needs

Counseling interventions address the client's attitude, knowledge base, beliefs, behaviors, and values relative to the medical condition. Individual and group interventions are tailored to meet the patient's

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PROGRAM SERVICES

Preventive/Rehabilitative Services for Primary Care Enhancement (P/RSPCE) (Cont'd.)

needs and include specific targeted actions that are more than simple didactic presentations of information. These actions are intended to be collaborations between the P/RSPCE, the PCP, and the patient.

Contact the PSC for more details on P/RSPCE services.

Missed Appointments

Medicaid beneficiaries cannot be charged for missed appointments. A missed appointment is not a distinct reimbursable Medicaid service, but a part of provider's overall costs of doing business. The Medicaid rate covers the cost of doing business, and providers may not impose separate charges on beneficiaries.

Home Health Services – Physician Requirements

Home health services are provided only by home health agencies that are certified by SCDHEC and have contracted with SCDHHS. Coverage is dependent upon a physician's orders and payable only to a contracted home health agency.

Plan of Care – Covered home health services must be ordered by the beneficiary's attending physician as part of a written plan of care, consistent with the functions the practitioner is legally authorized to perform. The plan of care should specify the treatment, services, items, or personnel needed by the patient and the expected outcome. The care must be appropriate to the home setting and to the patient's needs. For additional information, providers should contact the PSC at 1-888-289-0709 or submit an online inquiry http://www.scdhhs.gov/contact-us.

Community Long-Term Care Program

The Community Long-Term Care (CLTC) Program is designed to serve Medicaid-eligible aged and disabled adults who require long-term care. Careful assessment, service planning, and counseling allow each client to receive care in his or her own home, thus avoiding premature and costly nursing home admission.

For additional information, providers should contact the PSC or submit an online inquiry.

Nursing Home / Rest Home Facility Services

Services provided by a physician for a patient residing in a nursing home or long-term care facility must be medically necessary, requested by the patient or responsible party, or performed to meet the requirements of continued long-term care.

Services such as physical therapy, occupational therapy, recreational therapy, dietary consultation, social services, and nursing care are reimbursable only through the nursing home facility charges, according to the per diem rate.

If nursing home placement is not available, please refer to "Administrative Days" under "Inpatient and Outpatient Hospital Services" in this section.

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PROGRAM SERVICES

Nursing Home/Rest Home Facility Services (Cont'd.)

The attending physician must submit signed and dated certification by the 60th day of the patient's stay at the skilled nursing facility (SNF) in order for the patient to remain certified.

Documentation Requirements

Progress notes are required in the patient's record for all visits, including those performed to meet the requirements of continued long-term care. The medical record must justify and reflect the level of service billed. Nursing home visits are subject to post-payment review under the same Medicaid guidelines as any other medical services.

Injections

Coverage Guidelines (General)

Injectable drugs are covered if the following criteria are met:

- They are of the type that cannot be self-administered. The usual method of administration and the form of the drug given to the patient are two factors in determining whether a drug should be considered self-administered. If a form of the drug given to the patient is usually self-injected (*e.g.,* insulin), the drug is excluded from coverage unless administered to the patient in an emergency situation (*e.g.,* diabetic coma).
- The medical record must substantiate medical necessity. When acceptable oral and parenteral preparations exist for necessary treatment, the oral preparation should be the route of administration. If parenteral administration is necessary, the record should document the reason for choosing this route.
- Use of a drug or biological must be safe and effective, and otherwise reasonable and necessary. Drugs or biologicals approved for marketing by the FDA are considered safe and effective for purposes of this requirement when used for indications specified on the labeling. Occasionally, FDA-approved drugs are used for indications other than those specified on the labeling. Provided the FDA has not specified such use as non-approved, coverage is determined considering the generally accepted medical practice in the community.
- Drugs and biologicals that have not received final marketing approval by the FDA are not covered unless CMS advises otherwise.
- The injection must be furnished and administered by a physician, or by auxiliary personnel employed by the physician and under his or her personal supervision.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Coverage Guidelines (General) (Cont'd.)

- When billing for a drug administered in the office, the physician must bill an injection code. A prescription cannot be filled by a pharmacist and then returned to a physician's office for administration.

Orphan Drugs

An orphan drug is a drug or biological product used for the treatment or prevention of a rare disease or condition. Prior approval is required for orphan drugs that are not listed on the injection code list (*i.e.*, Ceredase).

Unlisted Injections

If an injection is not listed, procedure code J3490 and/or J9999 should be used. A description of the drug, the NDC number, and the dosage, along with the office record, flow record (if possible), and an invoice indicating the cost of the drug, must all be attached to the claim to be considered for payment. Claims containing this code without the required documentation will be rejected. Additional documentation may be required if the unlisted injection is being submitted for reimbursement for the first time. When a claim is rejected, providers must submit a new claim and attach the required documentation for medical review.

When billing multiple unlisted injection codes on the same claim, the documentation must identify the specific unlisted code that is to be considered for reimbursement.

Procedure code 96372 is billed per injection for administration.

Botox® (JO585, Injection, Onabotulinumtoxina, 1 Unit), Dysport ™ (J0586, 5 Units), Myobloc ® (J0587, Injection Rimabotulinumtoxinb, 100 Units), and Xeomin (J0587, Injection, Incobotulinumtoxina, 1 Unit)

Botox® - JO585, Injection, Onabotulinumtoxina, 1 Unit

Botox® is FDA-approved for strabismus, blepharospasm, severe primary axillary hyperhidrosis, upper limb spasticity in adults, cervical dystonia in adults, and for the prophylaxis of headaches in adult patients with chronic headache and chronic migraine prophylaxis (≥15 days per month with headache lasting 4 hours a day or longer). In addition, Botox® is (FDA)-approved to treat urinary incontinence due to detrusor overactivity associated with a neurologic condition [*e.g.*, spinal cord injury (SCI), multiple sclerosis (MS)] in adults who have an inadequate response to or are intolerant of an anticholinergic medication.

Dysport ™ - J0586, 5 Units

Dysport™ is FDA-approved for cervical dystonia in adults.

Myobloc ® - J0587, Injection, Rimabotulinumtoxinb, 100 Units

Myobloc® is FDA-approved for cervical dystonia in adults.

Xeomin® - J0588, Injection, Incobotulinumtoxina, 1 Unit

Xeomin® is FDA-approved for cervical dystonia in adults and for blepharospasm in adults previously treated with onabotulinumtoxinA (Botox®).

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Botox® (JO585, Injection, Onabotulinumtoxina, 1 Unit), Dysport™ (J0586, 5 Units), Myobloc® (J0587, Injection Rimabotulinumtoxinb, 100 Units), and Xeomin (J0587, Injection, Incobotulinumtoxina, 1 Unit) (Cont'd.)

The botulinum toxin products listed on the left share certain properties and some FDA approved indications. However, these agents are not identical. They have differing therapeutic and adverse even profiles. Botulinum toxin products are not directly interchangeable with one another.

For dates of service prior to July 31, 2012, SCDHHS requires support documentation to be submitted with claims filed for Botox®, Dysport™, Xeomin®, or Myobloc®. Medicaid will pay claims for Botox®, Dysport™, Xeomin® or Myobloc® only when administered for FDA-approved indications. Therefore, medical records submitted with the claim must:

1. Include the beneficiary's age
2. Clearly delineate the symptom or particular circumstance that necessitates the administration of Botox®, Dysport™, Xeomin®, or Myobloc®.

Claims will reject if information is omitted or if it cannot be determined that the product was given for an FDA-approved indication.

All Botulinum toxin products must be preauthorized by Magellan Rx Management except for those being administered to patients who are dually eligible for Medicare and Medicaid. (Please refer to "Utilization Review Services" in this section for more information.) Magellan Rx Management will pre-authorize all Botulinum Toxin – Type A for Botox® and Type B (Myobloc) when administered for FDA-approved indications.

Xolair® (Omalizumab)

Xolair® is FDA-approved for patients 12 years of age or older under some circumstances (see below for more detail). Physician CMS-1500 claims should be billed using code J2357 and must include the prior authorization number. Claims submitted without prior authorization number will be rejected. Providers should submit prior authorization requests to Magellan Rx Management at http://ih.magellanrx.com or by calling 1-800-424-8219.

For recipients receiving a prescription to be filled in a pharmacy effective with date of service August 1, 2004, SCDHHS requires prior approval for Xolair® (Omalizumab), 150 mg powder/vial. Prior authorization requests should be telephoned or faxed, toll-free, to the Magellan Medicaid Administration Clinical Call Center by the prescriber or the prescriber's designated office personnel at the following contact numbers:

Magellan Medicaid Administration Clinical Call Center
Telephone: 866-247-1181
Fax: 888-603-7696

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Xolair® (Omalizumab) (Cont'd.)

Authorizations will be based on the following criteria:

FDA-Labeled Indications:

Approved for treatment of patients 12 years of age or older with moderate persistent or severe persistent asthma for at least one year, who have had positive skin test or in vitro reactivity to a perennial aeroallergen and whose symptoms are inadequately controlled with inhaled corticosteroids.

Symptoms Not Adequately Controlled with the Following Three Treatments:

Patient must have tried or have a contraindication to inhaled corticosteroids.

Patient should have tried or have a contraindication to long acting Beta 2 agonists (Ref. NHLBI guidelines).

Patient should have tried or have a contraindication to a leukotriene receptor antagonist.

Length of Prior Authorization:

Six months

Provider must verify clinical improvement at each subsequent renewal if approved.

The Physician Requesting the Prior Approval Must Be One of the Following:

Allergist/Immunologist

Pulmonologist

Required Labs:

History of positive skin test or RAST test to a perennial aeroallergen

Pretreatment serum lgE level should be 30 to 700 IU/ml

Weight and height

National Drug Code (NDC) Billing Requirements for Drug-Related HCPCS Codes

To comply with Centers for Medicare and Medicaid Services (CMS) requirements related to the Deficit Reduction Act (DRA) of 2005, Medicaid requires providers billing for physician-administered drugs in an office, a clinic, or other outpatient setting to report the National Drug Code (NDC) when using a drug-related Healthcare Common Procedure Coding System (HCPCS) code. The HCPCS code must include the correct NDC 5-4-2 format (11 digits total) to receive reimbursement from Medicaid. The NDC must be used on all claims submission (electronic, Web Tool, and CMS-1500).

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PROGRAM SERVICES

National Drug Code (NDC) Billing Requirements for Drug-Related HCPCS Codes (Cont'd.)

Additionally, providers must implement a process to record and maintain the NDC(s) of the drug(s) administered to the beneficiary as well as the quantity of the drug(s) given.

Billing Unlisted/Not Otherwise Specified HCPCS Codes (J3490, J9999)

In addition to documentation detailing the drug that was administered and the medical necessity, providers must also include the product's 11-digit NDC. The claim will suspend for review. Please note that the drug-related procedure code is not payable if the 11-digit NDC is omitted.

NDC Not Found On The NDC To HCPCS Crosswalk

For a drug-related HCPCS code to be reimbursable by SCDHHS, the manufacturer of the drug must participate in the Federal Drug Rebate program. To determine whether the pharmaceutical manufacturer participates in the rebate program, please visit the following website for the NDC/HCPCS crosswalk at https://www.dmepdac.com/crosswalk/index.html. The first five digits of the NDC identify the manufacturer of the product. Prescribers should use the crosswalk and the criteria below to determine if the drug is reimbursable by SCDHHS:

- If the first five digits of the 11-digit NDC are listed on the crosswalk, the manufacturer participates in the rebate program and the claim should be submitted to Medicaid. The claim will suspend for review.
- If the first five digits of the 11-digit NDC are not on the crosswalk, the manufacturer does not participate in the rebate program. South Carolina Medicaid does not provide coverage of non-rebated drugs.

Please refer to Section 3 of this manual for information and instructions for claims submission.

Physician-Administered Injectable Drug Reimbursement Methodology

Effective with dates of service on or after October 1, 2010, the South Carolina Department of Health and Human Services (SCDHHS) will change the reimbursement methodology for injectable drugs administered in an office, clinic, or outpatient hospital setting.

The new reimbursement schedule has a four-tier structure. The reimbursement for drugs within each tier is set as follows:

- Tier 1 contains certain generic and injectable drugs in classes with therapeutic alternatives and is priced at Maximum Allowable Cost (MAC)/Least Cost Alternative (LCA).
- Tier 2 contains newer agents and higher cost drugs and is priced at Average Sales Price (ASP) plus 6%.

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PROGRAM SERVICES

Physician-Administered Injectable Drug Reimbursement Methodology (Cont'd.)

- Tier 3 contains moderately priced agents and older drugs where there are often significant Average Wholesale Price (AWP)/ASP differences and is priced at ASP plus 10%.
- Tier 4 contains drugs where ASP pricing is not available and is priced at AWP minus 18%.

The SCDHHS will adjust the provider-administered injectable drug fee schedule quarterly so that reimbursement levels reflect changes in market prices for acquiring and administering drugs. Fee schedules are located on the SCDHHS website at http://www.scdhhs.gov.

Billing Notes

A list of injection codes is provided in Section 4 of this manual. Injection codes include the cost of the drug only, not the administration.

The unit of measure for reimbursement for injectable drugs corresponds to the unit of measure noted in the code description. Indicate the same unit of measure in the days/units field (24G) on the claim form. For example, if the injection code lists one unit as 50 mg, be sure to indicate 50 mg as one unit. If 100 mg was administered, two units would be indicated on the claim.

Office E/M visits and additional office services are allowed as separate reimbursement from injection codes. If the administration of the drug is the only reason for the visit, then only a minimal established office E/M visit is allowed in addition to the administration code and the drug code. Code 96372 includes the syringe and administration of the drug. Minimal office visits include the observation time, if indicated.

On rare occasions, parenteral medications are provided by someone other than the physician (pharmaceutical company research, patient, etc.). In these cases, the physician may bill South Carolina Medicaid for a minimal office visit if this is the only reason for the visit and providing the service is normally covered.

Note: Beneficiaries are not allowed to use their Medicaid card to obtain non-self-injectable drugs. The reason this practice is not allowed is to prevent a possible duplicate payment from being made by Medicaid (*i.e.*, payment for drug to both the pharmacy provider and to the physician).

Codes for intravenous solutions are also listed. Code 99070 should be used for reimbursement of the IV setup, needle, and/or intra-catheter. Code 99070 is compensable in addition to the office visit and the appropriate intravenous solution code.

Guidelines on allergen immunotherapy can be found under the heading "Allergen and Clinical Immunology" and those for chemotherapy under the heading "Oncology and Hematology" in this section. Immunization guidelines can be located under the heading "Preventive Care Services."

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PROGRAM SERVICES

Synagis® (Palivizumab) 90378

Beginning with dates of service on or after October 1, 2005, if a 50 mg vial of Synagis® is administered to an infant up to 2 years old, revenue code 636 should be billed using procedure code 90378.

Due to the Health and Insurance Portability and Accountability Act of 1996 (HIPAA) requirements, SCDHHS was required to delete procedure code S9853 (100 mg vial of Synagis®) from the Medicaid Management Information System.

SCDHHS has established a 50 mg rate and a 100 mg rate. For multiples of 50 mg dosages (150 mg) or 3 units, SCDHHS will pay the 100 mg price plus the 50 mg price not to exceed 4 units. Procedure code 96372 (Therapeutic, Prophylactic, or Diagnostic Injections) may also be billed for the administration of the drug. Providers must use the dosage that is appropriate for each child according to his or her weight.

In order to ensure consistency, reimbursement for Synagis® is limited to physicians, hospitals, and infusion centers. To avoid possible duplicate reimbursement, SCDHHS will not reimburse pharmacy providers for Synagis®. Effective November 1, 2004, payment for Synagis® administration will be limited to six doses per Respiratory Synctial Virus (RSV) season given on or after October 1 and no later than March 31.

Prior approval is not required for up to six 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. Any dose over the limit of six or administered after the RSV season (October — March) will require prior approval. If prior approval is needed, please submit requests to:

South Carolina Department of Health and Human Services
Division of Hospital Services
Attn: Medical Review/Synagis® Program
Post Office Box 8206
Columbia, SC 29202-8206

SCDHHS will continue to utilize the American Academy of Pediatrics (AAP) 2012 guidelines for the administration of Synagis®. The AAP guidelines are available at http://www.aap.org. Prior approval by the SCDHHS Medical Director will still be required for any request to administer Synagis® outside of the AAP guidelines.

However, providers should use discretion in the administration of Synagis® to those infants born between 32 and 35 weeks of gestation who do not have chronic lung disease (CLD). SCDHHS will not reimburse providers for Synagis® administration to children in this age

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Synagis® (Palivizumab) 90378 (Cont'd.)

group that do not have two or more risk factors listed in the AAP guidelines.

SCDHHS will conduct ongoing post-payment reviews of medical records relating to the administration of Synagis® and recover funds for doses given outside the AAP guidelines.

Medicaid's policy is to provide medically necessary treatment to Medicaid beneficiaries while maintaining consistent reimbursement to providers. Therefore, the drug should be drawn up with caution and used only in accordance with the AAP's guidelines, which are outlined below:

1. Palivizumab, or Respiratory Syncytial Virus Immune Globulin Intravenous (Human) (RSV-IGIV), prophylaxis should be considered for infants and children younger than 2 years of age with chronic lung disease (CLD) who have required medical therapy for their CLD within six months before the anticipated RSV season.

   Patients with more severe CLD may benefit from prophylaxis for two RSV seasons, especially those who require medical therapy. Decisions regarding individual patients may need additional consultation from neonatologists, intensivists, or pulmonologists.

   There are limited data on the efficacy of palivizumab during the second year of age; risk of severe RSV disease exists for children with CLD who require medical therapy. Although those with less severe underlying disease may receive some benefit for the second season, immuno-prophylaxis may not be necessary.

2. Infants born at 32 weeks of gestation or earlier without CLD, or who do not meet the criteria in recommendation 1, also may benefit from RSV prophylaxis. In these infants, major risk factors to consider are gestational age and chronological age at the start of the RSV season:

   - Infants born at 28 weeks of gestation or earlier may benefit from prophylaxis up to 12 months of age.
   - Infants born at 29 to 32 weeks of gestation may benefit most from prophylaxis up to 6 months of age.

   Decisions regarding duration of prophylaxis should be individualized according to the duration of the RSV season. Practitioners may wish to use RSV re-hospitalization data from their own region to assist in the decision-making process.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Synagis® (Palivizumab) 90378 (Cont'd.)

3. Given the large number of patients born between 32 to 35 weeks and the cost of the drug, the use of palivizumab in this population should be reserved for those infants with additional risk factors until more data are available.
4. Palivizumab and RSV-IGIV are not licensed by the FDA for patients with Congenital Heart Disease (CHD). Available data indicate that RSV-IGIV is contraindicated in patients with cyanotic CHD. However, patients with CLD, who are premature, or both, who meet the criteria in recommendations 1 and 2, and who have asymptomatic acyanotic CHD (*e.g.*, patent ductus arteriosus or ventricular septal defect) may benefit from prophylaxis.
5. Palivizumab or RSV-IGIV prophylaxis has not been evaluated in randomized trials in immunocompromised children. Although specific recommendations for immunocompromised patients cannot be made, children with severe immunodeficiencies (*e.g.*, severe combined immunodeficiency or severe acquired immunodeficiency syndrome) may benefit from prophylaxis.

   If these infants and children are receiving standard IGIV monthly, physicians may consider substituting RSV-IGIV during the RSV season.
6. RSV prophylaxis should be initiated at the onset of the RSV season and terminated at the end of the RSV season. In most areas of the United States, the usual time for the beginning of RSV outbreaks is October to December, and termination is March to May, but regional differences occur. The onset of RSV infections occurs earlier in southern states than in northern states. Practitioners should contact their health departments and/or diagnostic virology laboratories in their geographic areas to determine the optimal time to begin administration.
7. RSV is known to be transmitted in the hospital setting and to cause serious disease in high-risk infants. In high-risk hospitalized infants, the major means to prevent RSV disease is strict observance of infection control practices, including the use of rapid means to identify and cohort RSV-infected infants. If an RSV outbreak is documented in a high-risk unit (*e.g.*, pediatric intensive care unit), primary emphasis should be placed on proper infection control practices. The need for and efficacy of prophylaxis in these situations has not been evaluated.
8. The guidelines for modification of immunizations after RSV-IGIV have not changed. Palivizumab does not interfere with the response to vaccines.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Preventive Care Services

Preventive measures are defined as any routine service exam for adults or children when the procedures are performed in the absence of an illness or complaint(s). Generally, the South Carolina Medicaid program requires that a complaint or illness be recorded before a service is compensable. The exceptions to this policy are listed below.

Cancer Screening Services

For dates of service on or before **September 30, 2015**, ICD-9-CM codes for cancer screening services are located on the Physicians Services Provider Manual webpage.

For dates of service on or after **October 1, 2015**, the cancer screening services in the following table are covered. Please refer to the current edition of the ICD-10 for the most appropriate diagnosis code. If a more appropriate code is not available, use diagnosis code Z00.8

Service	Procedure Code	Frequency Limitations	Comments
Mammography	77067	Baseline (ages 35-39*). 1 per year (ages 50 and over).	Must be referred by a physician.
Hemocult Test	One of the following: 82270, 82271 or 82272	1 per year age 50 and up for low-risk clients Age 40 and up for high-risk clients***	The hemocult code includes both the collection of the stool and interpretation of the test.
Sigmoidoscopy	G0104	1 per 5 years age 50 and up for low-risk clients. Age 40 and up for high-risk clients.	
Screening Colonoscopy	G0121 G0105	1 per 10 years age 50 and up for low-risk clients. Age 40 and up for high-risk clients.	

* The age limits on the cancer screening services are the recommended ages to begin screening services. If medically indicated, screening services are reimbursable to younger beneficiaries provided the medical documentation supports the screening service.

** Low-risk clients — no risk factors known.

*** High-risk clients — personal history of polyps, ulcerative colitis, or colorectal cancer; family history of breast or gynecological cancer.

South Carolina will sponsor reimbursement for mammography (77067) for dually eligible Medicare/Medicaid beneficiaries according to the frequency limitations listed. Claims rejected by Medicare for having exceeded their frequency limitations should be filed with Medicaid on a CMS-1500 claim form with no Medicare information provided.

All services must be physician-generated, and the physician must be currently enrolled in the Medicaid program.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

FFS Adult Nutritional Counseling Program

This policy currently targets those obese individuals who do not meet the criteria for gastric bypass surgery or related services. Obesity is defined for this program as anyone the age of 21 or older with a body mass index (BMI) of 30 or greater.

Currently, this program will exclude the following categories of beneficiaries:

- Pregnant women
- Patients, for whom medication use has significantly contributed to the beneficiary's obesity as determined by the treating physician, are not eligible to participate in the obesity program. Examples of medications that may cause weight gain are:
  - Atypical antipsychotics (aripiprazone, olanzapine, quetiapine, risperidone, ziprasidone)
  - Long-term use of oral corticosteroids (prednisone, prednisolone)
  - Certain anticonvulsant medications (valproic acid, carbamazepine)
  - Tricyclic antidepressants (amitriptyline)
- Beneficiaries who have had or are scheduled to have bariatric surgery/gastric banding/gastric sleeve
- Beneficiaries actively being treated with gastric bypass surgery/vertical-banded gastroplasty/sleeve gastrectomy

Please note, for Healthy Connections Medicaid members also receiving Medicare benefits, SCDHHS will only pay secondary payments to Medicare.

Medicaid obesity counseling intervention consists of three factors:

- Screening for obesity in adults using measurement of BMI. The BMI is calculated by dividing the patient's weight in kilograms by the square of height in meters.
- Dietary (nutritional) assessment
- Intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high intensity interventions related to diet and exercise

The following billing instructions apply to Fee for Service only. Providers who submit claims to a Managed Care Organizations (MCOs) should refer to the provider contract with the appropriate MCO for billing instructions.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

FFS Adult Nutritional Counseling Program (Cont'd.)

Provider Services

A "provider" is defined as a physician, physician assistant, or a nurse practitioner meeting the licensure and educational requirements within the state of South Carolina. All services must be rendered within the South Carolina Medicaid Service Area (SCMSA). The SCMSA is defined as South Carolina and adjacent areas within 25 miles of its borders.

During the patient's routine physical exam or office visit, the provider will assess the patient's need for an obesity intervention program. The provider can either schedule the patient for an independent visit or may bill the initial obesity visit on the same day as a routine physical exam or evaluation and management (E&M) service. If the provider chooses to bill for both services on the same day, the provider will need to append the 25 modifier to the billed claim for the second E&M service. Providers may only bill for two E&M services for the initial obesity visit. All obesity visits must be billed utilizing HCPCS code G0447. However, for the initial visit, the provider must append a SC modifier to the G0447 code.

Subsequent visits may be billed as a one-on-one session between the provider and patient or in a group setting. When billing for a group setting, the provider must append the HB modifier to HCPCS code G0447 indicating that a group session has been rendered. Group nutritional counseling sessions are limited to a maximum of five patients per group. A claim must be filed for each patient participating in the group sessions. The chart of valid codes and usages is located in the billing requirements section later in the policy.

All obesity visits must include the following components listed below:

- **Assess:** Ask about and assess behavioral health risk and factors affecting behavioral change goals/methods
- **Advise:** Give clear, specific and personalized behavioral advice, including information about personal health, harms, and benefits
- **Agree:** Collaborate with the patient to select appropriate treatment goals and methods based on the patient's interest and willingness to change behavioral patterns and habits
- **Assist:** Use behavioral change techniques (self-help and/or counseling) to aid the patient in achieving agreed upon goals by acquiring the skills, confidence, and social, environmental supports for behavioral change, supplemented with adjunctive medical treatments when appropriate

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

FFS Adult Nutritional Counseling Program (Cont'd.)

- **Arrange:** Schedule follow-up contacts to provide ongoing assistance and/or support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment

The **provider must** also emphasize the importance of exercise, developing a realistic exercise plan with goals. The obesity intervention plan must be documented in the patient's medical health record.

The provider will arrange for an individual nutritional assessment to be provided by a licensed and Medicaid-enrolled dietitian.

A follow-up exam must be completed by the provider to evaluate the progress the patient has made, reviewing compliance with the exercise and nutritional plan of the patient. Documentation of each service must include the patient's BMI, progress toward weight management goals, activities, and compliance with the treatment plan. The provider must record the patient's BMI in the chart. Providers may bill for all medically necessary diagnostic testing.

Dietitian Services

A dietitian is defined as any individual meeting the licensure and educational requirements in the state of South Carolina and/or the border states of Georgia and North Carolina. All services must be rendered within the South Carolina Medicaid Service Area (SCMSA). The SCMSA is defined as South Carolina and adjacent areas within 25 miles of its borders.

The dietitian is responsible for reviewing the patient's habits, providing dietary education, reinforcing the importance of exercise, developing a nutritional plan, and establishing goals. The dietitian must document the patient's progress, activities, and compliance with the nutritional and exercise plan. A written progress report must be submitted within 48 hours of the nutritional counseling visit to the ordering provider each time the patient is seen individually or in a group/class setting. The dietitian must maintain complete medical records of the patient's nutritional and exercise plan, and his or her compliance with the obesity treatment regimen.

The initial nutritional counseling visit with the dietitian must be billed utilizing HCPCS code S9470, defined as a face-to-face, 30-minute session.

All subsequent nutritional counseling must be billed utilizing HCPCS code S9452, defined as a one-on-one, 30-minute session between the dietitian and patient or in a group setting. When billing for a group setting, the provider must append the HB modifier to HCPCS code

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

FFS Adult Nutritional Counseling Program (Cont'd.)

S9452 and bill for each individual patient. All groups are limited to a maximum of five patients per group.

Billing Requirements

All providers and dietitians are required to bill with a primary diagnosis code. Secondary diagnosis codes must be in compliance with the ICD-CM and is based on the date of service. For dates of service on or before **September 30, 2015,** all V codes must be billed as secondary diagnosis codes. For dates of service on or after **October 1, 2015**, all Z codes must be billed as secondary diagnosis codes.

The following requirements must be met:

- For dates of service on or before **September 30, 2015**, providers and dietitians must bill utilizing the Adult Nutritional Counseling ICD-9 and HCPCS codes and modifier combinations found in Section 4 of this manual.

  For dates of service on or after **October 1, 2015**, providers and dietitians must bill utilizing the Adult Nutritional Counseling ICD-10 and HCPCS codes and modifier combinations found in Section 4 of this manual.

- Providers may only bill the **initial obesity visit** on the same day as an evaluation and management (E&M) service or physical exam. Providers must not bill for subsequent obesity exams on the same day as an E&M service.

- Nutritional counseling units are billed based on a 30-minute session and are limited to one unit per day.

All providers and dietitians are responsible for clearly documenting the patient's chart with all information referenced in this policy. All services provided by both providers and dietitians are subject to review by the Division of Program Integrity. Services not meeting the requirements reflected in this policy may be subject to recoupment by SCDHHS.

Additional Services

If the provider (or dietitian) has completed a series of six visits and the patient has been compliant with the obesity treatment plan and the provider (or dietitian) has determined that the patient would benefit from additional provider visits and nutritional counseling, the provider must submit documentation of medical necessity to:

SCDHHS
ATTN: Medical Director
Post Office Box 8206
Columbia, SC 29202

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Additional Services (Cont'd.)

In order to receive additional visits not to exceed six additional provider visits and six additional nutritional counseling sessions within a 12 month period, the following documentation must be submitted to SCDHHS by the physician, nurse practitioner, or physician assistant only:

- A letter of Medical Necessity
- Patient notes
- BMI start and end
- A1C
- Dietitian reports
- Exercise plan and notes on adherence

Additional Resources

For additional resources, providers should visit the Department of Health and Environmental Control's Obesity Resources for Community Partners webpage at http://www.scdhec.gov/Health/Nutrition/ResourcesforCommunityPartners/.

Some examples of current programs include:

- Statewide Obesity Action Plan
- Community Transformation Grant
- Worksite Wellness
- FitnessGram
- ABC Grow Healthy
- Farm to School
- SNAP Education

Adult Physical Exams

Adult physical exams are covered under the following guidelines:

- The exams are allowed once every **two** years per patient.
- The patient must be 21 years of age or older.
- For dates of service on or before **September 30, 2015**, procedure code 99385 – 99387 and 99395 – 99397 for the appropriate age and diagnosis code V70.9 should be used when billing.

  For dates of service on or after **October 1, 2015**, procedure code 99385 – 99387 and 99395 – 99397 for the appropriate age and diagnosis code Z00.8 should be used when billing.

  - 99385 – Preventive visit, new, age 18-39

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Adult Physical Exams (Cont'd.)

- 99386 – Preventive visit, new, age 40-64
- 99387 – Preventive visit, new, age 65+
- 99395 – Preventive visit, established, 18-39
- 99396 – Preventive visit, established, 40-64
- 99397 – Preventive visit, established, 65+

This exam may also be offered to patients with Medicare and Medicaid. The physical exam is expected to include the following:

- A past history for a new patient or an interval history on an established patient.
- A generalized physical overview of the following organ systems:
  - EENT
  - Lungs
  - Abdomen
  - Skin
  - Breasts (Female)
  - External Genitalia
  - Heart
  - Back
  - Pelvic (Female)*
  - Prostate (Male)
  - Rectal
  - Brief Neurological
  - Brief Muscular
  - Brief Skeletal
  - Peripheral Vascular
- Family planning counseling must be offered if the patient is female within childbearing years or men. (An additional family planning code may be billed for this service when provided. Please refer to "Obstetrics and Gynecology" in this section for the description of codes.)
- The following lab procedures are included in the reimbursement for the physical:

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PROGRAM SERVICES

Adult Physical Exams (Cont'd.)

- Hemocult
- Urinalysis
- Blood Sugar
- Hemoglobin

Any other lab procedures, x-rays, etc., may be billed separately. Portions of the physical may be omitted if not medically applicable to the patient's condition or if the patient is not cooperative and resists specific system examinations (despite encouragement by the physician and office staff). A note should be written in the record explaining why that part of the exam was omitted.

Diabetes Patient Education

Diabetes Management services are medically necessary, comprehensive self-management and counseling services provided by programs enrolled by SCDHHS. Enrolled programs must adhere to the National Standards for Diabetes Self-Management Education and be recognized by the American Diabetes Association, American Association of Diabetes Educators, Indian Health Services, or be managed by a Certified Diabetes Educator. An eligible beneficiary must have a diabetes diagnosis and be referred by their primary care physician.

For details on this service, please refer to the Enhanced Services Provider Manual. Contact the PSC for a list of recognized programs in your area or information on how to become a provider of diabetes education.

IMMUNIZATIONS

Immunizations for Children

The Vaccines for Children (VFC) Program is a federally funded program created by the Omnibus Budget Reconciliation Act of 1993 that provides vaccines at no cost to children who qualify. Children who are eligible for VFC are entitled to receive pediatric vaccines that are recommended by the Advisory Committee on Immunization Practices. In South Carolina, the VFC Program is managed by the South Carolina Department of Health and Environmental Control (SC DHEC).

Medicaid providers may obtain free vaccines from the SC DHEC through the VFC Program. Vaccines are delivered free of charge to providers enrolled in the program. For additional information on the VFC Program or to enroll as a provider in the program, you may contact SC DHEC at (803) 898-0460 (local) or 800-27-SHOTS (outside the Columbia area). You may also visit the SC DHEC website at http://www.scdhec.gov/Health/Vaccinations/.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Immunizations for Children (Cont'd)

Providers may bill for the administration of vaccines that are obtained through the VFC program and administered in the doctor's office. When billing for immunization services for children under the age of 19, both the administration code and the vaccine code for the administered vaccine must be listed on the claim to receive reimbursement for the vaccine administration only. For this code combination, only the administration code will be reimbursable (CPT codes 90460-90461).

Note: The Rabies vaccine is non-covered through the VFC for children as it is not considered routine. However, the Rabies vaccine is covered by Medicaid for children. Providers may bill the appropriate administration and vaccine code to receive reimbursement from Medicaid.

Respiratory Syncytial Virus Immune Globulin (Synagis®)

Medicaid covers the administration of Synagis® in accordance with the recommendation published by the American Academy of Pediatrics (AAP). The AAP guidelines are available at http://www.aap.org.

Immunizations for Adults

The following vaccines are covered in accordance with the Center for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) for adult beneficiaries 19 years of age and older:

- 13-valent pneumococcal conjugate (PCV13)
- 23-valent pneumococcal conjugate (PPSV23)
- Haemophilus influenza type b conjugate vaccine (Hib)
- Hepatitis A (HepA)
- Hepatitis B (HepB)
- Influenza
- Measles, mumps, and rubella (MMR)
- Measles, mumps, rubella, and varicella (MMRV)
- Rabies
- Serogroups A, C, W, and Y meningococcal conjugate or polysaccharide vaccine (MenACWY or MPSV4)
- Serogroup B meningococcal (MenB
- Tetanus and diphtheria toxoids (Td)
- Tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine (Tdap)
- Varicella (VAR)

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Immunizations for Adults (Cont'd.)

For details on specific products covered, please refer to the Center for Disease Control (CDC) website at https://www.cdc.gov/vaccines/index.html.

When billing for vaccines for beneficiaries 19 years of age and older, the provider should bill for both the vaccine and the immunization administration code. The Rabies, Influenza and Tdap vaccines for adults may be billed through the medical benefit or through the pharmacy. If the pharmacy is billed, then only the administration fee can be billed on the medical side.

Claims submitted for dually eligible patients must first be submitted to Medicare. Covered codes may be found on the Physicians Injectable Drug Fee Schedule located at https://www.scdhhs.gov.

PEDIATRICS AND NEONATOLOGY

All procedures, with the following exceptions, must be submitted under the child's own Medicaid number regardless of the child's age.

Routine Newborn Circumcision

Routine newborn circumcisions are non-covered services.

Routine Newborn Care Exam

Procedure code 99460 should be used to report routine newborn care. This procedure is an all-inclusive code for any visits made during the first day of the newborn's birth.

Routine Newborn Follow-up Care

Follow-up nursery visits made to a healthy newborn on subsequent days are reimbursable by billing procedure code 99462. Only one follow-up nursery visit is reimbursed per day regardless of the number of visits made to the nursery.

Newborn Discharged Early

Code 99463 should be used only to report the history and examination of a normal newborn who is assessed and discharged from the hospital on the day of delivery.

Physicians following a newborn who is discharged before a routine follow-up exam (procedure code 99462) can be performed may bill procedure code 99461 for the office follow-up exam. This procedure code has a frequency limit of one every 10 months.

Healthy Mothers/Healthy Futures Newborn Health Initiatives

If a physician performs the services listed below in addition to the newborn care exam, Medicaid will provide enhanced reimbursement using code 97802.

- Mother and infant referral to the WIC program at the county health department (for supplemental food and nutritional counseling)

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Healthy Mothers/Healthy Futures Newborn Health Initiatives (Cont'd.)

- Referral to the county health department to set up an infant home visit

Referral to the county DSS for infant eligibility and an appointment for the first EPSDT well-baby examination

Newborn Care Billing Notes

The following procedures may also be billed under the newborn's mother's Medicaid number:

99460 – Routine newborn care exam in hospital or birthing center

99461 – Normal newborn care not in hospital or birthing room setting

99462 – Follow-up care in nursery for a healthy newborn

99463 – History and examination

99465 – Newborn resuscitation

97802 – Mother/newborn WIC referral

99360 – Standby for newborn care, limited to two units (e.g., C-section/ high risk delivery)

99381 – E/M Initial Comprehensive Preventative Medicine

99391 – E/M Periodic Comprehensive Preventative Medicine

Note: Any other pediatric charges not noted in the above exceptions must be billed under the Child's Medicaid number.

Newborn Care for the Sick Newborn

A sick child is defined as a newborn not considered a well-baby, but not sick enough to be considered a neonate or critically ill. Procedure code 99460 should be used to report the newborn care exam for a sick newborn. If the newborn becomes critically ill, please refer to "Neonatology" in this section for coding instructions.

Follow-up Care for the Sick Newborn

Follow-up visits made to a sick newborn may be billed using the appropriate level subsequent hospital care code (99231-99233) or critical care code (99291-99292) depending on the severity of illness.

Sick Newborn Care Billing Notes

Sick child care **may not** be billed under the newborn's mother's Medicaid number. Sick child care must be billed under the newborn's Medicaid number.

High Risk Channeling Project (HRCP) Neonatal Risk Screening

Please refer to *Best Practice Guidelines for Perinatal Care (Replaces High Risk Channeling Project)* under "Obstetrics and Gynecology" in this section.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Postpartum Infant Home Visit

The postpartum infant home visit is designed to assess the environmental, social, and medical needs of the infant and mother. All Medicaid-sponsored postpartum mothers and newborns are eligible for this visit, within six weeks of delivery. Providers must be enrolled as a Postpartum Infant Home visit provider to perform this service. The Division of Care Management should be contacted for enrollment at (803) 898-4614. For further details on this service, providers should refer to the Enhanced Services Provider Manual.

Sudden Infant Death Syndrome (SIDS)

Sudden Infant Death Syndrome is defined as the unexpected and sudden death of an apparently normal and healthy infant that occurs during sleep and with no physical or autopsy evidence of disease. Procedure codes 99251-99255 should be used to bill for infants being tested for SIDS. They are allowed once and are all-inclusive.

Sick Child Care

Physicians are reimbursed for all services provided to Medicaid-eligible children as long as the services are medically necessary and a diagnostic reason for the service is documented in the physician's records. Children (age birth through the end of the month of 21st birthday) are eligible for unlimited office visits as long as the previously mentioned criteria are met.

Neonatology

Hospital Care for Sick Newborns

Hospital care for newborns who do not meet the criteria for Neonatal Intensive Care (NIC) codes should be billed using hospital care codes or critical care codes, if appropriate.

When the neonate no longer requires the intensity or level of care described in the NIC codes and remains under the care of the same group or physician, subsequent hospital care or critical care codes, if appropriate, may be used. When a neonate is transferred from one hospital to another hospital and remains under the same group or same physician's care, the appropriate level critical care or subsequent hospital care codes may be billed. NIC codes may not be billed if the neonate does not meet the severity of illness or intensity of treatment as defined in the CPT manual.

Newborns Stabilized for Transport

If a physician treats a critically ill newborn in a hospital and stabilizes the newborn for transport to a higher-level hospital, critical care codes 99291 and 99292 would be appropriate for those services. Code 36600 (arterial puncture, withdrawal of blood for diagnosis) may not be billed in addition to the critical care. However, codes 36620 (Insertion of arterial catheter for blood sampling or infusion, accessed through the skin) and 36660 (Insertion of catheter into an artery in navel, newborn) are allowed in addition to critical care.

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PROGRAM SERVICES

Neonatal Intensive Care Codes

Neonatology codes 99468, 99469, 99471, and 99472 are used to report services provided by a physician directing the inpatient care of a critically ill neonate/infant. Use of these codes **must** reflect the severity of the neonate's illness, the intensity of treatment, and the level of care as defined in the CPT.

Critical care codes may be used in place of NIC codes when direct physician care is given for an extended period of time exclusively to one neonate. Time must be clearly documented for critical care services.

Additionally, 99360 (physician standby service) and 99465 (newborn resuscitation) are to be used when the physician is standing by for the Caesarean section and newborn resuscitation is required.

Once the neonate is no longer considered to be critically ill, the codes for subsequent hospital care (99469) and, when appropriate, subsequent normal newborn hospital care should be used. Initial and subsequent neonatal care includes monitoring and treatment of the patient including nutritional, metabolic, and hematologic maintenance; parent counseling; and personal direct supervision of the health care team in the performance of cognitive and procedural activities.

99471 (Initial Pediatric Critical Care, Per-Day) – This code reflects initial evaluation and management of a critically ill infant or young child, 29 days up through 24 months of age. This code is allowed only once per day and includes 24 hours of care provided by the attending physician.

If a physician treats a critically ill infant/young child in a hospital and stabilizes the infant/young child for transport to a higher-level hospital, critical care codes 99291 and 99292 would be appropriate for those services. Code 36600 (arterial puncture, withdrawal of blood for diagnosis) may not be billed in addition to the critical care. However, codes 36620 (Insertion of arterial catheter for blood sampling or infusion, accessed through the skin) and 36660 (Insertion of catheter into an artery in navel, newborn) are allowed in addition to critical care.

The initial NIC code is also allowed for an infant/young child who has been treated for more than one day in one facility and is then transported to another facility for specialized treatment under another group or physician's care. The admitting physician at each facility may report the admission using this code. If the infant/young child is transferred back to the original facility, the appropriate subsequent level of care must be billed since this is considered a continuation of the same hospitalization.

If the neonate is released home and subsequently readmitted to the hospital, NIC codes cannot be billed. You must bill hospital care codes (99221-99239) or critical care codes (99291-99292).

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Neonatal Intensive Care Codes (Cont'd.)

99472 (Subsequent Pediatric Critical Care, Per Day) – This code reflects subsequent evaluation and management of a critically ill infant or young child, 29 days up through 24 months of age. This code is allowed only once per day and includes 24 hours of care provided by the attending physician.

99468 (Initial NIC Care, Once Per Physician or Group) – This code reflects the admission of a critically ill neonate when the intensity of care meets the definition set forth in the CPT. This code is allowed only one time and includes 24 hours of care provided by the attending physician.

99469 (Subsequent NIC Care, Per Day) – This code reflects subsequent evaluation and management of a critically ill neonate, 28 days of age or less. This code is allowed only once per day and includes 24 hours of care provided by the attending physician.

99478 (Subsequent NIC Care, Per Day) – This code reflects subsequent evaluation and management of the recovering very low birth weight infant (present body weight less than 1500 grams). This code is allowed only once per day and includes 24 hours of care provided by the attending physician.

99479 (Subsequent NIC Care, Per Day) – This code reflects subsequent evaluation and management of the recovering low birth weight infant (present body weight 1500-2500 grams). This code is allowed only once per day and includes 24 hours of care provided by the attending physician.

Additional Services

The following services may be billed in addition to the NIC codes. Documentation that the billing physician rendered the services or directly supervised the rendering of the services must be recorded in the medical record. The following list is not a complete list of additional services allowed, but the most frequently billed services only:

31720 – Tracheal Lavage*

99251–99255 – SIDS Evaluation

36400 – Insertion of needle into upper leg or neck vein, patient younger than 3 years

36405 – Insertion of needle into scalp vein, patient younger than 3 years

36406 – Insertion of needle into vein, patient younger than 3 years

36440 – Push blood transfusion, patient 2 years or younger

36450 – Exchange blood transfusion, newborn

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Additional Services (Cont'd.)

36625 – Cutdown Arterial Catheterization*

36640 – Arterial catheterization for prolonged infusion therapy,(chemotherapy), cutdown"

36660 – Insertion of catheter into an artery in navel, newborn

99360 – Prolonged physician standby service, each 30 minutes

** These codes are included in the description of the NIC codes in the CPT, however, Medicaid policy has made an exception and these codes may be billed in addition to the NIC codes.*

*** This code is used only for prolonged physician attendance prior to delivery.*

Primary or assistant surgeon charges may be billed in addition to the neonatal or critical care codes.

Extracorporeal Membrane Oxygenation Support (ECMO)

ECMO services are reimbursed by the following CPT codes:

36822 – Insertion of cannula(s) for prolonged extracorporeal circulation for cardiopulmonary insufficiency

33961 – Prolonged extracorporeal circulation for cardiopulmonary insufficiency, each additional 24 hours

Procedure code 33961 will be paid for each additional 24 hours up to four days. However, starting with day five, progress notes should be sent attached to the claim for appropriate reimbursement.

The initial and subsequent NIC care codes (99468, 99469, 99471, 99472, 99478, and 99479) may be billed in addition to the ECMO codes.

All other specific CPT surgical procedures that are not included in the 24-hour neonatal codes should be billed separately.

Step Down Neonatal Services

When a neonate is transferred from a Level III hospital to a Level II hospital and remains under the same group or same physician's care, the appropriate level of subsequent, critical care or hospital care codes should be billed depending on the service(s) provided. This coding is also applicable for neonates transferred from the NIC in a hospital to a lower level nursery or unit in the same hospital while remaining under the care of the same group or physician.

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PROGRAM SERVICES

Back Transfer of Neonatal Intensive Care Infants

Care must be transferred to another group or another physician's care in order to establish a permanent medical home for these high-risk infants. This coding is also applicable for neonates transferred from the NIC in a level III hospital to a lower level nursery or unit in the same hospital when their care is transferred to another group or physician.

T1028 – NICU discharge home visit

The following six codes can be billed as appropriate, depending on level of care:

99471 – Initial pediatric critical care, per day

99472 – Subsequent pediatric critical care, per day

99468 – Initial NIC care, once per physician or group

99469 – Subsequent NIC care, per day

99478 – Subsequent NIC care, per day, recovering very low birth weight (body weight less than 1500 grams)

99479 – Subsequent NIC care, per day, recovering low birth weight (body weight 1500-2500 grams)

Pre-Discharge Home Visit

The pre-discharge home visit is designed to assess the condition of the home of an infant who is, or has been a patient, in a neonatal intensive care unit (NICU), or who has had a significant medical problem. The goal is to ensure a safe environment, conducive to maintaining the health status of the infant, after discharge from the hospital.

The visit must be made in response to a referral by a physician directly involved in the care of the infant while hospitalized (unless the infant is a member of an MCO). This also applies to infants who have been transported from the Level III hospital back to their county of residence.

Forensic Medical Evaluations

Effective February 1, 2009, SCDHHS will reimburse Forensic Medical Evaluation services for beneficiaries up to age 21. The purpose of the forensic evaluation is to:

- Determine if a child has been abused, and to identify possible perpetrators
- Gather forensically sound facts necessary to assist law enforcement officials and protect the child
- Allow the child to disclose information in a non-threatening environment and assess the extent and nature of the alleged abuse
- Evaluate the child's social and behavioral functioning in order to make treatment recommendations, and to establish a foundation for effective treatment if needed

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Forensic Medical Evaluations (Cont'd.)

This service will be covered when billed in association with a South Carolina Office of Victims Assistance (SOVA) service that meets the threshold of state law Section 16-3-1350 that governs criminal sexual conduct or child sexual abuse. Coverage will also include those events that meet the reporting requirements of the South Carolina Department of Social Services (DSS) Child Protective Services state law Section 63-7-310 identifying and reporting child abuse and neglect. An event is defined as each original occurrence that meets the forensic evaluations requirements of SOVA and DSS.

All forensic evaluations must be medically necessary. Use the following Healthcare Common Procedure Coding System (HCPCS) codes to bill for these services:

New Code	SCDHHS Definition
G9008	Prolonged evaluation and management service before and/or after direct (face-to-face) patient care *(e.g.*, review of extensive records and test, communication with other professionals and/or the patient/family); first 30 minutes (list additional minutes separately) for other physician service(s) and/or inpatient or outpatient evaluation and management service. **Note**: **Code G9008 is used to report the accumulated duration of the time spent by a health care professional providing prolonged care, even if the time spent spans over more than one date of service. (The last date of service should be billed.)**
G9009	Each additional 15 minutes (list separately); must be used in conjunction with G9008
G9007	Medical team conference with interdisciplinary team of healthcare professionals, face-to-face *with* patient and/or family; 15 minutes or more participation by non-physician qualified healthcare professional. **Note: A non-physician qualified health care professional includes, but is not limited to, nurse practitioners and physician assistants.**
G9010	Medical team conference with interdisciplinary team of healthcare professionals, *without* patient and/or family; 15 minutes or more participation by physician
G9011	Participation by non-physician qualified healthcare professional; 15 minutes or more

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PROGRAM SERVICES

Forensic Medical Evaluations (Cont'd.)

All forensic evaluations must be medically necessary. Only Physicians and Nurse Practitioners may bill SCDHHS directly, using their NPI, for services rendered. Registered Nurses (P-SANE) and Physician Assistants must bill using the supervising Physicians NPI number in order to be reimbursed by SCDHHS. Modifiers will indicate which medical professional rendered services. All provider information must be maintained in the patient's records.

FFS Children's Nutritional Counseling Program

Medicaid-eligible children under the age of 21 may receive unlimited evaluation and management (E&M) visits as long as the services are medically necessary.

This policy currently targets those obese individuals who do not meet the criteria for gastric bypass surgery or related services. Obesity is defined for this program as anyone under age 21 with body mass index (BMI) greater than or equal to 95th percentile for age.

Provider Services

A "provider" is defined as a physician, physician assistant, or nurse practitioner meeting the licensure and educational requirements in the state of South Carolina and/or the border states of Georgia and North Carolina. All services must be rendered within the South Carolina Medicaid Service Area (SCMSA). The SCMSA is defined as South Carolina and adjacent areas within 25 miles of its borders.

During the child's routine physical or office visit, the provider must assess his or her need for obesity counseling intervention. The provider determining a need for obesity intervention must communicate with the child and his or her parents or legal guardian the weight loss goal and plans that lead to an incremental decrease in weight loss. The weight loss goals, laboratory work, and exercise plan must be documented in the child's medical records.

The provider should schedule the child for an independent visit for an E&M service to treat him or her for obesity. The provider must bill the appropriate level E&M service and document provided services in the child's medical record.

The provider must emphasize the importance of exercise, develop a realistic exercise plan with goals, and document the visit in the child's medical record. Children must be accompanied by a parent or legal guardian, and all treatment plans must be reviewed with a parent or legal guardian present. The provider will arrange for an individual nutritional assessment to be provided by a licensed and Medicaid-enrolled dietitian, if medically necessary.

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PROGRAM SERVICES

FFS Children's Nutritional Counseling Program (Cont'd.)

The provider must schedule follow-up exams with both child and parent or legal guardian to evaluate the progress of the obesity treatment developed by the dietitian. The follow-up exam must review compliance with the treatment plan and must include a discussion regarding the child's progress toward meeting their treatment goals.

Dietitian Services

A dietitian is defined as any individual meeting the licensure and educational requirements in the state of South Carolina and/or the border states of Georgia and North Carolina. All services must be rendered within the South Carolina Medicaid Service Area (SCMSA). The SCMSA is defined as South Carolina and adjacent areas within 25 miles of its borders.

The dietitian is responsible for reviewing the child's habits, providing dietary education for the child and his or her parent or legal guardian, reinforcing the importance of exercise, developing a nutritional plan, and establishing weight goals. The dietitian must document the child's progress, activities, and compliance with the nutritional and exercise plan. A written progress report must be submitted within 48 hours of the nutritional counseling visit to the ordering provider each time the child is seen individually or in a group/class setting. The dietitian must maintain complete medical records of the nutritional and exercise plan, and the child's compliance with the treatment plan.

The dietitian must bill the initial nutritional counseling visit utilizing HCPCS code 97802, Medical nutrition therapy, assessment and intervention, each 15 minutes. The dietitian may bill a maximum of two units for the initial visit.

All subsequent nutritional counseling visits must be billed utilizing HCPCS code 97803, Medical nutrition therapy re-assessment and intervention, each 15 minutes. A subsequent nutritional counseling visit is a one-on-one session with the patient or a session between the dietitian and patient in a group setting. The dietitian may bill 30-minute sessions, if medically necessary, which means that the dietitian would bill a maximum of two units in a day and a maximum of 10 units within a year. When billing for nutritional counseling in a group setting, the dietitian must append the HB modifier (adult program, nongeriatric) to HCPCS code 97803. Group nutritional counseling sessions are limited to a maximum of five patients per group.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Billing Requirements

All providers and dietitians are required to bill with a primary diagnosis code. Secondary diagnosis codes must be in compliance with the ICD-CM and is based on the date of service. For dates of service on or before **September 30, 2015,** all V codes must be billed as secondary diagnosis codes. For dates of service on or after **October 1, 2015**, all Z codes must be billed as secondary diagnosis codes.

The following requirements must be met:

- For dates of service on or before **September 30, 2015**, providers and dietitians must bill utilizing the Children's Nutritional Counseling ICD-9 and CPT/HCPCS codes and modifier combinations found in Section 4 of this manual.

  For dates of service on or after **October 1, 2015**, providers and dietitians must bill utilizing the Children's Nutritional Counseling ICD-10 and CPT/HCPCS codes and modifier combinations found in Section 4 of this manual.
- Providers must not bill for initial or subsequent obesity exams on the same day as an E&M service.
- Providers may bill subsequent visits with one-on-one counseling or group counseling by appending the HB modifier to the E&M service.
- Nutritional counseling units billed are based on a 15-minute session and are limited to two units per day, with a maximum of 12 units in a year.

Providers and dietitians are responsible for clearly documenting the child's chart with all information referenced in this policy. All services rendered by both providers and dietitians are subject to review by the Division of Program Integrity. Services not meeting the requirements reflected in this policy may be subject to recoupment by SCDHHS.

Additional Services

If the provider (or dietitian) has completed a series of six visits and the patient has been compliant with the obesity treatment plan and the provider (or dietitian) has determined that the patient would benefit from additional provider visits and nutritional counseling, the provider must submit documentation of medical necessity to:

SCDHHS
ATTN: Medical Director
Post Office Box 8206
Columbia, SC 29202

In order to receive additional visits not to exceed six additional provider visits and six additional nutritional counseling sessions within a 12

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Additional Services (Cont'd.)

month period, the following documentation must be submitted to SCDHHS by the physician, nurse practitioner, or physician assistant only:

- A letter of Medical Necessity
- Patient notes
- BMI start and end
- A1C
- Dietitian reports
- Exercise plan and notes on adherence

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The South Carolina Healthy Connections Medicaid Program, in accordance with federal requirements, Section 1905(r) of the Social Security Act, has developed an Early and Periodic Diagnosis, Screening, and Treatment (EPSDT) benefit for Medicaid-eligible children from birth to age twenty one (21).

EPSDT Standards

- To provide **Early** health assessments for the child who is Medicaid eligible so that potential diseases can be prevented
- To **Periodically** assess the child's health for normal growth and development
- To **Screen** the child through simple tests and procedures for conditions needing closer medical attention
- To **Diagnose** the nature and cause of conditions requiring attention, by synthesizing findings of the health history and physical examination
- To **Treat** abnormalities detected in their preliminary stages or make the appropriate referral whenever necessary.

Services Covered under EPSDT

The EPSDT benefit in South Carolina provides comprehensive and preventive health services needed to diagnose and treat a child's health and developmental conditions as early as possible.

1. **Periodic Screening Services**

   EPSDT covers regular screening services (check-ups) for infants, children and adolescents. At a minimum, children will receive services which constitute evaluations of their physical and mental health; their growth and development; vision, hearing and dental health; and their nutritional and immunization status.

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PROGRAM SERVICES

Services Covered under EPSDT (Cont'd.)

The SCDHHS has adopted the Bright Futures/American Academy of Pediatrics Recommendations for Pediatric Preventive Health Services that is comprised of a set of periodic screenings and procedures applicable at each stage of the child's life, also called the "Periodicity Schedule".

The age-appropriate required periodic screenings and procedures during an EPSDT visit are as follows:

a. Comprehensive Health and Physical Examination

   Includes history, measurements, unclothed age-appropriate physical examination

b. Sensory Screening

   Includes vision and hearing

c. Developmental/Behavioral Health Screenings

   Includes a general screening as part of the EPSDT screening component

d. Procedures

   Includes laboratory tests and procedures

e. Appropriate Immunization

   If at the time of screening, it is determined that immunization is needed and appropriate to provide, then immunization treatment must be provided at that time. For an age-appropriate immunization schedule, the provider must reference the Centers for Disease Control and Prevention (CDC) at https://www.cdc.gov/vaccines/schedules/ hcp/index.html

f. Oral Health

   Includes oral screening at each visit and when applicable, fluoride varnish and fluoride supplementation

g. Health Education and Anticipatory Guidance

   Includes age-appropriate health education (including anticipatory guidance) at each screening

For details of pediatric preventive health care screening services and their frequency, please refer to the Bright Futures/AAP Periodicity Schedule at https://msp.scdhhs.gov/epsdt/site-page/periodicity-schedule.

Note: Additionally, the SCDHHS policy exceeds the frequency and coverage recommended by the AAP and providers are

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Services Covered under EPSDT (Cont'd.)

required to follow the South Carolina specific information for the following areas:

a. Immunization

- For an age-appropriate immunization schedule, the provider must reference the Centers for Disease Control and Prevention (CDC) at https://www.cdc.gov/ vaccines/ schedules/hcp/index. html.
- Every visit should be an opportunity to update and complete a child's immunizations. If a child is unable to be immunized at the recommended time, the reason should be documented in the child's record.

b. Developmental/Behavioral Health Assessments

Follow-up developmental and behavioral health assessments are allowed as indicated by the general screening during a periodic or interperiodic visit.

c. Lead Screening

- Children enrolled in Medicaid must receive blood lead screening at ages 12 months and 24 months. Additionally, any child between ages 24 and 72 months with no record of a previous blood lead screening test must receive one. The completion of a risk assessment does not meet SCDHHS requirements.
- In collecting blood samples for lead testing, providers are required to follow the specimen and collection guidelines developed by the SC Department of Health and Environmental Control (SCDHEC). These guidelines are available on the SCDHEC Bureau of Laboratories webpage at http://www.scdhec.gov/health/lab.
- The South Carolina Code of Laws, Section 44-53-1380, mandates that any physician, hospital, public health nurse, or other diagnosing person or agency must report known or suspected cases of lead poisoning to the SCDHEC within seven days. If you would like more information about the South Carolina Childhood Lead Poisoning Prevention Program, please call (866) 466-5323.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Services Covered under EPSDT (Cont'd.)

d. Oral Health

Oral screenings are performed during each EPSDT visit through the month of the beneficiary's 21st birthday. For details on physicians' oral health services, please refer to the SCDHHS Oral Health Section of the Periodicity Schedule at https://msp. scdhhs.gov/epsdt/site-page/periodicity-schedule

2. Interperiodic Screening Services

EPSDT also covers medically necessary "interperiodic" screenings outside of the periodicity schedule when there is an indication of a medical need to diagnose an illness or condition that was not present at the regularly scheduled screening or to determine if there has been a change in a previously diagnosed illness or condition that requires additional services.

Note: All health related problems that are identified during an EPSDT visit should include referral—when indicated—to the proper entity for further evaluation and treatment. Referrals may include such services and evaluations to determine the need for assistive technology if it is determined that these services are medically necessary and that the child may benefit from them. These services must be medical in nature and not for educational purposes.

3. Diagnostic Services

EPSDT covers diagnostic services when a screening indicates the need for further evaluation.

4. Treatment Services

a. State Plan Covered Services

EPSDT covers necessary health care services for treatment of all physical and mental illnesses or conditions discovered by any screening and diagnostic procedure.

b. Non State Plan Covered Services – Medically Necessary Services

Additional health care services are available under the federal Medicaid program if they are medically necessary to treat, correct or ameliorate illnesses and conditions discovered regardless of whether the service is covered by the SC Medicaid State Plan. Medical necessity is determined by SC Medicaid on a case-by-case basis. Arbitrary

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Services Covered under EPSDT (Cont'd.)

limitations on services are not allowed within the EPSDT benefit, (*e.g.*, one pair of eyeglasses or ten (10) physical therapy visits per year). South Carolina Healthy Connections Medicaid will make the final determination as to which treatment it will cover among equally effective, available alternative treatments. All in-state resources must be exhausted prior to treatment outside of the state.

5. Additional Tests/Procedures

a. Sickle Cell Test – A screening test is administered when indicated by family, medical history or in the presence of anemia.

b. Parasites Test – A test for parasites is administered when indicated by medical history, physical assessment or a positive result of a previous test.

c. Tuberculin Skin Test – Mantoux test (with five (5) tuberculin units [TU] of purified protein derivative [PPD] administered intradermally) should be considered for all children at increased risk of exposure to individuals with tuberculosis. Providers may want to check with local, state or regional tuberculosis control officials (public health department) for more specific information relating to the epidemiology of tuberculosis in their area.

d. Topical Fluoride Varnish – South Carolina Healthy Connections children can receive topical fluoride varnish during sick or well child visits from the eruption of their first tooth through the month of their 21st birthday. Children ages zero through six may receive a maximum of four (4) applications per year, while children ages seven through 20 may receive one (1) application per year.

e. Developmental/Behavioral Health Assessments – Follow-up developmental and behavioral health assessments are allowed as indicated by the general screening during a periodic or interperiodic visit.

6. Transportation Services

Transportation services, including Non-Emergency Medical Transportation (NEMT), are available for EPSDT-eligible beneficiaries. To schedule NEMT trips to a medical appointment

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Services Covered under EPSDT (Cont'd.)

for beneficiaries not residing in a nursing facility, contact the Transportation Broker at https://memberinfo.logisticare.com/scmember/. To schedule NEMT trips to a medical appointment for beneficiaries residing in a nursing facility, contact the nursing facility directly.

Services Not Covered under EPSDT

The following services are not covered under EPSDT:

1. Experimental or investigational treatments
2. Services or items not generally accepted as effective and/or not within the normal course and duration of treatment
3. Services for caregiver or provider convenience
4. Home and Community Based (HCB) Waiver Services

   Services for which South Carolina Healthy Connections Medicaid has a waiver program are not considered to be state plan benefits, and therefore, are not a benefit under EPSDT. For example, items such as respite, vehicle modifications, and home modifications are not covered.
5. Sports, camp, or college physical examination

Enrollment Prerequisites

Professional practitioners and other providers must be licensed and/or certified by the appropriate standard setting agency to provide services covered by South Carolina Healthy Connections Medicaid.

1. Registered nurses working in county health department offices must meet the standards for performing EPSDT screenings established by SCDHEC.
2. Registered nurses who perform screenings in schools must have successfully completed the SCDHHS-approved Child Health Maintenance course. A physician should be available for consultation, if necessary.
3. Registered nurses in physicians' offices or clinics who assist in the performance of EPSDT screenings should do so under the direct supervision of a physician/nurse practitioner who assumes responsibility for quality of care. They are encouraged to successfully complete the SCDHEC course.
4. For application of Fluoride Varnish, providers must have successfully completed an Oral Health training module and keep the Certificate of Completion in their records. SCDHHS recognizes the following Oral Health trainings for the purpose of Certification:

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PROGRAM SERVICES

Enrollment Prerequisites (Cont'd.)

- The Bright Futures curriculum and Bright Smiles Oral Health Modules developed by the American Academy of Pediatrics (AAP), accessible at: http://www.smilesforlifeoralhealth.org/buildcontent.aspx?tut=584&pagekey=64563&cbreceipt=0.
- Smiles for Life excerpts and SCDHHS anticipatory guidance and policy guidelines can be found at https://msp.scdhhs.gov/qtip/sites/default/files/smiles%20for%20life%20fluoride%20varnish%20training%20plus%20SC%20DHHS%20policy%20%20updated%20march%202018.pdf.
- Connecting Smiles modules developed by the SCDHEC in collaboration with SCDHHS are accessible at: http://www.connectingsmilessc.org/flouride-varnish-training/.

5. Registered nurses in physicians' offices or clinics who assist in the performance of EPSDT screenings should do so under the direct supervision of a physician/nurse practitioner who assumes responsibility for quality of care. They are encouraged to successfully complete the SCDHEC course.

Beneficiary Eligibility for EPSDT Services by Provider Location

Based on the qualified healthcare practitioner's location, EPSDT services can be rendered to the beneficiaries as follows:

1. In the Physician's office
   - EPSDT services can be rendered for beneficiaries ages 0-20 (through the month of the 21st birthday)
2. In Federally Qualified Health Centers (FQHC)
   - EPSDT services can be rendered for beneficiaries ages 0 through 20 (through the month of the 21st birthday)
3. In Rural Health Clinics (RHC)
   - EPSDT services can be rendered for beneficiaries ages 0 through 20 (through the month of the 21st birthday)
4. In Convenient Care Clinics
   - EPSDT services can be rendered only for children ages 5 through 20 (through the month of the 21st birthday)

Billing for EPSDT Services

Providers can bill for EPSDT services and immunizations on the CMS-1500 claim form using the appropriate CPT codes. Providers who are set up for electronic billing may bill using the electronic billing system when using these CPT codes. Providers using the CMS-1500 claim

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Billing for EPSDT Services (Cont'd.)

form must bill under the Medicaid provider numbers they currently use for billing on the claim form such as:

- Physicians must bill under their group or individual provider numbers.
- Clinics must bill under their clinic numbers.
- Rural health clinics (RHCs) must bill under their RHC provider number.
- Federally qualified health centers (FQHCs) must bill under their FQHC provider number.

Providers using the CMS-1500 will be responsible for handling their own EPSDT scheduling for patients in their practice.

1. Periodic and Interperiodic Screening Services

a. All EPSDT screenings must be billed using the appropriate CPT codes (99381–99385 and 99391 – 99395) regardless of provider type or location.

b. Prior authorizations are NOT required for Periodic or Interperiodic screening services.

c. For FQHCs and RHCs, an EPSDT screening is considered an encounter; however, the appropriate CPT screening codes must be billed for reimbursement. A screening and an encounter code may not be billed on the same date of service.

d. Medicaid providers enrolled with SCDHEC in the VAFAC program may bill an immunization administration fee.

The following indicators must be used in field 24H of the CMS-1500 claim form when billing a screening:

Indicator 1 – Well-child care with treatment of an identified problem treated by the physician

Indicator 2 – Well-child care with a referral made for an identified problem to another provider

Indicator N – No problems found during visit

2. Medically Necessary Services

Providers must bill using the appropriate diagnosis and treatment code for each procedure. Providers must obtain a prior authorization for all medically necessary non-State Plan EPSDT services; submitting documentation of medical necessity and any additional information will assist in this determination.

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PROGRAM SERVICES

Reimbursement for EPSDT Services

Note: This policy applies only to the Physician's office and convenient care clinics. For reimbursement in FQHCs and RHCs, please refer to the respective sections of this manual.

1. EPSDT Periodic Screening

EPSDT periodic screenings will be reimbursed at a uniform rate. Although screening services vary according to age and schedule, the reimbursement is intended to be an equitable average fee. Any other test or treatment service performed should be billed separately. For FQHC and RHC facilities, the screening reimbursement rate is the facility's established contract daily rate. The following guidelines should be used when billing for periodic screening:

a. Screening components **cannot** be fragmented and billed separately.

b. The screening provider **cannot** bill an office visit on the same day a screening is billed.

c. South Carolina Medicaid policy does **not allow** providers to bill an EPSDT well-child screening on the same day as a sick visit.

d. If individual components of a screening are not performed, the reason must be appropriately documented. Reimbursement for the screening fee may be subject to recoupment if each age-appropriate component is not performed and not documented.

2. **EPSDT Interperiodic Screening**

Reimbursement for an interperiodic screening is the same as a periodic screening. The following guidelines should be used when billing for interperiodic screenings:

a. The provider must indicate the diagnosis code of the condition to justify the medical necessity for performing an interperiodic screening.

b. The interperiodic screening must include all the required screening components appropriate to the child's age.

c. Individual screening components or follow-up treatment cannot be billed as an interperiodic screening.

3. Medically Necessary Services

Providers should obtain a prior authorization for all medically necessary non-State Plan EPSDT services prior to service

Reimbursement for EPSDT Services (Cont'd.)

provision. Providers must submit documentation of medical necessity and any additional information that will assist in the determination of service coverage.

4. Additional Services

Additional services performed during an EPSDT visit may be covered separately from the EPSDT visit utilizing the appropriate CPT code and billed at a frequency according to the periodicity schedule available at https://msp.scdhhs.gov/epsdt/site-page/periodicity-schedule. The additional services include:

a. Immunization Administration

- When billing for an immunization administration and an EPSDT examination code on the same day, the provider must use modifier XU when billing the immunization administrative code in order to receive additional reimbursement.
- Providers may bill for the administration of vaccines that are obtained through the Vaccines for Children (VFC) Program and administered in the physician's office.
- When billing for immunization services for children under the age of 19, both the administration code and the vaccine code for the administered vaccine must be listed on the claim to receive reimbursement for the vaccine administration only. For this code combination, only the administration code will be reimbursable (CPT codes 90460-90461).

b. Topical Fluoride Varnish

- CPT Procedure code 99188 must be used when billing for the application of fluoride varnish.

c. Laboratory Tests and Analysis

- Reimbursement for the lab analysis is not part of the EPSDT service rate.
- Blood level assessments
  - If the provider office sends the blood lead samples to an outside laboratory for analysis, the laboratory will bill Medicaid directly for the blood lead analysis using CPT code 83655.
  - If the provider office is using the ESA LeadCare

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PROGRAM SERVICES

Reimbursement for EPSDT Services (Cont'd.)

Blood Lead Testing System to analyze the blood lead samples internally, then the office should bill Medicaid directly using CPT code 83655.

d. Age Limited Screenings

e. Elective Tests

f. Developmental and Behavioral Assessments

EPSDT providers are allowed to bill for standardized developmental, mental, emotional, behavioral and psychosocial assessments utilizing standardized screening tools that are culturally sensitive and have a moderate to high sensitivity, specificity and validity level. A general screening is recommended with follow-up screening, as indicated. Documentation must include a copy of the completed screening tool and the score per instrument screening tool. Billing for screenings follow coding guidelines and NCCI edits.

- Procedure code 96110 – Childhood and Adolescent Developmental Levels.

  This code is limited to a frequency of two (2) times per day for beneficiaries up to 18 years of age. Examples of standardized screening instruments include, but are not limited to:

  - Ages and Stages Questionnaire, 3rd Edition (ASQ)
  - Parents Evaluation of Developmental Status (PEDS)
  - Modified Checklist of Autism in Toddlers (MCHAT)

- Procedure code 96127 – Emotional and/or Behavioral Health Assessment

  This code is limited to a frequency of two (2) times per day for beneficiaries up to 18 years of age. Examples of standardized screening instruments include, but are not limited to:

  - Ages and Stages Questionnaire: Social-Emotional (ASQ: SE)
  - Pediatric Symptom Checklist (PSC) or Pediatric Symptom Checklist – Youth Report (PSC-Y)
  - Modified Patient Health Questionnaire (PHQ-9)
  - Screen for Child Anxiety Related Emotional Disorders (SCARED)

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PROGRAM SERVICES

Reimbursement for EPSDT Services (Cont'd.)

- Vanderbilt Diagnostic Rating Scale (Vanderbilt)

- Procedure code 96160 – patient focused health risk assessment (*e.g.,* health hazard appraisal). This code is limited to a frequency of two (2) times per day for beneficiaries through eighteen (18) years of age. Examples of standardized screening instruments include, but are not limited to:
  - Acute Concussion Evaluation (ACE)
  - CRAFFT Screening Interview
  - Guidelines for Adolescent Preventative Services (GAPS)
- Procedure code 96161 – caregiver-focused health risk assessment (*e.g.,* depression inventory) for the benefit of the patient. This code is limited to a frequency of two (2) times per date of service. Examples of standardized screening instruments include, but are not limited to:
  - Edinburgh Maternal Depression Screen
  - Safe Environment for Every Kid (SEEK)

Resources

To obtain a copy of the AAP Guidelines for Health Supervision please contact:

American Academy of Pediatrics
141 North West Point Boulevard
Post Office Box 927
Elk Grove Village, IL 60009-0927
(800) 433-9016

To order the Denver II test forms, screening manual, test kit, and training videotape, contact:

Denver Developmental Materials, Inc.
Post Office Box 371075
Denver, CO 80237-5075
(303) 355-4729

To obtain a hearing kit, contact:

BAM Work Market, Inc.
Post Office Box 10701
University Park Station
Denver, CO 80210

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PROGRAM SERVICES

Resources (Cont'd.)

To obtain a new or reconditioned audiometer, contact:

Health and Hygiene/ELB
605 Eastowne Drive
Chapel Hill, NC 27514

To order growth charts, contact:

Ross Laboratories
Division of Abbott Labs
Columbia, OH 43216
(614) 624-7677

Or

Mead Johnson and Company
Nutritional Division
Evansville, IN 47721
(812) 429-5000
(800) 227-5767

To order a well-child record system, contact:

Milcom
A Division of Hollister, Inc.
2000 Hollister Drive
Libertyville, IL 60048
(800) 243-5546

To order Anticipatory Guidance/TIPP educational materials, contact:

Materials Library/Educational Resources
Department of Health and Environmental Control
Columbia, SC 29201
(803) 898-3804

PHARMACY SERVICES

Medicaid provides prescription medications to beneficiaries with some restrictions. Details regarding the Medicaid pharmacy benefit are available in the SCDHHS Pharmacy Services Provider Manual.

Self-administered medications are generally only reimbursed through the pharmacy benefit.

Tamper-Resistant Prescription Pads

Pursuant to federal regulations, prescriptions for medications reimbursed by Medicaid must be written on a tamper-resistant pad.

To be considered tamper-resistant, a prescription pad must contain the following three characteristics:

- One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form

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PROGRAM SERVICES

Tamper-Resistant Prescription Pads (Cont'd.)

- One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber
- One or more industry-recognized features designed to prevent the use of counterfeit prescription forms

The requirement does NOT apply to prescriptions issued electronically, verbally, or via fax.

South Carolina Reporting and Identification Prescription Tracking System (SCRIPTS)

Beginning with dates of service on or after April 1, 2016, providers issuing any controlled substance in DEA Schedules II through IV must first evaluate the beneficiary's controlled substance history through the South Carolina Reporting and Identification Prescription Tracking System (SCRIPTS). Providers must maintain documentation that the SCRIPTS database was verified. Failure to consult SCRIPTS may result in recoupment of Medicaid funds for the office visit during which the prescription was issued.

For Medicaid beneficiaries treated chronically with controlled substances, SCDHHS requires that SCRIPTS be consulted at the initiation of therapy and at least every 90 days thereafter.

The following instances are exempt from this requirement: (1) issuance of less than a five-day supply of a controlled substance; (2) issuance of a controlled substance prescription to a Medicaid beneficiary who is enrolled in hospice; or (3) instances where a controlled substance is administered by a licensed health care provider, such as during an office visits or for a beneficiary who resides in a skilled nursing or assisted living facility.

Prior Authorization

Some self-administered medications that are covered by Medicaid require prior authorization. Details regarding prior authorization requirements for outpatient prescription medications are available in the Pharmacy Services manual and on the SC Medicaid Preferred Drug List (PDL). Requests for prior authorizations for outpatient prescription medications should be directed to Magellan Medicaid Administration. Providers may contact Magellan by phone at 866-247-1181 or by fax at 888-603-7696.

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PROGRAM SERVICES

"Buy and Bill" Prior Authorization Request

The following medications that are customarily billed through the medical benefit (*i.e.*, "buy and bill drugs) require prior authorization.

The following Medicaid beneficiary and Medicaid eligibility categories are excluded from obtaining an authorization by ICORE:

- Beneficiaries with current Medicare coverage (dual Medicare and Medicaid coverage)
- Beneficiaries who are incarcerated
- Beneficiaries enrolled in the Hospice program
- Beneficiaries enrolled in the PACE program
- Beneficiaries with limited benefits

J CODE	DRUG NAME	CATEGORY
J2505	Neulasta	Neutropenia
J9355	Herceptin	Oncology
J1745	Remicade	Inflammatory Conditions
J9263	Eloxatin	Oncology
J9305	Alimta	Oncology
J9055	Erbitux	Oncology
J9312	Rituximab	Inflammatory Conditions
J2323	Tysabri	Multiple Sclerosis
J2469	Aloxi	Anti-emetics
J9264	Abraxane	Oncology
J0881	Aranesp	Anemia
J0885	Procrit	Anemia
J0129	Orencia	Inflammatory Conditions
J1442	Neupogen	Neutropenia
J9303	Vectibix	Oncology
J9228	Yervoy	Oncology
J9179	Halavan	Oncology
J2507	Krystexxa	Inflammatory Conditions
J9354	Kadcyla	Oncology
Q2043	Provenge	Oncology
J3262	Actemra	Inflammatory Conditions
J0800	Acthar_HP	Endocrine Disorders
J0717	Cimzia	Inflammatory Conditions
J3380	Entyvio	Inflammatory Conditions
J9306	Perjeta	Oncology

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J CODE	DRUG NAME	CATEGORY
J1602	Simponi_ARIA	Inflammatory Conditions
J1300	Soliris	Hematological Conditions
J3357	Stelara	Psoriasis
J3358	Stelara	Inflammatory Conditions
Q5101	Zarxio	Oncology
J9271	Keytruda	Oncology
J9299	Opdivo	Oncology
J9035	Avastin	Oncology

DURABLE MEDICAL EQUIPMENT/SUPPLY

Durable Medical Equipment is equipment that provides therapeutic benefits or enables a beneficiary to perform certain tasks that he or she would be unable to undertake otherwise due to certain medical conditions and/or illness. This equipment can withstand repeated use and is primarily and customarily used for medical reasons. It is appropriate and suitable for use in the home. This includes medical products; surgical supplies; equipment such as wheelchairs, traction equipment, walkers, canes, crutches, ventilators, prosthetic and orthotic devices, oxygen; hearing aid services (provided by contractor only), hospital beds, and ostomy supplies; and other medically needed items when ordered by a physician as medically necessary in the treatment of a specific medical condition. The attending physician must prescribe the items and 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. Luxury and deluxe models are restricted if standard models would be appropriate. Repairs to medical equipment are covered if reasonable.

Providers who are enrolled in the Medicaid program as DME providers are reimbursed for providing equipment and/or supplies to eligible Medicaid beneficiaries in compliance with the Department of Durable Medical Equipment's (DME) policy.

For DME policy guidelines, contact the PSC at 1-888-289-0709, submit an online inquiry http://www.scdhhs.gov/contact-us *or* write to:

SCDHHS Department of Durable Medical Equipment
Post Office Box 8206
Columbia, SC 29202-8206

There are a select few DME items that are reimbursable through Physician Services. These items are listed as supplies under the heading "Additional Ambulatory Services" in this section.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

SERVICES FOR AIDS PATIENTS

In an effort to find a medical home for AIDS patients covered under the Medicaid program and to properly reimburse physicians for the complications involved with treating these patients, supplemental codes (see table below) have been developed for physicians treating Medicaid beneficiaries diagnosed with AIDS or AIDS Related Complex (ARC). In order to bill for these services, you must use the P4 modifier in correlation to the appropriate E/M code.

FREQUENCY DESCRIPTION	CODES*	LIMITS
OFFICE VISITS		
NEW PATIENT OFFICE VISIT	**99201-99205, 99211-**	**1/3 YEARS****
ESTABLISHED PATIENT OFFICE VISIT	**99215, 99251-99255**	**1/DAY**
HOSPITAL VISITS		
INITIAL HOSPITAL VISIT	**99221-99223**	**1/HOSPITAL ADMISSION**
SUBSEQUENT HOSPITAL VISIT		**1/DAY**
HOME VISITS		
NEW PATIENT HOME VISIT	**S6920**	**1/3 YEARS****
ESTABLISHED PATIENT HOME VISIT	**99341-99345, 99347-99350**	**1/DAY**
EMERGENCY VISIT		
ER VISIT	**99281-99285**	**1/DAY**
CONSULTANTS		
INITIAL CONSULTATION	**99241-99245**	**1/REFERRAL**
FOLLOW-UP CONSULTATION	**99211-99215**	**1/DAY (AS REQUESTED)**

* In order to use these codes, a documented diagnosis of AIDS or ARC must be on each patient's chart.
** New patient is defined as a patient not seen by any member of the group, regardless of specialty.

Additional CLTC Services

Aside from traditional Medicaid services (physician, hospital, drugs, etc.), SCDHHS offers home- and community-based waiver services through the Division of Community Long Term Care (CLTC). In addition to being HIV positive, the individual must meet an established medical level of care prior to receiving these services. Services available are listed below:

- Case management services
- Private duty nursing services
- Personal care aide services

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PROGRAM SERVICES

Additional CLTC Services (Cont'd.)

- Modified and therapeutic-diet home-delivered meals
- Counseling services
- Foster care services
- Limited nutritional supplements
- Environmental modifications
- Attendant care
- Home management
- Two additional prescription drugs per month

Incontinence Products

For incontinence products policy and procedures, please refer to the Home Health Services Provider Manual located on the SCDHHS website at http://www.scdhhs.gov/contact-us .

CLTC Offices

There are 11 area and three satellite CLTC offices statewide. Each office is staffed by service managers who are professional social workers and registered nurses. These service managers work with the person and/or the family to plan and coordinate the services the beneficiary may need.

If you have clients, who you feel may benefit from any of these services, or if you have questions about the CLTC program, please call your area CLTC office as listed in the table on the following page.

For additional information, please contact the PSC at 1-888-289-0709, submit an online inquiry http://www.scdhhs.gov/contact-us, or write to:

SCDHHS
Community Long-Term Care Department
Post Office Box 8206
Columbia, SC 29202

AREAS	COUNTIES SERVED	PHONE NUMBERS
Area 1 – Greenville	Greenville, Pickens	(864) 242-2211 (888) 535-8523
Area 2 – Spartanburg	Cherokee, Spartanburg, Union	(864) 587-4707 (888) 551-3864
Area 3 – Greenwood, IMS	Abbeville, Edgefield, Greenwood, Laurens, McCormick, Saluda	(864) 223-8622 (800) 628-3838
Area 4 – Rock Hill	Chester, Lancaster, York	(803) 327-9061 (888) 286-2078

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AREAS	COUNTIES SERVED	PHONE NUMBERS
Area 5 – Columbia	Fairfield, Lexington, Newberry, Richland	(803) 741-0826 (888) 847-0908
Area 6 – Orangeburg	Allendale, Bamberg, Calhoun, Orangeburg	(803) 536-0122 (888) 218-4915
Area 6A – Aiken Satellite Office	Aiken, Barnwell	(803) 641-7680 (888) 364-3310
Area 7 – Sumter	Clarendon, Kershaw, Lee, Sumter	(803) 905-1980 (888) 761-5991
Area 8 – Florence	Chesterfield, Darlington, Dillon, Florence, Marlboro	(843) 667-8718 (888) 798-8995
Area 9 – Conway	Georgetown, Horry, Marion, Williamsburg	(843) 248-7249 (888) 539-8796
Area 10 – Charleston	Berkeley, Charleston, Dorchester	(843) 529-0142 (888) 805-4397
Area 10A – Point South Satellite	Beaufort, Colleton, Hampton, Jasper Beaufort Line:	(843) 726-5353 (800) 262-3329 (843) 521-9191
Area 11 – Anderson, IMS	Anderson, Oconee	(864) 224-9452 (800) 713-8003

Outpatient Pediatric Aids Clinics

Outpatient Pediatric AIDS Clinics (OPACs) are designed to provide specialty care, consultation, and counseling services for HIV infected and exposed, Medicaid-eligible children and their families. Clinics presently contracted are located at the Medical University of South Carolina, Department of Pediatrics; the USC School of Medicine, Department of Pediatrics; and Greenville Hospital. The mission of OPAC is to follow children who have been exposed to HIV perinatally as children born to women infected with HIV.

ALCOHOL AND DRUG ABUSE REHABILITATION SERVICES

The medical benefits package for Medicaid beneficiaries includes outpatient alcohol and drug (A&D) rehabilitative services. Crisis Management is also available for patients who are experiencing emotional, physical, and/or psychological trauma.

The effectiveness of this program relies on the referrals by physicians. There are several alternatives a physician can use to refer a Medicaid beneficiary for A&D services. Likewise, there are several ways to bill for referral services.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Initial Medical Assessment and Referral

Procedure Code 90791 and 90792 – This is a face-to-face contact between physician and client to assess the patient status, provide diagnostic evaluation screening, and provide physician's referral for alcohol and drug rehabilitative services. This includes the completion of the Alcohol and Drug Medical Assessment signed and dated by the physician. A sample copy of the form can be found in the Forms section of this manual. Additional forms are available upon request from your county alcohol and drug abuse program. This form will be placed in the client's file at the local alcohol and drug abuse authority site. A copy should be retained in the patient's file. The assessment form completion is included in the reimbursement fee.

Local Alcohol and Drug Authorities Currently Enrolled in Medicaid

The chart beginning on the following page includes an address and telephone number for all of the local alcohol and drug authorities currently enrolled in Medicaid:

County	Program Name and Address	Telephone Number
	South Carolina Department of Alcohol and Drug Abuse (DAODAS) 101 Executive Center Drive, Suite 215 Columbia, South Carolina 29210	(803) 896-5555
Abbeville	Cornerstone 112 Whitehall Street Abbeville, South Carolina 29620	(864) 366-9661
Aiken	Aiken Center 1105 Gregg Highway Aiken, South Carolina 29801	(803) 649-1900
Allendale	New Life Center 570 Memorial Avenue Allendale, South Carolina 29810	(803) 584-4238
Anderson	Anderson/Oconee Behavioral Health Services 226 McGee Road Anderson, South Carolina 29625	(864) 260-4168
Bamberg	Dawn Center (Tri-County Commission of Alcohol and Drug Abuse) 608 North Main Street Bamberg, South Carolina 29003	(803) 245-4360

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

County	Program Name and Address	Telephone Number
Barnwell	Axis I Center of Barnwell 644 Jackson Street Barnwell, South Carolina 29812	(803) 541-1245
Beaufort	Beaufort County Department of Alcohol and Other Drug Services 1905 Duke Street Beaufort, South Carolina 29901	(843) 470-4545
Berkeley	Ernest E Kennedy Center 306 Airport Drive Monks Corner, South Carolina 29461	(843) 761-8272
Calhoun	Dawn Center (Tri-County Commission of Alcohol and Drug Abuse) Herlong Extension Industrial Park St. Matthews, South Carolina 29135	(803) 655-7963
Charleston	Charleston Center 5 Charleston Center Drive Charleston, South Carolina 29401	(843) 958-3300
Cherokee	Cherokee County Commission of Alcohol and Other Drug Services 201 West Montgomery Street Gaffney, South Carolina 29341	(864) 487-2721
Chester	Hazel Pittman Center 130 Hudson Street Chester, South Carolina 29706	(803) 377-8111
Chesterfield	Alpha Center 1218 East Boulevard Chesterfield, South Carolina 29709	(843) 623-7062
Clarendon	Clarendon County Commission on ADA 14 North Church Street Manning, South Carolina 29102	(803) 435-2121
Colleton	Colleton County Commission on ADA 1439 Thunderbolt Drive Walterboro, South Carolina 29488	(843) 538-4343

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

County	Program Name and Address	Telephone Number
Darlington	Rubicon Inc. 510 East Carolina Avenue Hartsville, south Carolina 29550	(843) 332-4156
Dillon	Trinity Behavioral Care 204 Martin Luther King Jr. Blvd. Dillon, South Carolina	(843) 774-6591
Dorchester	Dorchester Alcohol & Drug Commission 500 North Main Street, Suite 4 Summerville, South Carolina 29483	(843) 871-4790
Edgefield	Cornerstone 400 Church Street, Room 112 Edgefield, South Carolina 29824	(803) 637-4050
Fairfield	Fairfield County Substance Abuse Commission 200 Calhoun Street Winnsboro, South Carolina	(803) 635-2335
Florence	Circle Park Behavioral Health Services 601 Gregg Avenue Florence, South Carolina 29501	(843) 665-9349
Georgetown	Georgetown County ADA Commission 1423 Winyah Street Georgetown, South Carolina 29440	(843) 546-6081
Greenville	The Phoenix Center 1400 Cleveland Street Greenville, South Carolina 29607	(864) 467-3739
Greenwood	Cornerstone 1510 Spring Street Greenwood, South Carolina 29646	(864) 227-1001
Hampton	New Life Center 102 Ginn Altman Avenue, Suite C Hampton, South Carolina 29924	(803) 943-2800
Horry	Shoreline BHS 2404 Wise Road Conway, South Carolina 29526	(843) 365-8884

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PROGRAM SERVICES

County	Program Name and Address	Telephone Number
Jasper	New Life Center 113 East Wilson Street Ridgeland, South Carolina 29936	(843) 726-5996
Kershaw	Alpha Center 709 Mill Street Camden, South Carolina 29020	(803) 432-6902
Lancaster	Counseling Services of Lancaster 114 South Main Street Lancaster, South Carolina 29720	(803) 285-6911
Laurens	Gateway Counseling Center 219 Human Services Road Clinton, South Carolina 29325	(864) 833-6500
Lee	The Lee Center Family Counseling and Addiction Services 108 East Church Street Bishopville, South Carolina 29010	(803) 484-6025
Lexington	Lexington/Richland Alcohol and Drug Abuse Council (LRADAC) 130 North Hospital Drive West Columbia, South Carolina 29169	(803) 733-1390
Marion	Trinity Behavioral Care 103 Court Street Marion, South Carolina 29571	(843) 423-8292
Marlboro	Trinity Behavioral Care 211 North Marlboro Street, 2nd Floor Bennettsville, South Carolina 29512	(843) 479-5683
McCormick	Cornerstone 504 North Mine Street McCormick, South Carolina 29835	(864) 465-2631
Newberry	Westview Behavioral Health Services 800 Main Street or 909 College Street Newberry, South Carolina 29108	(803) 276-5690

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PROGRAM SERVICES

County	Program Name and Address	Telephone Number
Oconee	Anderson/Oconee Behavioral Health Services 691 South Oak Street Seneca, South Carolina 29678	(864) 882-7563
Orangeburg	Dawn Center (Tri-County Commission of Alcohol and Drug Abuse) 910 Cook Road Orangeburg, South Carolina 29118	(803) 536-4900
Pickens	Behavioral Health Services of Pickens County 309 East Main Street Pickens, South Carolina 29671	(864) 898-5800
Richland	Lexington/Richland Alcohol and Drug Abuse Council (LRADAC) 2711 Colonial Drive Columbia, South Carolina 29203	(803) 726-9300
Saluda	Saluda Behavioral Health System 204 Ramage Street Saluda, South Carolina 29138	(864) 445-2968
Spartanburg	Spartanburg County Alcohol and Drug Abuse Commission 187 West Broad Street, Suite 200 Spartanburg, South Carolina 29306	(864) 582-7588
Sumter	Sumter County Commission on ADA 115 North Harvin Street, 3rd Floor Sumter, South Carolina 29150	(803) 775-6815
Union	Union county Commission on ADA 201 South Herdon Street Union, South Carolina 29379	(864) 429-1656
Williamsburg	Williamsburg Commission on ADA 115 Short Street Kingstree, South Carolina 29556	(843) 354-9113
York	Keystone Substance Abuse Services 199 South Herlong Avenue Rock Hill, South Carolina 29732	(803) 324-1800

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PROGRAM SERVICES

ALCOHOL AND DRUG TESTING POLICY

Effective for dates of service beginning Jan. 1, 2016, the South Carolina Department of Health and Human Services (SCDHHS) will cover the following presumptive and definitive drug testing classifications. SCDHHS will reimburse for a maximum of one screening per procedure code per date of service, not to exceed 18 screenings per 12-month period. Providers should bill the most appropriate Healthcare Common Procedure Coding System (HCPCS) code for the service rendered.

Drug test(s), presumptive, any number of drug classes; any number of devices or procedures, (e.g., immunoassay) capable of being read by direct optical observation only (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service.

Drug test(s), presumptive, any number of drug classes; any number of devices or procedures by instrumented chemistry analyzers utilizing immunoassay, enzyme assay, TOF, MALDI, LDTD, DESI, DART, GHPC, GC mass spectrometry), includes sample validation when performed, per date of service.

Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)); qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 1-7 drug class(es), including metabolite(s) if performed.

SCDHHS policy has been and continues to be that alcohol and drug screenings, as with all lab tests, must be ordered by a qualified practitioner operating within their scope of practice and as allowed by state law. Qualified practitioners may authorize certain laboratory tests to be performed at defined intervals over a period of 60 days with one "standing order" only when used in connection with an extended course of treatment for substance abuse disorders. The ordering practitioner must document in the beneficiary's clinical record the medical necessity for the testing and the results of each test. Qualified practitioners ordering unnecessary tests for which Medicaid is billed may be subject to civil penalties.

A qualified practitioner is defined as a physician, nurse practitioner, or a physician assistant. The qualified practitioner may write an individualized standing order for the beneficiary, but must be updated every 60 days.

Laboratory standing orders must be in a written form, patient specific, and include a duration that cannot exceed 60 days. In all instances,

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Alcohol and Drug Testing Policy (Cont'd.)

standing orders are rendered invalid after 60 days from the date the initial test was ordered. Existing standing orders must be reviewed regularly to ensure their continuing validity.

Standing orders must include the following information:

- The treating physician, nurse practitioner, or physician assistant name, address, telephone number, license number, and NPI number
- The name, date of birth, sex, Medicaid ID number, diagnosis and statement of clinical symptoms that justify medical necessity of the beneficiary for whom the tests are ordered
- The date the test was ordered
- The name of all tests performed, listed individually
- Specific intervals, at which each individual test should be performed, based on the individual treatment needs
- Signature, title and date of qualified practitioner that evaluated the beneficiary and confirmed the medical necessity

Alcohol and drug screens for employment purposes or for a court ordered alcohol and drug screen are not covered under the Medicaid program.

TOBACCO CESSATION

Tobacco use is the leading cause of preventable disease and premature death in South Carolina. SCDHHS provides comprehensive coverage for tobacco cessation treatment through pharmacotherapy and counseling for all full-benefit Medicaid beneficiaries. SCDHHS also partners with SCDHEC to communicate about programs available to assist Medicaid beneficiaries with quitting tobacco use.

Providers are encouraged to screen beneficiaries for tobacco use during medical encounters and document nicotine dependence using the appropriate diagnosis codes.

Medication

SCDHHS covers prescriptions for the following tobacco cessation and nicotine replacement therapy (NRT) products:

- Bupropion sustained release (SR) products for tobacco use (Zyban)
- Varenicline (Chantix) tablets
- Nicotine gum
- Nicotine lozenge
- Nicotine nasal spray

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Medication (Cont'd.)

- Nicotine inhaler
- Nicotine patch

Tobacco cessation products are exempt from the adult monthly prescription limit, prior authorization, and copayment requirements. There is no limit to the number of quit attempts in a calendar year. The following medically appropriate combination therapies are also covered:

- Long-term nicotine patch + other NRT product (gum or spray)
- Nicotine patch + nicotine inhaler
- Nicotine patch + Bupropion SR

General edits on day supply are based on product dosing in manufacturer package inserts. Prescribers are encouraged to reference the AAFP Pharmacologic Product Guide for FDA-approved medications for smoking cessation for more information on product guidelines.

As with all other pharmaceuticals, SCDHHS reimburses only rebated products (brand or generic) for fee-for-service (FFS) beneficiaries. A beneficiary must provide a prescription to receive any medication, including OTC products. A dual-eligible member can receive OTC products through Medicaid coverage, but the individual's Medicare Part D prescription drug plan must cover prescriptions for legend (non-OTC) tobacco cessation products.

For further questions about this benefit, prescribers should contact the Magellan Medicaid Administration's Clinical Call Center at 866-247-1181.

Counseling

Tobacco cessation counseling in individual and group settings are covered when billed with CPT codes 99406 and 99407. Reimbursement for counseling is limited to four (4) sessions per quit attempt for up to two (2) quit attempts annually. Tobacco cessation counseling may be billed on the same day as an office visit using a 25 modifier.

SCDHHS policy requires that all tobacco cessation treatment must be ordered by a qualified practitioner defined as a physician, nurse practitioner, certified nurse midwife, or physician assistant. Medical documentation including time spent counseling the patient, treatment plan, and pharmacotherapy records must be maintained in the patient record.

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PROGRAM SERVICES

South Carolina Tobacco Quitline

One-on-one telephone counseling with web-based support are available to all South Carolinians without charge through the SC Tobacco Quitline. Participants in the Quitline program are connected with a personal Quit Coach, who helps the participant develop a quit plan and uses cognitive behavioral coaching and motivational interviewing techniques to support the quit process. This evidence-based program has been clinically proven to help participants quit tobacco use, and tailored programs are available for Hispanic, Native American, pregnant and youth callers, and smokeless tobacco users, as well as participants who have chronic medical and mental health conditions.

SCDHHS strongly encourages prescribers and pharmacists to refer patients to the SC Tobacco Quitline at 1-800-QUIT-NOW. Services are available 24 hours a day, seven days a week. Additional information is available at:

http://www.scdhec.gov/Health/TobaccoCessation/HelpYourPatientsQuit/

HOSPICE

Hospice services provide palliative care (relief of pain and uncomfortable symptoms) as opposed to curative care for terminally ill individuals. In addition to meeting the patient's medical needs, hospice care addresses the physical, psychosocial, and spiritual needs of the patient, as well as the psychosocial needs of the patient's family and caregiver.

Hospice services will be available to Medicaid beneficiaries who choose to elect the benefit and who have been certified to be terminally ill with a life expectancy of six months or less by their attending physician and/or medical director of the hospice.

Hospice services are provided to the beneficiary according to a plan of care developed by an interdisciplinary staff of the hospice. The services below are covered under the South Carolina Medicaid Hospice Program:

- Nursing care provided by or under the supervision of a registered nurse
- Medical social services provided by a social worker under the direction of a physician
- Physician's services provided by the hospice medical director or physician member of the interdisciplinary group (General supervisory services; participation in the establishment of plans of care; supervision of care and services; and establishment of governing policies are included in the hospices reimbursement rate and may not be billed as a physician's service.)

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Hospice (Cont'd.)

- Counseling services, including dietary and bereavement counseling, provided to the beneficiary and family
- Short-term inpatient care provided in a hospital or inpatient hospice unit
- Medical appliances and supplies, including drugs used for the relief of pain and symptom control related to the terminal illness and biologicals
- Home health aide services and homemaker services
- Physical therapy, occupational therapy, and speech language pathology services

A beneficiary who elects the hospice benefit must waive all rights to other Medicaid benefits for services related to treatment of the terminal condition for the duration of the election of hospice care. Specific services which must be waived include the following:

- Hospice care provided by a hospice other than the hospice designated by the individual (unless provided under arrangements made by the designated hospice)
- Any Medicaid services that are related to the treatment of the terminal condition for which hospice care was elected; or a related condition; or services that are equivalent to hospice care **except for the following:**
  - Services provided (either directly or under arrangement) by the designated hospice
  - Services provided by the individual's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services

SCDHHS will provide reimbursement for hospice services for children less than 21 years of age in conjunction with curative treatment of the child's terminal illness. Section 2302 of the Affordable Care Act, entitled "Concurrent Care for Children" removes the prohibition of receiving curative treatment upon the election of the hospice benefit by or on behalf of children enrolled in Medicaid or Children's Health Insurance Program (CHIP). This provision does not change the criteria for hospice. A physician must certify that the child is terminally ill with a life expectancy of six months or less. However, this provision allows parents with children under the age of 21 receiving hospice services to no longer forgo any other services to which the child is entitled under Medicaid treatment of the terminal condition. Services rendered by a provider other than the hospice must be discussed and coordinated with the hospice provider.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Hospice (Cont'd.)

Effective with dates of service on or after October 1, 2012, SCDHHS will require prior authorization for hospice services to Medicaid–only beneficiaries. Hospice providers must submit requests for prior authorization along with medical documentation to KEPRO. All hospice services except general inpatient (GIP) care must be pre-authorized for up to six months. If a beneficiary is in need of hospice services beyond the initial six months, the hospice provider must submit a new request to KEPRO.

For further information, call the PSC at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us.

INPATIENT AND OUTPATIENT HOSPITAL SERVICES

General Policy Guidelines

Services performed by the physician in a hospital are compensable if medically necessary. Special procedures are compensable if deemed a separate and reimbursable service. Services or supplies administered by the hospital or hospital employee are considered a part of the overall hospital service and are reimbursable **only** under the hospital allowable costs.

A physician who is either salaried or contracted by the hospital (a hospital-based physician), and who performs services under said contract or employment, may not bill for those services separately under his or her individual Medicaid provider number. The contracting hospital may claim these services under the professional fees allowable for the hospital under its hospital-based physician Medicaid number.

Levels of Service

The terminology for levels of service as defined in the American Medical Association (AMA) Current Procedural Terminology (CPT) guidelines will be recognized. The medical record must reflect the level of service billed.

Records and Documentation Requirements

Both the physician and hospital are expected to comply with South Carolina Medi**caid policy in providing the agency with medical records if requested.**

Hospital Visits

Initial Hospital Care

Please refer to the current CPT when multiple evaluation and management services are prescribed on the same date as initial hospital care.

Only one physician for each hospital admission is reimbursed. If two physicians of different specialties perform a comprehensive exam on

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Initial Hospital Care (Cont'd.)

admission day, one may use a consultation code (with the exception of a transfer), as long as the service meets the criteria of a consultation.

A comprehensive level of service is not allowed for readmission for the same illness or problem. A reduced level of service must be used if the patient is discharged and readmitted.

If a patient is transferred from one hospital to another, the receiving physician may bill for a comprehensive level of service (even if the transfer occurs on the day of admission).

Initial hospital care codes are exempt from the surgical package. For instructions on surgical package billing, please refer to "General Surgery" in this section.

Subsequent Hospital Care

Subsequent hospital care is generally allowable one visit per day per physician.

Postoperative visits by the surgeon are not allowed as a separate reimbursement since the visits are included in the surgical package unless the surgical procedure is not part of a surgical package.

Codes 99231 – 99233 will "multiply" and should be reported as one line item, with the number of visits indicated in the "units" column.

Hospital Discharge

Hospital discharge is a covered service. This charge is acceptable only if **billed in lieu of a hospital visit code**. It may not be charged if a surgical procedure was performed and the surgery is considered a surgical package. Reimbursement is made for only one physician for each hospital discharge.

Concurrent Care Guidelines

When two or more physicians render subsequent hospital care, consultations (office or inpatient), critical care, emergency room, nursing home, rest home, or office medical care to the same patient at the same time, this is referred to as "medical concurrent care."

Concurrent Care Criteria

If physicians of the same specialty or similar specialty render care for the same condition at the same time, benefits are provided only for the attending physician.

When two physicians render care for unrelated conditions at the same time, benefits are provided to each physician if both of the following apply:

- The physicians are not of the same or similar specialty.
- Each physician is treating the patient for a condition unique to his specialty.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Medical/Surgical

Benefits are provided for in-hospital medical services performed by a physician other than the admitting surgeon in addition to benefits for in-hospital surgical services under the following circumstances:

- The medical care rendered was not related to the condition causing surgery and was not part of routine pre- and postoperative care.
- The medical care required supplemental skills not possessed by the attending surgeon.
- A physician other than a surgeon admits a patient for medical treatment, and the need for surgery arises later during the hospitalization.
- A cardiovascular surgeon performs cardiac surgery and a cardiologist follows the patient during hospitalization even though the diagnosis is the same

Critical Care Services

Using the critical care guidelines as defined in the current CPT, codes 99291–99292 should be used to report critical care services. Follow current CPT guidelines indicating services are considered a part of critical care and not reimbursed separately. Up to four hours of critical care per day are allowed. Critical care must be billed per **date of service.** Critical care services are not included in the surgical package and may be billed separately.

EKG interpretations would not be covered separately when performed as part of, or in conjunction with, critical care.

Code 99291 (Critical Care, first hour) is used to report the services of a physician providing constant attention to an unstable, critically ill patient for a total of 30 minutes to 74 minutes on a given day. Reimbursement is limited to one per day. If the total duration of critical care on a given day is less than 30 minutes, the appropriate E/M code should be used. In the hospital setting, the higher level code 99233 would most often apply. Time must be clearly documented in the medical record.

Code 99292 (Critical Care, each additional 30 minutes) is used to report the services of a physician providing constant attention to an unstable, critically ill patient for up to 30 minutes beyond the first 74 minutes of care on a given day.

Reimbursement is limited to six per day for a total of three hours per day. Time must be clearly documented in the medical record.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Prolonged Services

Medicaid will reimburse for Prolonged Physician Services with Direct (face-to-face) Patient Contact – CPT codes 99354 and 99356.

Documentation for CPT codes 99354 and 99356 must clearly indicate that the service provided was direct (face-to-face) contact between the physician and the patient for more than one hour beyond the usual service for the level of E/M code billed. These codes are billed in addition to the appropriate E/M code. Please refer to the CPT guidelines for coding these services. CPT codes 99355 and 99357 (Prolonged Services each additional 30 minutes) are non-covered.

CPT codes 99358 and 99359 for Prolonged Physician Services without Direct (face-to-face) Patient Contact will remain non-covered.

Emergency Room (ER) Services

Outside Attending Physician

A private physician called to the hospital in an emergency situation may bill for emergency room services in the following instances:

- When a hospital-based ER physician is not available
- The physician is called in by the ER physician
- If a life-threatening situation develops

Hospital-Salaried or Hospital-Based ER Physicians

Medicaid has established policies and procedures for outpatient hospital services to distinguish between outpatient (OP) clinic services and emergency room services. Since some hospitals do not have separate and distinct OP clinics, the ER physician must designate in the patient's records if the patient's visit to the emergency room was actually an emergency situation.

Professional services rendered in an outpatient hospital environment must be charged on a CMS-1500 form. If a hospital-based or salaried physician renders a professional service in an emergency room, all services must be charged separately by submitting a CMS-1500 or by using a PAID or billing through the PAID Spin Off Program.

The physician's service must be charged using a CPT code in the 99281 – 99288 range. Procedures identifiable as a unique and separate service may be reported separately.

Levels of Service

Each level of service in the 99281-99285 **series** includes examinations, evaluations, and treatments that are medically necessary, and that are presented as an emergency in a hospital emergency room setting. These levels of service exclude the interpretation of diagnostic tests. Medicaid will only reimburse for one emergency room visit per day for the same or related diagnosis.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Emergency Life Support

Procedure code 99288 indicating physician direction of an emergency medical system (EMS) or ambulance transport service for advanced life support is covered when medically indicated. The service is compensable in addition to other medically necessary services performed by a physician. Emergency services performed by other hospital professionals are considered part of a technical charge by the hospital and may not be billed or charged as a separate professional service.

Transportation of Self-Administered Oxygen Dependent Beneficiaries

Effective June 1, 2014, SCDHHS amended the non-emergency transportation policy for self-administered oxygen dependent beneficiaries discharged from inpatient hospitals or emergency rooms. The policy applies to beneficiaries who are admitted, as an inpatient of a Hospital or Hospital Emergency Room, are oxygen dependent and currently do not have their portable oxygen system in their possession, and do not require transportation via ambulance for their return trip to their residence for any other reason. The hospital is responsible for arranging and acquiring a portable oxygen system complete with all medically necessary accessories, upon discharge. **Hospitals and Ambulance providers will no longer receive reimbursement for non-essential, non-medically necessary ambulance transportation for self-administered oxygen dependent beneficiaries.** All provider types and services are subject to post payment review by the Division of Program Integrity.

It is the responsibility of both the Hospital and DME provider to coordinate and dispense oxygen to the Medicaid beneficiary who is currently admitted to the Hospital or Hospital Emergency Room in order for the appropriate mode of non-emergent transportation to be arranged with the transportation broker upon discharge. The dispensing DME provider will be responsible for arranging the return of the portable oxygen system dispensed by their company at the time of discharge from the admitting hospital facility.

SCDHHS will reimburse for a portable oxygen system, E0443 billed with a U1 modifier, and the dispensing DME provider will be reimbursed at a rate of $20.00 per occurrence. SCDHHS will limit the number of occurrences per patient to no more than three occurrences per calendar month. Services that exceed three occurrences per calendar month will not be reimbursed.

It is the responsibility of EMS providers whenever possible to transport oxygen dependent beneficiaries with the beneficiary's personal portable oxygen system in anticipation of the beneficiary's medical/health needs.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Observation Unit

Medicaid will sponsor the professional reimbursement for evaluation and management services provided to patients requiring observation in a hospital. Please refer to the current CPT for coding guidelines. Observation codes should be billed with place of service 22.

Administrative Days

Medicaid sponsors Administrative Days in any South Carolina- enrolled acute care hospital and acute care hospitals enrolled within the South Carolina service area for Medicaid-eligible patients who no longer require acute hospital care but are in need of nursing home placement that is not available at the time.

Physicians who are treating these patients can bill for their services rendered to these patients using the same procedure codes that they use for their patients in nursing homes and rest home facilities. Those procedure codes are in the range 99304-99337 and are listed in your CPT manual. The specific code you use would depend on whether it is a new or established patient and on the level of care given. Use place of service **21** when billing.

One limited examination per 30 days is required for all Administrative Day patients. Additional visits may be allowed if medical justification is submitted

OBSTETRICS AND GYNECOLOGY

General

Pregnancy Determination

An examination to determine if a patient is pregnant should be coded as an office E/M visit. The exception would be if a positive pregnancy test was determined and the provider performed an initial OB exam in the same visit.

Healthy Mothers/Healthy Futures (HM/HF) Obstetrical Program

Obstetrical care provided under the Healthy Mothers/Healthy Futures program (HM/HF) must be billed as separate charges (fragmented), not as global OB care. The program includes increased reimbursement for health education, referral to the WIC program at the local county health department, and follow-up on missed appointments.

Standard obstetrical care, without the previously listed enhanced services, is also compensable. All services must be documented in the patient's chart.

Healthy Mothers/Healthy Futures Checklist – One way of documenting the additional services is the HM/HF checklist. A sample copy of the checklist can be found in the Forms section of this manual. The checklist is only an option for documenting services, and is by no

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Healthy Mothers/Healthy Futures (HM/HF) Obstetrical Program (Cont'd.)

means a requirement. The only requirement is that services be documented. If a practice chooses to use the HM/HF checklist, the physicians should sign and date the back of the checklist at the time of the initial visit so that it is not forgotten at a later date.

It is not necessary to cover all of the educational components on the checklist with each patient, but only the ones that pertain to each individual patient's health. If one component is discussed with the patient on more than one occasion, it may be checked and dated for each time. It is very important that at least one educational component on the checklist be checked and dated for each HM/HF enhanced visit that is billed to Medicaid.

Best Practice Guidelines for Perinatal Care (Replaces High Risk Channeling Project – HRCP) Best Practice

The High Risk Channeling Project (HRCP), a Freedom of Choice Waiver program that encouraged risk-appropriate care for Medicaid sponsored pregnant women and infants, expired on August 11, 2001. Because the waiver expired, SCDHHS transitioned to recommended best practice guidelines for perinatal care.

South Carolina Medicaid remains committed to the concept(s) of risk-appropriate care and enhancing maternal and child health outcomes. Therefore, the following Medicaid Best Practice guidelines are recommended:

- Early and continuous risk screening should be provided for all pregnant women.
- Early entry into prenatal care should be encouraged.
- Care for all prenatal women should be delivered by the provider level and specialty best suited to the risk of the patient. (American Academy of Pediatrics, American College of Obstetricians and Gynecologists. Guidelines for Perinatal Care. 8th ed. Elk Grove Village (IL): American Academy of Pediatrics; Washington, DC: American College of Obstetricians and Gynecologists, 2017.)
- All infants should receive risk-appropriate care in a setting that is best suited to the level of risk presented at delivery. (American Academy of Pediatrics, American College of Obstetricians and Gynecologists. Guidelines for Perinatal Care. 8th ed. Elk Grove Village (IL): American Academy of Pediatrics; Washington, DC: American College of Obstetricians and Gynecologists, 2017.)
- Risk assessment of the infant should be performed prior to discharge from the hospital.

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PROGRAM SERVICES

Best Practice Guidelines for Perinatal Care (Replaces High Risk Channeling Project – HRCP) Best Practice (Cont'd.)

- Every Medicaid-eligible mother and infant should receive a Postpartum/Infant Home Visit (PP/IHV).
- Effective communication/coordination regarding the perinatal plan of care between each provider is essential (*i.e.*, the specialist physician should communicate pertinent information back to the community level physician).
- A medical home should be established for the mother-infant unit after delivery to handle the long-term health care needs.
- Preventive/Rehabilitative Services for Primary Care Enhancement (P/RSPCE) referrals should be made when medically indicated.

For additional recommendations and guidelines for risk-appropriate ambulatory prenatal care for pregnant women, the "*Guidelines for Perinatal Care*," which are endorsed by the American Academy of Pediatrics (AAP) and the American College of Obstetrics and Gynecology (ACOG) may be referenced.

Initial OB Exam

A higher-level E/M code may be billed for OB visits other than those outlined in the manual; however, the visit must meet CPT guidelines for level of complexity and be documented in the patient's chart.

Only one initial OB exam (procedure code 99202 or 99203) may be billed per pregnancy.

Initial OB Exam (99203) HM/HF OB Program – An initial OB exam may be billed one time during a term of pregnancy. Requirements for the use of this HM/HF code are:

- Comprehensive medical exam
- Establishment of the patient's medical history
- Provision of health education materials
- WIC referral to the local county health department

The WIC referral can be made at a later date since the provider may not be aware that a patient has Medicaid benefits until later in her pregnancy. The WIC referral must be documented in the patient's chart.

Initial OB Exam (99202) without Enhanced Services – Use of this code has the same requirement as the HM/HF code (99203), except that a WIC referral is not required.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Screening Brief Intervention and Referral to Treatment Initiative

Effective with dates of service on or after July 1, 2014, the following codes and billing procedures must be utilized in order to receive payment for the Screening, Brief Intervention and Referral to Treatment (SBIRT) services.

SCDHHS began coverage for SBIRT in 2011 to improve birth outcomes and the overall health of moms and babies. SCDHHS has partnered with stakeholders across the state to help identify and treat pregnant beneficiaries who may experience alcohol or other substance abuse issues, depression, tobacco use or domestic violence. SBIRT services (screening and, when applicable, a brief intervention) are reimbursable in addition to an Evaluation and Management (E/M) code for pregnant women and/or those who are in the 12-month postpartum period.

SCDHHS will continue to use the Healthcare Common Procedure Coding System (HCPCS) codes of H0002 for screening and H0004 for intervention. The U1 modifier will no longer be covered as of July 1, 2014. A new modifier, HD, will now be required when the services rendered indicate a positive result and/ or when a referral is completed.

Providers must use the H0002 HCPCS code and the HD modifier when an SBIRT screening result is positive. Additionally, providers must use the H0004 HCPCS code with the HD modifier when a referral to treatment is made in conjunction with the brief intervention. These changes in billing procedures apply for Healthy Connections Medicaid members enrolled in both the Medicaid Fee for Service (FFS) and Medicaid Managed Care program.

- Screening – H0002 reimburses at $24.00 once per fiscal year
- Brief Intervention – H0004 reimburses at $48.00 twice per fiscal year

The Institute for Health and Recovery's Integrated Screening Tool, which is a validated and objective resource, must be used to receive reimbursement for screening and intervention. A copy of this screening tool is located in the "Forms" section of this manual.

When billing for SBIRT services using HCPCS codes H0002 and H0004, providers must bill using both their individual and group NPI numbers on the CMS-1500 form or an electronic claim. The individual provider's NPI number must be entered on line 24J for a paper claim or loop 2310B for an electronic claim. The pay-to-provider must be the group NPI number in field 33A of the CMS-1500 paper claim or on loop 2010AA for an electronic claim. If the provider is the owner, is a sole provider, and does not have a group NPI number; the provider may bill using his or her individual NPI number on both lines 24J and 33A or on both loops 2310B and 2010AA.

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PROGRAM SERVICES

Antepartum Visits

South Carolina Medicaid provides pregnant women with unlimited antepartum ambulatory care visits, and recognizes evaluation and management procedure codes as antepartum visits when billed in conjunction with a pregnancy diagnosis code. **To ensure that the E/M codes billed for antepartum care do not count towards the patient's limit of 12 ambulatory care visits per year, a pregnancy diagnosis code must be used on the claim.** For dates of service on or before **September 30, 2015**, the pregnancy diagnosis codes are V22, V23, V28, 640 – 648, 650 – 658, 671, 673,675, and 676.

For dates of service on or after **October 1, 2015**, please refer to Section 4 of this manual for ICD-10-CM pregnancy diagnosis codes.

Antepartum Visits (99213) with Additional Services – Antepartum care includes continuing physical exams and recording of weight, blood pressure, and fetal tones. The additional services necessary for use of this enhanced antepartum code include:

- Follow-up on referrals
- Follow-up on missed appointments
- Continued health education

The enhanced services may be documented by a notation in the woman's chart on each visit, or by dating the HM/HF checklist for the topic covered each visit. Use of the HM/HF checklist is optional. A sample copy of the checklist can be found in the Forms section of this manual.

Antepartum Visits (99212) without Additional Services – Use of procedure code 99212 for an antepartum visit must include continuing physical exams, recording of weight, blood pressure, and fetal tones.

Antepartum Visits with "Higher than Usual" Level of Care – If appropriate due to the level of care, a higher-level E/M code (99214 or 99215) may be billed for the antepartum visit. Documentation must justify the level of care.

Ultrasounds

SCDHHS policy allows three obstetrical ultrasounds per pregnancy for OB/GYN providers. Ultrasounds in the first trimester are performed to establish viability, gestational age, or to detect malformations. Two additional ultrasounds, performed during the second or third trimester, establishes more detailed anatomy and/or interval growth. Additional ultrasounds may be approved if supporting documentation is attached to the claim clearly indicating that the service provided is medically necessary. Examples of appropriate documentation include ultrasound reports and patient clinical records and history. If the documentation is

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Ultrasounds (Cont'd.)

insufficient or illegible, reimbursement for additional ultrasounds will be rejected. Claims for obstetrical ultrasounds that exceed the defined limits will be reviewed by KEPRO for medical necessity.

For Maternal Fetal Medicine (MFM) specialist, there is no limit on the number of ultrasounds that can be submitted for reimbursement. However, all ultrasounds provided by MFM specialists must have documentation to support medical necessity in the patient's medical record.

All ultrasound services that appear to fall outside of best practice guidelines are subject to post-payment review by the Division of Program Integrity. Multiple gestations billed with CPT add-on codes will be counted as one ultrasound if billed on the same claim with primary CPT codes.

Ultrasounds requested by the patient to determine the sex of the fetus or for other reasons are the responsibility of the patient.

When ultrasounds are performed at the hospital, a 26 modifier is required if the physician provides the interpretation. When the ultrasounds are performed in the office, no modifier is required if the physician owns the equipment. The physician's interpretation of the ultrasound must be documented in the patient's record.

No prior authorization is necessary for ultrasounds when performed within the guidelines as stated in the Current Procedural Terminology (CPT) book. Repeat ultrasounds are allowed when medically necessary. The medical record must substantiate the reason for the follow-up ultrasounds

Maternal Fetal Medicine Physician Ultrasound Override

Providers must register as a Maternal Fetal Medicine (MFM) specialist in order to receive an authorization number to bypass the limitation on antenatal ultrasounds. The provider's medical license must have the MFM specialty designation to be accepted. To register as an MFM specialist, providers must send a written request by mail or fax to:

Medicaid Provider Enrollment
Post Office Box 8809
Columbia, SC 29202-8809
Fax: (803) 870-9022

Questions should be directed to the PSC at 1-800-289-0709 or providers should submit an online inquiry at http://www.scdhhs.gov/contact-us.

Additional Services

Fetal Biophysical Profile (76818) – Fetal biophysical profiles must also be medically justified. The medical record must reflect medical necessity.

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PROGRAM SERVICES

Additional Services (Cont'd.)

Amniocentesis (59000) – Amniocentesis is a covered service when medically necessary. Justification must be documented in the medical record. Please refer to "Genetic Studies" for coverage criteria. Reimbursement is the same in the office or hospital (do not use 26 modifier for place of service 21 or 22).

Ultrasound for Amniocentesis Guidance (76946) – When performed in the hospital, do not use the 26 modifier since the code is for supervision and interpretation only.

Non-Stress Test (59025) – Non-stress tests (NST) are reimbursed when medically necessary. Reimbursement is not allowed when performed in the hospital by hospital personnel. If the physician provides the interpretation in place of service 21 or 22, he or she should bill with the 26 modifier. The physician's interpretation of the NST must be clearly documented in the patient's record.

Tocolytic – Tocolysis is non-compensable as a separate reimbursement under the Physician Services program. If a patient is admitted for tocolysis, the physician may bill for the appropriate hospital visits, prolonged services (99356), or critical care services when applicable. The medical record must reflect the level of service billed. Tocolysis agents and monitoring are considered an integral part of the hospital allowable charged.

Lab Procedures – If the physician sends a specimen to an independent lab, the lab will bill for their services.

- The collection of a urine specimen is included in the office visit.
- Finger/heel/ear stick for collection of specimen(s) will be included in office visit reimbursement or lab test reimbursement and may not be billed under code 36415. Lab tests performed in the office may be billed as a separate charge by billing the appropriate 80000 range CPT code allowed by the laboratory's CLIA certification category. Medicaid does not reimburse the maternal care provider for tests performed at an independent lab.

Venipuncture – When performing a venipuncture, bill the service using procedure code 36415. No documentation is required to be sent with the claim. If more than one venipuncture is performed on the same date of service, the claim must be billed hard copy with documentation of the number of venipunctures attached.

Non-Self-Injectable Drugs – The physician must provide any drugs that are not self-injectable and bill Medicaid the appropriate procedure code for the cost of the drug in addition to procedure code 96372 for the administration of the drug. A physician may not write the patient a

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Additional Services (Cont'd.)

prescription for the medication to be filled at a pharmacy with the expectation that the beneficiary return to the physician's office for administration. The pharmacy will not be reimbursed for the prescription.

Enhanced Services for Pregnant Women Offered by SCDHEC – In addition to traditional medical care, pregnant women often have nutritional, environmental, psychosocial, and educational needs that may influence pregnancy outcomes.

In an effort to address these needs, all Medicaid pregnant women are eligible for the following Family Support Services through SCDHEC:

- **Psychosocial Intervention** – Patients may be referred to SCDHEC for services by an appropriately credentialed social worker for an assessment followed by services based on an individualized plan of care.
- **Nutritional Services** – Patients may be referred to SCDHEC for services by an appropriately credentialed nutritionist or dietitian for an assessment followed by treatment that responds to individual patient needs and problems.
- **Health Education** – Information and process-oriented activities may be provided on an individual or group basis to predispose, enable, or reinforce patient adaptation or behavior conducive to health at the local health department.

For information on referrals to authorized providers of these services, call the PSC at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us.

17 Alpha Hydroxyprogesterone Caproate (Makena™ and 17P)

Effective December 20, 2013 South Carolina Department of Health and Human Services (SCDHHS) will cover both Makena™ and compounded hydroxyprogesterone caproate without a prior authorization. SCDHHS currently covers the use of 17 alpha hydroxyprogesterone caproate (17-P) intramuscular injections to support the prevention of preterm births. The therapy is considered effective in reducing negative outcomes and improving the quality of care in pregnant women. Makena™ and compounded 17-P will be covered on a weekly basis beginning at 16 weeks gestation through 36 weeks gestation when the patient presents with a history of spontaneous preterm delivery in a single pregnancy, before 37 weeks gestation. All other risk factors for preterm delivery and for the use of hydroxprogesterone caproate are considered investigational and not medically necessary.

Providers must bill Healthcare Common Procedure Coding system (HCPCS) code J1726 (Injection, hydroxyprogesterone caproate,

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

17 Alpha Hydroxyprogesterone Caproate (Makena™ and 17P) (Cont'd.)

(Makena®), 10 mg) and/or J1729 (Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg) and bill for the appropriate amount of units administered. Providers billing for compounded 17 alpha hydroxyprogesterone caproate will continue to bill HCPCS code J3490 using the TH modifier (obstetrical treatment/services, prenatal or postpartum) in order to be reimbursed. When billing for Makena or Compounded 17-P, the Current Procedural Terminology (CPT) code 96372 can be billed for administration of the drug, which must be given in the physician's office or clinic. The reimbursement for Makena™ J1726 (Injection, hydroxyprogesterone caproate, (Makena), 10 mg) and/or J1729 (Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg) is listed on our Other Physician's Fee Schedule at www.scdhhs.gov. When billing Medicaid, providers must include the National Drug Code in field 24A of the CMS-1500 claim form and the number of units in field 24G.

All providers must keep documentation showing the medical necessity for either Makena™ or 17-P in the patients chart. All claims are subject to potential Program Integrity Audits and therefore, it is the provider's responsibility to maintain the patient's records.

Perinatal Care

Emergency Room Visit – When the physician meets the maternal patient in the emergency room for immediate medical attention, the appropriate level emergency department code should be billed (99281 – 99285).

Observation Admission – When the physician meets the maternal patient at the emergency room or labor and delivery unit and admits the patient to the hospital for observation (less than 24 hours), the physician may bill the appropriate level hospital observation code (99217 – 99220) with place of service 22.

External Version (59412) – External version is reimbursable as a separate procedure. The physician may bill this procedure in addition to the delivery charge. If applicable, prolonged services may also be billed. The medical record must document the service billed. This procedure is compensable at 100% of the established rate when performed on the same day of delivery.

Note: No assistant is allowed for this procedure.

Uncomplicated (Routine) Deliveries

Both vaginal (59409 and 59612) and Caesarean section (59514 and 59620) deliveries are considered surgical packages. The following are inclusive in the surgical packages:

- Pitocin induction

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PROGRAM SERVICES

Uncomplicated (Routine) Deliveries (Cont'd.)

- Surgical or mechanical induction
- Fetal monitoring (internal or external)
- Amnio infusion
- Episiotomy
- Laceration repair
- Suture removal
- Standby for delivery
- Subsequent routine hospital care
- Hospital discharge
- Any related evaluation/management visits within 30 days following the delivery
- Routine follow-up care (However, one postpartum visit may be billed separately using procedure code 59430. Please refer to "Postpartum Care" under "Obstetrics and Gynecology" in this section.)
- Procedure code 59200, Insertion of Cervical Dilator (*e.g.*, laminaria, prostaglandin) is considered included in the surgical package and may not be billed in addition to the CPT code for the delivery. This applies whether being placed the day of delivery, or several days prior to delivery if placed by the delivering physician or physician within the same practicing group.

Effective with dates of service on or after August 1, 2012, providers are required to append the following modifiers, and in some cases complete the ACOG Patient Safety Checklist or a comparable patient safety justification form, when scheduling an induction of labor or a planned cesarean section for deliveries less than 39 weeks gestation. The provider is responsible for maintaining a copy of this documentation in their files and in the hospital record, which are subject to SCDHHS Program Integrity review.

Providers should append the following modifiers to all CPT codes when billing for vaginal deliveries and cesarean sections:

GB - 39 weeks gestation and or more

For all deliveries at 39 weeks gestation or more regardless of method (induction, cesarean section, or spontaneous labor)

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PROGRAM SERVICES

Uncomplicated (Routine) Deliveries (Cont'd.)

CG - Less than 39 weeks gestation

- For deliveries resulting from patients presenting in labor, or at risk of labor, and subsequently delivering before 39 weeks, or
- For inductions or cesarean sections that meet the ACOG or BOI-approved medically necessary guidelines, the appropriate ACOG Patient Safety Checklist must be completed and maintained for documentation in the patient's file, or
- For inductions or cesarean sections that do not meet the ACOG or approved BOI guidelines, the appropriate ACOG Patient Safety Checklist must be completed. In addition, the provider must obtain approval from the regional perinatal center's Maternal Fetal Medicine physician and maintain this documentation in the patient's file.

No Modifier - Elective non-medically necessary deliveries less than 39 weeks gestation

For deliveries less than 39 weeks gestation that do not meet ACOG or approved BOI guidelines or are not approved by the designated regional perinatal center's Maternal Fetal Medicine physician.

Delivery in Cases of Prolonged Labor

Effective with dates of service on or after January 1, 2012, SCDHHS modified the delivery policy in cases of prolonged labor when a vaginal delivery with failure to progress converts to a cesarean section. For beneficiaries that have been admitted to the hospital and have been in active labor for at least six hours, the procedure code 59514 and modifier UA should be used when billing for the cesarean delivery. The patient records must indicate the time the beneficiary was admitted to the hospital with active labor and the start time of the cesarean section. All claims and reimbursements are subject to an audit by the Division of Program Integrity

Hospital Admission for Delivery

The hospital admission codes 99221 – 99223 are not allowed if the delivering physician or group has provided prenatal care to the beneficiary. The appropriate level admission code may be billed with drop-in vaginal and Caesarean section deliveries only

Emergency Deliveries

If the patient gives birth outside the hospital setting and the patient's private physician did not perform the delivery, but later meets the maternal patient at the hospital for post-delivery services, the following procedures apply:

- The private physician should bill procedure code 59414 for delivery of the placenta, if applicable.

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PROGRAM SERVICES

Emergency Deliveries (Cont'd.)

- The private physician may also bill for subsequent hospital care and the hospital discharge, if applicable.

If a hospital-based physician actually performs the delivery and the private physician arrives in time to assist the hospital-based physician or arrives shortly after the delivery, the following apply:

- The hospital-based physician would bill for the delivery.
- The private physician would bill for the post-delivery services using procedure code 59414 if the private physician performed the services.
- The private physician may also bill for subsequent hospital care and the hospital discharge, if applicable.

If the private physician is not involved in the delivery or post-delivery services, then the following applies:

- The physician may bill for the admission (if appropriate), subsequent hospital care, and the discharge, if applicable, during the hospitalization for the delivery.

If a physician or certified nurse midwife is preparing to deliver a baby and it is decided that the baby must be delivered by an emergency C-section and an obstetrician must be called in, then the following applies:

- The physician or certified midwife may receive payment from Medicaid for his or her involvement in the case by billing the C-section code with an 80 modifier, assistant surgeon. Technically, the physician or certified nurse midwife would be billing as an assistant surgeon on the C-section. Reimbursement for this procedure is 20% of the C-section rate.

Multiple Births

If the patient delivers multiple babies, all either vaginally or by C-section, the first birth should be billed with no modifier, and each consecutive birth should be billed using modifier 51.

Example: Delivery of triplets, all vaginally

59409 (00) Vaginal Delivery

59409 (51) Vaginal Delivery

59409 (51) Vaginal Delivery

Billing Note: For multiple births of more than two, the claim should be sent hardcopy with operative notes attached.

If the patient delivers multiple babies, the first vaginally and one (or more) via C-section, the first birth should be billed with no modifier,

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PROGRAM SERVICES

Multiple Births (Cont'd.)

and the following birth, via C-section, should be billed using modifier 79.

Example: Delivery of triplets, 1st birth vaginally, 2nd and 3rd via C-Section

59409 (00)	Vaginal Delivery
59514 (79)	C-section Delivery
59514 (51)	C-section Delivery

If you should have further questions regarding multiple births, please contact PSC at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us.

Pre-Term Deliveries

Please refer to the "Abortion Guidelines" below for the policy on coding for a vaginal delivery or non-elective abortion.

Postpartum Care

Routine Postpartum Visit (59430) – The postpartum visit includes an uncomplicated routine GYN examination of the mother following a vaginal or C-section delivery. Only one postpartum exam per delivery is allowed. Reimbursement for all other routine postpartum visits is included in payment for the delivery.

Effective July 1, 2005, Family Planning counseling or instruction (99401 and 99402) may not be billed in addition to the postpartum code when Family Planning services are rendered and documented. Please refer to "Family Planning" in this section for the code description and more details.

Complication/Other Medical Attention During 30 Days Post Delivery – If E/M services unrelated to routine postpartum care are necessary during the 30 days post-delivery, bill these services using modifier 24. Documentation in the patient's chart should substantiate that the visit was unrelated to the delivery.

Note: Wound infection is not considered routine postpartum care.

Abortion Guidelines

Non-Elective Abortions

All non-elective abortions, including spontaneous, missed, incomplete, septic, hydatidiform mole, etc., require only that the medical record verify such a diagnosis. Medical procedures necessary to care for a patient with an ectopic pregnancy are not modified by this section and are compensable services.

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PROGRAM SERVICES

Therapeutic Abortions

In compliance with federal regulations (42 CFR 441.203 and 441.206), SCDHHS requires documentation for all charges associated with instances of therapeutic abortion. This includes the attending physician, the anesthesiologist, and the hospital.

Therapeutic abortions are sponsored only in cases that a physician has found, and certified in writing to the Medicaid agency, that on the basis of his or her professional judgment, the pregnancy is the result of an act of rape or incest; or the woman 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 woman in danger of death unless an abortion is performed.

The abortion statement must contain the name and address of the patient, the reason for the abortion, and the physician's signature and date. The patient's certification statement is only required in cases of rape or incest. The medical record must document that continued pregnancy would endanger the life of the mother or that the pregnancy is the result of an act of rape or incest. This may be reflected in the office admission history notes and physical, discharge summary, consultation reports, operative records, and/or pathology reports. Both the abortion statement and the appropriate medical records must be submitted with the claim. A sample copy of the abortion statement form can be found in the Forms section of this manual. If documentation is insufficient or the abortion statement is improperly completed, the claim will be rejected.

Questions should be directed to the PSC at 1-888-289-0709 or providers should submit an online inquiry at http://www.scdhhs.gov/contact-us

Billing Notes

When billing for any type of abortion, the procedures must be billed using the abortion procedure codes. The range 59812 – 59830 and 59870 should be used for spontaneous, missed, and septic abortions, and hydatidiform mole; and 59840 – 59857 should be used for therapeutic abortion. The vaginal delivery code should not be used to report an abortion procedure.

The only exception to this rule is if the physician actually performs the delivery of the fetus and only when the gestation is questionable and there is a probability of survival. The medical record must contain documented evidence that the fetus was delivered by the physician. If the physician did not perform the delivery, but problems necessitated his or her presence, then the appropriate E/M codes should be used to report these services.

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PROGRAM SERVICES

Billing Notes (Cont'd.)

For dates of service on or before **September 30, 2015**, diagnosis codes in the 635 range should be used only to report therapeutic abortions. Spontaneous, inevitable, and missed abortions should be reported with the appropriate other diagnosis codes (*e.g.*, 630, 631, 634, 636, and 637). Abortions, which are reported with diagnosis and procedure codes for therapeutic abortion, must be accompanied by complete medical records which substantiate life endangerment to the mother or that the pregnancy is a result of rape or incest, and the signed abortion statement.

For dates of service on or after **October 1, 2015**, diagnosis codes to be used only to report therapeutic abortions and diagnosis codes to be used to report spontaneous, inevitable and missed abortions. Please refer to Section 4 of this manual for ICD-10-CM diagnosis codes for these services. Abortions, which are reported with diagnosis and procedure codes for therapeutic abortion, must be accompanied by complete medical records which substantiate life endangerment to the mother or that the pregnancy is a result of rape or incest, and the signed abortion statement.

For dates of service on or before **September 30, 2015**, the following diagnosis codes do not require documentation: 630, 631, 632, 656.5 (0, 1, 3), or 658.2 (0, 1, 3).

For dates of service on or after **October 1, 2015**, please refer to Section 4 of this manual for diagnosis codes do not require documentation

Licensed Midwives

Medicaid sponsors the enrollment of licensed midwives. The scope of practice is limited to that defined in the South Carolina State Register, Volume 17, Issue 7, Chapter 61.

As Medicaid providers, licensed and certified midwives are required to maintain and disclose their records consistent with Section 1 of this manual, "General Information and Administration." As allied health professionals, licensed midwives are required by state law (SC Code Section 20-7-510) to report any signs of abuse or neglect to children that they may encounter in the office or home setting.

Additional enrollment and documentation requirements are specified below. For more information on Medicaid-sponsored midwifery services, please contact the PSC at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us.

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PROGRAM SERVICES

Requirements for Physician Backup

The same physician or group must agree to provide the following services:

- Two assessment visits as required by regulations
- Appropriate prescriptions for any medications that the midwife may administer at the time of the delivery according to the regulations (*e.g.*, Pitocin, RhoGam, eye prophylaxis, etc.)
- Medical evaluation and treatment in the event of a complication during pregnancy
- Delivery services in the event of an emergency

Licensed Midwife Documentation Requirements

The following documentation must be maintained for all services provided by a licensed midwife:

- The midwife's initial claim for prenatal services for each beneficiary must be accompanied by signed documentation from a physician credentialed in obstetrics who agrees to provide medical backup in the event of a complication or emergency.
- Documentation of the physician's hospital privileges must be provided to SCDHHS.
- Any changes in the physician backup must be reported in writing to the Division of Physician Services.
- The physician who agrees to provide backup must be enrolled as a Medicaid provider.

Additional Documentation That Must Be in the Patient's Record

The following additional documentation regarding the Licensed Midwife must be kept in the patient's medical record:

- A signed consent form that documents the beneficiary's awareness that her choice of provider can be made or changed at any point in the pregnancy
- A certification statement provided to the physician by the midwife that the particular home is an acceptable environment for a birth
- A copy of the plan for accessing emergency care with a confirmed source of transportation to the hospital provided to the beneficiary
- Documentation that the beneficiary has been advised of Family Support Services available through the SCDHEC

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Billing Procedures

Required Modifier for Licensed Midwives – When filing claims for services rendered by licensed midwives, all procedure codes must be filed with an SB modifier.

Initial OB Exam by the Licensed Midwife – The initial obstetrical exam by the licensed midwife must be billed using the appropriate level of evaluation and management CPT procedure code for the complexity of the exam. An initial OB exam may be billed one time only during the term of pregnancy. An exam billed using this procedure code must meet the following requirements:

- Must be a comprehensive medical exam
- Must establish the patient's medical history
- Must provide health education materials
- Must include a WIC referral to the local county health department (This referral can be made at a later date since the provider may not be aware that a patient has Medicaid benefits until later in her pregnancy. The WIC referral must be documented in the patient's chart.)

Physician Backup Coding – Each of the two obstetrical examinations by the backup physician must be billed using the appropriate level of complexity evaluation and management CPT procedure code.

Delivery Supply Code (S8415) – An additional code has been developed to reimburse for supplies used for delivery in the home setting. Procedure code S8415 may be billed by the licensed midwife in addition to the vaginal delivery code.

Newborn Care (99461) – The newborn examination should be billed with CPT code 99461 using the SB modifier.

Newborn Metabolic Screening (S3620) – In compliance with DHEC Newborn Screening regulations, if there is no attending physician, then the licensed midwife is responsible for the collection of specimens. Procedure code S3620 may be billed by the licensed midwife when an invoice has been sent to them from DHEC for the service. The invoice must be maintained in the medical records.

Birthing Centers

Medicaid will contract with birthing centers for obstetrical and newborn services. The birthing center must be licensed by SCDHEC prior to enrolling in the Medicaid program. For enrollment information, please contact our enrollment department at 1-888-289-0709.

OB/Newborn Care (59409) with TC modifier – Medicaid will reimburse for an all-inclusive facility fee. The facility fee will include

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PROGRAM SERVICES

Birthing Centers (Cont'd.)

all technical services provided by the birthing center including, but not limited to, administration, nursing, drugs, surgical dressings, supplies, and materials for anesthesia.

Observation for Maternity/Labor– Procedure code 99218 is billable for observation of maternity/labor. This code is billable only if the patient is at the birthing center laboring but the labor does not progress and the patient is sent home to return at a later time or discharged to the hospital.

Newborn Exam – Procedure code 99463 should be billed for newborn Exams.

Pulse Oximetry Policy

Effective July 1, 2014, SCDHHS will accept the South Carolina Department of Health and Environmental Control (DHEC) Pulse Oximetry Screening test on newborns to detect congenital heart defects. Pulse oximetry is a noninvasive test that estimates the percentage of hemoglobin in blood that is saturated with oxygen.

The "Emerson Rose Act" (Act) became effective September 11, 2013, mandating that DHEC require each birthing facility it licenses to perform a pulse oximetry screening test, or other DHEC approved screening to detect critical congenital heart defects, on every newborn in its care. A newborn may be exempt from the required screening if the parent of the newborn objects, in writing, for reasons pertaining to religious beliefs only.

In accordance with the Act, birthing facilities shall perform a pulse oximetry screening test, or other DHEC approved screening to detect critical congenital heart defects, on every newborn when the baby is twenty-four (24) to forty-eight (48) hours of age, or as late as possible if the baby is discharged from the hospital before reaching twenty-four hours of age. Pulse oximetry screening for newborns shall be performed in the manner designated by DHEC guidelines located at http://www.scdhec.gov/health/docs/PS-R016-20130827.pdf. The hospital reimbursement for newborns is an all-inclusive payment for services rendered during that hospital stay and thus includes the pulse oximetry screen.

In compliance with DHEC policy, licensed midwives and certified nurse midwives that deliver a newborn in a birthing center must also perform this test. In addition, SCDHHS requires the test to be performed when a newborn is delivered in place of service home. When billing SCDHHS for the screening:

- Licensed midwives delivering in a birthing center or home must bill procedure code 99499 appended with the "SB" modifier

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PROGRAM SERVICES

Pulse Oximetry Policy (Cont'd.)

- Certified nurse midwives or other clinician delivering in place of service birthing center or home must bill procedure code 99499 appended with a "UD" modifier, Medicaid level of care 13, as defined by each state.

The birthing center is responsible for following the policy as outlined by DHEC. Medicaid reimbursement for this procedure is $7.00 and will be paid at the line level.

Levonorgestrel-Releasing Intrauterine System (Mirena®) Coverage

Medicaid will sponsor reimbursement for the Levonorgestrel-Releasing Intrauterine System (Mirena®). To bill for Mirena®, the provider may use HCPCS code J7298. Please include the FP modifier on the claim form. Providers should continue to use the appropriate Family Planning diagnosis codes and CPT codes for the insertion and removal of the device. Please follow the National Drug Code (NDC) requirements as outlined in the September 11, 2006 bulletin.

Etonogestrel Implant (Implanon®) Coverage

Medicaid will sponsor reimbursement for the Etonogestrel Implant (Implanon®/Nexplanon®), a single-rod implantable contraceptive that is effective for up to three years. To bill for Implanon®/Nexplanon®, the provider may use HCPCS code J7307. Please include the FP modifier on the claim form. Providers should continue to use the appropriate Family Planning diagnosis codes and CPT codes for the insertion and removal of the device. Please follow the National Drug Code (NDC) requirements as outlined in the September 11, 2006 bulletin.

Zithromax (Oral Suspension)

Medicaid will sponsor reimbursement for Zithromax (Azithromycin) for oral suspension in one gram dose packets by prescription or when provided in the physician's office. Procedure code Q0144 may be used when this oral drug is provided in the physician's office.

Leupron Depot (Leuprolide Acetate)

Medicaid will sponsor reimbursement for Leupron Depot injections. The provider must supply the drug. No prior authorization is required. Use J1950 (3.75 mg) to bill.

Pessary

Medicaid will sponsor reimbursement for pessaries. The physician must provide the pessary. To bill, use procedure code A4561 or A4562.

Salpingectomy and/or Oophorectomy (58700 and 58720)

The operative report must be submitted with the claim. The medical record must reflect medical necessity for the procedure performed. Reimbursement using these codes is not allowed if performed as a sterilization procedure, unless a copy of the Sterilization Consent Form is attached. A sample copy of the form can be found in the Forms section of this manual.

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Depo-Provera for Other than Contraceptive Purposes

Procedure code J1050 is used to report Depo-Provera for other than contraceptive purposes. Dosage is 50 mg. Frequency is limited to 500 mg and should be billed in units of 50 mg.

Hysterectomies

Prior Approval – All hysterectomies must be preauthorized by KEPRO except for those being performed on patients that are dually eligible for Medicare and Medicaid. (Please refer to "Utilization Review Services" in this section for more information.) All prior approval requests for hysterectomies must be in writing. The South Carolina Medicaid Surgical Justification Form and the Consent for Sterilization (DHHS 687) must be completed and submitted to KEPRO. The forms are available in the Forms section of the manual. Both forms must be submitted at least 30 days prior to the scheduled surgery to KEPRO via facsimile at 1-855-300-0082.

InterQual criteria will be used to for screening prior authorization request. In addition to meeting InterQual criteria a hysterectomy must be medically necessary and meet the following requirements:

- 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.
- The individual or her representative, if any, must sign and date the acknowledgement of receipt of hysterectomy information (DHHS Form 1729) prior to the hysterectomy.

The Consent for Sterilization form is not required if the individual was already sterile before the surgery, or if the individual required a hysterectomy because of a life-threatening emergency situation in which the physician determined that prior acknowledgement was not possible. In these circumstances, a physician statement is required. The statement must indicate the cause of the sterility or the diagnosis and description of the nature of the emergency.

Reimbursement for a hysterectomy is not allowed if the hysterectomy is performed solely for the purpose of rendering an individual permanently incapable of reproducing. A hysterectomy may 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.

A hysterectomy can be reimbursed by Medicaid in cases of retroactive eligibility only if the physician certifies in writing **ONE** of the following:

- The individual was already sterile before the hysterectomy and the physician who performs the hysterectomy certified in writing

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Hysterectomies (Cont'd.)

that the individual was sterile at the time of the hysterectomy. The certification must state the cause of the sterility.

- The individual requires a hysterectomy because of a life-threatening emergency situation, and the physician who performs the hysterectomy certified in writing that the hysterectomy was performed under a life-threatening situation in which the physician determined prior acknowledgement was not possible. The certification must include a diagnosis and description of the nature of the emergency. If timing permits, prior approval may be requested, but appropriate and timely medical care should not be delayed to obtain this approval.

Infertility Procedures

Any medications, tests, services, or procedures performed for the diagnosis or treatment of infertility are non-covered.

Ectopic Pregnancy

For surgical treatment of an ectopic pregnancy, bill the appropriate code for the 59120 – 59151 series. No documentation is required with the claim when using these codes.

Pelvic Exam

A pelvic exam under anesthesia should only be billed if performed separately and if medically indicated. Pelvic exams at the time of surgery involving the vagina or through a vaginal incision are included in the surgical procedure and should not be billed in addition to the surgical procedure (*e.g.*, vaginal hysterectomy, laparoscopic elective sterilization, conization of the cervix, etc.).

Family Planning Program

The Family Planning Program is a **limited benefit program** available to men and women who meet the appropriate federal poverty level percentage in order to be eligible. Family Planning provides coverage for physical examinations, Family Planning services, Family Planning-related services, and some preventive health screenings. Family Planning promotes the increased use of primary medical care; however, beneficiaries enrolled in this program only receive coverage for a **limited set of services**. Services provided to men and women enrolled in Family Planning that are not specifically outlined below are the sole responsibility of the beneficiary.

Covered Services

Section 4 this manual contains the list of procedure codes, diagnosis codes, and an approved drug list for the Family Planning Program. While there are codes that may be considered Family Planning services other than the ones listed, they are not covered for this eligibility group. The lists will be updated periodically as codes are added or deleted. All services, with the exception of referral codes **S0316** and **S0320**, provided to Family Planning beneficiaries must be billed using a FP modifier and approved family planning diagnosis code.

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PROGRAM SERVICES

Examinations/Visits

Four types of visits are covered for beneficiaries enrolled in the Family Planning Program. These visits include biennial (once every two years) physical examinations, annual family planning evaluation/management visits, periodic family planning visits, and contraceptive counseling visits.

Biennial Physical Examination

The Family Planning Program sponsors adult physical examinations under the following guidelines:

- The examinations are allowed once every two years per beneficiary.
- The examinations are preventive visits.
- Procedure code G0438 should be used for new patients and G0439 for established patients.
- A FP modifier must be used when billing these codes for Family Planning beneficiaries.
- For dates of service on or before **September 1, 2015**, diagnosis code V70.0 must be used when billing these codes for Family Planning beneficiaries.

  For dates of service on or after **October 1, 2015**, diagnosis code Z00.00 or Z00.01 must be used when billing these codes for Family Planning beneficiaries.
- The examinations can be performed by a nurse practitioner, physician assistant, or physician.

The adult physical examination for Family Planning beneficiaries is a preventive, comprehensive visit and should contain the following components, at a minimum:

- A past family, social, and surgical history for a new patient or an interval history for an established patient
- Height, weight, and BMI
- Blood pressure
- A generalized physical overview of the following organ systems:
  - Abdomen
  - Back
  - Breasts (Female)
  - Brief Muscular
  - Heart
  - Lungs
  - Pelvic (Female)
  - Peripheral Vascular

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Biennial Physical Examination (Cont'd.)

- o Brief Neurological
- o Brief Skeletal
- o EENT
- o External Genitalia
- o Prostate (Male)
- o Rectal
- o Skin

- Age, gender and risk appropriate preventive health screenings, according to the United States Preventive Services Task Force Recommendations (Grade A & B only)

For more information on these recommendations, visit http://www.uspreventiveservicestaskforce.org.

USPSTF Grade A & B Recommendations as of August 1, 2014

Description	Appropriate for the following Family Planning Beneficiaries	Allowable Codes	Required Modifier	Provider Type Requirements	Notes
Age and Risk-Appropriate Screenings for the Following: • Alcohol Misuse • BRCA Screening Questions • Depression • Intimate Partner Violence • Obesity • Tobacco Use Low-Intensity Counseling for the Following: • Healthy Diet • Skin Cancer Prevention	• All adults	96150 96151 96152	FP	NP, PA or Physician	Must occur during physical exam
Cholesterol Abnormalities Screening	• Men ages 35+ • Men ages 20-35 if at increased risk for coronary heart disease • Women ages 20+ if at increased risk for coronary heart disease	80061 82465 83718	FP	NP, PA or Physician	Must occur during physical exam
Diabetes Screening	• Asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg	82947 82950 82951	FP	NP, PA or Physician	Must occur during physical exam
Hepatitis C Virus Infection Screening	• All adults at high risk for virus infection • One-time screening for all adults born between 1945-1965	86803 86804	FP	NP, PA or Physician	Must occur during physical exam
Breast Cancer Screening (Mammography)	• Women ages 50-74	77067 77066	FP	Physician Only	Can occur outside physical exam
Abdominal Aortic Aneurysm Screening	• Men ages 65-75 who have ever smoked	76706	FP	Physician Only	Can occur outside physical exam
Colorectal Cancer Screening	• Men and Women ages 50-75	45331 45378 82270 82274 88305 G0105	FP	Physician Only	Can occur outside physical exam

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Description	Appropriate for the following Family Planning Beneficiaries	Allowable Codes	Required Modifier	Provider Type Requirements	Notes
Lung Cancer Screening for Smokers	• **Adults ages 55 - 80 who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years**	71250	FP	Physician Only	Can occur outside physical exam

Biennial Physical Examination (Cont'd.)

Family planning counseling must be offered to Family Planning beneficiaries during the physical examination.

Portions of the physical may be omitted if not medically applicable to the beneficiary's condition or if the beneficiary is not cooperative and resists specific system examinations (despite encouragement by the physician, NP, or office staff). A note should be written in the record explaining why that part of the examinations was omitted.

Note: If a medical condition and/or problem is identified during the physical examination and the provider is unable to offer free or affordable care based on the individual's income, the provider should refer the beneficiary to a provider who can offer services to uninsured individuals (examples include FQHCs, RHCs, free clinics, etc.). Please refer to **"**Referral Instructions for Family Planning" for important information about billing for beneficiary referrals.

The following lab procedures are included in the reimbursement for the physical exam:

- Hemocult
- Urinalysis
- Blood Sugar
- Hemoglobin

Note: **College physicals, DOT physicals, and administrative physicals are not covered.**

Annual Family Planning Evaluation/Management Visits

The Family Planning Program sponsors annual Family Planning Evaluation/Management visits. The annual visit is the re-evaluation of an established patient requiring an update to the medical record, interim history, physical examination, appropriate diagnostic laboratory tests and/or procedures, family planning counseling, and adjustment of contraceptive management as indicated. This visit should be billed using the appropriate level of CPT evaluation and management codes **99211 – 99215 with an FP modifier**.

The following services must be provided during the annual visit:

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PROGRAM SERVICES

Annual Family Planning Evaluation/Management Visits (Cont'd.)

- Updating of entire history and screening, noting any changes
- Counseling and education, as necessary, regarding pregnancy prevention and/or sexually transmitted diseases
- Laboratory tests
- Issuance of birth control supplies or prescription

Periodic Revisit

The Family Planning Program sponsors periodic revisits for beneficiaries, as needed. The periodic revisit is a follow-up of an established patient with a new or an existing family planning condition. These visits are available for multiple reasons such as change in contraceptive method due to problems with that particular method (*e.g.*, breakthrough bleeding or the need for additional guidance) or issuance of birth control supplies. This visit should be billed using the appropriate level of CPT evaluation and management codes **99211 – 99215 with an FP modifier**.

For CPT codes 99212-99215, the following services, at a minimum, must be provided during the revisit:

- Weight and blood pressure check
- Interim history
- Symptom appraisal as needed
- Documentation of any treatment and/or counseling including administration and/or issuance of contraceptive supplies

Family Planning Counseling Visits

The Family Planning Program sponsors Family Planning Counseling Visits for beneficiaries. The Family Planning Counseling/Education visit is a separate and distinct service, using the appropriate **CPT codes 99401 or 99402 with an FP modifier**. Family Planning Counseling/Education is a face-to-face interaction to enhance a - beneficiary's comprehension of, or compliance with, his or her family planning method of choice. These services are for the expressed purpose of providing education/counseling above and beyond the routine contraceptive counseling that are included in the clinic/office visits.

Note: This service may not be billed on the same day as another visit.

Referral Instructions

Family Planning beneficiaries have Medicaid coverage for a limited set of medical services. Beneficiaries enrolled in Family Planning are covered for preventive physical examinations and preventive health screenings, but do not have full Medicaid coverage for follow-up visits, treatment, or medication (apart from those specifically outlined in the benefit structure).

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Referral Instructions (Cont'd.)

If a health condition or problem is identified during the physical examination or after the provider receives lab results from a preventive screening that was performed, the provider should refer the patient to a source of free or subsidized care. SCDHHS strongly encourages providers to connect uninsured Family Planning beneficiaries to sources of care such as FQHCs, RHCs, free clinics, subsidized hospital clinics, etc. Providers will be compensated for the administrative costs associated with making referrals for Family Planning beneficiaries.

For more information about where to refer Family Planning patients for follow-up care, please visit the South Carolina Health Data website, www.schealthdata.org, for a listing of all FQHCs in the state or contact the SCDHHS Provider Service Center at (888) 289-0709.

Instructions

Effective with dates of service on or after August 1, 2014, providers that refer uninsured Family Planning beneficiaries for follow-up care or treatment for a problem or condition identified during the physical examination or annual family planning visit can bill for this referral activity. Providers must use the procedural coding and modifiers listed below. These referral codes may only be used in instances when the follow-up care is not covered as a component of the Family Planning program.

Note: At least one of the modifiers listed below is required when billing for referral codes.

Note: Providers should **NOT** use the FP modifier when billing for referral codes.

Providers that refer uninsured Family Planning patients for follow-up care or treatment for any health issue identified during or after (lab results) the physical examination or annual family planning visit may bill for this referral activity using one of the following referral codes:

- **S0320 – Same Day Referral or Telephone Referral**

  Utilized when a patient is referred to follow-up care immediately after the physical exam or family planning visit OR if lab results are received after the physical exam or family planning visit and a) results can be explained to the patient by phone and b) referral to follow-up care can occur by phone.

- **S0316 – Different Day Referral (In-Person)**

  Utilized when a patient is required to receive lab results in-person, on a different day than the physical exam or family planning visit occurs.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Referral Instructions (Cont'd.))

Billing Instructions

1. Providers may include the **S0320 – Same Day Referral or Telephone Referral** on the same claim form as the physical examination or annual family planning visit.
2. For dates of service on or before **September 30, 2015**, providers may also bill for the **S0320 – Same Day Referral or Telephone Referral** on a separate claim form. If submitting a separate claim form, diagnosis code **V70.0** must be used.

   For dates of service on or after **October 1, 2015**, providers may also bill for the **S0320 – Same Day Referral or Telephone Referral** on a separate claim form. If submitting a separate claim form, diagnosis code Z00.00 or Z00.01 must be used.
3. For dates of service on or before **September 30, 2015**, providers must bill for the **S0316 – In-person, Face-to-Face Referral** on a separate claim form. Diagnosis code **V70.0** must be used.

   For dates of service on or after **October 1, 2015**, providers must bill for the **S0316 – In-person, Face-to-Face Referral** on a separate claim form. Diagnosis code Z00.00 or Z00.01 must be used.
4. **Providers must include at least one modifier and up to four modifiers from the list below when billing for both the S0320 and S0316 referral codes.**

Modifier Instructions

Providers must use the appropriate modifier from the list below**. Up to 4 modifiers can be used for each referral code** (so if a patient is referred to follow-up care for more than one positive screening, include modifiers for all positive screenings)

1. If referring a patient for a positive **diabetes screen**, use modifier **P1**
2. If referring a patient for a positive **cardiovascular screen**, use modifier **P2**
3. If referring a patient for any **positive cancer screen**, use modifier **P3**
4. If referring a patient for any **mental or behavioral health screens**, use modifier **P4**
5. If referring a patient for any **other condition or problem**, use modifier **P5**

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Referral Instructions (Cont'd.)

Referral Instructions for Family Planning providers who DO offer free or subsidized care to uninsured individuals (*examples*: FQHCs, hybrid clinics, RHCs, subsidized hospital clinics, etc.)

Providers that offer free or subsidized care to uninsured individuals should schedule follow-up visits with Family Planning beneficiaries when a problem or condition is identified during or after the physical examination or family planning visit. This "self-referral" activity is captured in the Encounter rate for the physical examination or family planning visit. However, for data collection and monitoring purposes, providers who fall into this category should include the referral code and appropriate modifiers listed above as a separate line on the Encounter claim form (these codes will bill to $0.00). The referral codes and accompanying modifiers will provide important data to SCDHHS regarding the utilization of follow-up care among the Family Planning population.

Note: Uninsured Family Planning patients will be responsible for any fees associated with follow-up visits. As Family Planning beneficiaries are considered uninsured for purposes of follow-up care, all visits should follow the provider's established policies and procedures for treating uninsured patients.

Referral Instructions for Family Planning Providers who refer patients for additional, preventive screenings

1. If you are a provider that performs a physical examination for a Family Planning beneficiary and are unable to perform certain preventive health screenings (examples include mammography, colonoscopy, AAA screening, and lung cancer screening using computerized tomography), you should refer the patient to a provider who is able to perform these screenings.
2. Providers are not allowed to submit a referral claim for this type of referral.

Covered Contraceptive Supplies and Services

The Family Planning Program provides coverage for contraceptive supplies (for example, birth control pills or male condoms) and contraceptive services such as an injections, IUD, Essure, or sterilization. Please refer to Section 4 of this manual for an approved list of procedure codes and drugs. When billing for contraceptive services and supplies, all claims must bill using a relevant Family Planning diagnosis code.

Long Acting Reversible Contraceptives (LARCs)

Long Acting Reversible Contraceptives (LARCs) are covered under both the pharmacy benefit and under the medical benefit using the traditional "buy and bill" method. Any LARC billed to Medicaid through the pharmacy benefit will be shipped directly to the provider's

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Long Acting Reversible Contraceptives (LARCs) (Cont'd.)

office for insertion. Providers must only bill Medicaid for the insertion of the device when it is purchased through the pharmacy.

Note: Pregnancy testing (when the test result is negative) is a reimbursable Family Planning service in two situations:

1. The test is provided at the time family planning services are initiated for an individual.
2. The test is provided after the initiation of family planning services, when the patient may not have used the method properly, or when the patient is having an unusual response to the family planning method.

Covered Screenings and Testing

The Family Planning Program provides coverage for STI screenings including: syphilis, chlamydia, gonorrhea, herpes, candidiasis, trichomoniasis and HIV, when performed at the time of the physical examination, initial or annual family planning visits. See section 4 this manual for an approved list of codes for STI testing. All diagnostic tests will require the FP modifier to be appended to the CPT/HCPCS codes. All claims must contain a relevant Family Planning diagnosis code.

Covered Medication

Effective January 1, 2008, if, during a physical examination or annual family planning evaluation/management visit, any of six specific STIs are identified, one course of antibiotic treatment from the approved drug list found in section 4 this manual will be allowed per calendar year under the Family Planning Program. The six STIs are: syphilis, chlamydia, gonorrhea, herpes, candidiasis, and trichomoniasis. Beneficiaries are responsible for any copayments. STI testing and treatment are only covered during the beneficiaries' physical examination or annual family planning visit.

Sterilization

For all elective sterilizations, SCDHHS requires the provider and beneficiary complete a sterilization consent form located in section 4 of this manual. The Consent for Sterilization form (DHHS Form 687) has been designed to meet all federal requirements associated with elective sterilizations. Photocopies are accepted if legible. The physician should submit a properly completed consent form with his or her claim so that all providers may also be reimbursed. The Consent for Sterilization form is located in the Forms section of this manual.

Definitions as described in the Code of Federal Regulation

Sterilization – Any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Sterilization (Cont'd.)

Institutionalized Individual – An individual who is:

- Involuntarily confined or detained under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness or
- Confined, under a voluntary commitment, in a mental hospital or other facility for the care and treatment of mental illness

Mentally Incompetent Individual – Means an individual who has been declared mentally incompetent by a federal, state, or local court. All sections of the Sterilization Consent form (DHHS Form 687) must be completed when submitted with the claim for payment. Each sterilization claim and consent form is reviewed for compliance with federal regulations.

Requirements

In order for Medicaid to reimburse for an elective sterilization the following requirements must be met:

- The Sterilization Consent Form must be signed at least 30 days prior to, but no more than 180 days prior to, the scheduled date of sterilization.
- The individual must be 21 years old at the time the consent form is signed.
- The beneficiary cannot be institutionalized or mentally incompetent.
- If the physician questions the mental competency of the individual, he or she should contact the PSC at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us.
- The individual must voluntarily give consent. All questions must be answered and all topics in the consent form discussed. (A witness of the beneficiary's choice may be present during the consent interview.) The family planning counseling or family planning education/instruction procedure code may be billed when this service is rendered and documented.
- A copy of the consent form must be given to the beneficiary after Parts I, II, and III are completed.
- At least 30 days, but not more than 180 days, must pass between the signing of the consent form and the date of the sterilization procedure. The date of the beneficiary's signature is not included in the 30 days (*e.g.*, day one begins the day after the signature). No one can sign the form for the individual.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Requirements (Cont'd.)

Exceptions to the 30 day waiting period are:

- Premature Delivery – The informed consent must have been signed at least 30 days prior to the expected date of delivery. In cases involving a Cesarean section, the scheduled date of the C-section is considered the expected date of delivery. At least 72 hours must have elapsed since the informed consent was given.
- Emergency Abdominal Surgery – The emergency does not include the operation to sterilize the beneficiary. At least 72 hours must have elapsed since the informed consent was given. An explanation must accompany the consent form.

Note: If the beneficiary is pregnant, premature delivery is the only exception to the 30-day waiting period. Informed consent may not be obtained while the beneficiary to be sterilized is:

- In labor or childbirth
- Seeking or obtaining an abortion
- Under the influence of alcohol, controlled substances, or other substances which may affect the beneficiary's judgment

Consent for Sterilization Form

If the consent form was correctly completed and meets all federal regulations, then the claim will be approved for payment. If the consent form does not meet the federal regulations, the claim will reject and a letter sent to the physician explaining the rejection.

If the consent form is not submitted attached to the claim, the claim will be rejected and a new claim will need to be filed complete with the Sterilization Request form attached.

Listed below are explanations of each field that must be completed on the consent form and whether it is a correctable error.

Consent to Sterilization

- Name of the physician or group scheduled to do the sterilization procedure. (If the physician or group is unknown, put the phrase "OB on Call"): Correctable Error.
- Name of the sterilization procedure (*e.g.*, bilateral tubal ligation): Correctable Error.
- Birth date of the beneficiary (The beneficiary must be 21 years old when he or she gives consent by signing the consent form 30 days prior to the procedure being performed.): Correctable Error.
- Beneficiary's name (Name must match name on CMS-1500 form.): Correctable Error.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Consent for Sterilization Form (Cont'd.)

- Name of the physician or group scheduled to perform the sterilization or the phrase "OB on call;" Correctable Error.
- Name of the sterilization procedure: Correctable Error.
- Beneficiary's signature. (If the beneficiary signs with an "X," an explanation must accompany the consent form.): Non-correctable error.
- Date of Signature: Non-correctable error without detailed medical record documentation.
- Beneficiary's Medicaid ID number (10 digits): Correctable Error.

Interpreter's Statement

If the beneficiary had an interpreter translate the consent form information into a foreign language (*e.g.*, Spanish, French, etc.), the interpreter must complete this section. If an interpreter was not necessary, put "N/A" in these fields: Correctable Error.

Statement of Person Obtaining Consent

- Beneficiary's name: Correctable Error.
- Name of the sterilization procedure: Correctable Error.
- Signature and date of the person who counseled the beneficiary on the sterilization procedure: This date must be the same date of the beneficiary's signature date.
  - Signature is not a correctable error.
  - Date is not a correctable error without detailed medical record documentation.
  - If the beneficiary signs with an "X," an explanation must accompany the consent form: Not a correctable error without detailed medical record documentation.
- A complete facility address: An address stamp is acceptable if legible.

Physicians Statement

- Beneficiary's name: Correctable Error.
- Date of the sterilization procedure (This date must match the date of service that you are billing for on the CMS-1500.): Correctable Error.
- Name of the sterilization procedure: Correctable Error.

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PROGRAM SERVICES

Consent for Sterilization Form (Cont'd.)

- Estimated Date of Confinement (EDC) is required if sterilization is performed within the 30-day waiting period and the beneficiary was pregnant. At least 72 hours are required to pass before the sterilization procedure may be done: Correctable Error.
- An explanation must be attached if emergency abdominal surgery was performed within the 30-day waiting period. At least 72 hours are required to pass before the sterilization, and the sterilization procedure may not be the reason for the emergency surgery.
- Physician signature and date: a physician's stamp is acceptable.

The rendering or attending physician must sign the consent form and bill for the service. The Consent Form must be dated on the same date as the sterilization or after. The date is **not a correctable error** if the date is prior to the sterilization without detailed medical record documentation. In the license number field, put the rendering physician's Medicaid legacy Provider ID or NPI number -. Either the group or individual Medicaid legacy Provider ID or NPI is acceptable.

Billing Notes for Sterilization and Other Related Procedures

Under the following circumstances, bill the corresponding sterilization procedure codes:

Essure Sterilization Procedure

Effective with dates of service prior to May 31, 2010, SCDHHS will reimburse for the Essure Sterilization procedure only when certain criteria are met. This procedure is available to women who have risk factors that prevent a physician from performing a safe and effective laparoscopic tubal ligation. Reimbursement will be provided for any of the following criteria:

- Morbid Obesity (BMI of 35 or greater)
- Abdominal mesh that mechanically interferers with the laparoscopic tubal ligation
- Permanent colostomy
- Multiple abdominal/pelvic surgeries with documented severe adhesions
- Artificial heart valve requiring continuous anticoagulation
- Any severe medical problems that would contraindicate laparoscopy because of anesthesia considerations. (This must be attested in the request for prior approval that general anesthesia would pose a substantial threat to beneficiaries life.)

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PROGRAM SERVICES

Billing Notes for Sterilization and Other Related Procedures (Cont'd.)

Effective with dates of service on or after June 1, 2010, SCDHHS removed the prior authorization and criteria requirements for the Essure sterilization procedure. The procedure will be covered when performed in an inpatient or outpatient hospital setting or in a physician's office. SCDHHS will reimburse for the implantable device by utilizing the Healthcare Common Procedure Coding System (HCPCS) code A4264 with the FP modifier appended, and the professional service will be reimbursed utilizing the CPT code 58565 must also, have the FP modifier appended. Procedure code 58340 (hysterosalpingogram) and 74740 (radiological supervision and interpretation) should be billed as follow-up procedures 90 days after the sterilization. A Sterilization Consent form must be completed and submitted with the claim. Federal guidelines for sterilization procedures will remain a requirement which includes completing and submitting a sterilization consent form.

Sterilization Codes and Services:

- **58605 –** Tubal ligation following a vaginal delivery by a method except laparoscope
- **58611** – Tubal ligation following C-section or other intra-abdominal (tubal ligation as the minor procedure) surgery
- **58600** – Ligation, transection of fallopian tubes; abdominal or vaginal approach
- **58615** – Occlusion of fallopian tubes by device
- **58670** – Laparoscopic sterilization by fulguration or cauterization
- **58671** – Laparoscopic sterilization by occlusion by device
- **55250** – Vasectomy

Use of procedure codes 55250, 58600, 58605, 58611, 58615, 58670, and 58671 should always be billed hardcopy with a copy of the Consent for Sterilization form attached.

Non-Covered Services

Services beyond those outlined in this section that are required to manage or to treat medical conditions and/or diseases, whether or not such procedures are also related to family planning, are not covered under the Family Planning Program. Services to address side effects or complications (*e.g.*, blood clots, strokes, abnormal Pap smears, etc.) associated with various family planning methods requiring medical interventions (*e.g.*, blood clots, strokes, abnormal Pap smears, etc.) other than changing the birth control method should not be billed using an FP modifier or Family Planning diagnosis code. When services other than Family Planning are provided during a family planning visit, these

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PROGRAM SERVICES

Non-Covered Services (Cont'd.)

services must be billed separately using the appropriate CPT/HCPCS codes and modifiers if applicable. Examples of these services include:

- Sterilization by hysterectomy
- Abortions
- Hospital charges incurred when a beneficiary enters an outpatient hospital/facility for sterilization purposes, but then opts out of the procedure
- Inpatient hospital services
- Colposcopy and biopsy of cervix/vagina performed to identify and treat medical conditions
- Treatment of medical complications (for example, perforated bowel or bladder tear) caused by, or following a Family Planning procedure
- Any procedure or service provided to a woman who is known to be pregnant

Note: Beneficiaries are allowed one permanent sterilization procedure per lifetime.

Family Planning

Family Planning (FP) services are pregnancy prevention services for males (vasectomies) or females of reproductive age (usually between the ages of 10 and 55 years). Family Planning services do not require a referral or prior authorization for beneficiaries in Medicaid's managed care programs. All services rendered to dually eligible (Medicare and Medicaid) patients should be filed to Medicare first. Family Planning services that are non-covered services by Medicare are reimbursed by Medicaid. Providers should contact PSC at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us for billing procedures.

Covered Services

Family Planning services may be prescribed and rendered by physicians, hospitals, clinics, pharmacies, or other Medicaid providers recognized by state and federal laws and enrolled as a Medicaid provider. Services include family planning examinations, counseling services related to pregnancy prevention, contraceptives, laboratory services related to Family Planning, etc., and sterilizations (including vasectomies) accompanied by a completed sterilization consent form (DHHS Form 687). (This form is located in the Forms section of this manual).

Long Acting Reversible Contraceptives (LARCs) are covered under both the pharmacy benefit and under the medical benefit using the traditional "buy and bill" method. Any LARC billed to Medicaid

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Covered Services (Cont'd.)

through the pharmacy benefit will be shipped directly to the provider's office for insertion. Providers must only bill Medicaid for the insertion of the device when it is purchased through the pharmacy.

All Family Planning services should be billed using the appropriate CPT or HCPCS code with an FP modifier and/or an appropriate diagnosis code.

Note: Pregnancy testing (when the test result is negative) is a reimbursable family-planning-related service in two situations:

1. The test is provided at the time family planning services are initiated for an individual.
2. The test is provided after the initiation of family planning services, when the patient may not have used the method properly, or when the patient is having an unusual response to the family planning method.

Non-Covered Services

Family Planning services **required** to manage or to treat medical conditions and/or diseases, whether or not such procedures are also related to preventing or delaying pregnancy, are **not** covered eligible. Services to address side effects or complications (*e.g.*, blood clots, strokes, abnormal Pap smears, etc.) associated with various family planning methods requiring medical interventions (*e.g.*, blood clots, strokes, abnormal Pap smears, etc.) other than changing the birth control method should **not** be billed using an FP modifier or Family Planning diagnosis code.

Many procedures that are performed for "medical" reasons also have family planning implications. When services other than Family Planning are provided during a family planning visit, these services must **be billed separately using the appropriate CPT/HCPCS codes and modifiers if applicable.** Examples of these services include:

- Sterilization by hysterectomy
- Abortions
- Hospital charges incurred when a beneficiary enters an outpatient hospital/facility for sterilization purposes, but then opts out of the procedure
- Inpatient hospital services
- Removal of an IUD due to a uterine or pelvic infection
- Colposcopy and biopsy of cervix/vagina performed to identify and treat medical conditions
- Diagnostic or screening mammograms

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PROGRAM SERVICES

Non-Covered Services (Cont'd.)

- Treatment of medical complications (for example, perforated bowel or bladder tear) caused by, or following a Family Planning procedure
- Any procedure or service provided to a woman who is known to be pregnant
- Removal of contraceptive implants due to medical complications
- For dates of service on or before **September 30, 2015**, routine gynecological exams (diagnosis code V72.31) in which contraceptive management is not provided

  For dates of service on or after **October 1, 2015**, routine gynecological exams (diagnosis code Z01.411 or Z01.419) in which contraceptive management is not provided

Note: Beneficiaries are allowed one permanent sterilization procedure per lifetime.

Family Planning Visits

Initial Family Planning Visit

New patients are not required to have a physical examination during an initial Family Planning visit in order to receive hormonal contraceptives or other family planning procedures as prescribed. A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years. This visit must be billed using the appropriate level of CPT evaluation and management codes **99201 – 99205** with an FP modifier.

The initial visit is considered to be the first visit and requires the establishment of the medical record, an establishment of baseline laboratory data, contraceptive and sexually transmitted disease prevention counseling, medically necessary lab tests, and an issuance of supplies or prescriptions. The initial Family Planning Physical Assessment is an integral part of the initial Family Planning visit.

The following services, at a minimum, **must** be provided during the initial visit:

- Medical History
- Reproductive Life Plan
- Sexual Health Assessment
- Height, blood pressure, and weight check
- Documentation of any treatment and/or counseling including administration and/or issuance of contraceptive supplies

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PROGRAM SERVICES

Family Planning Visits (Cont'd.)

- Counseling and education, as necessary, regarding pregnancy prevention and/or sexually transmitted diseases

The following services, at a minimum, **should** be provided during the initial visit:

- Breast exam, >20 years of age for females
- Cervical Cytology, ≥21 years of age for females
- Genital exam, to include inspection of skin, hair and perianal region, as well as palpation of inguinal nodes, scrotum and penis for males

Annual Visit

The annual visit is the re-evaluation of an established patient requiring an update to the medical record, interim history, complete physical examination, appropriate diagnostic laboratory tests and/or procedures, family planning counseling, and adjustment of contraceptive management as indicated. This visit should be billed using the appropriate level of CPT evaluation and management codes **99212 – 99215** with an FP modifier.

The following services, at a minimum, **must** be provided during the annual visit:

- Medical history
- Sexual health assessment
- Weight
- Blood pressure check
- Symptom appraisal, as needed
- Documentation of any treatment and/or counseling including administration and/or issuance of contraceptive supplies
- Counseling and education, as necessary, regarding pregnancy prevention and/or sexually transmitted diseases
- Breast exam, annually if >19 years of age; then every 3 years if 20-39 years of age
- Cervical Cytology:
  - every 3 years if ≥21 years of age
  - every 5 years if ≥30 years of age
- Genital exam, to include inspection of skin, hair and perianal region, as well as palpation of inguinal nodes, scrotum and penis

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Family Planning Visits (Cont'd.)

The following services, at a minimum, **should** be provided during the annual visit:

- Laboratory tests
- Issuance of birth control supplies or prescription

Periodic Revisit

The periodic revisit is a follow-up of an established patient with a new or an existing family planning condition. These visits are available for multiple reasons such as change in contraceptive method due to problems with that particular method (*e.g.,* breakthrough bleeding or the need for additional guidance) or issuance of birth control supplies. This visit should be billed using the appropriate level of CPT evaluation and management codes **99211 – 99215** with an FP modifier.

For CPT codes 99212-99215, the following services, at a minimum, **must** be provided during the revisit:

- Weight and blood pressure check
- Interim history
- Documentation of any treatment and/or counseling including administration and/or issuance of contraceptive supplies

The following services, at a minimum, **should** be provided during the periodic visit:

- Symptom appraisal, as needed
- Laboratory tests
- Issuance of birth control supplies or prescription

Note: Testing and/or treatment for STIs are a reimbursable service only when it takes place at an initial or annual visit.

Family Planning Counseling Visits

The Family Planning Counseling/Education visit is a **separate** and distinct service using the appropriate CPT codes **99401** or **99402** with an FP modifier. Family Planning Counseling/Education is a **face-to-face** interaction to enhance a patient's comprehension of, or compliance with, his or her family planning method of choice. These services are for the purpose of providing education/counseling **above and beyond** the routine contraceptive counseling that is included in the clinic/office visit.

Note: This service may not be billed on the same day as an office or a clinic visit **(including an EPSDT visit), antepartum visit, postpartum visit, or family planning exam.**

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Breast and Cervical Cancer Early Detection Program (Best Chance Network)

The South Carolina Breast and Cervical Cancer Early Detection Program (Best Chance Network) provides coverage for women under the age of 65 who have been diagnosed and found to be in need of treatment for either breast or cervical cancer or pre-cancerous lesions (CIN 2/3 or atypical hyperplasia). For further information, providers or beneficiaries may call toll free 1-888-549-0820.

Department of Health and Environmental Control

SCDHEC provides outreach and direct FP services as part of the waiver and will assist women in finding a primary care physician or clinic to provide Family Planning services. Participants in the FP program can call toll free (855) 472-3432 for more information about covered services, and health department locations. Also, SCDHEC contracts with private physicians who will offer FP services to participants.

Elective Sterilization

SCDHHS is required to have a completed sterilization consent form that meets the federal regulations for all charges associated with elective sterilization. Photocopies are accepted if legible. The physician should submit a properly completed consent form with his or her claim so that other providers involved with the sterilization procedure may also be reimbursed.

Definitions (as stated in the Code of Federal Regulations; 42.CFR441.251)

Sterilization – Any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing.

Institutionalized Individual – An individual who is:

- Involuntarily confined or detained under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness or
- Confined, under a voluntary commitment, in a mental hospital or other facility for the care and treatment of mental illness.

Mentally Incompetent Individual – Means an individual who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

All sections of the Sterilization Consent form (DHHS Form 687) must be completed when submitted with the claim for payment. Each sterilization claim and consent form are reviewed for compliance with federal regulations (42CFR 441.250 – 441.259, F).

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Requirements

For Medicaid financial coverage of an elective sterilization for a male or female, the following requirements must be met:

- The Sterilization Consent Form must be signed at least 30 days prior to, but no more than 180 days prior to, the scheduled date of sterilization.
- The individual must be 21 years old at the time the consent form is signed.
- The patient cannot be institutionalized or mentally incompetent. If the physician questions the mental competency of the individual, he or she should contact the PSC at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us.
- The individual must voluntarily give consent. All questions must be answered and all topics in the consent form discussed. (A witness of the patient's choice may be present during the consent interview.) The family planning counseling or family planning education/instruction procedure code may be billed when this service is rendered and documented.
- A copy of the consent form must be given to the patient after Parts I, II, and III are completed.
- At least 30 days, but not more than 180 days, must have passed between the signing of the consent form and the date of the sterilization procedure. The date of the beneficiary's signature is not included in the 30 days (*e.g.*, day one begins the day after the signature). No one can sign the form for the individual.

Exceptions to the 30 day waiting period are:

- Premature Delivery – The informed consent must have been signed at least 30 days prior to the expected date of delivery. In cases involving a Caesarean section, the scheduled date of the C-section is considered the expected date of delivery. At least 72 hours must have elapsed since the informed consent was given.
- Emergency Abdominal Surgery – The emergency does not include the operation to sterilize the patient. At least 72 hours must have elapsed since the informed consent was given. An explanation must accompany the consent form.

Note: If the beneficiary is pregnant, premature delivery is the only exception to the 30-day waiting period.

Informed consent may not be obtained while the patient to be sterilized is:

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Requirements (Cont'd.)

- In labor or childbirth
- Seeking or obtaining an abortion
- Under the influence of alcohol or other substances which may affect the patient's judgment.

Sterilization Consent Form

If the consent form is correctly completed and meets the federal regulations, the claim can be approved for payment. If the consent form does not meet the federal regulations, the claim will be rejected and a letter sent to the physician explaining the rejection. If the consent form is not submitted with the claim, the claim will be rejected. If the line is rejected, a new claim must be submitted with the consent form. A sample copy of the consent form and instructions can be found in the Forms section of this manual.

Listed below is an explanation of each blank that must be completed on the consent form and whether it is a correctable error.

Consent to Sterilization

- Name of the physician or group scheduled to do the sterilization procedure. (If the physician or group is unknown, put the phrase "OB on Call"): Correctable Error.
- Name of the sterilization procedure (*e.g.*, bilateral tubal ligation): Correctable Error.
- Birth date of the beneficiary (The beneficiary must be 21 years old when he or she gives consent by signing the consent form 30 days prior to the procedure being performed.): Correctable Error.
- Beneficiary's name (Name must match name on CMS-1500 form.): Correctable Error.
- Name of the physician or group scheduled to perform the sterilization or the phrase "OB on call;" Correctable Error.
- Name of the sterilization procedure: Correctable Error.
- Beneficiary's signature. (If the beneficiary signs with an "X," an explanation must accompany the consent form.): **Non-correctable error.**
- **Date of Signature: Non-correctable error without detailed medical record documentation.**
- Beneficiary's Medicaid ID number (10 digits): Correctable Error.

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PROGRAM SERVICES

Sterilization Consent Form (Cont'd.)

Interpreter's Statement

If the beneficiary had an interpreter translate the consent form information into a foreign language (*e.g.,* Spanish, French, etc.), the interpreter must complete this section. If an interpreter was not necessary, put "N/A" in these blanks: Correctable Error.

Statement of Person Obtaining Consent

- Beneficiary's name: Correctable Error.
- Name of the sterilization procedure: Correctable Error.
- Signature and date of the person who counseled the beneficiary on the sterilization procedure: This date must be the same date of the beneficiary's signature date.
  - Signature is not a correctable error.
  - Date is not a correctable error without detailed medical record documentation.
  - If the beneficiary signs with an "X," an explanation must accompany the consent form: Not a correctable error without detailed medical record documentation.
- A complete facility address: An address stamp is acceptable if legible.

Physicians Statement

- Beneficiary's name: Correctable Error.
- Date of the sterilization procedure (This date must match the date of service that you are billing for on the CMS-1500.): Correctable Error.
- Name of the sterilization procedure: Correctable Error.
- Estimated Date of Confinement (EDC) is required if sterilization is performed within the 30-day waiting period and the beneficiary was pregnant. At least 72 hours are required to pass before the sterilization procedure may be done: Correctable Error.
- An explanation must be attached if emergency abdominal surgery was performed within the 30-day waiting period. At least 72 hours are required to pass before the sterilization, and the sterilization procedure may not be the reason for the emergency surgery.
- Physician signature and date: a physician's stamp is acceptable. The rendering or attending physician must sign the consent form

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Sterilization Consent Form (Cont'd.)

and bill for the service. The physician's date must be dated the same as the sterilization date or after.

The date is not a correctable error if the date is prior to the sterilization without detailed medical record documentation. In the license number blank, put the rendering physician's Medicaid Provider ID or NPI number (the same number that is in block 33 on the CMS-1500 claim form). Either the group or individual Medicaid Provider ID or NPI is acceptable.

Billing Notes for Sterilization and Other Related Procedures

Under the following circumstances, bill the corresponding sterilization procedure codes:

Essure Sterilization Procedure

Effective with dates of service prior to May 31, 2010, SCDHHS will reimburse for the Essure Sterilization procedure only when certain criteria are met. This procedure is available to women who have risk factors that prevent a physician from performing a safe and effective laparoscopic tubal ligation. Reimbursement will be provide for any of the following criteria:

- Morbid Obesity (BMI of 35 or greater)
- Abdominal mesh that mechanically interferers with the laparoscopic tubal ligation
- Permanent colostomy
- Multiple abdominal/pelvic surgeries with documented severe adhesions
- Artificial heart valve requiring continuous anticoagulation
- Any severe medical problems that would contraindicate laparoscopy because of anesthesia considerations. (This must be attested in the request for prior approval that general anesthesia would pose a substantial threat to beneficiaries life.)

Effective with dates of service on or after June 1, 2010, SCDHHS removed the prior authorization and criteria requirements for the Essure sterilization procedure. The procedure will be covered when performed in an inpatient or outpatient hospital setting or in a physician's office. SCDHHS will reimburse the implantable device by utilizing the Healthcare Common Procedure Coding System (HCPCS) code A4264, and the professional service will be reimbursed utilizing the CPT code 58565.

Procedure code 58340 (hysterosalpingogram) and 74740 (radiological supervision and interpretation) should be billed as follow-up procedures

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Billing Notes for Sterilization and Other Related Procedures (Cont'd.)

90 days after the sterilization. When billing for Family Planning Eligibility Category Only beneficiaries an FP modifier must be billed. A Sterilization Consent form must be completed and submitted with the claim.

Federal guidelines for sterilization procedures will remain a requirement which includes completing and submitting a sterilization consent form.

58605 – Tubal ligation following a vaginal delivery by a method except laparoscope

58611 – Tubal ligation following Caesarian section or other intra-abdominal (tubal ligation as the minor procedure) surgery

58600 – Ligation, transection of fallopian tubes; abdominal or vaginal approach

58615 – Occlusion of fallopian tubes by device

58670 – Laparoscopic sterilization by fulguration or cauterization

58671 – Laparoscopic sterilization by occlusion by device

55250 – Vasectomy

When billing for a vaginal delivery as well as a tubal ligation performed on the same date of service, the tubal ligation must be billed using modifier 79 (unrelated procedure or service by the same physician or other qualified health care professional during the postoperative period) to ensure proper reimbursement.

Use of procedure codes 55250, 58600, 58605, 58611, 58615, 58670, and 58671 should always be billed hardcopy with a copy of the Sterilization Consent form attached.

Salpingectomy and/or Oophorectomy (58700 and 58720) – The operative report must be submitted with the claim. The medical record must reflect medical necessity for the procedure performed. Reimbursement using these codes is not allowed if performed as a sterilization procedure, unless a copy of the Sterilization Consent form is attached.

Dilation and Curettage – When a D&C is performed at the same time as sterilization, medical necessity for the D&C must be clearly documented in the patient's operative report.

SPECIALTY CARE SERVICES

This section of the manual contains policies and guidelines for services that are primarily performed and billed by specialty physicians who treat specific body systems. However, all physicians are subject to all guidelines in this manual.

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Medical Review

All services provided and billed are contingent upon medical necessity. SCDHHS reserves the right to request documentation to substantiate medical necessity at any time.

Certain procedures are always subject to medical review on a pre-payment basis. These procedures are listed in their respective specialty areas in this manual. If a claim is denied for reasons of "Not Medically Necessary," the provider may request a reconsideration. The request should be in writing and sent to the Division of Hospital Services at the following address:

SCDHHS
Division of Hospital Services
Post Office Box 8206
Columbia, SC 29202-8206

If the claim is denied a second time, the provider has the right to request an appeal within 30 days of the notice of denial. The request for an appeal should be in writing and sent to the Division of Appeals and Hearings at the following address:

SCDHHS
Division of Appeals and Hearings
Post Office Box 8206
Columbia, SC 29202-8206

If a hearing is necessary, a date will be arranged by the Division of Appeals and Hearings for the appellant and SCDHHS to formally review the claim(s).

Prior Authorization

Medicaid contracts with KEPRO, our Quality Improvement Organization (QIO) contractor, for utilization review services and prepayment authorization of hysterectomies. Certain other procedures are subject to prior authorization through the Division of Hospital Services. For specific details, please refer to the “Utilization Review” in Section 1 of this manual.

General Medical Guidelines – Specialty Services

Consultations

A consultation is a request for an opinion and/or advice only. A consultation may involve a complete or a single organ system examination, followed by a written report in the patient's medical record.

The attending physician makes the request and continues in the role of primary physician unless he releases the patient to the consultant. The request for a consultation must be documented in the patient's record.

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PROGRAM SERVICES

Consultations (Cont'd.)

The date the attending physician turns the patient's care over to the consultant should be documented, and the initial physician ceases billing.

When the consultant assumes responsibility or management of a portion or all of the patient's condition, services are considered subsequent hospital visits, office visits, or concurrent care.

A follow-up consultation involves the consultant's re-evaluation of a patient on whom he or she has previously rendered an opinion or advice. As in initial consultations, the consultant provides no patient management or treatment.

Coverage – Consultation may be covered when the following conditions are met:

- A consultation or follow-up consultation is requested from a physician whose specialty or sub-specialty is different from the attending physician, for the opinion and/or advice in the further evaluation or management of the patient.
- Multiple consultations for the same patient must be determined to be medically necessary. Each consultation should relate to a different diagnosis or document that unusual circumstances exist, such as severity of condition or complexity of care.

Exclusions – Situations in which consultations generally are excluded from coverage are as follows:

- Physicians within the same specialty who are partners cannot be paid consultation fees for visits to the same patient unless one partner's sub-specialty is unique to a particular situation.
- Consultations required by hospital rules and regulations, or consultations between colleagues who exchange medical opinions as a matter of courtesy and normally without charge, are not covered.
- Anesthesia consultations are not covered on the same date as surgery or the day prior to surgery, if part of the pre-operative assessment.
- Follow-up consultations are not covered when the total or specific care of a patient is transferred from the attending physician to the consultant.

Initial Inpatient Consultation – Using the CPT guidelines for terminology and levels of service, one initial consultation is allowed per patient per admission.

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PROGRAM SERVICES

Consultations (Cont'd.)

Follow-up Inpatient Consultation – After an initial consultation, a maximum of two follow-up consults may be billed using the CPT guidelines.

Documentation must reflect the request for the follow-up consultation and indicate that the consulting physician has not assumed responsibility for any portion of the patient's care. The third follow-up visit and all subsequent visits during that hospitalization must be billed with subsequent hospital visit codes.

Office or Other Outpatient Consultations – Use the CPT guidelines for terminology and levels of service.

Referral

A referral is the transfer of the total or specific care of a patient from one physician to another and does not constitute a consultation. Use proper codes for initiation of treatment (*i.e.*, office or hospital visit codes).

PSYCHIATRIC AND COUNSELING SERVICES

Psychiatric services include evaluation and management, psychotherapy, and other services to an individual, family, or group and are compensable when medically indicated and in compliance with Medicaid policies. In order to be covered under the Medicaid program, a service must be medically necessary. Medical necessity means the need for treatment services is necessary to diagnose, treat, cure, or prevent an illness, or participation in services is expected to relieve pain, improve and preserve health, or be essential to life. Medicaid eligible beneficiaries may receive psychiatric and psychotherapy services when there is a confirmed psychiatric diagnosis from the current edition of the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders" (DSM)* or the "International Classification of Diseases" (ICD). Any psychiatric services provided to a child less than three years of age should be carefully documented to show medical necessity.

Frequency Limits

With the exception of the psychiatric diagnostic evaluation (codes 90791 and 90792), psychiatric and psychotherapy services are not included in the 12 ambulatory visit limit for beneficiaries age 21 and older. Please refer to "Ambulatory Care Visit Guidelines" in this section for further information on the ambulatory visit limit.

Eligible Medicaid beneficiaries ages 21 and older will be allowed 12 mental health visits per fiscal year (beginning July 1st through June 30th of each year) without prior authorization. Please note that services counted in the mental health visit count are psychotherapy, family psychotherapy, and group psychotherapy. Evaluation and Management codes without a psychotherapy add-on code will not be included in the

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PROGRAM SERVICES

Frequency Limits (Cont'd.)

12 mental health visit limit. Please refer to "Description of Covered Services" in this section for details. Beneficiaries under age 21 are exempt from this limitation.

Quality Improvement Organization (QIO) Authorization

SCDHHS will allow for the review and prior authorization of additional mental health visits (psychotherapy, family psychotherapy, and group psychotherapy). The beneficiary's physician must request, in writing, prior authorization through SCDHHS to override the 12 allowable mental health visits. The prior authorization request must be submitted to the SCDHHS designated Quality Improvement Organization (QIO) by faxing the DHHS Mental Health Form (in the Forms section of the manual). The signature of the physician making the request must be on the form. The prior authorization request must include sufficient clinical information to determine the need for additional mental health visits. The physician will be notified via QIO approval letter if the authorization request is approved and prior authorizations will only be indicated for a six-month period. All requests should be sent to the current QIO, Keystone Peer Review Organization, Inc. (KEPRO), using one of the following methods:

- Fax: 1-855-300-0082
- Web Portal: http://scdhhs.kepro.com

Other KEPRO contact information:

- Customer Service: 1-855-326-5219
- Provider Issues email: atrezzoissues@Kepro.com

When an emergency situation arises and there is insufficient time to obtain prior approval, the treating physician should prepare the required documentation and submit it for retrospective review. Claims requiring retrospective review are still subject to timely filing guidelines.

Coverage Guidelines

Clinical Services Covered

Covered psychiatric and psychotherapy services include the following:

- Psychiatric Diagnostic Evaluation
- Environmental Intervention for Medical Management
- Psychological Testing
- Psychotherapy
- Family Psychotherapy with patient present
- Family Psychotherapy without patient present
- Group Psychotherapy
- Psychotherapy for Crisis

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PROGRAM SERVICES

Clinical Services Covered (Cont'd.)

- Medical Evaluation and Management

These services are provided to, or directed exclusively toward, the treatment of the Medicaid-eligible beneficiary for the purpose of ameliorating disabilities, improving the beneficiary's ability to function independently, and restoring maximum functioning.

Please refer to "Description of Covered Services" in this section for appropriate codes for each covered service listed above and who is eligible to bill for these services.

Providers Qualified to Prescribe Services

Psychiatric and psychotherapy services must be prescribed by an individual listed below:

- Physician/Psychiatrist
- Psychiatric Nurse Practitioner (NP)

Providers Eligible to Bill for Services

SCDHHS will reimburse an eligible provider for covered psychiatric and psychotherapy services personally provided by the physician or NP or by an allied professional under the direct supervision of the physician/NP. Allied professionals rendering the service cannot be directly reimbursed under the Medicaid Physician Services program. All allied professionals must be under the direct supervision of the physician/NP to whom reimbursement is made. Covered services differ based on the provider providing the service.

Medicaid reimburses for medically necessary services delivered by the following allied professional under the supervision and direction of a physician or NP:

- Licensed Master Social Worker (LMSW) – A master's or doctoral degree from a social work program accredited by the Council on Social Work Education and one year of experience working with the population to be served.

All allied professionals are responsible for providing services within their scope of practice as prescribed by South Carolina State Law. Interns are not eligible to provide services to Medicaid beneficiaries and their services are non-billable.

Referral to Allied Professionals

The psychiatric diagnostic evaluation completed by the physician/NP (also referred to as the supervising clinician) shall result in a determination of the beneficiary's need for psychiatric services and/or psychotherapy services. The physician/NP must document all treatment services authorized to be provided to the beneficiary. If appropriate, the physician/NP may authorize services to be rendered by an allied professional. The physician/NP must:

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PROGRAM SERVICES

Referral to Allied Professionals (Cont'd.)

- See each beneficiary initially unless the beneficiary was accepted as a referral from another physician.
- Authorize the treatment services to be provided by the allied professional.
- Participate in patient staffing with the allied professional to document progress summaries.

If the beneficiary is referred by a non-physician (e.g., Department of Social Services, school counselor, etc.), the referral source must be documented in the chart.

When scheduling is a problem or the beneficiary's condition requires immediate treatment, a maximum of two psychotherapy visits in 14 days will be allowed by an allied professional under supervision prior to an initial psychiatric diagnostic evaluation (90791 or 90792) by the supervising clinician. The supervising clinician must then perform the initial psychiatric diagnostic evaluation before any further psychotherapy services can be provided.

In all cases, the supervising clinician must assume all professional liability for services rendered by staff under his or her supervision. In the event of a post-payment review, the supervising clinician who is reimbursed by Medicaid is responsible for all records. Credentials of allied professionals who provided services must be on file and will be part of the post-payment review. If the allied professional's credentials are not on file or do not meet the qualifications, the supervising clinician's payments will be subject to recoupment.

Supervision

Direct supervision in the physician's office, group practice, or clinic setting means that the supervising clinician must be responsible for all services rendered and be accessible at all times during the diagnosis and treatment of the beneficiary.

Services provided under direct supervision are covered only if the following conditions are met:

- The allied professional must be a part-time, full-time, or contracted employee of the supervising clinician, physician group practice, or of the legal entity that employs the supervising clinician; or the allied professional must be an independent contractor engaged by the physician/NP through a written agreement.
- The supervising clinician cannot be employed by the allied professional.

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PROGRAM SERVICES

Supervision (Cont'd.)

- The supervising clinician must be accessible to the allied professional while services are being delivered and must meet with the allied professional at a minimum of every 90 days to review beneficiary progress.
- The service must be furnished in connection with a covered physician/NP service that was billed to SCDHHS; therefore, the beneficiary must be one who has been seen by the physician/NP.

A psychiatric diagnostic evaluation has to be performed by the supervising clinician.

The allied professional providing psychotherapy personally works with the beneficiary to develop the Individualized Plan of Care (IPOC) and the supervising clinician meets with the beneficiary periodically during the course of treatment to monitor the service being delivered and to review the need for continued services. There must be subsequent services by the supervising clinician of a frequency that reflects his/her continued participation in the management of the course of treatment. The supervising clinician assumes professional responsibility and liability for all services provided by allied professionals.

The supervising clinician must spend as much time as necessary directly supervising the services to ensure that patients are receiving services in a safe and efficient manner in accordance with accepted standards of practice. The supervising clinician must meet with the allied professional and document the monitoring of performance, consultation, guidance and education at a minimum of every 90 days to ensure the delivery of medically necessary services.

A supervising clinician is limited to supervising no more than three allied professionals who meet the qualifications to render psychotherapy services. Prior to services being rendered by allied professionals, the names and credentials of the three allied professionals being supervised must be submitted to:

SCDHHS
Division of Behavioral Health
Post Office Box 8206
Columbia, SC 29202-8206
Fax: 803-255-8204

This information must be updated as necessary or at least every 12 months. To satisfy this requirement, complete and return a copy of the Allied Professional Supervision Form found in the Forms section of this manual. Additionally, the credentials of the allied professionals must be maintained on file at the office where services are being provided.

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Individualized Plan of Care (IPOC)

If it is determined through the psychiatric diagnostic evaluation that a beneficiary needs psychotherapy services and a referral is made to an allied professional OR psychotherapy services will be provided by the physician/NP, an Individualized Plan of Care (IPOC) is required within 45 days of the date of the initial psychiatric diagnostic evaluation. The IPOC is an individualized, comprehensive treatment plan, which is based on the assessment and is created in partnership with the beneficiary and/or legally responsible person, except in the case of an emergency. The IPOC is designed to improve and/or stabilize the beneficiary's condition and should encompass all treatment goals and objectives.

The following services are not required to be listed on the IPOC:

- Psychiatric Diagnostic Evaluation
- Psychotherapy for Crisis
- Environmental Intervention
- Evaluation and Management
- Psychological Testing

Services not outlined in the treatment plan, other than those listed above, are non-billable and subject to recoupment. The allied professional providing psychotherapy services under the supervision of a physician/NP may develop the IPOC, but the IPOC must be signed by both the allied professional and the supervising clinician when psychotherapy is being provided by an allied professional.

The IPOC provides the overall direction for the treatment of the beneficiary and must include the following elements:

- Individualized treatment goals developed in conjunction with the beneficiary and/or family.
- Specific interventions and strategies that will be used to meet goals.
- Outcomes that are anticipated to be achieved by provision of the service and projected date of achievement.
- A projected schedule for service delivery, including the expected frequency and duration of each treatment method.
- The beneficiary and/or legally responsible person must sign the IPOC indicating that they were involved in the planning process and were offered a copy of the IPOC. If the beneficiary does not sign the IPOC, the reason must be documented in the clinical record.

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PROGRAM SERVICES

Individualized Plan of Care (IPOC) (Cont'd.)

- The physician/NP's signature is required on the IPOC to confirm the diagnosis, medical necessity of the treatment, and the appropriateness of care.

The original IPOC supervising clinician's signature date stands as the date to be used for all subsequent progress summaries, reviews, and reformulations. Each page of the IPOC must be signed, titled and signature dated by the supervising clinician. Services added or frequencies of services changed in an existing IPOC must be signed and dated by the supervising clinician. An updated copy must be provided to the beneficiary. The IPOC must be filed in the beneficiary's clinical record with any supporting clinical documentation.

Progress Summary

A progress summary is a periodic evaluation and review of the beneficiary's progress toward the treatment goals, the appropriateness of the services being provided, and the need for the beneficiary's continued participation in treatment. If psychotherapy services are being provided by an allied professional, the supervising clinician and allied professional must meet to review the beneficiary's participation in all services every 90 days with completion during the calendar month in which it is due. Reviews may be conducted more frequently if the nature of needed services changes or if there is a change in the beneficiary's condition or status as determined by the physician/NP.

Progress summaries shall be documented in detail in the beneficiary's record and include:

- The beneficiary's progress towards treatment goals
- The appropriateness of the services provided and their frequency
- The need for continued treatment
- Recommendations for continued services
- The signature and title of the supervising clinician and allied professional

If it is determined during the progress summary that the IPOC needs to be modified, then an updated IPOC also must be developed.

IPOC Reformulation

The maximum duration of an IPOC is 12 months (365 days) from the date of the signature of the supervising clinician. The allied professional must evaluate with the beneficiary his/her progress in reference to each of the treatment goals and desired outcomes. Based on the progress of the beneficiary, the IPOC should be reformulated annually to include updated treatment goals and outcomes. The signature of the supervising clinician is required on the reformulated IPOC.

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Clinical Records

Providers must maintain a clinical record for each Medicaid eligible beneficiary receiving services that fully describes the extent of the treatment services provided. The clinical record must contain sufficient medical documentation to justify medical necessity for the level of service reimbursed and clearly specify the course of treatment. The absence of appropriate and complete records may result in recoupment of previous payments by SCDHHS. Each beneficiary's clinical record must contain the following documentation:

- Full demographic information, including beneficiary's full name, contact information, date of birth, race, gender, and admission date
- Consent forms, pertinent medical history, assessments and instructions to the beneficiary
- All physician's orders, reports of treatments and medications, and other pertinent information necessary to monitor the beneficiary's progress
- Reports of physical examinations, diagnostic and laboratory results, and consultative findings
- Documentation of communication regarding coordination of care activities
- The beneficiary's name on each page generated by the provider
- The beneficiary's Medicaid number on all clinical documentation and billing records

Clinical Service Notes

All psychiatric and psychotherapy services must be documented in a clinical service note (CSN) upon the delivery of services. The purpose of the CSN is to record the nature of the beneficiary's treatment, any changes in treatment, discharge, crisis interventions and any changes in medical, behavioral or psychiatric status. The CSN must include:

- Date of service
- Name of the service provided
- Place of service
- Purpose of the contact (for psychotherapy notes, this must be tied back to the IPOC treatment goals)
- Description of treatment or interventions performed
- Effectiveness of the intervention(s) and the beneficiary's response or progress

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PROGRAM SERVICES

Clinical Service Notes (Cont'd.)

- Duration of the service (start and end time for each service delivered)
- Signature, title, and signature date of the person responsible for the provision of services and supervising clinician, if appropriate

CSNs must be completed and placed in the clinical record within 10 business days from the date of rendering the service.

Error Correction

Medical records are legal documents. Providers must be extremely cautious in making alterations to records. In the event that errors are made, adhere to the following guidelines:

- Draw one line through the error and write "error", "ER", "Mistaken Entry", or "ME" to the side of the error in parenthesis. Enter the correction, sign or initial and date it.
- Errors cannot be totally marked through. The information in error must remain legible.
- No correction fluid may be used.

Late Entries

Late entries may be necessary at times to handle omissions in the documentation. Late entries should be rarely used and then only used to correct a genuine error of omission or to add new information that was not discovered until a later date. Whenever late entries are made, adhere to the following guidelines:

- Identify the new entry as "late entry"
- Enter the current date and time
- Identify or refer to the date and incident for which the late entry is written
- If the late entry is used to document an omission, validate the source of additional information as much as possible
- When using late entries, document as soon as possible

Transition/Discharge

The supervising clinician is responsible for determining the duration of treatment based on the individual needs of the beneficiary. The allied professional involved in the delivery of services to the beneficiary may gather and/or give information to assist with this process. Beneficiaries should be discharged from treatment when they meet one of the following criteria:

- Level of functioning has significantly improved with respect to goals outlined in treatment plan

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Transition/Discharge (Cont'd.)

- All treatment goals have been achieved
- Beneficiary has developed skills and resources needed to transition to a lower level of care
- Beneficiary requests discharge (and is not imminently dangerous to self or others)
- Beneficiary requires a higher level of care (*e.g.*, inpatient hospitalization or PRTF)

Description of Covered Services

Psychiatric Diagnostic Evaluation

Psychiatric diagnostic evaluation is an integrated biopsychosocial assessment, including history, mental status, and recommendations. The evaluation may include communication with family or other sources and review and ordering of diagnostic studies.

Psychiatric diagnostic evaluation with medical services is an integrated biopsychosocial and medical assessment, including history, mental status, other physical examination elements as indicated, and recommendations. The evaluation may include communication with family or other sources, prescription of medications, and review and ordering of laboratory or other diagnostic studies.

90791 – Psychiatric Diagnostic Evaluation

90792 – Psychiatric Diagnostic Evaluation with Medical Services

These codes may be reported once every six months and not on the same day as an Evaluation and Management Service performed by the same individual for the same beneficiary.

Note: These codes are included in the ambulatory visit limit.

Eligible to bill: Physician/Psychiatrist

Psychiatric Nurse Practitioner

Psychological Testing

Psychological testing includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology (*e.g.*, MMPI, Rorschach, WAIS) per hour of the physician's time, both face-to-face time administering tests to the beneficiary and time interpreting these test results and preparing the report.

96101 – Psychological Testing

96130 – Psychological testing evaluation services by physician or other qualified health care professional, including

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Psychological Testing (Cont'd.)

integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour

96131 – Each additional hour (List separately in addition to code for primary procedure)

These procedures are reimbursed per hour, not per test. Report time as face-to-face time with patient and the time spent interpreting and preparing the report. Only three hours are allowable per day with a maximum limit of 12 hours in one year.

Note: These codes are not included in the mental health visit limit.

Eligible to bill: Physician/Psychiatrist

Psychiatric Nurse Practitioner

Environmental Intervention for Medical Management

Environmental intervention for medical management purposes on a psychiatric patient's behalf, including coordination of services. This code can be billed when the supervising clinician meets with an allied professional to coordinate services, discusses treatment issues, and review the treatment plan for a beneficiary and must be clearly documented in the progress summary and signed by the supervising clinician. This code cannot be billed each time the clinician signs the chart only. One progress summary is required every 90 days. Medicaid will reimburse only the supervising clinician for this service.

90882 – Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions

This procedure is reimbursed in 30-minute increments (units), not to exceed an hour and a half per day. The supervising clinician, when coordinating services with allied professionals, may bill one unit of this code.

Note: This code is not included in the mental health visit limit.

Eligible to bill: Physician/Psychiatrist

Psychiatric Nurse Practitioner

Psychotherapy

Psychotherapy is the treatment of mental illness and behavioral disturbances in which the physician or other qualified healthcare professional, through definitive therapeutic communication, addresses the emotional disturbance, reverses or changes maladaptive patterns of behavior, and encourages personality growth and development.

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PROGRAM SERVICES

Psychotherapy (Cont'd.)

Psychotherapy times are for face-to-face services with beneficiary and/or family member. The beneficiary must be present for all or some of the service.

90832 – Psychotherapy, 30 minutes

90834 – Psychotherapy, 45 minutes

90837 – Psychotherapy, 60 minutes

One session, regardless of time, is allowed per day within this range of codes. If this service is being billed, an IPOC must have been completed for the beneficiary.

Note: These codes are included in the mental health visit limit.

Eligible to bill: Physician/Psychiatrist

Psychiatric Nurse Practitioner

LMSW – with HO Modifier

Psychotherapy with Medical Evaluation and Management Services

Some psychiatric patients receive a medical evaluation and management (E/M) service on the same day as a psychotherapy service by the same physician/NP. To report both E/M and psychotherapy, the two services must be significant and separately identifiable. Please refer to the current CPT for further instruction. These services are reported by using the following codes specific for psychotherapy when performed with E/M Services as add-on codes to the E/M service:

90833 – Psychotherapy, 30 minutes

90836 – Psychotherapy, 45 minutes

90838 – Psychotherapy, 60 minutes

One session, regardless of time, is allowed per day within this range of codes. If this service is being billed, an IPOC must have been completed for the beneficiary.

Note: These codes are included in the mental health visit limit.

Eligible to bill: Physician/Psychiatrist

Psychiatric Nurse Practitioner

Family Psychotherapy

Family psychotherapy is a face-to-face intervention with family members of the beneficiary with the purpose of treating the beneficiary's condition and improving the interaction between the beneficiary and family member(s) so that the beneficiary may be restored to their best possible functional level. Family Psychotherapy may be rendered with or without the beneficiary to family members of

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PROGRAM SERVICES

Family Psychotherapy (Cont'd.)

the identified beneficiary as long as the identified beneficiary is the focus of the sessions. The identified beneficiary is the family member with the symptom that has brought the family into treatment. Only issues pertinent to the identified beneficiary may be addressed under this service.

90847 – Family Psychotherapy including patient, 50 minutes

90846 – Family Psychotherapy, 50 minutes

One session, regardless of time, is allowed per day within this range of codes. If this service is being billed, an IPOC must have been completed for the beneficiary.

Note: These codes are included in the mental health visit limit.

Eligible to bill: Physician/Psychiatrist

Psychiatric Nurse Practitioner

LMSW – with HO Modifier

Group Psychotherapy

Group psychotherapy is a face-to-face intervention with a group of beneficiaries who are addressing similar issues with the purpose of restoring the beneficiary to his/her best possible functional level. Therapy is conducted in small groups. The group must be a part of an active treatment plan and the goals of group therapy must match the overall treatment plan for the individual beneficiary. The focus of the therapy sessions must not be exclusively educational or supportive in nature. Groups must consist of one professional and no more than eight beneficiaries.

90853 – Group Psychotherapy – other than of a multiple-family group

This code is covered for eligible beneficiaries in a group, even when the whole group is not Medicaid eligible. Medicaid will reimburse a clinician for one group session per day per Medicaid-eligible beneficiary. If this service is being billed, an IPOC must have been completed for the beneficiary.

Note: This code is included in the mental health visit limit.

Eligible to bill: Physician/Psychiatrist

Psychiatric Nurse Practitioner

LMSW – with HO Modifier

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PROGRAM SERVICES

Psychotherapy for Crisis

Psychotherapy for Crisis is an urgent assessment and history of a crisis state, a mental status exam, and a disposition. The treatment includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma. The presenting problem is typically life threatening or complex and requires immediate attention to a beneficiary in high distress.

90839 – Psychotherapy for crisis, first 60 minutes – This code is used to report the first 30-74 minutes of psychotherapy for crisis on a given date. It should be used only once per date even if the time spent by the physician or other qualified health care professional is not continuous on that date. The beneficiary must be present for all or some of the service.

90840 – This code is used in conjunction with 90839 to report each additional 30 minutes of crisis for psychotherapy.

Note: These codes do not count toward the mental health visit limit.

Eligible to bill: Physician/Psychiatrist

Psychiatric Nurse Practitioner

LMSW – with HO Modifier

Medical Evaluation and Management Services

Some psychiatry services may be reported with Medical Evaluation and Management (E/M) Services or other services when performed. Evaluation and Management Services may be reported for treatment of psychiatric conditions, rather than using Psychiatry Services codes, when appropriate. Please refer to the current CPT as E/M codes are classified by type of service, place of service, and the patient's status.

Eligible to bill: Physician/Psychiatrist

Psychiatric Nurse Practitioner

Interactive Complexity

Interactive Complexity refers to specific communication factors that complicate the delivery of a psychiatric procedure. Please refer to the current CPT for complete definition. Code 90785 is an add-on code for interactive complexity to be reported in conjunction with codes for diagnostic psychiatric evaluation, psychotherapy, psychotherapy when performed with an evaluation and management service, and group psychotherapy.

Note: This code does not count toward the mental health visit limit.

Eligible to bill: Physician/Psychiatrist

Psychiatric Nurse Practitioner

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Additional Billable Codes

Additional codes that may be billed by a physician specializing in psychiatric care are 90870 and 90887.

Non-Covered Psychiatric Services

The following CPT codes are non-compensable:

90845 – Psychoanalysis

90849 – Multiple-family group psychotherapy

90865 – Narcosynthesis for psychiatric diagnostic and therapeutic purposes (*e.g.*, sodium amobarbital [amytal] interview)

90875 – Individual psychophysiological therapy incorporating biofeedback training with psychotherapy, 30 minutes

90876 – Individual psychophysiological therapy incorporating biofeedback training with psychotherapy, 45 minutes

90880 – Hypnotherapy

Psychotherapy services are non-covered in an inpatient setting when reimbursement of this service is included in the hospital reimbursement.

Pediatric Sub-Specialist Program

SCDHHS will reimburse an enhanced rate to certain pediatric sub-specialists that meet the enrollment requirements. Please refer to "The Pediatric Sub-Specialist Program" under "Special Coverage Groups" in this section for full eligibility criteria to participate in this program.

Inpatient Admissions

SCDHHS will require Prior Authorization for all acute (general hospital) inpatient admissions. KEPRO, the Medicaid Quality Improvement Organization (QIO), will perform the review and will accept prior authorization review requests via

- Fax: 1-855-300-0082
- Web Portal: http://scdhhs.kepro.com

KEPRO nurse reviewers will screen the medical information provided using InterQual criteria. It is the responsibility of the attending physician to submit the Request for Prior Approval Review form and all current medical documents that support the medical necessity of the admission to KEPRO. If criteria are met, the admission will be approved and an authorization number assigned and faxed to the requesting provider.

For emergent or urgent admissions, providers must contact KEPRO for authorization within 24 hours of the date of the admission.

For admission to Psychiatric Residential Treatment Facilities (PRTF's) or Inpatient Psychiatric Hospitals for beneficiaries under age 21, please refer to the Psychiatric Hospital Services Provider Manual.

Note: Inpatient services are excluded from the mental health visit limit.

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PROGRAM SERVICES

NEPHROLOGY AND END STAGE RENAL DISEASE (ESRD) SERVICES

The following guidelines define policy and procedures as they relate to patient services and providers involved in End Stage Renal Disease treatments

Medicare/Medicaid – Dual Eligibility

Medicare is the primary sponsor for ESRD services. Medicaid reimburses based on the fee schedule for dually eligible beneficiaries. Fee schedules are located on the SCDHHS website at http://www.scdhhs.gov.

Medicaid reimburses as primary sponsor for the initial 90-day waiting period required for Medicare coverage. Providers must notify their program manager immediately if Medicare coverage is denied after the 90-day waiting period at PSC at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us.

Medicaid will not reimburse for ESRD services after the initial 90-day waiting period if the Medicare determination is still pending. The claims will reject for a 960 edit code. If Medicare denies coverage, Medicaid will then reimburse for these services. Providers must submit new claim with edit code 960 and the Medicare denial letter attached, to the following address:

Medicaid Claims Receipt
Post Office Box 1412
Columbia, SC 29202-1412

Medicaid will not reimburse as primary sponsor for any Medicare covered services until a denial of eligibility from the Social Security Administration is received. Medicare does not require the 90-day waiting period for individuals who are candidates for a renal transplant or for those on home dialysis.

Claims submitted to Medicaid prior to the patient being enrolled with Medicaid as an ESRD patient will be rejected for edit code 957. All patient ESRD enrollment forms must be submitted to Medicaid concurrently with the initial course of treatment and application to Social Security for Medicare coverage.

Medicaid Only – Reimbursement Guidelines

CPT Codes 90935 – 90999: Physician-related Dialysis Procedures

In Center Dialysis – Medicaid reimburses the nephrologist or other supervising internist an all-inclusive monthly fee for the supervision of ESRD services. These services are defined as monthly supervision of medical care, dietetic services, social services, and procedures directly related to the physician's role in the treatment of end stage renal disease.

If billing for a complete month of treatment supervision, the monthly code should be used. The date of service should be the last date in the

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Medicaid Only – Reimbursement Guidelines (Cont'd.)

month and the "days" unit block should be a "one," indicating one full month of supervision.

The monthly ESRD code includes all services rendered to the patient for all days of the month. Office visits should not be billed in addition to the monthly supervision. Special procedures may be billed separately (*e.g.*, shunt revision, cannula declotting).

If the patient is hospitalized, or for some reason did not have a full month of in-center treatments, the partial month procedure code should be used with the appropriate number of days of supervision in the days/unit column on the CMS-1500 claim form and the appropriate "to" and "from" dates of service.

Inpatient Dialysis – If an ESRD patient is hospitalized, the hospitalization may or may not be due to a renal-related condition. In either case, the patient must continue dialysis.

Inpatient dialysis usually requires more intense physician involvement for a prolonged period and/or multiple visits. Physicians will be reimbursed for inpatient dialysis services to either acute renal failure (ARF) or ESRD patients on a fee-for-service basis. These services should be charged with the CPT codes 90935 – 90947. Guidelines are the same for inpatient dialysis whether the patient is ARF or ESRD.

Complications or hospitalization for reasons not related to dialysis or the treatment of dialysis may be charged separately. However, when dialysis codes are charged, hospital visits may not be charged for the same date of service.

Visits may be charged on alternate dialysis days when applicable. Special procedures (*e.g.*, an EKG) may be charged when clearly justified as a service outside of the normal dialysis management.

For inpatient dialysis, services Medicaid will apply the same rules as it does for all reasonable charge determinations. The services must meet the following criteria:

- They must be covered physician services.
- They must be medically necessary.
- They must be personally furnished by the physician.
- They must be within the requirements under Part B Medicare.

Home Dialysis – Medicare is the primary sponsor for patients receiving home dialysis services and Medicaid, if available, is the secondary sponsor of coinsurance and deductibles. The Social Security Administration does not require a delayed period for home services, and Medicare will reimburse from the initial course of treatment.

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Medicaid Only – Reimbursement Guidelines (Cont'd.)

In this case, Medicaid will not reimburse for home treatments during the first ninety days of services as primary sponsor, but will pay coinsurance and deductibles.

In certain instances where Medicaid is the primary sponsor, the physician supervising the home dialysis patient should adhere to policies for in-center supervision. Reimbursement will be per full month of supervision, or per day for partial months. The monthly supervision fee includes all the services outlined for the alternate method of reimbursement. A home training supervision fee is allowed for the first month of home dialysis in addition to the regular monthly fee for treatment supervision.

Dialysis Training – Dialysis training is a covered service for ESRD patients. The initial completed course (90989) and per training session (90993) should be billed for training services for any mode (self, peritoneal, or hemodialysis). The initial course is allowed only once in a lifetime. Training services for self-dialysis performed after the initial course is completed (retraining) are compensable on a per day basis, and under the following Medicare guidelines:

- The patient changes from one mode of dialysis to another.
- The patient's home dialysis equipment changes.
- The patient's dialysis setting changes.
- The patient's dialysis partner changes.
- The patient's medical condition changes (the patient must continue to be an appropriate patient for self-dialysis).

Home support services (*e.g.*, reviewing the patient's technique and instructing him or her in any corrections) are not compensable as training services. Support services are included in the monthly or partial month ESRD supervision fees.

OPHTHALMOLOGY AND OPTOMETRY

South Carolina Department of Health and Human Services (SCDHHS) recognizes parity between ophthalmologists and optometrists as defined by state law with respect to reimbursement. Covered services for optometrists are based on SCDHHS policy and the South Carolina Labor and Licensing Board of Examiners in Optometry. For purposes of this policy under the age of 21 represents all children from birth up to but not including their 21st birthday. An adult is defined as an individual 21 years and older.

Routine vision services for beneficiaries 21 and over are non-covered services. Routine vision services are defined as services related to refractive care: routine eye exams, refractions, corrective lenses, and

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Ophthalmology and Optometry (Cont'd.)

glasses. Services related to disease of the eye are covered for an example glaucoma, conjunctivitis and cataracts.

Providers are responsible for billing codes that are within the scope of practice as defined by South Carolina Department of Labor and Licensing Regulatory Authority. When reporting services provided in an office, home, hospital, or an institutional facility that are not specific ophthalmology codes providers must utilize evaluation and management codes (E&M) listed in the American Medical Association Current Procedural Terminology manual (CPT). Providers are responsible for all National Correct Coding Initiative (NCCI) rules and regulations.

If an E&M code is used for treatment of a disease, it **cannot** be used in conjunction with a comprehensive exam code for treatment on the same date of service (as defined by NCCI). The provider must bill either the E&M code or the comprehensive exam code. Providers must refer to the CPT manual to determine which E&M code is the most appropriate when using 99000 series codes. The patients' record must reflect the level of service performed and must be well documented in the patients' chart. All services billed are subject to a Program Integrity review. During post-payment reviews (audits), auditors will monitor these codes closely to ensure that the code reflects the service billed and best meets the description reflected in the documentation. The use of E&M codes will count toward the 12 maximum visits allowed for all patients over the age of 21, for the fiscal year. The fiscal year begins July 1st of every year and ends June 30th of every year.

Part I – Vision Care Services

Vision care services are defined as those that are medically necessary for the diagnosis and treatment of conditions of the eye. Refractive care is defined as the exam and treatment of visual states such as, but not limited to, the correction of amblyopia, presbyopia and for all services that can be corrected by the provision of corrective lenses. Referrals from local DSS offices or staff, schools, and patient's actual complaints of visual acuity constitute justification to provide eye exams and other refractive services for children under the age of 21. Providers should note these referrals and complaints in the patients' medical records.

Exam and Glasses for Birth to age 21

For the treatment of children under the age of 21, one complete comprehensive eye exam is covered within a 365-day period (12 consecutive months).

A complete set of glasses is provided every 365 days when medically necessary.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Exam and Glasses for Birth to age 21 (Cont'd.)

Repair and Replacement

Eyeglasses must be repaired without additional reimbursement when the repair or replacement of eyeglass parts is required due to defects in quality of materials or workmanship. Reimbursement is available for repair or replacement of eyeglass parts in situations where the damage is the result of causes other than defective materials or workmanship. Replacement parts should duplicate the original prescription and frame style. Repairs to frames may be rendered as necessary.

Providers should use the appropriate procedure code for the repair or replacement of component parts of eyeglasses. When a component part of eyeglasses is replaced, the modifier "U8" should be affixed to the procedure code (V2020) for the component part that is being replaced. The reason for the repair or replacement of parts must be documented in the recipients' records.

Replacement of a Complete Pair of Eyeglasses

Reimbursement is available for one complete pair of replacement eyeglasses that has been lost or destroyed within twelve consecutive months. The replacement for a complete pair of eyeglasses should duplicate the original prescription and frames. The modifier "U9" is affixed to those procedure codes (V2020 and/or V2025) identifying fitting of eyeglasses and materials when claiming replacement of a complete pair of eyeglasses that has been lost or destroyed**.** An explanation of the circumstances surrounding replacement of the complete pair of eyeglasses must be maintained in the enrollee's record.

If a beneficiary has surgery or prescriptive change with a minimum of one-half diopter (0.50) during a 12 consecutive months, **only** replacement lenses (not frames) will be covered. Providers must document medical necessity in the patient's medical record.

Contact lenses are allowed when prescriptive glasses are medically unsuitable. Documentation must indicate the medical necessity for contact lenses over glasses.

Non-Covered Services

The following services are non-covered under the Vision Care program:

- Routine eye exams for beneficiaries beginning on their 21st birthday and older
- Refractions for beneficiaries beginning on their 21st birthday
- Lenses and frames for beneficiaries beginning on their 21st birthday
- Optometric hypnosis

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Non-Covered Services (Cont'd.)

- Broken appointments
- Special reports
- Extended wear contact lenses, cosmetic lenses, tinted, and/or colored contacts
- Transitional and progressive lenses

Guidelines for Lenses and Frames

Fabrication of eyeglasses shall conform to the current American National Standards Institute (ANSI) prescription requirements; and all lenses, frames and frame parts must be guaranteed against defects in manufacture and assembly. The provider who receives reimbursement for dispensing the eyeglasses has the final responsibility for this guarantee.

When adjustments to eyeglasses are required, the adjustment must be made without additional reimbursement whenever the enrollee returns to the original dispenser.

If the enrollee selects frames or lenses that are not Medicaid reimbursable, the enrollee must be informed prior to the fabrication of the eyeglasses that he/she will be financially responsible. In such cases, Medicaid may **not** be billed for all or part of the cost of said frames or lenses.

Lenses

All lenses for children under the age of 21 are to be first quality impact resistant lenses meeting FDA regulations, free of surface imperfections such as pits, scratches or grayness. The lenses should not contain bubbles, striations, or other surface abrasions.

Special Types of Lenses

Polycarbonate Lenses

All lenses provided to beneficiaries up to the age of 21, must be polycarbonate lenses and billed with the appropriate HCPCS vision code. Non-polycarbonate lenses are non-covered by SCDHHS.

High Index Lenses

A 10 diopters (10DS) or greater lens is reimbursable at acquisition cost that is documented by an itemized invoice when such cost is greater than the fee listed for the lens code in the fee schedule. The fee schedule can be found on the SCDHHS website http://www.scdhhs.gov/.

Frames

Frames supplied are to be first quality frames. All frames must have eye size, bridge size, temple length and manufacturer's name or trademark imprinted on them.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Guidelines for Lenses and Frames (Cont'd.)

If the enrollee returns to the original dispenser to obtain the service, future fittings must be made by that dispenser without additional reimbursement.

V2020 – Frame Complete – $50.00

V2025 – Deluxe Frame – $65.00

Guidelines for Contact Lenses

Daily wear contact lenses will be covered for beneficiaries under the age of 21, if medical necessity has been established and prescription glasses are not suitable for the beneficiary. Daily wear contact lenses will be supplied in monthly increments. **Contact lens procedure codes are per lens and the correct number of units should be indicated in the "units" column of the claim form/electronic record.**

Providers must file for payment using the examination date as the date of service. Use CPT procedure codes for the fitting and dispensing of contact lens. These codes include the contact lens fitting, all follow-up visits, solutions, and supplies. This reimbursement does not include the initial eye examination.

Special Requests

If the covered contacts do not meet the needs of the patient, providers can contact the PSC at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us before dispensing the contacts. Special requests will require medical justification prior to dispensing. The PSC will forward all requests to the Division of Health and Medical Services, which will review the requests and contact the provider with a decision. Health and Medical Services are responsible for all reviews and exceptions.

Procedure Codes for the Contact Lens Products

Procedure codes for contact lens products are as follows:

V2500 – Contact lens, PMMA, spherical, per lens

V2501 – Contact lens, PMMA, toric or prism ballast, per lens

V2510 – Contact lens, gas permeable, spherical, per lens

V2511 – Contact lens, gas permeable, toric, and prism ballast per lens, or a high plus or minus gas permeable post cataract, per lens

V2520 – Contact lens, hydrophilic, spherical, per lens

V2521 – Contact lens, hydrophilic, toric or prism ballast, per lens

V2755 – UV lens, per lens

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Procedure Codes for the Contact Lens Products (Cont'd.)

V2599 – Contact lens, other type. (Providers must contact and send documentation via the PSC. The PSC will forward the documentation to the Division of Health and Medical Services.

Dispensing Codes for Contact Lenses and Glasses

The following dispensing codes and fees for contacts and glasses may be used when applicable for the services to be rendered.

92310 – Prescription of optical and physical characteristics of the fitting of contact lenses, with medical supervision of adaptation; corneal lenses. **The dispensing procedure is bilateral and the fee listed is for both eyes.**

92311 – Prescription of a corneal lens for aphakia. **The dispensing procedure is unilateral and the fee listed is for one eye.**

92312 – Prescription of corneal lenses for aphakia. **The dispensing procedure is bilateral and the fee listed is for both eyes.**

92313 – Prescription of a corneoscleral (large lens). **The dispensing procedure is unilateral and the fee listed is for one eye.**

92340 – Fitting of spectacles, except for aphakia. **This code should only be filed when the glasses are physically received at the physician's office for the dispensing of glasses. The date of service when filing this procedure should always be the date the eye exam was performed.**

92370 – **Repair and refitting of spectacles; except for aphakia.**

Optician

Effective January 1, 2014, SCDHHS will no longer have a single source provider for eyewear. Beneficiaries will have the option to choose a provider for eyewear needs.

Providers should show eligible recipients the complete selection of Medicaid-reimbursable frames and explain that Medicaid pays **only** for frames that falls within the reimbursement limit.

Providers must have a selection of nickel-free frames for beneficiaries that have allergies to nickel. Providers must have a selection of oversized frames or special needs frames for children readily available as an option in the frame selection.

V2020 – Frame Complete – $50.00

V2025 – Deluxe Frame – $65.00

Providers must file for payment using the examination date as the date of service. Reimbursement for eyewear does not include the initial eye examination. All records and medical justification must be documented and located in the patient's charts for auditing purposes.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Optician (Cont'd.)

Prescription requests must be written in language common to all health care practitioners providing vision care in the United States. Criteria for the prescription requests include, but are not limited to, the following:

- Unaided visual acuity at distance and near should be 20/30 or less. Aided and unaided visual acuities must be stated in the patient's records.
- Corrective lenses must be at least plus or minus 0.50 sphere or more, or plus or minus 0.50 cylinder or more in each eye; or 0.75 in one eye.
- Vertical and horizontal prisms will be authorized if medically necessary. The prescription must be remedial and not training -by nature.
- Replacement of lenses requires medical justification.

Self-Employed Optometrist

Reimbursement is provided for the following materials and services in accordance with the fee schedule:

- Complete optometric eye examination
- Office-based evaluation and management services, consultations, diagnostic examinations, and non-invasive procedures for the diagnosis and treatment of diseases of the eye and the prescribing of pharmaceutical agents authorized under State Law
- Eyeglass lenses
- Contact lenses
- Repairs and refitting of eyeglasses
- Fitting of eyeglasses

Retail Optical Establishments and Ophthalmic Dispensers

Reimbursement is provided for the following materials and services in accordance with the fee schedule:

- Complete optometric eye examination (limited to retail optical establishments and ophthalmic dispensers who employ an optometrist)
- Office-based evaluation and management services, consultations, diagnostic examinations, and non-invasive procedures for the diagnosis and treatment of diseases of the eye and the prescribing of pharmaceutical agents authorized under state law (limited to retail optical establishments and ophthalmic dispensers who employ and optometrist)

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Optician (Cont'd.)

- Eyeglass lenses
- Contact lenses
- Repairs and refitting of eyeglasses
- Fitting of eyeglasses

The fee schedule for vision services is located on the SCDHHS website at http://www.scdhhs.gov/.

Part II - Diagnostic Ophthalmology Services

Diagnostic services included in the CPT coding range 92018-92287 are compensable as separate procedures if performed as a distinct and individual service and not included in the ophthalmological or E/M exam, with the following restrictions:

Covered Services

Refractions – The determination of the refractive state is allowed as a separate procedure in addition to the ophthalmology exam.

Ophthalmoscopy – Routine ophthalmoscopy (direct or indirect) is a part of general and specific ophthalmologic services, whenever indicated. It is not reported separately. Ophthalmoscopy, extended (92225, 92226), with retinal drawing, as for retinal detachment, melanoma, with interpretation and report, may be billed in addition to an ophthalmological exam or an E/M services procedure code. If medically necessary, this code may be billed one time per eye per date of service.

Visual Field Examination – This exam is compensable when medically indicated as separate from the ophthalmological or E/M exam.

Vision Therapy – The following procedures are allowed for vision therapy services only:

95999 – Unlisted neurological or neuromuscular diagnostic procedure (Support documentation of therapy service must be attached to the claim.)

96110 – Developmental testing; limited (e.g., Developmental Screening Test II, Early Language Milestone Screen) with interpretation and report

96112 – Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour

96113 – Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Covered Services (Cont'd.)

developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; each additional 30 minutes (List separately in addition to code for primary procedure)

96116 – Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour

Note: If an eye examination indicates a need for corrective lenses, the examining provider performing the comprehensive exam must complete the course of treatment.

This includes the eye examination and written prescription (Rx) for ordering the glasses for the Medicaid beneficiary.

Non-Covered Services

Glare Testing: This is considered non-standardized and has not been proven effective in the diagnosis of visual disabilities. Therefore, no separate reimbursement is allowed for this procedure.

Schirmer Test: This is considered an integral part of the ophthalmological or E/M exam. Separate reimbursement for this test is not allowed.

Orthotic or Pleoptic Training: Non-covered

Color Vision Examination: Non-covered

Dark Adaptation Examination: Non-covered

Radial Keratotomy: Non-covered

Vision Screenings: Non-covered for those individuals age 21 or over

Part III - Ocular Surgery

Post-Operative Management of Cataract Surgery: South Carolina Medicaid allows optometrists to bill for post-operative management only for the following CPT procedure codes: 66821, 66825, 66983, 66984, and 66985. These are global codes and cover both the surgical care and post-operative management.

In order for an optometrist to bill and be reimbursed for post-operative management, optometrists must bill the above referenced codes using modifier 55 only. Ophthalmologists must bill the above referenced codes with modifier 54, surgical care only. If the ophthalmologist does not bill using a modifier, the provider will be reimbursed for the entire global fee, which includes both surgical care and post-operative management.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Part III - Ocular Surgery (Cont'd.)

Ocular Prosthesis – The prescription and fitting of ocular prostheses are covered for all eligible beneficiaries. The molding and manufacturing of the actual prosthesis is through our Agent, Medical University of South Carolina (MUSC) Maxillofacial Prosthodontic Clinic. Providers must contact MUSC Maxillofacial Prosthodontic Clinic at:

Phone Number: (843) 876-1001

Facsimile Number: (843) 876-1098

Providers are responsible for forwarding all medically necessary documentation to our Agent in order for services to be rendered.

Intraocular Lenses: Physicians who supply these lenses may bill using the codes listed below. The codes are for the supply of lenses and should be billed in addition to the surgical procedure.

V2630 – Anterior chamber angle fixation lens

V2632 – Posterior chamber lens

Ptosis: Lid correction procedures are covered only when there is documented medical necessity for the improvement of visual disabilities. Services must be preauthorized by KEPRO, the Quality Improvement Organization (QIO) contractor, for utilization review.

Note: Simple blepharoplasty is considered a cosmetic procedure and therefore non-compensable.

Keratoplasty: Corneal transplants are compensable. Physician reimbursement includes only the surgery. Reimbursement to the hospital includes all technical services including donor preparation.

Special Ophthalmological Services

The following medical ophthalmology codes may be billed separately from an ophthalmology exam or an evaluation and management services code. These codes may be billed one time per eye per date of service when medically necessary.

92225 – Ophthalmoscopy, extended, with retinal drawing, as for retinal detachment, melanoma with interpretation and report; initial

92226 – Ophthalmoscopy, extended; subsequent

92230 – Fluorescein angioscopy with interpretation and report

92235 – Fluorescein angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral

92240 – Indocyanine-green angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Special Ophthalmological Services (Cont'd.)

92260 – Ophthalmodynamometry

92270 – Electro-oculography with interpretation and report

92273 – Electroretinography (ERG), with interpretation and report; full field (ie, ffERG, flash ERG, Ganzfeld ERG)

92274 – Electroretinography (ERG), with interpretation and report; multifocal (mfERG)

92285 – External ocular photography with interpretation and report for documentation of medical progress

92286 – Special anterior segment photography with interpretation and report; with specular endothelial microscopy and cell count

92287 – Special anterior photography with fluorescein angiography

Use of Modifiers With Procedure Codes

If it is medically necessary to repeat an ophthalmology procedure on the same date of service and the procedure is bilateral (*i.e.,* the procedure is for both eyes), then the total charge amount for both eyes must be listed on the first line and again on the line recording the repeated procedure.

In order for the claim to process, the modifier on the first line must be "00" (two zeros), and the modifier on the line recording the repeated procedure must be (76). This is the only time these two modifiers should be used. It is imperative that the medical record of this patient indicates and justifies the medical necessity of repeating this service on the same day. The use of two modifiers indicates that the procedure was done bilaterally on the first occurrence and again bilaterally on the second occurrence. Indicate a (1) in the Units column for the number of units on each line.

When medically necessary to repeat the same procedure on the same date of service and the procedure is unilateral, then the total charge amount for one eye must be listed on the first line utilizing an RT, right side (used to identify procedures performed on the right side of the body) or LT modifier, left side (used to identify procedures performed on the left side of the body). The second line for the repeated procedure should be billed utilizing a 76 modifier. The medical record of the patient must indicate and justify the medical necessity for the repeat procedure.

REMINDER**:** In all cases, the fee listed for all ophthalmological procedures is for both eyes, unless otherwise indicated.

The use of modifiers AP (determination of refractive state was not performed in the course of diagnostic ophthalmological examination) is not reimbursed by SCDHHS and will result in rejected claims.

The following modifiers should be used for replacement of parts:

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Use of Modifiers With Procedure Codes (Cont'd.)

U8 = Replacement of a part of frames

U9 = Replacement of a part

OTORHINOLARYNGOLOGY (ENT)

General ENT Services

Diagnostic or treatment procedures usually included in an otorhinolaryngologic exam are reported as an integrated medical service and should not be reported separately.

Microsurgical Techniques – PT 69990 is a procedure code that describes "microsurgical techniques requiring use of operating microscope." It can be billed in addition to the primary surgical procedure if it is not an inclusive part of the surgical procedure and if the documentation supports the use of microsurgical techniques. It is not for visualization of the operative field alone, but is intended to be employed when the surgical services are performed using the techniques of microsurgery.

If the use of the operating microscope is an inclusive component of a procedure, the use of the operating microscope cannot be unbundled and billed as 69990. The Centers for Medicare and Medicaid Services does not pay separately for services that should be paid together.

Endoscopic Procedures – Please refer to guidelines for endoscopic procedures under "General Surgery Guidelines" in this section.

Uvulopalatopharyngoplasty – Documentation (admission history and physical and operative report) is required with claims submitted for this procedure. The record must substantiate medical necessity as well as clarify the procedures performed.

Septoplasty, Turbinectomy – These and any other nasal reconstructive surgeries are covered only when there is a loss or serious impairment of bodily function, usually as a result of trauma, and the surgery restores the disabled function. The office record must document the functional deficit or the need for prompt correction

Speech and Hearing Services

Services rendered by ENT specialists or therapists supervised by a physician are compensable using the series 92502 – 92595 in the CPT with the following restrictions:

- Speech and Hearing Therapy (92507 – 92508) – Non-compensable. Please refer to "Specialized Speech and Hearing Services for Children Under 21" below regarding services for children.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Speech and Hearing Services (Cont'd.)

- Vestibular Function Test Without Recording (92531 – 92534) – Non-compensable (included in visit code).
- Ear Protector Attenuation Measurements (ear plugs) – Non-compensable.
- Hearing Aids and Hearing Aid Accessories – Must be pre-authorized and obtained through the SCDHEC. Services are limited to children under age 21. For prior approval, send request to:

  Division of Children's Rehabilitative Services
  Box 101106, Mills Complex
  Columbia, SC 29211
  (803) 898-0784

- Ear Molds – To report, physicians must use the following supplemental codes:
  - **V5264** – Ear mold, not disposable, any type
  - **V5265** – Ear mold, disposable, any type
  - Use modifiers RT (right side) and LT (left side) to indicate which ear.
  - These codes are allowed four times every 12 months per ear for children under age 21.
- Cochlear Device Implantation – Requires prior approval from KEPRO one of the following methods:

  KEPRO Customer Service: 1-855-326-5219
  KEPRO Fax: 1-855-300-0082

- Specialized Speech and Hearing Services for Children Under 21 – Services are available through clinics certified by SCDHEC and through individual speech language pathologists/audiologists who are licensed by the South Carolina State Board of Examiners in Speech-Language Pathology and Audiology and enrolled with the South Carolina Medicaid program. Speech/language and audiology services rendered by these providers must be pre-authorized by SCDHEC, DDSN, or a school district. ENT specialists who provide these specialized services in their office or clinic may apply for certification. If certified by SCDHEC, the physician must enroll as a speech and hearing clinic with South Carolina Medicaid in order to obtain payment for these services (for children under 21). For information on SCDHEC certification requirements, you may write to:

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Speech and Hearing Services (Cont'd.)

Department of Health and Environmental Control
Clinic Certification
2600 Bull Street
Columbia, SC 29201

CARDIOLOGY

Cardiography

Physicians performing these services in their office may bill for the complete procedure code, which includes the tracing, interpretation, and report. Those providers interpreting the recording only must use the code that stipulates interpretation and report only. The modifier 26 is not necessary when the code clearly defines the professional component only (interpretation and/or report).

For more detail regarding EKG interpretations, please refer to "Radiology Reimbursement Limitations" under "Radiology and Nuclear Medicine" in this section.

Cardiac Catheterization

The cardiologist must bill for the catheterization that describes the procedure and technique utilized; fragmenting the codes is not allowed.

If medically indicated, intracardiac electrophysiological procedures may be billed in addition to the catheterization angiogram procedure.

Cardiac Magnetic Resonance Imaging (MRI) of the Heart – Procedure codes 75557, 75559, 75561, 75563 are used to report the physician's attendance and participation in the MRI of the heart. When filing for this procedure, bill appropriate MRI code depending on level of service. Use modifier 26 when billing the professional component only. The technical portion will be reimbursed to the hospital under the revenue code for MRI. Medical necessity for both the MRI and heart catheter (if needed) must be documented in the beneficiary's chart. The procedure should be performed in lieu of heart catheterization, when possible. The code will be allowed reimbursement only once per date of service, regardless of how many sessions or images are performed.

Vascular Studies

Reimbursement to a provider for services purchased from an outside supplier or lab is not allowed. Reimbursement is only allowed to the provider who performed the service and is enrolled with South Carolina Medicaid.

Independent physiology labs performing monitoring services must be enrolled for participation. The physician requesting the service may only bill for the interpretation of the study if performed.

Thermography is non-covered.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

PULMONARY MEDICINE

Oxygen therapy given in the office is compensable when medically indicated and clearly identifiable as a separate procedure. Documentation must be submitted with the claim.

Questions regarding oxygen therapy equipment for home use should be directed to the PSC at 1-888-289-0709. Providers may also submit on online inquiry at http://www.scdhhs.gov/contact-us for additional information.

To report tracheostomy tube change in the office setting, use code T1031 or T1030. This may be used in addition to the appropriate level office E/M visit codes.

Code 95827 should be billed for the overnight sleep apnea study.

TUBERCULOSIS (TB) POLICY

Effective on or after November 1, 2014, SCDHHS has implemented a new program that offers Medicaid coverage for persons with latent tuberculosis (TB) infection or TB disease. The TB Only Program will help defer costs for the care of TB-related medical services. South Carolina Department of Health and Environmental Control (SCDHEC) will manage the TB program.

TB only services will cover treatment directly related to the care of TB which falls under the following categories:

- Prescribed medications
- Physician services
- Out-patient hospital services
- Public health clinics
- Laboratory
- Radiology
- Case Management

Note: This policy does not cover hospital stays, room and board or observation stays.

Treatment of a beneficiary with TB is most successful within a comprehensive framework that addresses both clinical and social issues of relevance to the beneficiary. It is essential that treatment be tailored and supervised based on each beneficiary's individual clinical and social needs (patient-centered care). SCDHEC is ultimately responsible for ensuring that adequate, appropriate diagnostic and treatment services are available, and for monitoring the results of therapy.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Tuberculosis Policy (TB) (Cont'd.)

Initial TB Screening

The initial TB screening will be covered when performed by a Nurse Practitioner, Physician Assistant, or Registered Nurse employed by the SCDHEC clinic. The initial screening includes, but is not limited to the following:

- Brief mental and physical assessment
- Exposure history
- Referral for Laboratory testing and or Radiology services
- Referral for social services
- Referral for other medical services
- Consultation with TB Medical Clinician

SCDHEC will bill SCDHHS for an Evaluation and Management (EM) code 99202.

For beneficiaries that are not in the limited benefits category (Family Planning and/or TB Only), SCDHEC will provide a referral for the beneficiary to be seen by a physician if medically necessary and maintained in the beneficiary's medical health record. The physician must bill SCDHHS utilizing a new patient examination 99203 Current Procedural Terminology (CPT) code. The physician will be reimbursed for the initial consultation as long as the consultation is done within a 30-day period from the date of the initial TB screening service provided by SCDHEC, or all initial and subsequent treatment will be denied. If SCDHEC determines that it is medically necessary for the beneficiary to see a physician for subsequent visits, they are responsible for providing authorization, which must be maintained in the beneficiary's medical health records. All services are subject to Audit by SCDHHS Division of Program Integrity.

Subsequent Nursing Services

Subsequent nursing services are covered services when performed by a Nurse Practitioner, Registered Nurse, and Licensed Practical Nurse, in the SCDHEC clinic or home setting. SCDHEC must bill all medically necessary exams to SCDHHS utilizing Evaluation and Management code 99211. The maximum number of visits allowed for a treatment cycle is 360 for a beneficiary with latent TB infection and 360 for a beneficiary with TB disease. Medical necessity must be maintained within the beneficiary's medical health records.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Tuberculosis Policy (TB) (Cont'd.)

Case Management

All Care Management services will be patient-centered and will include an adherence plan that emphasizes direct observed therapy (DOT), in which a beneficiary is observed to ingest each dose of anti-tuberculosis medications, to maximize the likelihood of completion of therapy. Each beneficiary's management plan must be individualized to incorporate strategies that facilitate adherence to the treatment regimen. Such measures may include, for example, social service support, treatment incentives and enablers, housing assistance, referral for treatment of substance abuse, and coordination of the tuberculosis services with those of other providers.

SCDHEC is responsible for providing all Case Management services utilizing G9012. Case Management services include but are not limited to:

- Medication Monitoring
- Providing services in the patient's home
- Referring all medically necessary laboratory tests
- Referring all medically necessary radiology tests
- Referring patient to a physician for consultation when medically necessary

Case Management services are limited to 360 visits per year, one visit per day. Case Management services will be covered when performed by a Nurse Practitioner, Physician Assistant, Registered Nurse or Social Worker employed by the SCDHEC clinic.

Multidrug-Resistant Tuberculosis (MDR-TB) Treatment Protocol

Multidrug-resistant tuberculosis (MDR-TB) is a form of TB that is resistant to two or more of the primary drugs (isoniazid and rifampin) used for the treatment of TB. The MDR-TB patient treatment model may involve a step approach. First high dose oral medications are used that may include drugs such as isoniazid, pyrazinamide, and ethambutol. Then treatment can move to injectable drugs, such as capreomycin, kanamycin, and amikacin. Treatment length maybe extended to manage the disease.

The use of this very intense treatment regimen also requires that the MDR-TB patient receive additional services. For these patients the below additional procedures codes are covered. For all services providers should follow NCCI correct coding:

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Tuberculosis Policy (TB) (Cont'd.)

- Eye and medical examination up to six times per year (CPT codes 92002, 92004, 92012, and 92014)
- Labs (CPT codes (80050, 80053, 80051, and 83735)
- **36568** – Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; younger than 5 years of age
- **36569** – Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; age 5 years or older

Pharmacotherapy

All treatment medications will be provided by SCDHEC for SCDHEC patients who have been diagnosed with TB disease and/or latent TB infection regardless of enrollment status (FFS or TB only eligible). All medications will be reimbursed via 340B pricing. SCDHEC must submit the acquisition cost plus dispensing fee to SCDHHS. SCDHHS will then reimburse SCDHEC for the TB medications submitted.

The following intravenous medications are covered when deemed medically necessary:

The following intravenous service codes are covered when medically indicated:

HCPCS CODE	DESCRIPTION
J0278	Injection, amikacin sulfate, 100 mg
J1840	Injection, kanamycin sulfate, up to 500 mg
J1956	Injection, levofloxacin, 250 mg
J2020	Injection, linezolid, 200 mg
J2280	Injection, moxifloxacin, 100 mg

CPT CODE	DESCRIPTION
J3000	Injection, streptomycin, up to 1 g
96365	Infusion into a vein for therapy, prevention, or diagnosis up to 1 hour
96366	Infusion into a vein for therapy, prevention, or diagnosis

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Tuberculosis Policy (TB) (Cont'd.)

CPT CODE	DESCRIPTION
96367	Additional sequential infusion of a new drug/substance, up to 1 hour
96368	Infusion into a vein for therapy, prevention, or diagnosis, concurrent with another infusion
96374	Injection of drug or substance into a vein for therapy, diagnosis, or prevention
96375	Injection of different drug or substance into a vein for therapy, diagnosis, or prevention

Laboratory Tests:

Please refer to the following chart for covered laboratory tests:

CPT CODE	TEST DESCRIPTION
80051	Electrolyte Panel
80053	Comprehensive Metabolic Panel
80076	Hepatic Function Panel
80185	Phenytoin; Total
80299	Quantitation of Drug, Not Specified Elsewhere
83735	Magnesium
85025	Complete blood cell count (red cells, white blood cell, platelets), automated test
86480	TB test, cell mediated immunity antigen response measurement: gamma interferon
86481	Enumeration of gamma interferon-producing T-cells in cell suspension
86580	Tuberculosis, intradermal
87116	Culture, tubercle or other acid-fast bacilli any source, with isolation and presumptive identification of isolates
87149	Identification by nucleic acid probe, direct probe technique, per culture or isolate, each organism probed
87143	Gas liquid chromatography or high pressure liquid chromatography

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Tuberculosis Policy (TB) (Cont'd.)

CPT CODE	TEST DESCRIPTION
87190	Antimicrobial study, mycobacteria (TB organism family)
87184	Evaluation of antimicrobial drug (antibiotic, antifungal, antiviral)
87188	Evaluation of antimicrobial drug (antibiotic, antifungal, antiviral)
87206	Smear, primary source with interpretation; fluorescent and/or acid fast stain for bacteria, fungi, parasites, viruses or cell types
87260	Infectious agent antigen detection by immunofluorescent technique; adenovirus
87389	Infectious agent antigen detection by immunoassay technique, qualitative or semiquantitative, multiple-step method; HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies, single result
87556	Infectious agent detection by nucleic acid (DNA or RNA); Mycobacte
89220	Sputum, obtaining specimen, aerosol induced technique (separate procedure)
36415	Venipuncture

All laboratory tests are subject to medical necessity guidelines and documentation must be maintained in the beneficiary's chart.

Labora**tory tests should be billed with a "00" modifier. If the laboratory tests are** referred to an outside laboratory, then SCDHEC will provide authorization which will be maintained in the beneficiary's medical health records.

Radiology Tests:

The following radiology tests including interpretation of exams are covered if performed by a Nurse Practitioner, Physician Assistant, or Physician:

CPT CODE	TEST DESCRIPTION
71045	X-ray of chest, 1 view
71046	X-ray of chest, 2 views

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Tuberculosis Policy (TB) (Cont'd.)

CPT CODE	TEST DESCRIPTION
71047	X-ray of chest, 3 views
71048	X-ray of chest, minimum of 4 views
71250	CT, thorax; without contrast material
71260	CT, thorax with contrast material
71270	CT, thorax, without and with contrast material
71550	MRI , chest, without contrast material
71551	MRI, chest with contrast material
71552	MRI, chest, with and without contrast materials, followed by contrast materials and further sequences

All radiology procedures must be billed with the appropriate modifiers. See below for a list of modifiers and descriptions:

- Modifier 00 must be appended to the CPT code when the provider has rendered both the technical component (the physical taking of an x-ray) and the professional component (interpretation of results).
- Modifier TC (technical component) must be appended to the CPT code when the provider has only rendered the taking of the x-ray.
- Modifier 26 must be appended to the CPT code when the provider has rendered the interpretation only. Providers are required to write a report and sign, and date.

Documentation Requirements

All providers must keep documentation in the beneficiary's medical record to justify medical necessity for the level of service reimbursed, including history, illness, physical findings, diagnosis, laboratory results, radiology results, and records on medications prescribed and delivered. Providers must follow National Correct Coding initiative and coding rules and practices. All services are subject to retrospective review by our Division of Program Integrity.

ALLERGY AND IMMUNOTHERAPY

Allergy Testing

Scratch testing is the Gold standard for Allergy Testing and is a covered service. Beneficiaries should be instructed not to take antihistamines for

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

ALLERGY AND IMMUNOTHERAPY (CONT'D.)

three days prior to testing in order to insure accurate results. Allergy testing under anesthesia and RAST testing is not a covered service. Allergy testing for food allergies is not normally considered medically necessary. Therefore, if the provider is testing for food allergies, they must clearly state the medical necessity and supporting documentation in the beneficiary's medical record. All services are subject to audit through the SCDHHS Division of Program Integrity.

Allergen Immunotherapy

Allergen Immunotherapy is performed by providing injections of pertinent allergens to the patient on a regular basis with the goal of reducing the signs and symptoms of an allergic reaction or prevention of future anaphylaxis. This is usually done with allergen dosages that gradually increased over a period of months.

Providers may bill for professional services for allergen immunotherapy not including provision of allergenic extracts by billing CPT codes 95115-95117. These codes are for professional services only and do not cover reimbursement for antigen extract or venom.

Procedure codes 95120-95134 are not covered.

Antigen and Preparation

Procedure codes 95144 through 95170 can be used for the supervision, preparation and provision of antigens for allergen immunotherapy. Please note that all services must comply to CMS 100-4,12,200 detailed below.

Providers should not be billing for an Evaluation and Management Service on the same day as an allergen injection utilizing CPT codes 95115 and 95117.

Allergy Testing and Immunotherapy B3-15050

A. Allergy Testing

The MPFSDB fee amounts for allergy testing services billed under codes 95004-95052 are established for single tests. Therefore, the number of tests must be shown on the claim.

EXAMPLE: If a physician performs 25 percutaneous tests (scratch, puncture, or prick) with allergenic extract, the physician must bill code 95004 and specify 25 in the nits field of Form CMS-1500 (paper claims or electronic format). To compute payment, the Medicare carrier multiplies the payment for one test (i.e., the payment listed in the fee schedule) by the quantity listed in the units field.

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PROGRAM SERVICES

ALLERGY AND IMMUNOTHERAPY (CONT'D.)

B. Allergy Immunotherapy

For services rendered on or after January 1, 1995, all antigen/allergy immunotherapy services are paid for under the Medicare physician fee schedule. Prior to that date, only the antigen injection services, i.e., only codes 95115 and 95117, were paid for under the fee schedule. Codes representing antigens and their preparation and single codes representing both the antigens and their injection were paid for under the Medicare reasonable charge system. A legislative change brought all of these services under the fee schedule at the beginning of 1995 and the following policies are effective as of January 1, 1995:

1. CPT codes 95120 through 95134 are not valid for Medicare. Codes 95120 through 95134 represent complete services, i.e., services that include both the injection service as well as the antigen and its preparation.

2. Separate coding for injection only codes (*i.e.,* codes 95115 and 95117) and/or the codes representing antigens and their preparation (*i.e.,* codes 95144 through 95170) must be used.

If both services are provided both codes are billed.

This includes allergists who provide both services through the use of treatment boards.

3. If a physician bills both an injection code plus either codes 95165 or 95144, carriers pay the appropriate injection code (i.e., code 95115 or code 95117) plus the code 95165 rate. When a provider bills for codes 95115 or 95117 plus code 95144, carriers change 95144 to 95165 and pay accordingly. Code 95144 (single dose vials of antigen) should be billed only if the physician providing the antigen is providing it to be injected by some other entity. Single dose vials, which should be used only as a means of insuring proper dosage amounts for injections, are more costly than multiple dose vials (i.e., code 95165) and therefore their payment rate is higher. Allergists who prepare antigens are assumed to be able to administer proper doses from the less costly multiple dose vials. Thus, regardless of whether they use or bill for single or multiple dose vials at the same time that they are billing for an injection service, they are paid at the multiple dose vial rate.

4. The fee schedule amounts for the antigen codes (95144 through 95170) are for a single dose. When billing those codes, physicians are to specify the number of doses provided. When making payment, carriers multiply the fee schedule amount by the number of doses specified in the units field.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

ALLERGY AND IMMUNOTHERAPY (CONT'D.)

5. If a patient's doses are adjusted, e.g., because of patient reaction, and the antigen provided is actually more or fewer doses than originally anticipated, the physician is to make no change in the number of doses for which he or she bills. The number of doses anticipated at the time of the antigen preparation is the number of doses to be billed. This is consistent with the notes on page 30 of the Spring 1994 issue of the American Medical Association's CPT Assistant. Those notes indicate that the antigen codes mean that the physician is to identify the number of doses "prospectively planned to be provided." The physician is to "identify the number of doses scheduled when the vial is provided." This means that in cases where the patient actually gets more doses than originally anticipated (because dose amounts were decreased during treatment) and in cases where the patient gets fewer doses (because dose amounts were increased), no change is to be made in the billing. In the first case, carriers are not to pay more because the number of doses provided in the original vial(s) increased. In the second case, carriers are not to seek recoupment (if carriers have already made payment) because the number of doses is less than originally planned. This is the case for both venom and nonvenom antigen codes.

6. Venom Doses and Catch-Up Billing - Venom doses are prepared in separate vials and not mixed together - except in the case of the three vespid mix (white and yellow hornets and yellow jackets). A dose of code 95146 (the two-venom code) means getting some of two venoms. Similarly, a dose of code 95147 means getting some of three venoms; a dose of code 95148 means getting some of four venoms; and a dose of 95149 means getting some of five venoms. Some amount of each of the venoms must be provided. Questions arise when the administration of these venoms does not remain synchronized because of dosage adjustments due to patient reaction. For example, a physician prepares ten doses of code 95148 (the four venom code) in two vials - one containing 10 doses of three vespid mix and another containing 10 doses of wasp venom. Because of dose adjustment, the three vespid mix doses last longer, *i.e.*, they last for 15 doses. Consequently, questions arise regarding the amount of "replacement" wasp venom antigen that should be prepared and how it should be billed. Medicare pricing amounts have savings built into the use of the higher venom codes. Therefore, if a patient is in two venom, three venom, four venom or five venom therapy, the carrier objective is to pay at the highest venom level possible. This means that, to the greatest

SECTION 2 POLICIES AND PROCEDURES

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ALLERGY AND IMMUNOTHERAPY (CONT'D.)

extent possible, code 95146 is to be billed for a patient in two venom therapy, code 95147 is to be billed for a patient in three venom therapy, code 95148 is to be billed for a patient in four venom therapy, and code 95149 is to be billed for a patient in five venom therapy. Thus, physicians are to be instructed that the venom antigen preparation, after dose adjustment, must be done in a manner that, as soon as possible, synchronizes the preparation back to the highest venom code possible. In the above example, the physician should prepare and bill for only 5 doses of "replacement" wasp venom - billing five doses of code 95145 (the one venom code). This will permit the physician to get back to preparing the four venoms at one time and therefore billing the doses of the "cheaper" four venom code. Use of a code below the venom treatment number for the particular patient should occur only for the purpose of "catching up."

7. Code 95165 Doses. - Code 95165 represents preparation of vials of non-venom antigens. As in the case of venoms, some non-venom antigens cannot be mixed together, i.e., they must be prepared in separate vials. An example of this is mold and pollen. Therefore, some patients will be injected at one time from one vial - containing in one mixture all of the appropriate antigens - while other patients will be injected at one time from more than one vial. In establishing the practice expense component for mixing a multidose vial of antigens, we observed that the most common practice was to prepare a 10 cc vial; we also observed that the most common use was to remove aliquots with a volume of 1 cc. Our PE computations were based on those facts. Therefore, a physician's removing 10 1cc aliquot doses captures the entire PE component for the service.

This does not mean that the physician must remove 1 cc aliquot doses from a multidose vial. It means that the practice expenses payable for the preparation of a 10cc vial remain the same irrespective of the size or number of aliquots removed from the vial. Therefore, a physician may not bill this vial preparation code for more than 10 doses per vial; paying more than 10 doses per multidose vial would significantly overpay the practice expense component attributable to this service. (NOTE: that this code does not include the injection of antigen(s); injection of antigen(s) is separately billable.)

When a multidose vial contains less than 10cc, physicians should bill Medicare for the number of 1 cc aliquots that may be removed from the vial. That is, a physician may bill Medicare up to a maximum of 10 doses per multidose vial, but should bill Medicare for fewer than 10 doses per vial when there is less than 10cc in the vial.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

ALLERGY AND IMMUNOTHERAPY (CONT'D.)

If it is medically necessary, physicians may bill Medicare for preparation of more than one multidose vial.

EXAMPLES:

(1) If a 10cc multidose vial is filled to 6cc with antigen, the physician may bill Medicare for 6 doses since six 1cc aliquots may be removed from the vial.

(2) If a 5cc multidose vial is filled completely, the physician may bill Medicare for 5 doses for this vial.

(3) If a physician removes ½ cc aliquots from a 10cc multidose vial for a total of 20 doses from one vial, he/she may only bill Medicare for 10 doses. Billing for more than 10 doses would mean that Medicare is overpaying for the practice expense of making the vial.

(4) If a physician prepares two 10cc multidose vials, he/she may bill Medicare for 20 doses. However, he/she may remove aliquots of any amount from those vials. For example, the physician may remove ½ aliquots from one vial, and 1cc aliquots from the other vial, but may bill no more than a total of 20 doses.

(5) If a physician prepares a 20cc multidose vial, he/she may bill Medicare for 20 doses, since the practice expense is calculated based on the physician's removing 1cc aliquots from a vial. If a physician removes 2cc aliquots from this vial, thus getting only 10 doses, he/she may nonetheless bill Medicare for 20 doses because the PE for 20 doses reflects the actual practice expense of preparing the vial.

(6) If a physician prepares a 5cc multidose vial, he may bill Medicare for 5 doses, based on the way that the practice expense component is calculated. However, if the physician removes ten ½ cc aliquots from the vial, he/she may still bill only 5 doses because the practice expense of preparing the vial is the same, without regard to the number of additional doses that are removed from the vial.

C. Allergy Shots and Visit Services on the Same Day

At the outset of the physician fee schedule, the question was posed as to whether visits should be billed on the same day as an allergy injection (CPT codes 95115-95117), since these codes have status indicators of A rather than T. Visits should not be billed with allergy injection services 95115 or 95117 unless the visit represents another separately identifiable service. This language parallels CPT editorial language that accompanies the allergen immunotherapy codes, which include codes

SECTION 2 POLICIES AND PROCEDURES

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ALLERGY AND IMMUNOTHERAPY (CONT'D.)

95115 and 95117. Prior to January 1, 1995, you appeared to be enforcing this policy through three (3) different means:

- Advising physician to use modifier 25 with the visit service;
- Denying payment for the visit unless documentation has been provided; and
- Paying for both the visit and the allergy shot if both are billed for.

For services rendered on or after January 1, 1995, you are to enforce the requirement that visits not be billed and paid for on the same day as an allergy injection through the following means. Effective for services rendered on or after that date, the global surgery policies will apply to all codes in the allergen immunotherapy series, including the allergy shot codes 95115 and 95117. To accomplish this, CMS changed the global surgery indicator for allergen immunotherapy codes from XXX, which meant that the global surgery concept did not apply to those codes, to 000, which means that the global surgery concept applies, but that there are no days in the postoperative global period.

Now that the global surgery policies apply to these services, you are to rely on the use of modifier 25 as the only means through which you can make payment for visit services provided on the same day as allergen immunotherapy services. In order for a physician to receive payment for a visit service provided on the same day that the physician also provides a service in the allergen immunotherapy series (*i.e.*, any service in the series from 95115 through 95199), the physician is to bill a modifier 25 with the visit code, indicating that the patient's condition required a significant, separately identifiable visit service above and beyond the allergen immunotherapy service provided.

D. Reasonable Supply of Antigens

See CMS Manual System, Internet Only Manual, Medicare Benefits Policy Manual, CMS Pub. 100-02 Chapter 15, section 50.4.4, regarding the coverage of antigens, including what constitutes a reasonable supply of antigens.

Providers should only bill Medicaid for a 90-day (3-month) supply of Antigens and/or Venoms for each Medicaid beneficiary. When the provider notices that the beneficiary is running low on antigens, he or she should arrange for more antigens to be made and delivered. Please note that these services cannot be over lapped and reimbursed. Therefore, if a provider bills for a 90-day supply of antigen on 1/1/2014, then the provider would not be eligible for reimbursement until date of service 4/1/2014.

SECTION 2 POLICIES AND PROCEDURES

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DERMATOLOGY

Visits and treatments for dermatological services must be medically necessary. Services provided for cosmetic reasons are non-covered.

For dates of service on or before **September 30, 2015**, the acne diagnosis code (706.1) is covered only when the patient is 18 years of age or younger (non-covered beginning on the 19th birthday), and the acne condition is infected, cystic, or pustular.

For dates of service on or after **October 1, 2015**, the acne diagnosis codes (L70.0 - L70.9, L73.0) are covered only when the patient is 18 years of age or younger (non-covered beginning on the 19th birthday), and the acne condition is infected, cystic, or pustular.

Support documentation is not required for billing purposes; however, the patient's record must clearly document the condition and medical necessity.

For dates of service on or before **September 30, 2015**, the keloid scar diagnosis 701.4 is covered only in severe cases with pain, intractable itching, or interference with range of movement.

For dates of service on or after **October 1, 2015**, the keloid scar diagnosis L91.0 is covered only in severe cases with pain, intractable itching, or interference with range of movement.

Support documentation is not required for billing purposes; however, the patient's record must clearly document the condition and medical necessity.

ONCOLOGY AND HEMATOLOGY

Chemotherapy Administered in a Physician's Office

When a patient receives the entire regimen of chemotherapy in an office setting, including lab work, hydration, premedication, and all chemotherapy agents, CPT codes 96401 – 96542 would be the appropriate codes to bill. These procedures indicate an infusion or injection by the physician or an employee of the physician. The following are appropriate codes to bill:

- If the patient received chemotherapy over four hours in the office via IV infusion:

  96413 – Chemotherapy administration, intravenous infusion technique; up to an hour, single or initial substance/drug

  96415 – Each additional hour, 1 to 8 hours
  J Codes – Appropriate medication charges

- E/M Services (CPT codes 99201 – 99215) are allowed when a separate and identifiable medical necessity exists and is clearly

SECTION 2 POLICIES AND PROCEDURES

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Chemotherapy Administered in a Physician's Office (Cont'd.)

documented in the patient's chart. The physician should not routinely bill an E/M service for every patient prior to chemotherapy administration. Only one E/M service is billable per patient per day.

- Prolonged Services (CPT codes 99354 and 99356) may be billed in addition to the E/M code when there is more than an hour of actual face-to-face physician time required beyond the usual service for the level of the E/M code billed. This code should only be used when the physician's expertise is medically necessary in evaluating and managing the patient over a prolonged period and specific documentation describes the content and duration of the service.
- Critical Care Services (CPT codes 99291 – 99292) should only be used in situations requiring constant physician attendance of an unstable or critically ill patient. These codes should only be used in situations significantly more complex than other chemotherapy situations.

If a physician or physician group leases space in a clinic or hospital, they may bill for the chemotherapy administration and drugs provided **all** the following criteria are met:

- They are using their own employees, equipment, supplies, and drugs.
- The services are provided in the leased area of the hospital designated as an office.
- The patient is not a registered inpatient or outpatient of the hospital.

A physician's office within an institution must be confined to a separately identified part of the facility that is used solely as the physician's office and cannot be construed to extend throughout the entire institution. Services performed outside the "office" area will be subject to coverage rules applicable to services furnished outside the office setting.

A distinction must be made between the physician's office practice and the institution. For services to be covered, auxiliary medical staff must be office staff rather than institution staff, and the cost of supplies must represent an expense to the physician's office practice. The physician must directly supervise services performed by his or her employees outside the office area; the physician's presence in the facility as a whole would not be sufficient.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Chemotherapy Administered in a Physician's Office (Cont'd.)

If services are provided in an inpatient, outpatient, or infusion center setting, the physician can only bill for the E/M service and/or prolonged care, critical care services when appropriate. Reimbursement for chemotherapy administration, drugs, supplies, equipment, and nursing are included in the hospital or infusion center's reimbursement.

Inpatient and Outpatient Hospital Services

Services or supplies administered by the hospital or hospital employees are considered a part of the overall hospital service and are reimbursable only under the hospital allowable costs. A physician who is either salaried or contracted by the hospital, and who performs services under contract or employment, may not bill for those services separately under his or her individual Medicaid provider number. The contracting hospital may claim these services under the professional fees allowable for the hospital under their hospital-based physician Medicaid number.

Billing Notes

Infusion start and stop time should be clearly documented. Start time does not include the E/M service or delivery of adjunctive therapy by a nurse or physician.

Codes 96409 and 96420, chemotherapy administrations, push technique, are only for pushing a chemotherapy agent and are not to be billed when pushing premedications or providing other incidental services. Only one push technique code will be allowed per day. These codes cannot be billed when given in a hospital setting.

If routine maintenance (flushing with heparin and saline) of an access device is the only service rendered, and is rendered by the nurse, the office visit code 99211 is appropriate.

Therapeutic or Diagnostic Infusions codes should only be billed when a therapeutic or diagnostic agent other than chemotherapy must be infused over an extended period of time. Payment of these codes is considered bundled into the payment for chemotherapy infusion when administered simultaneously. Separate payment is allowed when these services are administered sequentially or as a separate procedure. These codes cannot be billed in a hospital setting or in addition to prolonged service codes.

Blood transfusions may be billed only when the physician or an employee of the physician actually performs the transfusion. It should be billed per unit of blood. If the transfusion requires prolonged physician attendance, then it is appropriate to charge for this service. The medical record must substantiate this service. If hospital personnel administer the blood transfusion, it is reimbursable only under the hospital allowable costs.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Billing Notes (Cont'd.)

A listing of Chemotherapy Drug Codes can be found in Section 4 of this manual. The codes include the cost of the drug only, not the administration. Chemotherapy agents provided by a hospital are considered a technical cost and may not be charged by a physician. The hospital is reimbursed for all technical costs.

GASTROENTEROLOGY

Diagnostic procedures are defined in codes 91010-91299. Services listed are covered as separate procedures if medically necessary and justified.

Obesity is now recognized as a disease state. Policy is currently being written and will be published at a later date.

The following services are non-covered by Medicaid:

- Supplemental fasting
- Intestinal bypass surgery
- Gastric balloon for treatment of obesity

The following procedures to treat obesity are covered based on InterQual criteria. KEPRO must preauthorize all claims for these services. Approval will be based on medical records that document established InterQual criteria.

Bariatric Surgery

Bariatric surgery is a covered service for members who meet InterQual guidelines for medical necessity. Prior authorization is required for these procedures and should be requested from KEPRO.

Panniculectomy

Panniculectomy is the surgical excision of the abdominal apron containing superficial fat in obese individuals. The procedure codes, 15830 (Lipectomy) and 15847 (Abdominoplasty), can be covered by Medicaid if:

- It is medically appropriate and necessary for the individual to have such surgery.
- The surgery is performed to correct an illness caused by or aggravated by the pannus.

Prior authorization is needed and should be obtained by submitting documentation to KEPRO via fax, email, or website. InterQual criteria apply.

Gastrostomy Button Device Feeding Tube Kit

Effective April 1, 2007, the SCDHHS will reimburse CPT code 91299, Unlisted Diagnostic Gastroenterology procedure, for the supply item Gastrostomy Button Device Feeding Tube. This service will be covered for beneficiaries under the age of 21 when performed in the physician's office setting to cover the cost associated with purchasing the device.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Gastrostomy Button Device Feeding Tube Kit (Cont'd.)

Claims must be processed on a CMS-1500 claim form and include a copy of the invoice and appropriate documentation supporting the medical necessity of the device.

PHYSICAL MEDICINE AND THERAPY

Physical, occupational or speech therapy (PT, OT, ST) may be rendered in an office, or out-patient setting. Licensed therapist performing these services must continue to meet the state licensure regulations specified by the South Carolina Department of Labor, Licensing, and Regulation (LLR). Licensed therapists may bill directly and be reimbursed for services rendered.

Recipients age 21 and over who receive services in one of the above listed settings must be pre-authorized by the QIO, KEPRO.

At a minimum, physical therapy services must improve or restore physical functioning as well as prevent injury, impairments, functional limitations and disability following disease, injury or loss of limb or body part.

Occupational therapy must prevent, improve, or restore physical and/or cognitive impairment following disease or injury.

Speech language pathology must improve or restore cognitive functioning, communication skills and/or swallowing skills following congenital or acquired disease or injury.

Medical documentation must be submitted to KEPRO to justify the medical necessity for the physical therapy. Documentation includes, but not limited to, patient medical history, radiology, pharmacology records and letter of medical necessity which clearly indicates the medical justification for the service being requested. Any requests sent without medical documentation will be administratively denied. InterQual criteria will be used to make all determinations.

Physicians/nurse practitioners are required to submit the applicable Current Procedural Terminology (CPT) codes as defined in the CPT reference guide for the specified therapy. Therapy procedures are defined in 15 minute sessions, SCDHHS will define 15 minutes as one unit. Therapy sessions are limited to four units/one hour per date of service. A complete list of therapy codes requiring prior authorization is listed in Section 4 of the manual.

KEPRO is responsible for the initial authorization which includes the initial evaluation and the first four weeks of therapy. After four weeks of therapy a concurrent review is performed to re-evaluate the patient's condition and response to treatment. At that time the physician/nurse practitioner may request up to an additional eight weeks of therapy. The

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Physical Medicine and Therapy (Cont'd.)

provider is responsible for submitting any additional medical documentation needed for KEPRO to review for prior authorization of additional therapy.

Patients with Medicare or any other payer are only required to obtain a prior authorization if Medicare or the primary carrier did not make a payment or the service is considered not covered.

For Children under the age of 21 PT/OT/ST services are available through rehabilitation centers certified by SCDHEC, and through individual licensed practitioners. Policy guidelines are located in the Private Rehabilitative Therapy and Audiological Service Provider Manual on our website located at www.scdhhs.gov.

SCDHHS will require prior authorization for Rehabilitative Therapy for children. The checkpoint will apply to private rehabilitative providers as well as to those performed in the outpatient hospital clinic. Requests for therapy services for all children that exceed the checkpoints for combined rehabilitative therapy services (105 hours or 420 units must be submitted to KEPRO for authorization. KEPRO will use InterQual's Outpatient Rehabilitation criteria for medical necessity determinations. Requests for therapy services may be submitted by the primary care physician, nurse practitioner, physician assistant, physical, occupational or speech therapist but must follow the guidelines outlined in the Private Rehabilitative Therapy and Audiological Services Provider Manual.

For a complete listing of covered codes, please refer to Section 4 of the Private Rehabilitative Therapy and Audiological Services Provider Manual.

Biofeedback therapy is a non-covered service

Osteopathic Manipulative Treatment

Osteopathic Manipulative Treatment (OMT) is allowed as a separate procedure when medically necessary, justified, and performed by a physician, or licensed physical therapist employed by the physician. These procedures should be reported using procedure codes 98925 – 98929.

An E/M office code may be billed in addition to an OMT code if the E/M service performed is documented as a significant, separately identifiable service.

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PROGRAM SERVICES

CHIROPRACTIC SERVICES

SCDHHS provides Medicaid reimbursement for a limited array of chiropractic services provided to Medicaid beneficiaries. Coverage is limited to treatment by means of manual manipulation of the spine for the purpose of correcting a subluxation demonstrated on x-ray. For the purposes of this program, "subluxation" means an incomplete dislocation, off centering, misalignment, fixation, or abnormal spacing of the vertebrae anatomically that is demonstrable on a radiographic film (x-ray).

It is the provider's responsibility to ensure that services provided are due to medical necessity and are documented in the patient's medical charts, and that the beneficiary's Medicaid eligibility is current before chiropractic services are provided.

The provider should check the beneficiary's Medicaid card before rendering services. Providers must call the toll-free number 1-888-549-0820 listed on the back of the Medicaid insurance card to verify eligibility every time the Medicaid beneficiary is seen for chiropractic services. Eligibility changes on the first of each month. If services are provided, and are later denied because eligibility was not checked, Medicaid will not pay for the services and providers should not bill the patient for these services.

Eligible Medicaid beneficiaries, regardless of age, are allowed **six** chiropractic visits per year, commencing on July 1 of each year.

Provider Qualifications

To qualify as a Medicaid provider for chiropractic services, an individual must be licensed by the South Carolina Board of Chiropractic Examiners as a Doctor of Chiropractic. In order to participate in the Medicaid program, a chiropractor must enroll with Medicaid and receive a Medicaid ID number. Both individual chiropractors and chiropractic groups are eligible to enroll. For questions regarding enrollment, please contact Medicaid Provider Enrollment at 1-888-289-0709.

Medical Necessity

Medicaid will only pay for services that are medically necessary. The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment. Additionally, the manipulative services rendered must have a direct therapeutic relationship to the patient's condition. Spinal axis aches, strains, sprains, nerve pains, and functional mechanical disabilities of the spine are considered to provide therapeutic grounds for chiropractic manipulative treatment. Most other non-spinal diseases and pathological disorders (*e.g.*, rheumatoid arthritis, muscular dystrophy, multiple sclerosis, pneumonia, and emphysema) are not considered therapeutic grounds for chiropractic manipulative treatment.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Covered Services

Billing for chiropractic manipulative treatment is limited to one procedure per visit and one visit per day, with a maximum of **six** visits during a state fiscal year (July 1 – June 30), with no exceptions. Effective July 1, 2009, eligible Medicaid beneficiaries, regardless of age, will be allowed **six** chiropractic visits per state fiscal year Providers must call the toll-free telephone number on the back of the Medicaid insurance card to verify a patient's current eligibility and number of visits used to date during the current state fiscal year. Visits not used in one year do not carry over to the next year.

Note: For dually eligible Medicaid and Medicare beneficiaries, Medicare is the primary payer. Bill all chiropractic services to Medicare first. Once a dually eligible beneficiary has exhausted his or her Medicare-allowed chiropractic services, Medicaid reimbursement for chiropractic services is no longer available.

Medicaid-reimbursable chiropractic manipulative treatment services are limited to the following three procedure codes only:

- **Chiropractic manipulative treatment, 1-2 spinal regions**
  - Procedure Code = 98940
  - Unit of Service = 1 treatment
  - Frequency = 1 per day
- **Chiropractic manipulative treatment, 3 t4 spinal regions**
  - Procedure Code = 98941
  - Unit of Service = 1 treatment
  - Frequency = 1 per day
- **Chiropractic manipulative treatment, 5 spinal regions**
  - Procedure Code = 98942
  - Unit of Service = 1 treatment
    Frequency = 1 per day

Radiologic Examination (X-ray)

Billing for radiologic examination is limited to two x-rays per beneficiary per state fiscal year (July 1 – June 30). Medicaid-reimbursable radiology services are limited to the following:

- **Radiologic Examination; Spine, Entire, Survey Study; Anteroposterior and Lateral**
  - Unit of Service = 1 x-ray

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PROGRAM SERVICES

Radiologic Examination (X-ray) (Cont'd.)

- **X-ray of spine of neck, 2 or 3 views**
  - Procedure Code = 72040
  - Unit of Service = 1 x-ray
- **X-ray of middle spine, 3 views**
  - Procedure Code = 72070
  - Unit of Service = 1 x-ray
- **X-ray of middle and lower spine, 2 views**
  - Procedure Code = 72080
  - Unit of Service = 1 x-ray
- **X-ray of lower and sacral spine, 2 or 3 views**
  - Procedure Code = 72100
  - Unit of Service = 1 x-ray

X-Rays

The documenting radiographic film (x-ray) must have been taken at a time reasonably proximate to the initiation of the course of treatment. Unless the chiropractor concludes that more specific x-ray evidence is warranted, an x-ray is considered reasonably proximate if it was taken no more than six months prior to the initiation of a course of chiropractic treatment. Neither a magnetic resonance image (MRI) nor computerized axial tomogram (CAT scan) may be used instead of an x-ray to document subluxation.

The x-ray is required Medicaid documentation and must be maintained in the patient's medical record. X-ray films must have permanent identification of the patient's name, the date the film was taken, and the name of the facility where taken. Films must be marked right or left side. If the x-ray was taken elsewhere (*e.g.*, doctor's office or other medical facility), the written report must be present in the patient's medical record.

Documentation

As a condition of participation in the South Carolina Medicaid program, providers are required to maintain and allow appropriate access to clinical records that fully disclose the extent of services provided to the Medicaid patient. The maintenance of adequate records is regarded as essential for the delivery of appropriate services and quality medical care.

Providers must be aware that these records are key documents for post-payment review. In the absence of appropriately completed clinical records, previous payments may be recovered by SCDHHS. It is

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PROGRAM SERVICES

Documentation (Cont'd.)

essential for the provider to conduct internal record reviews to ensure that services are medically necessary and that service delivery, documentation, and billing comply with Medicaid policies and procedures.

Clinical Records

Providers are required to maintain a clinical record on each Medicaid patient that includes documentation of all Medicaid-reimbursable services. This documentation must be sufficient to justify Medicaid participation. Clinical records must be current and consistently organized, meet documentation requirements, and provide a clear description of services rendered and progress toward treatment goals. Clinical records should be arranged logically, so that information may be easily reviewed, copied, and audited.

Clinical records must be retained for a period of three years. If litigation, claims, or other actions involving the records are initiated prior to the expiration of the three-year period, the records must be retained until completion of the action and resolution of all issues or until the end of the three-year period, whichever is later.

Each Medicaid patient's clinical record must include, at a minimum, the following:

- A Release of Information form signed by the patient authorizing the release of any medical information necessary to process Medicaid claims and requesting payment of government benefits on behalf of the patient
- The initial written physician prescription (original or fax) and documentation of subsequent prescriptions required after every third visit
- Patient history to include the following:
  - A general patient history, including review of systems
  - Chief complaint/systems causing patient to seek chiropractic treatment
  - Onset and duration of symptomatic problem, which may include quality and character of problem; intensity; frequency; location and radiation; onset; duration; aggravating or relieving factors; prior interventions and treatments, including medications; and secondary complaints
  - Family history (if indicated)
  - Past health history to include general health statement; prior illnesses; surgical history; prior injuries or traumas; past hospitalizations; medications; allergies; and pregnancies and outcomes.

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PROGRAM SERVICES

Clinical Records (Cont'd.)

- A physical examination report to include:
  - Evaluation of the musculoskeletal and nervous system
  - Evaluation of the cardiovascular and gastrointestinal systems, and of the eye, ear, nose, and throat (both vascular and endocrine), if appropriate to symptoms causing patient to seek chiropractic treatment
  - Analytical procedures used to determine vertebral subluxation (level and severity) and contraindications to treatment (*e.g.*, inspection, palpation)
- Radiographic film (x-ray) and interpretation
- A written report/assessment of the patient's condition, including the precise area of subluxation
- A treatment plan
- Clinical service notes

Treatment Plan

If an evaluation indicates that treatment is warranted, the chiropractor must develop and maintain a treatment plan that outlines short- and long-term goals, as well as the recommended scope, frequency, and duration of treatment. The treatment plan should serve as a comprehensive plan of care by outlining the service delivery that will address the specific needs of the patient. The treatment plan must be individualized and should specify the problems to be addressed, goals and objectives of treatment, types of interventions to be utilized, planned frequency of service delivery, criteria for achievement, and estimated duration of treatment. The treatment plan must contain the signature and title of the chiropractor and the date signed.

The individualized treatment plan should be reviewed and updated according to the level of progress. If a determination is made during treatment that additional services are required, these services should be added to the treatment plan. When long-term treatment is required, a new treatment plan must be developed each year. In the event that services are discontinued, the chiropractor must ensure that the reason for discontinuing treatment is indicated in the treatment plan.

Clinical Service Notes

Chiropractic services must be documented by clinical service notes. A clinical service note is a written summary of each treatment session. The purpose of these notes is to record the nature of the patient's treatment by recording the service provided and summarizing the patient's participation in treatment.

Clinical service notes should do the following:

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PROGRAM SERVICES

Clinical Service Notes (Cont'd.)

- Furnish a pertinent clinical description of the activities that took place during the session, including an indication of the patient's response to treatment as related to stated goals and objectives
- Reflect delivery of a specific billable service as identified in the patient's treatment plan
- Document that the services rendered correspond to billing as to date of service, type of service rendered, and length of time of service delivery

Error Correction Procedures

The patient's clinical record is a legal document; therefore, extreme caution should be used when altering any part of this record. Appropriate error correction procedures must be followed when correcting an error in the patient's clinical record.

Errors in documentation should never be totally eradicated, and correction fluid should never be used. Draw one line through the error, enter the correction, and add signature (or initials) and date next to the correction. If warranted, an explanation of the correction may be appropriate. In extreme circumstances, having the corrected notation witnessed may be appropriate.

NEUROLOGY

Neurological testing procedure codes are 95805-95999. These codes include the technical component, interpretation, and the physician's professional services. Physicians doing only the interpretation must use the 26 modifier with the appropriate procedure code. All procedures must be medically justified.

Nerve Conduction Studies are covered as medically necessary when performed with needle electromyography (EMG) studies to confirm the diagnosis. It is recommended by the American Association of Neuromuscular and Electrodiagnostic Medicine (AANEM) that the nerve conduction study and a needle EMG be performed together to ensure an accurate diagnosis. Neurological testing procedure codes 95805 - 95999 include the technical component, the interpretation, and the physician's professional services. Physicians performing only the interpretation must use the 26 modifier with the appropriate procedure code. All procedures must be medically justified.

Nerve conduction studies must be billed using CPT guidelines indicating each nerve and all site(s) along the nerve, not each site. Codes that indicate "each nerve" will multiply for payment, and must be submitted on one line with the number of tests (or hours) indicated in the "units" column on the claim form. Claims submitted with more than the allowed amount of units will reject with Edit Code 713. Providers may submit a

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

NEUROLOGY (CONT'D.)

new claim with documentation for medical review. If justified, reimbursement may be made to the provider.

HYPERBARIC OXYGEN THERAPY

For purposes of coverage, hyperbaric oxygen (HBO) therapy is a modality in which the entire body is exposed to oxygen under increased atmospheric pressure.

Covered Conditions

Program reimbursement for HBO therapy will be limited to that which is administered in a chamber (including the one-man unit) for the following conditions:

- Acute carbon monoxide intoxication
- Decompression illness
- Gas embolism
- Gas gangrene
- Acute traumatic peripheral ischemia (HBO therapy is a valuable adjunctive treatment to be used in combination with accepted standard therapeutic measures, when loss of function, limb, or life is threatened.)
- Crush injuries and suturing of severed limbs (As in the previous conditions, HBO therapy would be an adjunctive treatment employed when loss of function, limb, or life is threatened.)
- Meleney ulcers (The use of hyperbaric oxygen in any other types of cutaneous ulcer is not covered.)
- Acute peripheral arterial insufficiency
- Preparation and preservation of compromised skin grafts
- Chronic refractory osteomyelitis that is unresponsive to conventional medical and surgical management
- Osteoradionecrosis as an adjunct to conventional treatment
- Cyanide poisoning
- Actinomycosis, but only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment
- Soft tissue radionecrosis

Non-Covered Conditions

No program payment may be made for HBO in the treatment of the following conditions:

- Cutaneous, decubitus, and statis ulcers

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Non-Covered Conditions (Cont'd.)

- Chronic peripheral vascular insufficiency
- Anaerobic septicemia and infection other than clostridial
- Skin burns (thermal)
- Senility
- Myocardial infarction
- Cardiogenic shock
- Sickle cell crisis
- Acute thermal and chemical pulmonary damage (*i.e.*, smoke inhalation with pulmonary insufficiency)
- Acute or chronic cerebral vascular insufficiency
- Hepatic necrosis
- Aerobic septicemia
- Non-vascular causes of chronic brain syndrome (Pick's disease, Alzheimer's disease, Korsakoff's disease)
- Tetanus
- Systemic aerobic infection
- Organ transplantation
- Organ storage
- Pulmonary emphysema
- Exceptional blood loss anemia
- Multiple sclerosis
- Arthritic disease
- Acute cerebral edema

Reasonable Utilization Parameters

Payment should be made where HBO therapy is clinically practical. HBO therapy should not be a replacement for other standard, successful therapeutic measures. Depending on the response of the individual patient and the severity of the original problem, treatment may range from less than one week to several months duration, with the average being two to four weeks. The medical necessity for use of hyperbaric oxygen for more than two months, regardless of the condition of the patient, should be reviewed and documented before further reimbursement is requested.

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PROGRAM SERVICES

Topical Application of Oxygen

This method of administering oxygen does not meet the definition of HBO therapy as stated above. Also, its clinical efficacy has not been established. Therefore, no reimbursement is allowed for the topical application of oxygen.

Enrollment

Hyperbaric units must be contracted with a hospital even if certified as a freestanding clinic by the Centers for Medicare and Medicaid Services. This contractual agreement with the hospital involves reimbursement for the technical portion of the therapy only.

Billing Procedures

Technical Component – All technical services must be billed on the UB-04 hospital claim form. Payment for outpatient hyperbaric therapy is allowed. Inpatient therapy cannot be billed separately as the fee is included in the hospital DRG or per diem rate.

Professional Component – If a physician directly supervises the HBO therapy, procedure codes for HBO may be billed on the CMS-1500 claim form. No modifier is necessary. The professional component should be coded as one of the following:

- Initial Treatment – An initial treatment is compensable only once per course of treatment for a specific diagnosis. HBO initial treatment is not billed in units of time, but rather the first day of the initial therapy.
- Subsequent Care – All subsequent HBO therapy treatments must be coded as such. Subsequent therapy is defined as any length of therapy following the initial treatment on any given day. If two subsequent treatments are performed on the same date of service (at different times of the day), a second charge may be used with a 76 modifier. HBO therapy is not billed in units of time, but rather in episodes of treatment.

GENERAL SURGERY GUIDELINES

Coverage Guidelines

Criteria outlined in this section are contingent upon demonstrated medical necessity. The medical record must substantiate the need for surgical services including information to support the medical justification. Compensable services include correcting conditions that meet any of the following criteria:

- Conditions that directly threaten the life of the beneficiary
- Conditions that have the potential for causing irreparable physical damage

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PROGRAM SERVICES

Coverage Guidelines (Cont'd.)

- Conditions that can result in the loss or serious impairment of a bodily function
- Conditions that can result in the impairment of normal physical growth and development
- Conditions that result from trauma and must be promptly corrected (*i.e.*, as soon as medically feasible)

When care is furnished outside of these conditions, documentation must be included in the medical record, or when designated, justification must be attached to the CMS-1500 claim form for payment. This includes the history and physical, operative report, discharge summary, and pathology report.

If a claim is submitted that requires support documentation, and the required documentation is not attached to the claim form, the claim will be rejected. In this case, the documentation must be attached to a new claim for review.

Note: All unlisted procedure codes must have documentation attached to the claim form to ensure equitable pricing of the procedure.

To avoid delay in the processing of your claim, do not use an unlisted code when a descriptive code is available. All unlisted codes suspend for review and pricing.

If the reviewer finds a code comparable for the procedure, the unlisted code will be priced at the same rate as the descriptive code. The reviewer may also choose to notify the provider of the proper code to use for future reference.

Hospital Acquired Conditions (HACs)

Effective with dates of service on or after July 1, 2014, SCDHHS will make zero payments to providers for Other Provider Preventable Conditions which includes Never Events. The reporting requirements for Never Events include Ambulatory Surgical Centers (ASCs) and Practitioners. These providers will be required to report Never Events on the CMS-1500 claim form or the 837-P claim transaction. Avoidable errors that fall under this policy include:

- Wrong surgical or other invasive procedure performed on a patient
- Surgery or other invasive procedure on the wrong body part
- Surgical or other invasive procedure performed on the wrong patient

Providers are required to follow the following procedures for reporting avoidable errors (Never Events):

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PROGRAM SERVICES

Hospital Acquired Conditions (HACs) (Cont'd.)

Claims submitted using the CMS-1500 claim form or 837-P claim transaction, must include the appropriate modifier appended to all lines that relate to the erroneous surgery(s) or procedure(s) using one of the following applicable National Coverage Determination modifiers:

- **PA** – Surgery wrong body part
- **PB** – Surgery wrong patient
- **PC** – Wrong surgery on patient

For dates of service on or before **September 30, 2015**, the non-covered claim must also include an ICD-9-CM diagnosis code. Hospital acquired conditions (HACs) ICD-9-CM codes are located on the SCDHHS website on the Physicians Services Provider Manual webpage.

For dates of service on or after **October 1, 2015**, the non-covered claim must also include one of the following ICD-10-CM diagnosis codes reported:

- **Y65.51** – Performance of wrong procedure (operation) on correct patient
- **Y65.52** – Performance of procedure (operation) on patient not scheduled for surgery
- **Y65.53** – Performance of correct procedure (operation) on wrong side or body part

Related Claims

Within 30 days of receiving a claim for a surgical error, SCDHHS shall begin to review beneficiary history for related claims as appropriate (both claims already received and processed and those received subsequent to the notification of the surgical error). Also, the Program Integrity (PI) Division or its designee will audit all claims for the recipient to determine if they relate to or have the potential to be related to the original Never Event claim. When, PI or its designee identifies such claims, it will take appropriate action to deny such claims and to recover any overpayments on claims already processed.

Every 30 days for an 18-month period from the date of the surgical error, PI or its designee will continue to review recipient history for related claims and take appropriate action as necessary. Related services do not include performance of the correct procedure.

General Provisions

Medicaid will not pay any claims for "provider-preventable conditions" for any member who is Medicare/Medicaid eligible.

No reduction in payment will be imposed on a provider for a provider preventable condition, when the condition defined as a PPC for the

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

General Provisions (Cont'd.)

particular member existed prior to the initiation of the treatment for that member by that provider.

Reductions in Provider payments may be limited to the extent that the following apply:

- The identified PPC would otherwise result in an increase in payment.
- The SCDHHS can reasonably isolate for nonpayment the portion of the payment directly related to treatment for and related to the PPC.

To review the complete Health Acquired Conditions policy you may go to http://www.cms.gov/HospitalAcqCond.

Limitations

Certain surgical procedures are routinely not covered. These non-covered procedures typically fall into one of the following categories:

- Do not restore a bodily function
- Are performed for cosmetic reasons
- Have an alternative non-operative treatment
- Frequently are performed for less than adequate diagnostic indications
- Are not proven effective
- Are experimental/investigational in nature
- Are for the convenience of the patient

No reimbursement will be made for subsequent procedures that do not add significantly to the complexity of the major surgery or are rendered incidentally and performed at the same time as the major surgery (*e.g.*, incidental appendectomies, incidental scar excisions, puncture of ovarian cysts, simple lysis of adhesions, simple repair of hiatal hernias).

Exploratory Procedures

If a procedure is carried out through the laparotomy incision, the physician may choose to bill for either the laparotomy or the actual procedure performed during the surgery; most likely, it will be the code that reimburses the higher rate. In any case, South Carolina Medicaid will sponsor payment for either the procedure or the laparotomy, not both.

Under the same principle, when a surgical procedure is performed through an endoscope, the diagnostic endoscopy is inclusive in the reimbursement. The physician may be reimbursed for either the endoscopic procedure or the diagnostic endoscopy, not both.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Exploratory Procedures (Cont'd.)

When endoscopy procedures are performed in the office, small supplies and materials provided by the physician over and above those usually included with the office visit may be billed using procedure code 99070. A minor surgical tray may also be billed using procedure code 99070.

Multiple Surgery Guidelines

Multiple surgeries include separate procedures performed through a single incision, or separate procedures performed through second and subsequent incisions or approaches. All surgical procedures for the same date of service should be filed on one claim form when possible.

Payment Guidelines

When multiple surgeries are performed at the same operative session, the procedure that reimburses the highest established rate will be considered the primary procedure and will be reimbursed at 100% of the established rate. All second and subsequent surgeries performed at the same operative setting will be reimbursed at 50% of the established rate. Procedure codes that are exempt from multiple procedure reduction as outlined by the AMA in the Current Procedural Terminology Standard Edition are reimbursed at 100%.

A vaginal delivery and tubal ligation performed on the same date of service will not be affected by this policy. Both procedures are reimbursed at 100%, even when performed on the same day. Use the 79 modifier on the tubal ligation to ensure correct reimbursement.

Modifiers

Listed services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance must be identified by the addition of the appropriate modifier code, which must be reported by adding a two-digit number (modifier) placed after the procedure number. Modifiers commonly used in surgery are listed in the surgery section of the CPT and in Section 4 of this manual. Only the first modifier indicated will be used to process the claim – Medicaid will key only the first modifier indicated for each procedure.

Billing

Claims for surgery must be filed using the CPT code that most closely describes the surgical procedure that was performed. When this is not applicable, an unlisted procedure code may be used and the appropriate documentation should be attached to the claim form for adequate reimbursement.

Claims for more than one surgical procedure performed at the same time by the same physician must be billed as follows:

- On a single claim form, unless more than six procedures are performed

  Note: If more than one surgical procedure is billed for the same DOS on different claims, the second claim that processes may

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Billing (Cont'd.)

reject. To avoid this delay, file all surgical procedures for the same DOS on one claim form.

- Only for subsequent procedures which add significantly to the major surgery or are not incidental to the major surgery
- Using the appropriate modifier (Medicaid will key the first modifier indicated for each procedure only)
- With charges listed separately for each procedure

When identical procedures (not bilateral) are billed for the same day, the first should be billed without a modifier, and the second with modifier 51. If the same procedure is billed a third time, the claim must be filed hardcopy with supporting documentation.

Modifier 62 should be used to indicate that the skills of two surgeons were required. Modifier 66 should be used to indicate circumstances requiring a surgical team. These modifiers will ensure proper reimbursement for each provider involved.

Modifier 52 should be used to describe reduced services. Modifier 53 is used to describe a discontinued procedure. Both modifiers will be reimbursed at 50% when billed with a surgical procedure.

Separate Procedures Performed on the Same Date of Service

When two separate surgical procedures are performed on the same date of service at different operative sessions, both procedures will be allowed 100% of the established rate.

To report, submit the second procedure with the 78 or 79 modifier. This will ensure that both procedures will be paid at 100%. If not reported in this manner, the lower priced of the two procedures will be reimbursed at 50%. All surgical procedures performed on the same date of service should be filed on the same claim form whenever possible.

Procedure Codes That Multiply

Occasionally the CPT defines certain procedure codes as "each," indicating the possibility of multiple procedures. When filing these types of codes, list the code one time for the date of service and bill the appropriate number of units in the "units" column of the claim form and the total charge for the number of units billed. If there is only one surgical procedure for the date of service and multiple units are billed, payment for codes that multiply will be 100% of the established rate for the first unit and 50% for each additional unit(s) filed. If a surgical procedure with a higher established rate is performed on the same date of service, the higher established rate will be allowed and the code(s) to multiply will pay 50% of the established rate per unit filed.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Automatic Adjustments to Paid Surgical Procedures

All surgical procedure codes for the same patient and same date of service should be filed on the same claim form. This ensures that the correct procedure will reimburse at 100% of the established rate. At times, however, surgical codes are filed on separate claim forms, causing incorrect payments and the need for adjustments.

Automatic adjustments work in the following manner: When a claim for a surgical procedure code is submitted, the system will review the paid claims history for that patient, date of service, and provider. If there is no previously paid surgical code(s) on file for that date of service, the surgery will pay at 100% of the established rate. If, however, there is a previously paid surgery on file for that patient, date of service, and provider, the system will compare the previously paid surgery and the newly submitted surgical code. It will then determine which of the codes should correctly reimburse the provider at 100%. If the newly submitted surgical code should pay at 100%, the system will make an automatic adjustment against the previously paid surgical code by subtracting 50% of the previously paid procedure from the amount to be reimbursed for the newly submitted surgical code. Therefore, the newly submitted surgical code will be allowed at 100% although the payment may not reflect the full amount due because of the recoupment of 50% of the previously paid procedure.

When the system reviews paid claims history for a patient, date of service, and provider, and finds that the previous surgical claim paid correctly at 100% and the second surgical claim should pay at 50% of the established rate, there will be no adjustment as the claim will pay correctly.

Bilateral Surgery

To report a bilateral procedure, bill the first procedure with no modifier, and the second procedure with a 50 modifier. Report on two lines instead of one. A bilateral procedure billed with only one line will result in underpayment. Codes with bilateral descriptions may not be billed with a 50 modifier.

Claims filed for an assistant surgeon performing a bilateral procedure should be filed hardcopy with documentation using the 80, 81, or 82 modifier on both lines of the procedure code that is bilaterally performed.

Bilateral procedures will be reimbursed at 100% for the first procedure, and 50% for the second procedure (same as multiple procedures). If the bilateral procedure is billed in conjunction with another procedure that is normally reimbursed at a higher rate than the bilateral procedure, then each of the bilateral procedures will be reimbursed at 50%.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Billing Procedures

Surgical endoscopic procedures **always include** the diagnostic endoscopy. Therefore, the diagnostic endoscopy code is not allowed in addition to the surgical endoscopy for the same anatomical site.

Under the same principle, when a surgical procedure is performed through an endoscope, the diagnostic endoscopy is inclusive in the reimbursement. The physician may be reimbursed for either the endoscopic procedure, or the diagnostic endoscopy, not both.

Endoscopic procedures do not require a 26 modifier when performed in the inpatient or outpatient hospital setting.

When two endoscopic procedures are performed on the same date of service, the first procedure should be reported without a modifier, and the second procedure should be reported with modifier 51.

Surgical Supplies

Please refer to "Supplies" under "Additional Ambulatory Services" in this section for more detail.

Ambulatory Surgical Services

Many surgical procedures ordinarily performed on an inpatient or outpatient basis consistent with sound medical practice can be performed in an Ambulatory Surgical Center (ASC) for less cost. South Carolina Medicaid recognizes these procedures as compensable if performed in an ASC and included on the ASC list of covered procedures.

Surgeons should utilize only those ASC facilities contracted with South Carolina Medicaid for their Medicaid patients. South Carolina Medicaid reimburses the ASC for the facility charges under strict guidelines. Each ASC contracted is provided with a list of covered procedures (which is subject to change from time to time).

Note: The surgeon should verify with the ASC that the elective procedure is covered under ASC guidelines**.**

To bill for the professional service, the surgeon should submit claims following the usual surgical guidelines, using place of service "24."

Surgical Package

Guidelines

The surgical package includes postoperative care for 30 days following surgery. Postoperative services rendered and billed during this 30-day period will be rejected for an 854 edit code. Normal postoperative care is considered part of the surgical package and includes office examinations and all hospital follow-up visits, including discharge management. Hospital and office E/M visits are allowed up to and including the day of surgery.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Guidelines (Cont'd.)

Emergency room services and critical care are not considered part of the surgical package. They may be billed in addition to the surgery performed. For guidelines on delivery admissions, please refer to "Perinatal Care" under "Obstetrics and Gynecology" in this section.

Surgical procedures that are billed within 30 days prior to a paid office or hospital visit will suspend for review. If applicable, the office or hospital visit(s) will be recouped and the surgery claim will process for payment. The surgical procedure may be rejected with edit 855. In that case, providers should submit a new claim and indicate that the surgery should be paid and the visits should be recouped.

Ambulatory Surgical Services

Complications or services rendered for a diagnostic reason unrelated to the surgery may be billed with a separate examination code if the primary diagnosis reflects a different reason for the service.

To report postoperative visits unrelated to surgery, submit the visit code(s) with modifier 24 or 25. The medical record must substantiate that a visit(s) was justified outside of the surgical package limitation.

Follow-up care in the office and/or hospital may be billed if the surgery is an exception to the surgical package. **A complete table of codes that are considered part of the surgical package is located in Section 4 of this manual ("Procedure Codes").**

Assistant Surgeon

Guidelines

All guidelines that apply to the primary surgeon also apply to the assistant surgeon. The CPT surgical procedure codes (10000 – 69999) that allow an assistant surgeon's fee are listed in Section 4 of this manual ("Procedure Codes").

Note: These allowances are subject to change and should be used as a reference only.

When billing for the assistant surgeon's fee, the modifier 80, 81, or 82 must accompany all procedure codes filed. Assistant surgeons must be physicians. Medicaid will not reimburse non-physician surgery assistants.

If, due to unforeseen circumstances, the surgery did require an assistant, and an assistant surgeon is not allowed for the surgical procedure, Medicaid will review the claim for reimbursement. Providers may submit a new claim with documentation for medical review. The medical record must justify the special need for an assistant surgeon.

An assistant surgeon will be reimbursed at 20% of the total allowable fee per procedure.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Billing

An assistant surgeon must use the same CPT procedure codes as the primary operating surgeon. The assistant surgeon modifier is the only modifier required for each procedure billed. Medicaid will only key the first modifier indicated.

The claim for the assistant surgeon must be submitted with a different individual provider number (rendering physician) from the primary surgeon. The assistant surgeon must be enrolled with South Carolina Medicaid in order to receive reimbursement.

Claims filed for an assistant surgeon performing a bilateral procedure should be filed using the 80, 81, or 82 modifier.

SURGICAL GUIDELINES FOR SPECIFIC SYSTEMS

Integumentary System

Lesion Removal

Excision/treatment of non-malignant dermal lesions and other dermal anomalies are not covered routinely. However, Medicaid will provide coverage of these anomalies if the therapy conforms with accepted treatment standards of the particular problem and meets **one** of the following conditions:

- The lesion is pre-cancerous or suspected to be cancerous by physical findings, appearance, or changes in characteristics.
- The anomaly causes pain, irritation, or numbness that result in the functional impairment of bodily functions or normal growth and development.
- At least two alternative methods of treatment (*i.e.,* steroid injection, compression, silicone gel treatment, etc.) have been attempted and found ineffective.
- The anomaly is responsible for the loss of a bodily function and the treatment restores the disabled function.

Medicaid will not provide coverage for excision/treatment of non-malignant dermal lesions and dermal anomalies under the following circumstances:

- The treatment is performed for cosmetic or emotional purposes.
- The therapy is experimental or investigational.

For dates of service on or before **September 30, 2015**, supporting documentation is required for a claim submitted for a lesion and a dermal anomaly removal or revision with diagnosis codes 701.4 and

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Lesion Removal (Cont'd.)

709.2. Medicaid will **not** cover treatment that is considered to be experimental, investigational (*i.e.*, chemical peels, cryosurgery, dermabrasion, punch grafts, bleomycin, interferon, and verapimil injections), or done for cosmetic or emotional purposes.

For dates of service on or after **October 1, 2015**, supporting documentation is required for a claim submitted for a lesion and a dermal anomaly removal or revision with diagnosis codes L91.0 and L90.5. Medicaid will not cover treatment that is considered to be experimental, investigational (*i.e.*, chemical peels, cryosurgery, dermabrasion, punch grafts, bleomycin, interferon, and verapimil injections), or done for cosmetic or emotional purposes.

Keloid/Scar Conditions

Medicaid will provide coverage of excision and/or treatment of a Keloid scar and scar conditions and fibrosis of the skin if the therapy conforms to accepted standards of the particular problem and meets one of the following conditions:

- The scar causes functional impairment which interferes with daily living.
- The scar is symptomatic with a history of ulceration or inflammation that causes repeat office visits. At least two methods of treatment such as radiation (silicone gel treatment), compression, steroids, and laser surgery have been tried and failed.
- There is a history of repeated infections with the scar.

Claims for the above treatments must be accompanied by documentation that supports the criteria as outlined above. Medicaid will not provide coverage for excision and/or treatment of nonmalignant dermal lesions, dermal anomalies and Keloid/scar conditions under the following circumstances:

- The treatment is performed for cosmetic or emotional purposes.
- The therapy is experimental or investigational.

Examples include chemical peels, cryosurgery, dermabrasion and punch grafts.

Skin Grafts (15100, et. al.)

Providers should follow CPT guidelines when billing for skin grafts. Procedures are identified by size and location of the defect (beneficiary area) and the type of graft. Skin graft codes that pertain to subsequent (each additional square centimeter) areas should be billed in units.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Destruction Codes (17000, et. al.)

Treatment must be medically indicated according to the criteria set forth in the guidelines previously stated. Procedure codes 17360 and 17380 are considered cosmetic and therefore non-compensable.

Cosmetic Procedures

Cosmetic surgery or expenses incurred in connection with such services are non-covered. Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt repair of accidental injury (*i.e.*, as soon as medically feasible), or for the improvement of the functioning of a malformed body member. This exclusion does not apply to surgery for therapeutic purposes which coincidentally also serves some cosmetic purposes.

Cosmetic otoplasty is not covered under normal circumstances. Payment will be considered for otoplasty procedures for children under 21, but only if there is documented evidence of psychological trauma because of their appearance. A psychiatric evaluation performed by a psychiatrist recommending treatment, plus pertinent medical documentation, must be attached to the claim. Lack of – or insufficient documentation will result in a rejected claim. All otoplastic procedures must be preauthorized by KEPRO, the Quality Improvement Organization (QIO) contractor.

Repair of the following birth defects is not considered cosmetic surgery: cleft lip, cleft palate, clubfoot, webbed fingers and toes, congenital ptosis, and other birth defects which impair bodily functions.

Chemosurgery (Moh's Technique)

Codes 17311 – 17315 are compensable if medically justified and not performed for cosmetic purposes.

Mohs micrographic surgery is defined by the American Medical Association's (AMA) *Current Procedural Terminology* as a technique for the removal of complex or ill-defined skin cancer with the histologic examination of 100% of the surgical margins. It requires a single physician to act in two integrated but separate and distinct capacities: surgeon and pathologist.

Prior Authorization for Mammaplasty and Mastectomy and Reconstructive Procedures

Reduction mammaplasty and gynecomastia, mastectomy procedures must be preauthorized by KEPRO using InterQual criteria. A Request for Prior Approval form must be used when submitting a request for these services. A sample copy of the Request for Prior Approval form can be found in the Forms section of this manual. The attending physician shall obtain prior authorization and submit all necessary documentation to KEPRO.

The following policies should be followed for reduction mammaplasty and gynecomastia:

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PROGRAM SERVICES

Prior Authorization for Mammaplasty and Mastectomy and Reconstructive Procedures (Cont'd.)

- Prior authorization is required for all ages.
- Photographs must be submitted with all requests.
- Pathology/operative reports are no longer needed.
- KEPRO will conduct all reviews.
- Physicians are responsible for verifying beneficiary eligibility prior to the prior authorization request being submitted.
- Physicians are responsible for providing the prior authorization number to any facility or medical provider who will submit a Medicaid claim.

Reduction Mammaplasty

Reduction mammaplasty for large, pendulous breasts on a female may be considered medically necessary when InterQual screening criteria are met. Prior Authorization is required for all ages. A claim is reviewed for medical necessity and must be submitted with the preoperative assessment from the patient's record.

Reconstructive Breast Surgery

Reimbursement is allowed for reconstructive breast surgery following a mastectomy performed for the removal of cancer or for prompt repair of accidental injury. Prior authorization and/or support documentation must be obtained. KEPRO is responsible for prior authorization and support documentation requests. InterQual screening criteria applies.

Breast reconstruction done for cosmetic reasons is non-covered. Augmentation is non-covered under all circumstances. Payment is made for special bras through the Durable Medical Equipment program for women who have undergone any type of mastectomy.

Gynecomastia

Although unilateral or bilateral mastectomy in a male is rarely indicated, this procedure may be allowed when medically necessary. Prior authorization must be obtained by the attending physician.

South Carolina Medicaid Request for Prior Approval Form and all necessary documentation should be sent to KEPRO. InterQual screening criteria applies.

Male Gynecomastia

Repeat Male Gynecomastia may be considered when supporting documentation meets InterQual screening criteria.

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PROGRAM SERVICES

Musculoskeletal System

Facial Reconstructive Codes

Certain facial reconstructive procedures are covered. The criteria are contingent upon medical necessity as outlined in the General Surgery guidelines. Justification includes result of severe trauma and/or congenital malformations. Each claim must have support documentation attached. If there is no documentation, the claim will be rejected.

If the reconstructive process must be performed in stages, each claim must have documentation that includes all prior stages. A consultant for the specialty will review each claim and make a determination.

Under no circumstances is payment allowed for reconstructive surgery performed for cosmetic reasons alone.

Fracture Repair (For Acute Care of an Injured Part)

All codes listed in the musculoskeletal section of the CPT are considered surgical packages with the exceptions of those listed in this manual.

The original application of a cast, splint, strapping, or traction device is included in the treatment of a fracture or dislocation and may not be billed separately.

Grafts

Most bone, cartilage, and fascia graft procedures include the obtaining of the graft by the operating surgeon. When the assistant surgeon obtains the graft for the operating surgeon, the additional service may be identified and reported separately (20900-20926).

Casts

Application – The original application of a cast, splint, strapping, or traction device is included in the treatment of a fracture or dislocation and may not be billed separately except for the application of a halo type body cast, Risser jacket, turnbuckle jacket, body cast, or hip spica cast. Supplemental codes A4580 (plaster) or A4590 (fiberglass) can be billed additionally for cast supplies.

Plaster casts for rehabilitation are compensable using the appropriate CPT codes for the upper or lower extremity. Reimbursement includes the actual application of the cast. Supply codes may be billed in addition to the application.

Synthetic casts (fiberglass) are covered, but may only be billed one time during the patient's course of treatment. A delayed or non-union replacement or the replacement of a patellar-tendon-bearing (PTB) cast is covered.

Replacement – The application of a cast, splint, strapping, or traction device is reimbursable if it is a replacement or subsequent replacement to the original cast, splint, strapping, or traction device.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Casts (Cont'd.)

Removal – Codes for cast removals are reimbursable only if another physician applied the cast.

Repair – To report any repairs made to a cast, use the supplemental codes A4580 – cast supplies (plaster), or A4590 – cast supplies (fiberglass).

Cast Codes – Cast codes 29035, 29040, 29044, 29046, 29305, and 29325 will reimburse in an outpatient setting when the physician applies the cast. If these codes are applied by a hospital technician, then no reimbursement to the physician will be allowed.

Application or Strapping – If cast application or strapping is provided as an initial service (*e.g.*, casting of a sprained ankle or knee) in which no other procedure or treatment (*e.g.*, surgical repair, reduction of a fracture or joint dislocation) is performed or is expected to be performed by a physician rendering the initial care only, use the casting, strapping, and/or supply code (99070) in addition to an evaluation and management code as appropriate.

Splints

Plaster splints – Plaster splints are compensable using the appropriate CPT-4 codes for the upper or lower extremity. The reimbursement includes the materials used as well as the actual application of the splint.

Synthetic splints – Synthetic splints (fiberglass) are covered, but may only be billed one time during the patient's course of treatment. Any replacement is non-covered and cannot be billed except a PTB, delayed, or non-union cast.

Custom Splints – Custom-made splints are recognized as a viable part in the patient's rehabilitative period of treatment. Reimbursement is allowed for these splints only when made by a licensed orthotist or occupational therapist. To report any repairs or adjustments made to a splint, use code 99070.

Prefab Splints – Prefabricated splints (velcro closure) are non-compensable under the Physician Services program.

Orthotic Supplies

Please refer to the heading "Durable Medical Equipment/Supply" in this section.

Cardiovascular System

Vascular Injection Procedures

Listed services for injection procedures include necessary local anesthesia, introduction of needles or catheters, injection of contrast medium with or without automatic power injection, and/or necessary pre- and post-injection care specifically related to the injection procedure. For injection procedures in conjunction with cardiac

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Vascular Injection Procedures (Cont'd.)

catheterization, please refer to "Cardiology" under "Specialty Care Services" in this section.

Radiological vascular injections performed by a single physician are compensable separate from the radiology service. Catheters, drugs, and contrast media are not included in the listed service for these injection procedures.

For insertion of a Swan-Ganz catheter **not** associated with cardiac catheterization, use procedure codes from the 36000 range (in lieu of a heart cath code).

Implantable Vascular Access Portal/Catheter

For port-a-cath maintenance, use the appropriate J codes, supply codes, and office visit code when applicable. Do not use an unlisted CPT code for catheter maintenance.

Digestive System (et. al.) (40490 – 49999)

Contralateral Inguinal Exploration

Medicaid will reimburse for a contralateral inguinal exploration when a unilateral herniorrhaphy has been performed on an infant (under age five years). To report this service, use procedure code 49500 along with the procedure code for herniorrhaphy and attach support documentation for medical review.

Gastric Bypass

Please refer to "Gastroenterology" under "Specialty Care Services" in this section regarding treatment of obesity and bariatric surgical procedures.

Urinary System (50010 – 53899)

Services listed in this section are covered when medically necessary, with the following restrictions:

- Endoscopic Procedures – Follow guidelines for endoscopic procedures under General Surgery guidelines.
- Urodynamics (51725 – 51798) – These procedures may be billed in addition to the appropriate surgical code (Cystourethroscopy). Reimbursement includes equipment and supplies.

  When performed (and billed) on the same DOS as the surgery, these services are not considered surgical and will be reimbursed at 100% of the established rate. Use code 51798 when billing the measurement of post-void residual urine by ultrasound. Documentation should include the urine measurement.
- Urinary Supplies – Please refer to the "Durable Medical Equipment/ Supply" heading in this section.
- Lithotripsy – Percutaneous, extracorporeal shock wave, and cystourethroscope lithotripsy are covered services when

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Urinary System (50010 – 53899) (Cont'd.)

medically necessary. The physician is reimbursed only for the professional service. If the procedure is performed bilaterally, bill on two lines adding no modifier to the first procedure, and a 50 modifier to the second (bilateral) procedure.

Male Genital System

Routine newborn circumcisions are non-covered services.

Circumcisions to be performed due to medical justification require prior approval, which must be granted utilizing the "**Request for Prior Approval Review" form found in the "Forms" portion of the appendices section of the manual. Support documentation must accompany the form and be faxed "Attention Circumcision Review" to 803-255-8255.** Cosmetic reconstruction of the penis is non-compensable without medical justification. Prior approval must be granted by Medical Services Review before services are considered for payment.

Penile implants are non-covered unless prior approval is obtained. Reimbursement will not be allowed for penile prosthesis if the only reason is sexual dysfunction. The criteria for approval are based on medical necessity. Examples would be chronic depression as a result of sexual dysfunction or a paraplegic with decubitus problems who would benefit from better condom urine drainage.

The following support documentation is required:

- Summary of psychiatric care
- The medical condition that surgery is expected to improve
- History and physical

As with cosmetic reconstruction, prior approval must be granted by KEPRO, the Quality Improvement Organization (QIO) contractor. A complete list of procedures requiring prior authorization is located in Section 4 of this manual.

Sterilization requirements are the same as for females. (Please refer to "Elective Sterilization" under "Obstetrics and Gynecology" in this section.)

Nervous System (61000 – 64999)

No special restrictions apply other than those defined in the general surgery and pain therapy guidelines.

Spinal Procedures for Injection of Anesthetic Substance

Codes 62274 – 62279 are reimbursed for the initial placement of an indwelling catheter for anesthesia purposes. Subsequent injections of the anesthetic agent are not allowed under the injection code. For maintenance of an epidural, please refer to "Anesthesia Services" and "Pain Management Services" in this section for additional information.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Implantable Infusion Pumps

An implantable infusion pump is covered when used to administer anti-spasmodic drugs intrathecally (*e.g.*, Baclofen) to treat chronic intractable spasticity in patients who have proven unresponsive to less invasive medical therapy as determined by the following criteria:

- As indicated by at least a six-week trial, the patient cannot be maintained on non-invasive methods of spasm control.
- Prior to pump implantation, the patient must have responded favorably to a trial intrathecal dose of the anti-spasmodic drug.

Each claim will be reviewed for these criteria. Claims submitted without documentation will reject.

Implantable infusion pumps are also covered for treatment of pain. Please refer to "Pain Management Services" in this section for additional information.

UTILIZATION REVIEW SERVICES

SCDHHS contracts for utilization review services with KEPRO, the current QIO contractor.

The QIO review consists of:

- Pre-surgical justification for all hysterectomies
- Select preauthorization review
- Support documentation review
- A retrospective review of a sample of paid inpatient/outpatient hospital claims
- Select project studies as determined by SCDHHS

Screening criteria may be obtained upon request from KEPRO. Any questions or concerns should be directed to KEPRO customer service at 1-855-326-5219 or emailed to atrezzoissues@Kepro.com. Please be advised that a beneficiary should not contact KEPRO directly.

Telephone or written approval from the QIO is not a guarantee of Medicaid payment. All cases will be subject to retrospective review to validate the medical record documentation.

SCDHHS reserves the right to review retrospectively any case that has received prior approval to assure accuracy and compliance with South Carolina Medicaid guidelines and federal requirements.

Prior Approval for Hysterectomy

All prior approval requests for hysterectomies must be in writing. Forms are accepted via fax, email, or website using the South Carolina Medicaid Program Surgical Justification Form and Consent for Sterilization Form (DHHS 687). Copies of these forms are located in the

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Prior Approval for Hysterectomy (Cont'd.)

Forms section of this manual. Completed forms must be submitted at least 30 days prior to the scheduled date of surgery.

All requests for prior authorizations **must** be submitted via facsimile, email, or website to KEPRO. Requests for prior authorization must be submitted **before** the service is rendered. Exceptions to this policy include emergency, urgent case or retroactive eligibility. Emergency or urgent cases **must also** be submitted for approval via facsimile before the claim is sent to processing.

Prior authorization, support documentation, quality assurance, and quality care inquires must be submitted to KEPRO using one of the following methods:

KEPRO Customer Service:	1-855-326-5219
KEPRO Fax:	1-855-300-0082
For Provider Issues email:	atrezzoissues@Kepro.com

KEPRO urgent and emergent hysterectomy cases will be reviewed retrospectively. Please refer to "Special Coverage Issues" in this section for additional Medicaid policies for hysterectomies. Cases that do not meet the QIO criteria will be referred for physician review. The physician will use clinical judgment to determine whether the proposed treatment was appropriate to the individual circumstances of the referred case. Pre-approved cases will not be subject to retrospective review by the QIO. However, SCDHHS reserves the right to review any paid claim and recoup payment when medical necessity requirements are not met. The patient and physician shall make the final decision as to whether to undergo surgery. Medicaid will not sponsor the hospital-related expenses associated with the surgery if the QIO physician consultant determines that the proposed surgery is not appropriate.

Medicaid Prior Approval from KEPRO

For dates of service on or before **September 30, 2015**, please refer to Section 4 of this manual for a list of the CPT and ICD-9 codes that require either prior authorization or support documentation submitted to KEPRO.

For dates of service on or after **October 1, 2015**, please refer to Section 4 of this manual for a list of the CPT and ICD-10 codes that require either prior authorization or support documentation submitted to KEPRO.

Instructions for Obtaining Prior Approval

The responsibility for obtaining pre-admission/pre-procedure review rests with the attending physician. The physician must submit all necessary documents, including the Request for Prior Approval Review Form, to KEPRO.

Requests for prior authorizations from KEPRO may be submitted using one of the following methods:

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Instructions for Obtaining Prior Approval (Cont'd.)

KEPRO Customer Service:	1-855-326-5219
KEPRO Fax:	1-855-300-0082
For Provider Issues email:	atrezzoissues@Kepro.com

If the beneficiary has a primary coverage through Medicare or any other private health insurance, prior authorization by KEPRO is not required

The QIO reviewer will screen the medical information provided, using appropriate QIO or InterQual criteria for non-physician review

If criteria are met, the procedure will be approved and an authorization number assigned. Notification of the approval and authorization number will be given by written confirmation to the physician. Write this number in block 23 of the CMS-1500 claim form.

If criteria are not met or a case is otherwise questioned, the QIO reviewer will refer the procedure request to a physician reviewer. If the physician reviewer cannot approve the admission/procedure based on the initial information provided, he or she will make a reasonable effort to contact the attending physician for additional supporting documentation of the need for the procedure.

The physician reviewer will document any additional information provided, as well as his/her decision regarding the medical necessity and appropriateness of the procedure.

Review personnel will assign an authorization number (if the procedure is approved), and a written copy of the authorization number will be sent to the physician.

If the physician reviewer cannot approve the procedure based on the additional information, he or she will document the reasons for the decision. QIO review personnel will attempt to notify the attending physician's office of the denial.

QIO will verify all initial procedure denial decisions by issuing written notices to the attending physician.

The attending physician may request a reconsideration of the initial denial decision by submitting a written request outlining the rationale for recommending the procedure. Reconsideration may be requested whether the case was pre-procedure or post-procedure reviewed. The request should be in writing to KEPRO. If a case is denied upon reconsideration, the determination is final and binding upon all parties (CFA 473.38).

Points of Emphasis for Prior Authorization

KEPRO **will accept medical review documentation via facsimile, telephone, or via their website.** Providers are responsible for verifying beneficiary eligibility prior to the prior authorization request being submitted and again prior to performing a service. Eligibility and

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Points of Emphasis for Prior Authorization (Cont'd.)

managed care enrollment status may change during the time a request is submitted and approved and the actual date the procedure is performed.

A prior authorization request for beneficiaries enrolled in a managed care organization (MCO) must be handled by the MCO. If you have any additional questions regarding the MCO you may contact the MCO's Provider Services department, or the Managed Care area at (803) 898-4614. Contact information for the MCOs is located in the Managed Care Supplement.

Physician providers are responsible for providing the prior authorization number to any facility or medical provider who will submit a Medicaid claim.

The hysterectomy policy has changed. Please refer to "Prior Approval for Hysterectomies from KEPRO" in this section for more detail.

For instructions on how to obtain a prior authorization from KEPRO, please refer to "Medicaid Prior Approval from KEPRO" in this section.

ORGAN TRANSPLANTATION

KEPRO will provide direct oversight of the Medicaid transplant program. SCDHHS will only support the referral of patients for an evaluation to Centers for Medicare and Medicaid Services (CMS) certified transplant centers. This will include certified facilities that are contracted with SCDHHS as well as certified facilities that are located outside of the South Carolina medical service area (less than 25 miles of the South Carolina borders). For a complete listing of transplant services requiring prior authorization by KEPRO, please refer to Section 4 of this manual.

Group I – Kidney and Corneal

Kidney Transplantation

Medicaid will reimburse for kidney transplants. Professional services, including the nephrectomy and transplantation of the new organ, performed by a physician team, are reimbursed separately. Inclusive charges are compensable for the services rendered on behalf of the Medicaid-eligible beneficiary. Medicare coverage is primary and Medicaid will only pay if Medicare benefits are either not available or have been denied

A Medicare denial of benefits must accompany the claim, and the patient must be End Stage Renal Disease (ESRD) enrolled with Medicaid. (Please refer to "Nephrology and End Stage Renal Disease Services" under "Specialty Care Services" in this section.)

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Corneal Transplantation (Keratoplasty)

Corneal transplants are compensable. The reimbursement to the hospital includes all technical services, including donor testing and preparation.

Professional services are compensable using CPT codes 65710-65755. All general surgery guidelines apply when billing for keratoplasty.

SCDHHS will cover the cost of the corneal tissue when a corneal transplant is performed in an Ambulatory Surgical Center (ASC). The ASC will be reimbursed for the transplant surgical procedure and the corneal tissue must be submitted with the HCPCS procedure code V2785 (processing, preserving, and transporting covered tissue). ASC providers must attach a copy of the invoice reflecting the cost of the tissue along with the claim to avoid delays in payment.

Transportation for Medicaid Beneficiaries Requiring Group I Transplants

Transportation arrangement for Group I transplants are coordinated through the Division of Preventive Care. For information on the transportation program, you may call the PSC at 1-888-289-0709, submit an online inquiry at http://www.scdhhs.gov/contact-us, or write to:

SCDHHS
Division of Preventive Care
Post Office Box 8206
Columbia, SC 29202

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

All Group II organ transplants, with the exception of Bone Marrow (Autologous Inpatient and Outpatient, Allogenic Related and Unrelated, Cord, and Mismatched), require prior authorization from KEPRO. Referral requests for organ transplants to both in-state and out-of-state centers must be submitted to KEPRO before services are rendered.

Requests for prior authorizations from KEPRO may be submitted using one of the following methods:

KEPRO Customer Service:	1-855-326-5219
KEPRO Fax:	1-855-300-0082
For Provider Issues email:	atrezzoissues@Kepro.com

In addition to completing the Transplant Prior Authorization Request Form, the request must also include a letter from the attending physician with the following patient information:

- The description of the type of transplant needed
- The patient's current medical status
- The patient's course of treatment
- The name of the center to which the patient is being referred

Upon approval, KEPRO will issue an authorization number to the

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

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 (Cont'd.)

requesting physician with instructions for its use. The transplant authorization number must be included on all claims submitted for reimbursement. Transplant Prior Authorization Request Form can be found in the Forms section of this manual.

KEPRO reserves the right to make recommendations to the provider for services at a certified center that has provided transplant services to Medicaid beneficiaries in the past. Please note that the approval of a transplant evaluation **does not** guarantee the approval of the actual transplant.

The appropriate transplant team, utilizing uniform professional and administrative guidelines, will determine medical necessity and clinical acceptability. For more information, please contact KEPRO at 1-855-326-5219.

ANESTHESIA SERVICES

Anesthesia services consist of services rendered by a physician, a certified registered nurse anesthetist (CRNA), or anesthetist assistant (AA) other than the attending surgeon or his or her assistant, and shall include the administration of a spinal or rectal anesthesia, or a drug, or other anesthetic agent. The agent may be administered by injection or inhalation, except by local infiltration, the purpose and effect of which administration is the obtaining of muscular relaxation, loss of sensation, or loss of consciousness. The reporting of anesthesia services is appropriate by or under the responsible supervision of a physician.

CPT codes 00100 – 01999 are accepted for the billing of anesthesia services. Use of the surgical procedure code will result in a rejection. When multiple surgical procedures are performed during the same period of anesthesia, only the anesthesia procedure code for the major procedure should be billed and the total time should reflect coverage for all procedures. Base time associated with the procedure code will be automatically assigned from the procedure code billed.

There is no additional payment for anesthesia services rendered by the attending surgeon or assistant surgeon when performed on an inpatient or outpatient basis.

Time Reporting

Anesthesia time involves the continuous, actual presence of the anesthesiologist or the medically directed CRNA/AA. It starts when the anesthesiologist begins to prepare the patient for anesthesia care in the operating room and ends when the anesthesiologist is no longer in continuous, actual attendance.

South Carolina Medicaid only accepts actual time when billing for anesthesia services. **Report time in minutes in the units field (Item 24G) of the CMS-1500 claim form.**

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Time Reporting (Cont'd.)

Example:

Anesthesia Start Time – 1:15
Anesthesia Stop Time – 2:45
Total Anesthesia Time Billed in Minutes – 90

Modifiers of Anesthesia Services

Unless anesthesia services are provided and billed as supervision, the administration of anesthesia must be personally provided by the physician, who remains in constant attendance of the patient. Anesthesiologists must indicate this by using the AA modifier in conjunction with the appropriate anesthesia CPT code.

Anesthesiologists billing as a member of the anesthesia team, for supervision of anesthesia services rendered by a CRNA/AA, resident, or intern, must use the modifier listed below which best reflects the situation:

QY – Medical direction of one CRNA by an anesthesiologist

QK – Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals

AD – Medical direction of more than four concurrent procedures involving qualified individuals.

Anesthesia procedures that involve both a supervising anesthesiologist and a CRNA/AA will have reimbursement divided so that the anesthesiologist receives 60% and the CRNA/AA will receive 50% of the established reimbursement rate for the procedure. The anesthesiologist will bill his or her services using the QY modifier and the CRNA will bill using QX.

If the complexity of a surgery or complications that develop during surgery require both the CRNA and the anesthesiologist to be involved completely and fully in a single anesthesia case, both providers may bill for their services. **The complexity of service or complications must be clearly documented in the patient's records and submitted with the claim.** The anesthesiologist must bill using the AA modifier, anesthesia services performed personally by anesthesiologist. The CRNA must bill using the QZ modifier. These claims must be filed hardcopy with documentation supporting the need for both professionals.

Routine scheduling of a CRNA/AA, resident, or intern to assist an anesthesiologist in the care of a single patient <u>does not</u> justify medical necessity.

CRNAs billing for services rendered under the medical direction of a surgeon must indicate this by using the QZ modifier (CRNA service: without medical direction by a physician) in conjunction with the

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Modifiers of Anesthesia Services (Cont'd.)

appropriate CPT anesthesia code. CRNAs not working under the medical direction of a surgeon will be reimbursed at 87% of the anesthesiologist reimbursement rate.

CRNA/AAs billing for services rendered as a member of the anesthesia team, under the supervision of an anesthesiologist, must indicate this by using the QX modifier in conjunction with the appropriate CPT anesthesia code.

The following CPT modifiers are non-covered:

P1 – A normal healthy patient

P2 – A patient with mild systemic disease

P3 – A patient with severe systemic disease

P4 – A patient with severe systemic disease that is a constant threat to life

P5 – A moribund patient who is not expected to survive without the operation

P6 – A declared brain-dead patient whose organs are being removed for donor purposes

The monitored anesthesia care modifiers QS, G8, and G9 do not describe medical direction involved in the anesthesia procedure. The monitored anesthesia care modifiers describe the type of anesthesia care. It is important to use a modifier that describes the medical direction involved as the first modifier when using more than one. Medicaid only accepts one modifier.

Anesthesia Risk Factors

Procedures

The 99100 – 99140 risk factor codes are non-covered.

Intubation

Payment is allowed for intubation (31500) performed in the ICU or emergency room by an anesthesiologist or CRNA. Intubation is considered a regular part of anesthesia services and may not be a fragmented charge when performed in conjunction with anesthesia services.

Catheter Placement

Anesthesiologists are reimbursed for placement of central venous, subclavian, arterial, or Swan-Ganz catheters in addition to anesthesia services. CRNA/AAs <u>will not</u> be reimbursed for these codes. The anesthesiologist files these codes with **no modifier**.

36010*	36555	36620
36011	36556	36625
36012	36568	36640

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Catheter Placement (Cont'd.)

36013	36569	93503 (Swan-Ganz)
36014	36580	
36015	36584	

*This code may not be billed in addition to general anesthesia procedure codes.

Spine and Spinal Cord Puncture for Injection

Medicaid reimburses personally performing anesthesiologists and CRNAs for the following spine and spinal cord puncture codes. Either the anesthesiologist or CRNA may bill for the codes listed below without a modifier, but not both.

62272	62282	62291	62324 62325
62273	62284	62292	62326 62327
62280	62287	62320	62321
62281	62290	62322	62323

For placement of the continuous epidural catheter, an anesthesiologist or CRNA, personally performing or supervised, bills 62326 or 62327 with the appropriate modifier.

Laboring Epidural

The continuous epidural codes for the vaginal delivery (01967) and a vaginal delivery becoming a caesarean (01968) reimburses a flat rate regardless of the time involved. The anesthesiologist and CRNA must bill with the appropriate modifier indicating personally performed or as part of an anesthesia team.

When a vaginal delivery becomes a Caesarean section and the catheter remains in place for the Caesarean section, you must bill for the vaginal delivery (01967) and then use the add-on code 01968. CPT code 01968 is an add-on code and therefore must be billed in conjunction with the 01967.

If the Caesarean section is performed under general anesthesia you may bill the time for the Caesarean section only, using procedure code 01961 in addition to the labor and delivery epidural (01967).

For a scheduled Caesarean section, an anesthesiologist or CRNA bills (01961) with payment based on time.

When a tubal is performed at a later surgical session and the same catheter remains in place and is redosed, it is not appropriate to bill general anesthesia based on time. A procedure code from 62273, 62281 – 62282, or 62320 – 62327 would be appropriate.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Anesthesia Consultations

Consultative services rendered on behalf of any direct or indirect patient care are included in the basic value of the anesthesia payment and may not be charged separately. However, if an anesthesiologist is requested to consult with another physician or hospital anesthetist, or examines a patient to determine the appropriate anesthetic agent and does not furnish direct anesthesia services or assume direct supervision of the anesthesia service, then the anesthesiologist may bill a separate consultation code based on the appropriate level of service.

The anesthesiologist may bill a consultative code if the surgery is cancelled. An anesthesiologist may not charge a consultative service in addition to any anesthesia service (either for supervision or direct care).

Fragmented Charges

Services considered an integral part of anesthesia services, such as blood gases, venipuncture, oxygen capacity, blood transfusions, administration of medications, intubation in the operating room, etc., are non-compensable when billed separately.

PAIN MANAGEMENT SERVICES

The complaint of pain remains the single greatest reason for seeking medical attention. Pain is defined as an unpleasant sensory and emotional experience associated with actual or potential tissue damage. The condition is considered chronic pain when it has been present continuously or intermittently for six months or more, or it has extended two to three months beyond the expected recovery time. It is of utmost importance that medical providers seek the source of the pain in addition to working to relieve and resolve the pain. Patient history must be reviewed to ensure all areas of treatment have been explored. Appropriate referrals for concurrent medical or psychological treatment must be made. This requires all physicians, not just pain specialists, to understand the pain symptoms and their underlying cause.

The primary objectives of pain management must be to accomplish the following:

- Eliminate the use of optional health care services for primary pain complaints
- Increase physical activities and return the patient to productive activity
- Increase the patient's ability to manage pain and related problems
- Reduce the use and misuse of medication
- Decrease the intensity of subjective or illusory pain

The policies outlined in the remainder of the "Pain Management Services" segment apply to physicians of all specialties.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Documentation Requirements

Patient records must indicate medical necessity and are subject to post-payment review. Documentation in the record must indicate the treatment process, which includes the service(s) to be provided, diagnostic procedures, and treatment goals. Goals should be specific according to patient needs and the services to be rendered.

Progress summaries must be documented at a minimum of every three months. The summaries must address the patient's progress toward treatment goals, appropriateness of services rendered, and recommendations for the continued need for services.

Evaluation and Management (E/M) Visits

Adult Medicaid beneficiaries (age 21 and older) have a limited number of ambulatory care visits each fiscal year. Please refer to "Ambulatory Care Visit Guidelines" in this section for additional guidance when billing for ambulatory visits for adults.

All covered ancillary services, including other diagnostic lab and x-ray services, are compensable. Surgical and diagnostic procedures, hospital care, and other medically necessary services are reimbursed regardless of the number of ambulatory visits used by the patient.

One office or inpatient consultation necessary for screening a beneficiary focusing on identifying the cause of the pain and developing a pain management plan will be covered. When the consultant assumes responsibility for a portion or all of the patient's condition, appropriate office visit or subsequent hospital care codes should be used after the initial consultation. Consultative services related to any direct or indirect patient care are included in the basic value of an anesthesia payment and cannot be billed separately.

Evaluation and management guidelines apply to office, inpatient, and outpatient hospital care for pain management.

Postoperative Pain Management

Physicians billing for postoperative pain management should bill procedure code 62320-62321 (single) or 62324-62325 (continuous) when the insertion of the epidural catheter is for purposes other than surgical anesthesia. These codes include an allowance for insertion of the needle or catheter into the epidural space, and an allowance for injecting the drug or medication through the portal. If a continuous epidural is used for surgical anesthesia and remains in for postoperative pain, an additional insertion cannot be billed for management of the postoperative pain. Procedure codes 62320-62321 and 62324-62325 should be billed with no modifier for the initial insertion.

Procedure code 01996 should be billed for daily management of the epidural analgesia on days subsequent to the day of insertion of the

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PROGRAM SERVICES

Postoperative Pain Management (Cont'd.)

epidural catheter. Up to five days of postoperative pain management may be allowed without additional documentation to justify the extended service. Unless a separately identifiable service has been rendered on the same day, do not bill any other service, including an E/M code with procedure code 01996.

Modifier QZ or AA (anesthesia services performed personally by anesthesiologist) must be used with procedure code 01996. Please refer to "Anesthesia Services" in this section for a description of these modifiers.

External Infusion Pumps

The condition of external infusion pumps is covered for the following:

- Opioid drugs for intractable cancer pain
- Treatment for acute iron poisoning or iron overload
- Chemotherapy for liver cancer
- Treatment for thromboembolic disease and/or pulmonary embolism

Other uses of the external infusion pump may be reimbursable if the provider can document the medical necessity and appropriateness of this type of therapy and pump for the individual patient. Prior approval must be requested in writing for a condition other than those listed above.

Spinal Cord Neurostimulators

Neurostimulator now require prior authorization by KEPRO, the quality improvement organization. For a complete list of procedures that require prior authorization, please refer to Section 4 of this manual. The implantation of spinal cord neurostimulators will be covered for the treatment of severe and chronic pain. Implantation of this device, related services and supplies, may be covered if InterQual criteria are met.

The implantation of the neurostimulator may be performed on an inpatient or outpatient basis according to medical necessity.

Procedure codes 63650, 63655, or 63685 may be used to bill for the implantation.

Implantable Infusion Pumps

The use of implantable infusion pumps is covered for the following conditions:

- Chemotherapy treatment of liver cancer
- Delivery of anti-spasmodic drugs for severe spasticity
- Treatment of chronic intractable pain

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PROGRAM SERVICES

Chemotherapy for Liver Cancer

The implantable pump is covered for the treatment of liver cancer in patients in whom the metastases are limited to the liver, and where one of the following applies:

- The disease is unresponsive.
- The patient refuses surgical excision of the tumor.

Anti-Spasmodic Drugs for Severe Spasticity

An implantable infusion pump is covered when used to administer antispasmodic drugs intrathecally (*e.g.*, Baclofen) to treat chronic intractable spasticity in patients who have proven unresponsive to less invasive therapy when both of the following criteria are met:

- As indicated by at least a six-week trial, the patient cannot be maintained on non-invasive methods of spasm control such as oral anti-spasmodic drugs, because these methods either fail to adequately control the spasticity, or they produce intolerable side effects.
- Prior to pump implantation, the patient must have responded favorably to a trial intrathecal dose of anti-spasmodic drug.

Treatment of Chronic Intractable Pain

An implantable pump is covered when used to administer opioid drugs (*e.g.*, morphine) intrathecally or epidurally for the treatment of severe or chronic intractable pain in patients who have a life expectancy of at least three months, and who have proven unresponsive to less invasive medical therapy when ALL of the following criteria have been met:

- Coordination must be made with other attending physicians in order to identify and treat the cause of the pain, rather than symptoms, if at all possible.
- The patient's history must indicate that he or she would not respond adequately to non-invasive methods of pain control.
- A preliminary trial of intraspinal opioid drug administration must be undertaken with a temporary catheter to monitor acceptable pain relief, degree of side effects, and patient acceptance.

Procedure code 62350 may be used to bill for the placement of the epidural catheter that is to be hooked up to an implantable infusion pump.

Refilling and maintenance of the implantable pump will be allowed when administered by a physician. Procedure code 96522 will be allowed one time per month unless documented medical necessity warrants additional units.

Determinations may be made on coverage of other uses for implantable infusion pumps if the provider can verify ALL of the following:

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Treatment of Chronic Intractable Pain (Cont'd.)

- The drug is reasonable and necessary for treatment of the individual patient.
- It is medically necessary that the drug be administered via an implantable infusion pump.
- The FDA-approved labeling for the pump specifies that the drug being administered and the purpose for its administration is an indicated use for the pump.

Nerve Blocks

Physicians are reimbursed for injection of anesthetic agents for nerve blocks. Anesthesiologists bill for these services using procedure codes 64400–64530 with **no modifier**. Procedure codes 20552 and 20553 for trigger point injections may also be billed by the anesthesiologist with **no modifier**.

Injecting any substance through the needles, including small amounts of contrast to confirm the position of the needle, is considered an integral part of the procedure and is not reimbursed separately.

When destruction of the facet joint nerve is performed following the block, only the codes for the nerve destruction should be billed, since their allowance includes the nerve block procedure.

Post-Payment Review

Post-payment review of pain management services will be conducted regularly, at which time documentation of treatment and methods of resolving the source of the pain will be requested from the provider.

Non-Reimbursable Services

There is no reimbursement to physicians or CRNAs for the setup or subsequent daily management of patient-controlled analgesia (PCA) pumps. Behavioral modification, physical therapy, psychiatric services, and related services are also non-compensable as pain management or pain therapy services.

PATHOLOGY AND LABORATORY SERVICES

In accordance with federal regulations (42 CFR 493.1809), all laboratory sites must have an appropriate Clinical Laboratory Improvement Amendments (CLIA) certificate to provide laboratory services. CLIA is a regulatory program administered by the Centers for Medicare and Medicaid Services. For more detail, please refer to the "Clinical Laboratory Improvement Amendments (CLIA)" in this section.

Pathology includes services rendered by attending physicians and pathologists. Hospital laboratories should reference the Hospital Services Medicaid Provider Manual. Independent laboratories will be covered in this section.

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PROGRAM SERVICES

General Guidelines

Laboratory services/tests must be ordered by the attending physician, appropriate to the study of the patient (*i.e.*, consistent with the diagnosis and treatment of the patient's condition and medically necessary for the appropriate care of the patient). Medicaid reimbursement will generally include obtaining the specimen, the performance of the test, supplies used in the performance of the test, and recording of the test(s). In addition, the reimbursement includes reporting of the test results.

The date of service for all billing must be the date the specimen was collected. For specimen collections that span more than a 24-month period, the date of service should be reported as the date the collection began. For laboratory tests that require a specimen from stored collections, the date of service should be defined as the date the specimen was obtained from archives. Procedures reimbursed in components will be identified later and separate allowable handling fees will be defined in this section.

Reimbursement Methodology

In accordance with Title XIX of the Social Security Act, Medicaid reimbursement for laboratory fees cannot be higher than the Medicare fee schedule established for laboratory services. Fee schedules are located on the SCDHHS website at http://www.scdhhs.gov.

It is further mandated that only the actual provider of the service or the provider performing the test may charge and receive Medicaid reimbursement. Providers cannot bill Medicaid patients when Medicaid would have paid for the lab service if the appropriate billing procedures and referral procedures had been followed.

Services or supplies administered by the hospital or hospital employees are considered a part of the overall hospital service and are reimbursable only under the hospital allowable costs. A physician who is either salaried or contracted by the hospital, and who performs services under contract or employment, may not bill for those services separately under his or her individual Medicaid provider number. The contracting hospital may file for these services under the professional fees allowable for the hospital under their hospital-based physician’s Medicaid number.

Attending Physician Services

Guidelines

The attending physician is responsible for the study of the patient, medical necessity, and appropriateness of procedures ordered. Physicians may not bill for lab tests performed outside their offices. Physicians may not bill a patient for lab services performed in the office that are normally covered by Medicaid when the service would have been paid if a Medicaid claim

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Guidelines (Cont'd.)

was submitted, provided the physician has accepted the patient's Medicaid benefits for the office visit or other procedure on the same date.

The performance of a test(s) prior to seeing the patient is a screening procedure and is not compensable. The only exceptions are pregnancy tests and prenatal lab work.

All laboratory tests must be ordered for the appropriate diagnosis and treatment of the patient's illness. Laboratory services requested or performed as general screening services are non-compensable, with the exception of services rendered under the healthy adult physical as outlined in the Preventive Care section. General health panels are non-compensable. Fertility tests are non-compensable. Routine paternity tests are non-covered, but medically necessary exceptions will be considered. Claims must be submitted with documentation justifying the service.

Chlamydia Rapid Test – CPT code 87270 is used to report the chlamydia rapid test.

Venipuncture

A separate handling charge for blood products drawn through venipuncture is allowed and compensable. To report a routine venipuncture, use procedure code 36415. Finger/heel/ear stick for collection of specimen(s) will be included in the office visit or lab test reimbursement and may not be billed separately. Filing for only the collection of specimen(s) is permissible, but an office visit or lab test reimbursement charge cannot be filed for the same date of service. The physician or clinic provider may charge a separate venipuncture code if he or she provided the entire diagnostic lab service or only extracted the blood for referral to an outside lab.

Catheterization

Urine specimens collected by all methods are not considered a separate compensable charge. The patient is also not liable for the charge since the collection fee is considered part of the lab test or office examination. The provider may charge for a separate catheterization regardless of whether the specimen was collected for a test in the office or for referral to an outside laboratory.

Automated Chemistry Tests and Panels

Guidelines

Clinical laboratory tests are covered under Medicaid if they are reasonable and necessary for the diagnosis or treatment of an illness or injury. A physician who orders a series of clinical lab tests must specify the actual tests to be performed. If a panel is requested, the professional judgment of the physician must dictate the medical necessity of the

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Guidelines (Cont'd.)

complete panel instead of an individual test. Likewise, individual tests ordered by a physician must indicate a medical reason for the individual test in lieu of a panel that is less expensive.

Automated Multi-Channel Chemistry Tests

The following list contains tests that are frequently performed as groups and combinations. If three or more of the tests are performed on the same date of service, they will be grouped together and paid according to the number of tests performed. Duplicate payments and payments that are not consistent with Medicaid policy will be recouped at post-payment review.

82040	82565	83690	84100	84478
82150	82947	83718	84132	84520
82310	82960	83719	84155	84550
82374	82962	83721	84160	
82435	82977	83735	84295	
82465	83540	84075	84450	
82550	83615	84078	84460	

Pathology Panels

Medicaid recognizes the current CPT terminology as acceptable criteria for billing organ or disease-oriented panels. Please refer to the current CPT for guidelines.

Reimbursement Policy

)

The AMA CPT-approved codes for organ and disease panels include CPT codes 80048 – 80076. In accordance with CMS policy and the CPT guidelines, South Carolina Medicaid is now requiring providers to follow the 2004 CPT coding for these panels. Along with this change, providers billing for automated multi-channel chemistry tests may bill these tests individually as described in the CPT coding manual. The system will bundle specific tests and reimburse one rate based on the number of tests performed. Claims with less than three of these tests will pay each individual test based on the fee schedule. The list above identifies those codes, when billing three or more, that are bundled to pay one rate based on the number of tests. A provider may also bill for individual tests that are assigned to a panel. If the individual tests are included on the list, these tests will also bundle when three or more are filed on the same claim form and pay one rate based on the number of tests.

Fee schedules are located on the SCDHHS website at http://www.scdhhs.gov.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Clinical Pathology Services

South Carolina Medicaid will recognize both a professional and technical component for all pathology codes. These codes will require the 26 modifier if the service was provided in the hospital setting.

All of the following pathology codes require a 26 modifier in a hospital setting:

83020	88130	88261	88312	88362
84165	88140	88262	88313	88365
85390	88155	88263	88314	88371
85576	88160	88267	88319	88372
86255	88161	88269	88321	89060
86256	88162	88280	88323	
86320	88172	88283	88325	
86325	88173	88285	88329	
86327	88182	88289	88331	
86334	88230	88300	88332	
87164	88233	88302	88342	
87207	88235	88304	88346	
88104	88237	88305	88348	
88106	88239	88307	88355	
88108	88245	88309	88356	
88125	88248	88311	88358	

Blood

Medicaid requires that the securing supplier of blood products bill those products or packed cells. If a hospital laboratory secures the packed cells and washes, then the hospital must charge for the blood. A physician, clinic, or other non-securing provider may not bill for the blood. In addition to the products, the securing provider may only bill for additional type and cross matching, if appropriate, and the transfusion.

Professional Pathology Services

A pathologist may charge for a clinical lab interpretation if requested by the attending physician and reported as a contribution to direct patient care. This diagnostic procedure must be charged using procedure code 80500 and 80502 for limited and comprehensive services, respectively.

Interpretation of clinical lab tests will not be reimbursed. Only charges for consultations on clinical lab tests may be recognized. A professional component modifier is not required (26). General consultation

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Professional Pathology Services (Cont'd.)

procedures 99251 – 99255 are not compensable for professional clinical lab services.

Anatomical

Medicaid recognizes the expertise of professional pathology services when charged separately for the interpretation of all anatomical and surgical tissues. Postmortem examinations (88000 – 88099) are non-covered by Medicaid.

Blood Smears, Bone Marrows, and Blood Bank Services

Procedure code 85060 is compensable as a professional service. The 26 modifier is not required when performed in a hospital setting.

Bone marrows, including smears, aspiration, staining, biopsy, and interpretation, are compensable as separate professional services. Care should be taken when coding bone marrow interpretation procedures. Code 85097 is compensable as a professional component when performed in a hospital or office setting. The 26 modifier is not required.

Blood bank services are covered. No modifier is required when performed in a hospital setting (86077 – 86079).

Cytopathology and Surgical Pathology

CPT procedures 88104 through 88399 include accession, handling, and reporting. The handling and interpretation of surgical tissues must be charged separately if rendered by a pathologist in a hospital or office when only the professional interpretation is necessary, using a distinct physician provider number and a 26 modifier. Only an independent laboratory may charge for the total lab procedure when the laboratory has actually performed the total service (*i.e.*, both technical and professional component related to the surgical tissue).

Medicaid recognizes the current CPT terminology as criteria for billing procedure codes 88300 – 88309.

Some surgical pathology codes (88300 – 88319 and 88329 – 88365) will multiply by units for payment. When filing a claim, list the appropriate CPT code for the date of service one time and the number of units in the Days/Units column and the total charges for the number of units billed. A frequency limitation of 10 units has been placed on these codes. Services exceeding 10 units will require documentation.

Pap Smears

Medicaid reimburses a pathologist for a professional interpretation of a Pap smear with procedure code 88141. An attending physician must specifically order code 88155 with definite hormonal evaluation.

Medicaid covers pap smears for dually eligible Medicare/Medicaid beneficiaries who have exceeded the Medicare Frequency limit. When the Medicare denial is received, the charges should be billed using the CMS-1500 claim form. Please refer to the heading "Cancer Screening Services" in this section for frequency limitations.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Specimen Referrals

The pathologist should use procedure codes 88321 and 88323 to designate review and report of referred material only. Procedure code 88325 is used for comprehensive consultation with review of medical records and specimens, with report, on referred material.

Referral Out-of-State

Specimens must be referred to a South Carolina Medicaid-enrolled independent laboratory, pathologist, or hospital. Out-of-state referrals to non-enrolled providers are not compensable through the Medicaid program. Providers cannot bill Medicaid beneficiaries when Medicaid would have paid the lab service if appropriate billing and referral procedures had been followed.

Billing and Coding Requirements

Professional component services constitute the professional interpretation and report and must be charged using the 26 modifier. Claims for professional pathology services indicating a hospital as the place of service will be rejected if submitted without the 26 modifier. Only anatomical, surgical, and the clinical pathology procedures listed earlier in this section are reimbursable with a 26 modifier.

Technical component services are those services usually performed by a hospital in the administration of a hospital lab. These services include payment for a lab technician, equipment, and supplies. Only a hospital may bill for separate technical lab services.

Total lab procedures are a combination of both the professional and technical components. Usually an independent laboratory or a private practicing physician performing his or her own lab services is the only provider eligible for a total lab reimbursement rate. Pathologists and laboratories may bill for beneficiaries that are in the Family Planning Eligibility Category Only, but a valid family planning diagnosis code must be present on the claim, along with the FP modifier.

Genetic Studies

Medicaid will reimburse for genetic studies if ordered by an attending physician and requested as a direct diagnosis and treatment tool. The genetic study may be ordered as a preventive measure; however, the prevention must have a direct correlation with the treatment of the patient and the patient's family, or serve as an inhibitor to institutionalization. Medicaid will not reimburse for genetic research.

Chromosome Analysis

Genetic centers are permitted to fragment chromosome charges into the “tissue culture for chromosome analysis” charge (codes 88230 – 88239) and the analysis charge (codes 88245 – 88269). Chromosome studies must be medically necessary.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Chromosome Analysis (Cont'd.)

In addition, reimbursement may be allowed for the following expanded services: extended chromosome analysis, R-Bands, and Fragile X analysis.

The following conditions may be used as indications of analysis:

- Intellectual disabilities
- Dysmorphic fractures
- Multiple congenital abnormalities
- Abnormal sexual development
- Abnormalities of growth
- Certain types of malignancies

Genetic Studies Also Covered by Medicaid

Lysosomal enzyme analysis for developmental regression – (*e.g.*, Tay-Sachs disease). Indications are as follows:

- Growth failure
- Development regression
- Clouding of corneas
- Hepatosplenomegaly
- Coarsening of facial features
- Abnormalities of skeletal system

Amino acid analysis for infants and children – The following indications must be present:

- Feeding abnormalities
- Growth failure
- Development failure
- Seizures
- Uncommon acidosis

Organic acid analysis for infants – The following indications must be present:

- Feeding abnormalities
- Unexplained acidosis
- Growth failure
- Seizures

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Genetic Studies Also Covered by Medicaid (Cont'd.)

Carbohydrate analysis for infants and children – One of the following conditions must be present:

- Cataracts
- Hepatosplenomegaly
- Jaundice
- Growth failure
- Acidosis
- Seizures

Other tests for infants and children – These tests include the following:

- Metabolic screen
- Alpha fetoprotein
- Sialic acid
- Sulfate incorporation

Amniocentesis for prenatal diagnosis – Allowable for the following categories of patient:

- Women over 35 years of age
- Previous child with chromosomal disorder
- Multiple spontaneous abortions
- Patients with neural tube defects
- Patients at risk for having children with X-linked disorder (*i.e.*, hemophilia or Duchenne muscular dystrophy, or metabolic disorders such as Tay-Sachs disease)

Tests for the detection of other genetic diseases – These include the following:

- Skeletal Dysplasias
- Huntington's Disease
- Sickle Cell
- Hemoglobinopathies

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Independent Laboratories

Enrollment

Medicaid requires that all enrolled independent laboratories meet Clinical Laboratory Improvement Amendments. (CLIA) regulations. CLIA is a regulatory program administered by the federal Centers for Medicare and Medicaid Services.

Information concerning CLIA regulations and participation may be obtained through SCDHEC's Division of Certification at (803) 545-4205. For Medicaid enrollment information, call or write to:

Medicaid Provider Enrollment
Post Office Box 8809
Columbia, SC 29202-8809
1-888-289-0709

All independent laboratories must be certified by CMS to perform laboratory tests. CLIA certification must be on file with Medicaid Provider Enrollment. Procedures performed and/or charged when the lab is not certified to perform that particular test will be rejected. Medicaid will not reimburse for services performed prior to certification or prior to enrollment. Independent laboratories that have not enrolled in CLIA also cannot bill Medicaid beneficiaries directly for any services rendered.

Billing Notes

Whenever an independent laboratory charges Medicaid with an unlisted procedure, support documentation is required. Since SCDHHS and most independent laboratories recognize the mutual benefits of automated claims processing, steps should be taken to insure timely and efficient claims submission.

When a laboratory initiates a new lab test(s) or a new combination, notification should be sent to the Pathology program manager. This preliminary process will quicken the assignment of a code and approval for Medicaid payment.

Independent laboratories must submit charges on a CMS-1500 claim form with the appropriate CPT or supplemental code. The place of service must be an "81" and the date of service when the test was performed must be indicated.

Independent labs may bill for beneficiaries who are in the Family Planning Eligibility Category Only. A valid family planning diagnosis and modifier must be present on the claim.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Clinical Laboratory Improvement Amendments (CLIA)

Certification Requirements

As described above, Medicaid requires that all enrolled independent laboratories meet CLIA regulations. In accordance with federal regulations (42 CFR 493.1809), SCDHHS requires that in order to perform laboratory tests, all laboratory testing sites must have one of the following CLIA certifications:

- Certificate of Registration
- Certificate of Accreditation or Partial Accreditation
- Certificate of Compliance
- Certificate of Waiver
- Physician Performed Microscopy Procedures (PPMP) Certificate

In addition, each site must have an assigned unique 10-digit certification number. Information concerning CLIA regulations and participation guidelines may be obtained from SCDHEC at (803) 545-4203 or by writing to:

SCDHEC
Division of Certification
2600 Bull Street
Columbia, SC 29201-1708

Claims Editing

Claims will be denied for lab services delivered by any lab site meeting one or more of the following descriptions:

- A lab that does not have CLIA certification
- A lab that submits claims for services not covered by CLIA certificate
- A lab that submits claims for services rendered outside the effective dates of the CLIA certificate

Individual physicians who are members of a group should bill under the group number. The CLIA editing is based on the provider number in field 33 of the CMS-1500. For more detailed information, please refer to Section 3 of this manual ("Billing Procedures").

Lab Procedures

The following sections indicate the lab procedures allowed for each type of certification. Current CLIA information can be found on the Internet at http://www.cms.hhs.gov/clia/.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Lab Procedures (Cont'd.)

Labs issued a **Certificate of Registration**, **Certificate of Accreditation or Partial Accreditation**, or **Certificate of Compliance** are allowed to perform and bill for the following procedures:

80047 – **89398** – All pathology and lab procedures

78110 – Plasma volume, radiopharmaceutical volume-dilution technique (separate procedure); single sampling

78111 – Plasma volume, radiopharmaceutical volume-dilution technique (separate procedure); multiple areas

78120 – Red cell volume determination (separate procedure); single sampling

78121 – Red cell volume determination (separate procedure); multiple samplings

78122 – Whole blood volume determination, including separate measurement of plasma volume and red cell volume (radiopharmaceutical volume-dilution technique)

78130 – Red cell survival study

78191 – Platelet survival study

P7001 – Culture and sensitivity urine only

Labs issued a **Certificate of Waiver** are limited to performing only the following procedures:

80061 – Lipid panel

81002 – Urinalysis, by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketone, leukocytes, nitrite, pH, protein specific gravity, urobilinogen, any number of constituents; non-automated, without microscopy

81003 – Urinalysis, by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketone, leukocytes, nitrite, pH, protein specific gravity, urobilinogen, any number of constituents; automated, without microscopy

81007 – Bacteriuria screen, exp culture/dips

81025 – Urine pregnancy test, by visual color comparison methods

82044 – Albumin, urine, microalbumin, semiquantitative (e.g., reagent strip assay)

82120 – Amines, vaginal fluid, qualitative

82270 – Blood, occult; feces, one to three simultaneous determinations

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Lab Procedures (Cont'd.)

82465 – Cholesterol, serum, total

82523 – Collagen cross links test, (urine test to evaluate bone health)

82570 – Creatinine; other source

82947 – Glucose; quantitative

82950 – Glucose; post glucose dose (includes glucose)

82951 – Glucose; tolerance test (GTT), three specimens (includes glucose)

82952 – Glucose; tolerance test, each additional beyond three specimens

82962 – Glucose, blood, by glucose monitoring device(s) cleared by the FDA specifically for home use

82979 – Glutathione Reductase RBC

82985 – Glycated protein

83001 – Gonadotropin, follicle stimulating (reproductive hormone) level

83002 – Gonadotropin, luteinizing (reproductive hormone) level

83026 – Hemoglobin; by copper sulfate method, non-automated

83036 – Hemoglobin; glycated

83518 – Immunoassay analyte not antibody, single step method

83605 – Luctate (Actic acid)

83718 – Lipoprotein, direct measurement; high-density cholesterol (HDL cholesterol)

83986 – pH, body fluid, except blood

84460 – Liver enzyme (SGPT), level

84478 – Triglycerides

84703 – Gonadotropin chorionic qualitative

84999 – Unlisted chemistry procedure

85013 – Blood count; spun microhematocrit

85014 – Blood count; other than spun hematocrit

85018 – Blood count; hemoglobin

85610 – Prothrombin time

85651 – Red blood cell sedimentation rate, to detect inflammation

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Lab Procedures (Cont'd.)

86294 – Immunoassay for tumor antigen, qualitative or semiquantitative; (EG, bladder tumor antigen)

86308 – Heterophile antibodies; screening

86318 – Immunoassay for infectious agent antibody, qualitative or semiquantitative, single step method (e.g., reagent strip)

86618 – Antibody; borellia bufgdorferi (Lyme Disease)

87077 – Culture, bacterial; aerobic isolate, additional methods for definitive identification, each isolate

87449 – Infectious agent antigen detection by enzyme immunoassay technique qualitative or semiquantitative; multiple steo method, not otherwise specified, each organism

87804 – Infectious agent antigen detectin by immunoassay with direct optical observation; influenza

87880 – Strep test (Streptococcus, group A)

87076 – Anerobic isolate, additional methods required for definitive identification, each isolate

87077 – Aerobic isolate, additional methods required for definitive identification, each isolate

The following code is non-covered:

84830 – Ovulation tests by visual color comparison methods for human luteinizing hormone

Labs issued **PPMP Certificate**s are allowed to perform the above listed procedures for Certificate of Waiver **AND** the following procedures:

87205 – Fecal Leukocyte examination

G0027 – Semen analysis

Q0111 – Wet mount, including preparations of vaginal, cervical, or skin specimens

Q0112 – All potassium hydroxide (KOH) preparations

Q0113 – Pinworm examinations

81000 – Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy

81001 – Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrate, pH,

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Lab Procedures (Cont'd.)

protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy

81015 – Urinalysis; microscopic only

81020 – Urinalysis; two or three glass test

89190 – Nasal smear for eosinophil

The following codes are non-covered services:

Q0114 – Fern test

Q0115 – Post-coital direct, qualitative examinations of vaginal or cervical mucous

OUT-OF-STATE (OOS) SERVICES

Treatment Rendered Outside the South Carolina Medical Service Area

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. Medicare/Medicaid beneficiaries do not require prior approval from Medicaid for covered services from providers located within the SCMSA.

The South Carolina Medicaid Program will compensate medical providers outside the SCMSA in the following situations:

- Emergency medical services for beneficiaries traveling outside the SCMSA whose health would be endangered if necessary care were postponed until their return to South Carolina. This includes all pregnancy-related services and delivery.
- When a SCMSA physician certifies that needed services are not available within the SCMSA and properly refers the beneficiary to an out-of-state provider

Prior Approval

In all but emergency situations, the **referring physician** should request approval prior to the out-of-state service. Referrals should be made to an out-of-state provider only when the procedure or service is not available within the SCMSA. All available resources must have been considered and indicated in the request to SCDHHS for the out-of-state referral. The referring physician is the one most aware of the client's medical history and needs, and will best be able to justify the necessity for the out-of-state referral.

Prior to contacting SCDHHS, the **referring physician** must first contact any out-of-state provider who will render a service to the client and inform them of the client's medical status. The out-of-state provider must

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Prior Approval (Cont'd.)

confirm, in writing, that he or she will enroll in the South Carolina Medicaid program and will accept Medicaid reimbursement as payment in full. The written confirmation must be submitted to SCDHHS along with the completed Referral Request form for out-of-state services.

The **referring physician** must complete the "Referral Request for Out-of-State Services" form. A sample copy of the form can be found in the Forms section of this manual. The written requests for out-of-state referral must include the following information:

- Beneficiary's name and Medicaid number
- Date of service (state as "tentative" if unscheduled at the time of request).
- An explanation as to why you feel these services must be rendered out-of-state versus within the SCMSA
- Name, address, telephone, and fax number of the out-of-state providers(s) who will render the medical services. (For example: hospital and physicians(s) involved in that patient's medical treatment)A copy of the beneficiary's medical records for the past year relating to the treatment of the condition
- Any experimental and/or investigational services identified by the referring physicians that are sponsored under a research program, or performed in only a few medical centers across the United States

SCDHHS reserves the right to determine, on the basis of medical advisement, that the needed medical services, or necessary supplementary resources, are more readily available in the other state. SCDHHS will reject referrals for the following reasons:

- All information required on the referral form is not provided with the requested attached documentation.
- The provider rendering the service(s) is not willing to enroll in South Carolina Medicaid and adhere to the enrollment criteria.
- The provider rendering the service(s) will not accept the South Carolina Medicaid reimbursement as payment in full.

To obtain approval for out-of-state referrals, the out-of-state coordinator can be reached by fax at (803) 255-8255, or by mail at:

Medicaid Claims Receipt
Post Office Box 1412
Columbia, SC 29202-1412

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Prior Approval (Cont'd.)

The **referring physician** is responsible for communicating with the out-of-state provider coordinating services for the patient. Patients being referred out of state, as well as their escorts, can be provided transportation when necessary. Transportation and any other assistance are only provided when there are no other means available to the patient to meet the needs connected with out-of-state travel. Adequate advance notice, as well as prior approval, is mandatory in order to make the necessary travel arrangements. Providers should contact the PSC at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us for additional information.

When a beneficiary is in one of the Medicaid Managed Care Organizations (MCOs), the requests for out-of-state services must be completed through the MCO. For assistance with authorizations for MCO-enrolled members, providers should contact the MCO's Provider Services department, or the Managed Care area at (803) 898-4614. Contact information for the MCOs is located in the Managed Care Supplement.

Exceptions to Prior Approval

Medicaid will accept and review for medical necessity out-of-state claims from medical providers who did not seek any type of approval before filing their claim. However, experience has proven that these providers put themselves at an otherwise avoidable risk of non-payment or delayed payment due to the lack of knowledge of the South Carolina Medicaid claim filing policies and procedures.

Foster Children Residing Out of the SCMSA

The South Carolina Department of Social Services (DSS) will be responsible for all Medicaid-eligible foster children when they reside out of state. The county case manager assigned to the case should assist with medical services. Prior approval is not required for services rendered to foster children who live out of state; however, medical necessity remains a requirement. The out-of-state coordinator must to be contacted for two reasons:

1. The coordinator must determine whether the medical services can be reimbursed through the Medicaid program or whether DSS will reimburse the medical provider.
2. If Medicaid can reimburse for the services, proper enrollment and billing information needs to be sent to the medical providers involved.

Providers must contact the PSC at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us for additional information.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Retroactive Eligibility

When retroactive eligibility for Medicaid is granted, the beneficiary is responsible for notifying the medical provider that retroactive eligibility has been granted.

For additional information regarding retroactive eligibility, Please refer to Section 1 of this manual.

Dually Eligible Beneficiaries

When a beneficiary has both Medicare and Medicaid, Medicare is considered the primary payer. However, if the beneficiary does not have Part A benefits, medically necessary inpatient hospital services will require approval.

In order to verify eligibility on Medicare/Medicaid patients, contact the PSC at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us.

Ancillary and Other OOS Services

Other health care services are compensable under the South Carolina Medicaid Out-of-State program. For out-of-state referral questions, please contact the PSC, submit an online inquiry, or write to SCDHHS for more information. For professional claims, providers should write to:

Medicaid Claims Receipt
Post Office Box 1412
Columbia, SC 29202-1412

For institutional claims, providers should write to:

Medicaid Claims Receipt
Post Office Box 1458
Columbia, SC 29202-1458

RADIOLOGY AND NUCLEAR MEDICINE

Radiology services are those services performed by a radiologist/physician in conjunction with an x-ray, ultrasound, PET, CAT scan, or MRI. Radiological services are covered only when such services are consistent with the diagnosis and treatment of an illness or injury. **Screening procedures are not reimbursable** unless outlined as covered items in this manual.

Effective March 1, 2014, SCDHHS will no longer prior authorize high-tech radiology services. All radiology services will be based on medical necessity and held to the American College of Radiology (ACR) standards. ACR standards can be found at http://www.acr.org.

This policy pertains to all fee-for-service recipients and SCDHHS will no longer exclude anyone based on category or whether they have third

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Radiology and Nuclear Medicine (Cont'd.)

party liability primary coverage. Providers must continue to refer members in an MCO to the appropriate MCO provider in order to determine if prior authorization applies to radiology services.

Documentation Required for Medical Necessity and Post-Payment Review: All radiology and diagnostic services must be medically necessary and directed to the diagnosis, maintenance, improvement, and treatment of illness and/or disability. All providers must use American College of Radiology best practice guidelines when determining the need for radiology services. The purposes of the guidelines are to improve the quality of services to patients and to promote the safe and effective use of diagnostic and therapeutic radiology. Therefore, the justification for any radiological treatment or service will align with best practice guidelines and must be documented in the patient medical record.

Medicaid requires that the attending/ordering physician must order all radiology services. The NPI of the attending ordering physician must be present on the claim in order for Medicaid to reimburse for services. The attending/ordering physician will be responsible for maintaining and/or providing access to the required documentation, regardless of whether the radiology procedures were provided in a hospital, outpatient facility, office, freestanding imaging center or mobile unit. As noted in the Documentation Standards below, this information may be recorded in the patient medical chart, nursing reports, radiology records, inpatient or outpatient medical information storage areas, or -in the electronic health record. Services rendered in a hospital setting must be adequately documented, including the above-cited records by the physician, with corresponding records retained by the hospital.

High-Tech Radiology: SCDHHS will review Medicaid reimbursements for high-cost diagnostic radiology procedures to determine medical necessity. Claims received with duplicated diagnosis and services ordered by multiple providers are not reimbursable and are not considered medically necessary. Physicians, when referring patients to specialists for consultations, must send their patients with copies of films and/or a portable device (thumb drive, CD).

Radiology and Nuclear Medicine (Cont'd.)

Standards for Documenting Medical Necessity and Provision of Services: The following standards are taken from ACR and the Society of Interventional Radiology Practice Guideline (SIR) http://www.sirweb.org for the Reporting and Archiving of Interventional Radiology Procedures revised 2009. The guidelines must be followed when documenting medical necessity in the patient records. A medical record

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Radiology and Nuclear Medicine (Cont'd.)

consists of a patient's medical information recorded in either written or electronic format. This information may be recorded in the patient medical chart, nursing reports, radiology records, inpatient or outpatient medical information storage areas. The medical record must include, as appropriate, the following information:

1. Documentation of pre-procedural inpatient and/or office consultation
2. Immediate pre-procedure note
3. Immediate post-procedure note
4. Final report
5. Documentation of post-procedure inpatient and/or office contact

A. Pre-procedure Documentation

The pre-procedural documentation provides a baseline record of patient status and documents the indication/justification for the procedure. It should be written in the chart before the procedure. Pre-procedural documentation should, as appropriate depending on the complexity and/or clinical urgency of the procedure, include the following information:

1. The plan for each procedure to be performed
2. Indication/justification for procedure and brief history
3. Findings of targeted physical examination
4. Relevant laboratory and other diagnostic findings
5. Risk stratification, such as the American Society of Anesthesiologists Physical Status Classification
6. Documentation of informed consent (consistent with state and federal laws) or, in the case of an emergency, that this was an emergency medical procedure

B. Immediate Post-Procedure Note

Before a patient is transferred to the next level of care, an immediate post-procedure note or a final report should be completed and available. The immediate post-procedure note should include, as appropriate:

1. Diagnosis
2. Procedure
3. Physician
4. Assistant

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Radiology and Nuclear Medicine (Cont'd.)

5. Sedation
6. Medications
7. Findings
8. Blood Loss
9. Specimen

It is not necessary for the listed items to be recorded in the order given above.

C. Final Report

1. A final report is required:
    a. To transmit procedural information to all members of the health care community who may participate in subsequent care of the patient
    b. For legal purposes
    c. For reimbursement
2. Specific information to be included in this report depends on the procedure. The following elements are recommended, although all of them may not be applicable:
    a. Procedure
    b. Date
    c. Operator(s)
    d. Indication
    e. Method of anesthesia or sedation
    f. Procedure/technique: a technical description of the procedure. This information should include, as appropriate, access site (and attempted access sites), guidance modalities, catheters/guidewires/needles used, vessels or organs accessed technique, and hemostasis. Each major vessel catheterized for imaging or intervention should be noted specifically.
    g. For inserted medical devices, appropriate identifying information such as the product name, vendor, and lot numbers
    h. Medications, dosages, and route of administration, including any pre-medications and contrast agents
    i. Estimated radiation dose (fluoroscopy time if no other measurement is available)

SECTION 2 POLICIES AND PROCEDURES

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j. Findings and results

k. Complications

l. Conclusion

m. Post-procedure disposition

Failure to maintain documentation that follows the above referenced (ACR/SIR) guidelines, as well as failure to comply with other payment rules established by the policies in this section, may result in a recovery action by SCDHHS and may result in provider sanctions.

Radiology Reimbursement Limitations: In addition to the medical necessity documentation, SCDHHS will include in post-payment reviews an assessment of providers' compliance with the following policies and payment rules. Post-payment reviews indicating unnecessary radiological procedures and interpretations or non-covered or unallowable services will result in recoupment of any Medicaid payments.

- When both the emergency room physician and radiologist or cardiologist interpret an x-ray or EKG done in the ER, payment will be made for the interpretation and report that directly contributes to the diagnosis and treatment of the patient. The specialty of the physician rendering the service will not be the primary factor considered. The interpretation billed by the cardiologist or radiologist is payable if the interpretation is performed at the time of the diagnosis and treatment of the patient. Separate payment to the hospital medical staff is not made for interpretations performed solely for quality control and liability purposes under hospital policy.
- Reinterpretations, unordered images, and second opinions are not reimbursable. Medical necessity must be documented for additional or repeat procedures for the same date of service (*i.e.*, additional images were needed, patient in congestive heart failure, catheter placement, etc.).
- CPT procedures are compensable if ordered by an attending/ordering physician and deemed medically necessary for the diagnosis and treatment of the patient's condition.
- Routine chest x-rays without a diagnostic reason are not reimbursable.
- Radiological procedures performed as a screening mechanism, without a diagnostic reason for justification, are non-covered.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Radiology and Nuclear Medicine (Cont'd.)

- Separate consultative procedures are non-covered. SCDHHS will also use post-payment review to determine adherence to correct coding to include:
- Correct use of modifiers
- Correct use of supervision and consultation codes when used in conjunction with a radiological procedure
- Use of unlisted procedure code
- All other service and coverage requirements listed in this section.

The incorrect use of modifiers or coding which results in an over-payment or improper payment to the provider will result in recovery of the over-payment and will result in a recovery action and/or sanction

Positron Emission Tomography (PET) Scans: PET scan reimbursement will be limited to two scans in a 12 consecutive month period. PET scans will only be covered for the staging and restaging of cancer malignances.

Staging:

- The stage of the cancer remains in doubt after completion of a standard diagnostic workup, including conventional imaging such as computed tomography (CT), magnetic resonance imaging (MRI), or ultrasound; or
- The use of a PET scan could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient; and
- Clinical management of the patient would differ depending on the stage of the cancer identified.

Restaging:

- Detecting residual disease
- Detecting suspected recurrence or metastasis
- Determining the extent of recurrence
- Potentially replacing one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient

PET scans will **not** be utilized for screening purposes. The use of PET scans to monitor tumor response during a planned course of treatment will **not** be covered. Restaging only occurs after a course of treatment is completed and 90 days has lapsed prior to the restaging PET scan. PET

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Radiology and Nuclear Medicine (Cont'd.)

scans will be subject to retrospective review to include paid inpatient/outpatient hospital and physician claims. Documentation must be maintained in the beneficiary's medical records and must support medical necessity. **SCDHHS will not cover any additional PET scans over the frequency limitation of two in a 12 consecutive month period.**

Providers billing for radiopharmaceutical diagnostic imaging agents utilizing a CMS-1500 claim form should select the appropriate HCPCS code. When billing for an unlisted radiopharmaceutical agent the provider must include a copy of the invoice with the CMS-1500 claim form for review.

Diagnostic Radiology: Medicaid requires that all facilities providing screening and diagnostic mammography services meet Food and Drug Administration (FDA) regulations. Medicaid claims for mammography services will be reviewed to ensure FDA criteria are met. Medicaid will not reimburse for mammography services performed by providers who are not certified and providers cannot bill the Medicaid beneficiaries for the denied Medicaid services. An FDA certificate for screening mammography services must be in the provider enrollment file. Questions regarding enrollment should contact:

Medicaid Provider Enrollment
Post Office Box 8809
Columbia, SC 29202-8809
1-888-289-0709

Diagnostic Ultrasound: Ultrasound procedures are recorded as complete, limited, or repeat procedures. Full documentation must justify the use of the complete procedure code. A complete procedure is one that the provider furnished both the professional and technical components. Please refer to "Obstetrics and Gynecology" in this section for pregnancy related guidelines.

Radiology Oncology: A preliminary evaluation/consultation of the patient is allowed prior to the decision to treat and should be identified by the appropriate evaluation and management code. Once the therapist assumes responsibility for the treatment and care of the patient, a separate consultation or evaluation and management code will not be covered.

Please refer to CPT reference manual for appropriate codes for the treatment planning, radiation physics, treatment delivery, and treatment management of radiation oncology.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Radiology and Nuclear Medicine (Cont'd.)

Clinical Treatment Planning: Please refer to the CPT reference manual for appropriate codes for the treatment and planning process. These services include test interpretation, tumor localization, treatment volume determination, time/dosage determination, treatment modality, number and size of ports, and selection of treatment devices.

Medical Radiation Physics: Please refer to the CPT reference manual for appropriate codes for services by the physician and physicist involved in radiation physics, dosimetry calculation, construction of treatment devices, and other special services.

Radiation Treatment Delivery: Radiation treatment codes reflect the technical portion of radiation therapy services. The codes will be found in your CPT reference manual and represent individual sessions of service delivery or daily services. Multiple treatment sessions on the same date of service are allowed as long as there is a distinct break in therapy services/individual session.

Clinical Treatment Management: Please refer to the CPT reference manual for appropriate codes. Clinical treatment management codes reflect the professional component of treatment on a weekly basis. These codes are used to describe the physician's weekly radiotherapy management services at all energy levels. A weekly unit is equal to five fractions, or treatment sessions, regardless of whether the fraction or treatment sessions are furnished on consecutive days or without regard to the actual time period in which the services are provided.

If at the final billing of the treatment course, there are three or four fractions beyond a multiple of five, those three or four fractions are considered a week. If there are only one or two fractions beyond a multiple of five, reimbursement for the sessions will be considered as having been covered through prior payment.

When the patient receives a mixture of simple, intermediate, and/or complex services, bill the code that represents the majority of the fractions furnished during the five fraction week.

Hyperthermia: Treatments include external and internal procedures. Hyperthermia is used only as an adjunct to radiation/chemotherapy. It may be initiated by microwave, ultrasound, low energy radio-frequency conduction, or by probes.

Clinical Brachytherapy: Please refer to your CPT reference manual for all codes. Services bundled within the procedure codes include hospital admission, daily visits, follow up care, dilation, insertion and removal of

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Radiology and Nuclear Medicine (Cont'd.)

applicators. They do not include preparation of the element calculation of dosage, or loading of the element.

Nuclear Medicine: Please refer to the CPT reference manual for appropriate codes for services related to diagnostic and therapeutic nuclear medicine. The procedures may be performed and charged separately, or as part of a course of treatment. Radioimmunoassay tests are found in the clinical pathology section of the CPT reference manual.

Contrasts and Radiopharmaceuticals: For appropriate codes for billing contrasts and radiopharmaceuticals providers should refer to the HCPCS reference manual. Physicians must not bill for radiopharmaceuticals and/or contrasts that are provided by the hospital.

Independent Imaging Centers and Mobile Imaging Units: Under Independent Imaging Centers and Mobile Imaging Units: Medicaid will reimburse for services provided by a freestanding imaging centers, mobile ultrasound units, and mobile imaging units when the services are consistent with diagnosis, treatment, injury or covered preventative services as found in Family Planning

Freestanding imaging centers and mobile imaging units must be enrolled with SCDHHS in order to be reimbursed for services provided. Mobile imaging units must meet South Carolina Department of Health and Environmental Control (SCDHEC) certification. Freestanding imaging centers and mobile ultrasound units must be certified by Medicare.

For enrollment information, contact provider enrollment at 1-888-289-0709 or visit the website at http://provider.scdhhs.gov.

Radiology and Nuclear Medicine (Cont'd.)

Independent imaging centers, mobile ultrasound units, and mobile imagining units can only be reimbursed for the technical portion of an x-ray or other imaging service. Separate reimbursement will be made to the physician for the professional interpretation of the radiology procedure. The physician's name must be on the radiology report as the reading/interpreting physician. Reimbursement will be sent to the reading/interpreting physician or reading/interpreting physician group practice. The reading/interpreting physician must be enrolled with SCDHHS as an in-state provider. All out-of-state providers must go through the out-of-state approval process. Out-of-state physicians must attach a copy of the approval letter to each CMS-1500 submitted for reimbursement.

Mobile units may bill the following codes for set-up and transportation in addition to the x-ray or EKG when the patient would require special transportation. These codes should be billed without a modifier:

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Radiology and Nuclear Medicine (Cont'd.)

Q0092 – Set up of portable x-ray equipment in a nursing facility, per radiological procedure (other than re-takes of the same procedure). Medicaid will not reimburse for re-takes

R0070 – Round trip transportation of portable x-ray equipment and personnel to nursing home, per trip to facility or location; one patient seen

R0075 – Round trip transportation of portable x-ray equipment and personnel to nursing home, per trip to facility or location; more than one patient seen, per patient

R0076 – Round trip transportation of portable EKG to facility or location; per patient

Charges should be submitted on a CMS-1500 claim form with the following restrictions:

- All CPT procedure codes should be submitted with a TC (technical component) modifier.
- Separate charges for injection of contrast mediums, radiopharmaceuticals, or catheterizations are not covered.

Modifiers and Components: Radiology services are divided into the following defined components:

- **Technical Component –** Includes equipment, supplies and technician time and effort. Provider must bill using the TC modifier.
- **Professional Component –** Includes the physician's supervision, interpretation, and report, and when appropriate, the physician's administration of an injection or catheterization. Payment will be made to the physician or radiologist who performed the interpretation and written report at the time of the diagnosis and treatment. Provider must bill using the 26 modifier.
- **Complete Procedure –** Is the combination of both the technical and professional services. Provider must bill 00 modifier.
- **76 modifier –** The use of the 76 modifier can only be used on medically necessary repeat radiology procedures performed on the same date of service and must include both the technical and professional components.

Providers must bill using the appropriate modifiers which are determined by the parameters of services rendered. Therefore, if a rendering provider is only submitting the technical component of the

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Radiology and Nuclear Medicine (Cont'd.)

procedure, use the TC modifier along with the procedure code performed. If the claim is submitted utilizing the UB format, the modifier TC will be assumed. No further payment will be made to any additional provider for the technical component for this procedure.

If the rendering provider is submitting the professional component/interpretation of the radiological procedure, use the 26 modifier along with the procedure code performed. No further payment will be made to any additional providers for the professional component of the procedure.

PODIATRY SERVICES

Podiatry services are those services that are responsible and necessary for the diagnosis and treatment of foot conditions. These services are limited to the specialized care of the foot as outlined under the laws of the state of South Carolina.

Podiatric services for beneficiaries over the age of 21 are non-covered services.

Office Examinations

Level of service guidelines must be followed as described in the current CPT. Podiatric exams may be charged at all levels of services as medically necessary for new or established office E/M visits.

Services

Treatment of Subluxation of the Foot

Subluxation of the foot is defined as partial dislocation to displacement of joint surfaces, tendons, ligaments, or muscles of the foot.

Reasonable and necessary diagnosis and treatment (except by the use of orthopedic shoes or other supportive devices for the foot) of symptomatic conditions such as osteoarthritis, bursitis, tendonitis, etc., that result from or are associated with partial displacement of foot structures are covered services. Surgical correction of a subluxed foot structure that is either an integral part of the treatment of a foot injury, or that is undertaken to improve the function of the foot, or that is undertaken to alleviate an induced or associated symptomatic condition, is a covered service. The presentation of symptoms is clearly the paramount factor in coverage. Surgical and non-surgical treatments undertaken for the sole purpose of correcting the subluxed structure of the foot as an isolated entity are not covered.

Treatment of Flat Foot

The term "flat foot" is defined as a condition in which one or more of the arches of the foot have flattened out. Services directed toward the care or correction of such a condition is not covered. However, the services or procedures required to make the initial diagnosis may be considered reasonable and necessary and are covered.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Supportive Devices for the Feet

Orthopedic shoes and other supportive devices for the feet are not covered unless the shoe is an integral part of a leg brace.

Prosthetic Shoe

A prosthetic shoe (a device used when all or a substantial portion of the front part of the foot is missing) can be covered as a terminal device (*i.e.*, a structural supplement replacing a totally or substantially absent foot). The beneficiary should be referred to a Durable Medical Equipment supplier for such devices.

Excision of Nail

When a procedure indicates a partial or total permanent nail removal, separate billing is not to be used for the medial and lateral borders of the same toe. The number of toes should be indicated if multiple toes are corrected at the same time.

Plantar Warts

Treatment for Verruca vulgaris and intractable plantar keratoma are covered services.

Mycotic Nail

Mycotic nail and other infections of the feet and toenails require professional services that are outside the scope of routine foot care and are covered services if the subsequent criteria are met. Treatment of a fungal (mycotic) infection of the toenail can be covered under the following circumstances:

- Clinical evidence of mycosis of the toenail
- Medical documentation that the patient has either a limitation of ambulation requiring active treatment of the foot; or, in the case of a non-ambulatory patient, a condition that is likely to result in significant medical complications in the absence of such treatment

Routine Foot Care

Routine foot care includes the cutting or removal of corns or calluses, the trimming of nails, and other hygienic and preventative maintenance care.

Reimbursement for routine foot care is allowed under the medical conditions listed below when the patient is under the active care of a physician and the service is provided by an osteopath or doctor of medicine. It is essential that the patient has seen a physician for treatment and/or evaluation of the complicating disease process during the six months prior to the date of service. The allowable conditions are as follows:

- Diabetes mellitus
- Chronic thrombophlebitis
- Peripheral neuropathies involving the feet associated with:

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Routine Foot Care (Cont'd.)

- Malnutrition and vitamin deficiency
- Malnutrition (general, pellagra)
- Alcoholism
- Malabsorption (celiac disease, tropical sprue)
- Pernicious anemia
- Carcinoma
- Diabetes mellitus
- Drugs and toxins
- Multiple sclerosis
- Uremia (chronic renal disease)

In evaluating whether the routine services can be reimbursed, a presumption of coverage is made where the evidence available discloses certain physical and/or clinical findings consistent with the diagnosis, and indicative of surface peripheral involvement.

The presumption of coverage is applied when a physician rendering the routine foot care has identified one Class A finding as noted below, two Class B findings, or one Class B and two Class C findings as follows:

Class A Findings:

- Non-traumatic amputation of the foot or an integral skeletal portion thereof

Class B Findings:

- Absent posterior tibial pulse
- Absent dorsalis pedis pulse
- A minimum of three trophic changes as follows:
  - Hair growth (decrease or absence)
  - Nail changes (thickening)
  - Pigmentary changes (discoloration)
  - Skin texture (thin, shiny)
  - Skin color (rubor or redness)

Class C Findings:

- Claudication
- Temperature changes (*e.g.*, cold feet)
- Edema

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Routine Foot Care (Cont'd.)

- Paresthesias (abnormal spontaneous sensations in the feet)
- Burning

Additional services ordinarily considered routine may also be covered if they are performed as a necessary and integral part of otherwise covered services, such as diagnosis and treatment of diabetic ulcers, wounds, and infections.

Nursing Home Visits

Podiatry care may be rendered to patients in nursing or rest home facilities, provided the service is medically necessary and meets the policies defined in this manual. Podiatry care must be requested by one of the following:

- The attending physician
- The patient
- The patient's family when the patient is incompetent
- Nursing service*

* Nursing service requests must be documented in the patient's chart. The podiatrist's records must indicate who made the request for services in this situation.

FEDERALLY QUALIFIED HEALTH CENTER SERVICES

The following billing procedures apply to the Federally Qualified Health Center (FQHC) program:

Core Services

In 1992, the Healthcare Financing Administration (now CMS) issued Medicare regulation for the FQHC program. The FQHC laws established a set of health care services called "FQHC services" for which Medicare and/or Medicaid must cover on a reasonable cost basis when provided by an FQHC. For any questions concerning cost reports and cost settlements, please contact the PSC at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us.

The subsections below outline a list of services referred to as FQHC core services. Core services are reimbursed using encounter codes.

Encounter Services

Currently the definition of a visit is a face-to-face encounter between an FQHC patient and a physician, physician assistant, nurse practitioner, certified nurse midwife, chiropractor, clinical psychologist, or clinical social worker, during which a Medicaid-covered FQHC core service is furnished. The South Carolina Medicaid program does not cover nutrition, health education, social work, or other related ancillary services unless noted in this section. For billing purposes, SCDHHS has deemed a "visit" an "encounter." Physicians and practitioners providing

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Encounter Services (Cont'd.)

services under the FQHC program must meet the regular Medicaid enrollment requirements to provide services to Medicaid patients.

Only one encounter code is allowed per day with the exception of the psychiatry and counseling encounter, which can be billed in addition to another encounter on the same day. FQHC services are covered when furnished to patients at the center, in a skilled nursing facility, or at the client's place of residence. Services provided to hospital patients, including emergency room services, are not considered FQHC services.

Physician Services

Physician services refer to the professional services (diagnosis, treatment, therapy, surgery, and consultation) that a physician performs at the center.

Physician Assistant, Nurse Practitioner, and Certified Nurse Midwife

Physician assistant, nurse practitioner, and certified nurse midwife services refer to the professional services performed by one of these providers who:

- Is employed by or receives payment from the FQHC
- Is under a physician's general (or direct, if required by state law) medical supervision
- Provides services according to clinic policies or any physician's medical orders for the care and treatment of the patient
- Provides the type of services that a certified nurse midwife, nurse practitioner, or physician assistant is legally permitted by the state to perform
- Provides the type of services that Medicare/Medicaid would cover if provided by a physician or incidental to physician services

Clinical Psychologist and Clinical Social Worker Services

Clinical psychologist and clinical social worker services refer to professional services performed by one of these providers who:

- Is employed by or receives compensation from the FQHC
- Provides services of any type that the professional is legally permitted to perform by the state in which the services are furnished
- Provides the type of services that Medicaid would cover if furnished by a physician

Services and Supplies

Supplies, lab work, injections, etc., are not billable services. These services and supply costs are included in the encounter rate when provided in the course of a physician, physician assistant, nurse

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Services and Supplies (Cont'd.)

practitioner, certified nurse midwife, chiropractor, clinical psychologist, and/or clinical social worker visit. The types of services and supplies included in the encounter are:

- Commonly provided in a physician's office
- Commonly provided either without charge or included in the FQHC's bill (*i.e.*, lab tests)
- Provided as incidental, although an integral part of the above provider's services
- Provided under the physician's direct, personal supervision to the extent allowed under written center policies
- Provided by a clinic employee
- Not self-administered (drug, biological)

Immunizations

Vaccinations are covered as indicated in the Immunization section of this manual.

FQHC Adult Nutritional Counseling Program

Effective August 1, 2015, SCDHHS will implement the Obesity initiative. This policy currently targets those obese individuals who do not meet the criteria for gastric bypass surgery or related services. Obesity is defined for this program as an adult patient with a body mass index (BMI) of 30 or greater.

Currently, this program will exclude the following categories of beneficiaries:

- Pregnant women
- Patients, for whom medication use has significantly contributed to the beneficiary's obesity as determined by the treating physician, are not eligible to participate in the obesity program
- Beneficiaries who have had or scheduled to have bariatric surgery/gastric banding/gastric sleeve
- Beneficiaries actively being treated with gastric bypass surgery/vertical-banded gastroplasty/sleeve gastrectomy

There is an exhaustive list of medications that could contribute to obesity. Here are examples of medications that may cause weight gain:

- Atypical antipsychotics (aripiprazone, olanzapine, quetiapine, risperidone, ziprasidone)

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

FQHC Adult Nutritional Counseling Program (Cont'd.)

- Long-term use of oral corticosteroids (prednisone, prednisolone)
- Certain anticonvulsant medications (valproic acid, carbamazepine)
- Tricyclic antidepressants (amitriptyline)

Please note, for Healthy Connections Medicaid members also receiving Medicare benefits, SCDHHS will only pay secondary payments to Medicare.

The program consists of intensive behavioral therapy for obesity and includes three factors:

- Screening for obesity in adults using measurement of BMI calculated by dividing the patient's weight in kilograms by the square of height in meters
- Dietary (nutritional) assessment
- Intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high intensity interventions on diet and exercise

The following billing instructions apply to Fee for Service only. Providers who submit claims to a Managed Care Organizations (MCOs) should refer to the provider contract with the appropriate MCO for billing instructions.

Provider

For this policy the word "provider" is defined as a physician, physician assistant, or a nurse practitioner meeting the licensure and educational requirements in the state of South Carolina. All services must be within the South Carolina Medicaid Service Area (SCMSA). SCMSA is defined as South Carolina and adjacent areas within 25 miles of its borders.

During the patient's routine physical exam or office visit, the provider will assess the patient's needs and whether he or she will benefit from participating in an obesity intervention program. The provider must bill utilizing HCPCS code T1015 for the encounter. The provider must also bill HCPCS code G0447 with the SC modifier. This is for tracking purposes only.

Remember, only one encounter code is allowed per day with the exception of psychiatry and counseling encounters, which can be billed in addition to other encounters on the same day.

All subsequent obesity visits must be billed utilizing HCPCS code T1015. The provider must bill HCPCS code G0447 with a penny

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

FQHC Adult Nutritional Counseling Program (Cont'd.)

reimbursement in the charge field. HCPCS code G0447 is used for tracking purposes only. Subsequent visits may be billed as a one-on-one session between the provider and the patient or in a group setting. When billing for a group setting, the provider must append the HB modifier to the T1015 code indicating that a group session has been rendered. All groups are limited to a maximum of five patients per group. The chart of valid codes and usages can be found in Section 4 of the manual.

All obesity visits must include the following components listed below:

- **Assess:** Ask about and assess behavioral health risk and factors affecting behavioral change goals/methods
- **Advise:** Give clear, specific and personalized behavioral advice, including information about personal health, harms, and benefits
- **Agree:** Collaborate with the patient to select appropriate treatment goals and methods based on the patient's interest and willingness to change behavioral patterns and habits
- **Assist:** Use behavioral change techniques (self-help and/or counseling) to aid the patient in achieving agreed upon goals by acquiring the skills, confidence, and social, environmental supports for behavioral change, supplemented with adjunctive medical treatments when appropriate
- **Arrange:** Schedule follow up contacts to provide ongoing assistance and or support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment

The provider must also address the importance of exercise, developing a realistic exercise plan with goals. The obesity intervention plan must be documented in the patient's medical health record. The provider will arrange for an individual nutritional assessment to be provided by a licensed and Medicaid-enrolled dietitian within their facility.

The provider must schedule a follow-up exam with the patient to evaluate the progress he or she has made, reviewing compliance with the exercise plan and nutritional plan provided by the dietitian. Each time the provider sees the patient, he or she must clearly document the patient's progress, activities, and compliance with the treatment plan. The provider must record the patient's BMI in the chart.

The provider may perform all medically necessary diagnostic testing including but, not limited to A1C, cholesterol, triglycerides, T3, T4, TSH laboratory tests, and EKGs. Reimbursements for lab work, supplies, injections, surgical procedures (unless noted in "Special Clinic Services" of this section), and other medical items are included in the encounter code.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

FQHC Adult Nutritional Counseling Program (Cont'd.)

All fee-for-service beneficiaries age 21 and older are limited to 12 encounters per state fiscal year. If the patient has reached the maximum units allowed for the fiscal year, the provider may append a P4 modifier to HCPCS code T1015 and the service will be reimbursed.

Note: The P4 modifier should not be used to bypass the six provider visits and six nutritional encounters allowed for subsequent service in accordance with this Obesity policy.

If the provider has determined that additional visits are medically necessary and the patient has complied with the program, the provider may request additional visits in accordance with the policy outlined in "Additional Services" in this section.

All service information must be written and maintained in the patient's medical record. All services are subject to review and recoupment by the Division of Program Integrity.

Dietitian

A dietitian is defined as any individual meeting the licensure and educational requirements in the state of South Carolina and/or the border states of Georgia and North Carolina. All services must be rendered within the South Carolina Medicaid Service Area (SCMSA). SCMSA is defined as South Carolina and adjacent areas within 25 miles of its borders.

The dietitian is responsible for reviewing the patient's habits, providing education, reinforcing of the importance of exercise, developing a nutritional plan, and establishing goals. The dietitian must document the patient's progress, activities, and compliance with the nutritional and exercise plan. The dietitian must submit a written report to the ordering provider each time the patient is seen individually or in a group/class setting. The dietitian must maintain complete records of the nutritional plan, compliance, and exercise plan in the patient's medical record.

HCPCS code T1015 encompasses both the provider's and dietitian's time and will be used for both the initial and follow-up encounters. Please note that the initial dietitian visit must be an individual one-on-one counseling session. In order for SCDHHS to track the dietitian visits, the FQHC must bill utilizing HCPCS code S9470 (nutritional counseling, dietitian visit). When billing subsequent dietitian visits, the FQHC must bill S9452 (nutrition classes, non-physician provider) for tracking purposes. For all a group nutritional classes, the FQHC will append the HB modifier for HCPCS code S9452. All groups are limited to a maximum of five patients per group. All services for the provider and dietitian must occur on the same day utilizing one encounter of T1015.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Billing Requirements

All ICD-CM codes for FQHC Adult Nutritional Counseling must be billed as secondary diagnosis codes. In addition, providers and dietitians are required to bill with a primary diagnosis code. The correct combination of ICD-CM and HCPCS codes and modifier must be utilized to receive reimbursement for services. For ICD-CM codes, HCPCS codes, and modifiers, please refer to Section 4 of this manual.

The following requirements must be met:

- Providers may bill subsequent visits with one-on-one counseling or group counseling.
- Services will be reimbursed for place of service 22 (clinics).
- Dietitians must bill utilizing the above referenced codes.
- Nutritional counseling units are billed based on a 30-minute session and are limited to one unit per day.

All providers and dietitians are responsible for clearly documenting the patient's chart with all information referenced in this policy. All services rendered by both providers and dietitians are subject to review by the Division of Program Integrity. Services not meeting the requirements reflected in this policy may be subject to recoupment by SCDHHS.

Additional Services

If the provider has completed a series of six visits and the patient has been compliant with the treatment plan and the provider has determined that the patient would benefit from additional treatment, the provider must submit documentation of medical necessity to the following address:

SCDHHS
ATTN: Medical Director
Post Office Box 8206
Columbia, SC 29202

In order to receive additional visits not to exceed six additional provider visits and six additional nutritional counseling sessions within a 12 month period, the following documentation must be submitted by a physician, nurse practitioner, or physician assistant only:

- A letter of Medical Necessity
- Patient notes
- BMI start and end
- A1C
- Dietitian reports
- Exercise plan and notes on adherence

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Additional Services (Cont'd.)

All requests will be reviewed by SCDHHS medical directors for medical necessity and compliance with the Obesity program.

FQHC Children's Nutritional Counseling Program

The following billing instructions apply to Fee for Service only. Providers who submit claims to a Managed Care Organizations (MCOs) should refer to the provider contract with the appropriate MCO for billing instructions.

FQHCs must follow all Obesity policy guidelines listed under "FFS Children's Nutritional Counseling Program" in this section for both providers and dietitians. However, FQHCs must bill utilizing the HCPCS encounter code T1015. HCPCS code T1015 includes both the dietitian and the provider visit within one unit. FQHCs can only bill for individual obesity visits and cannot bill for group therapy visits under this policy. All documentation standards listed in the Obesity policy apply.

Medicaid-eligible children under the age of 21 may receive unlimited evaluation and management (E&M) visits as long as the services are medically necessary. For this policy the word "provider" is defined as a physician, physician assistant, or nurse practitioner meeting the licensure and educational requirements in the state of South Carolina and/or the border states of Georgia and North Carolina. All services must be rendered within the South Carolina Medicaid Service Area (SCMSA). The SCMSA is defined as South Carolina and adjacent areas within 25 miles of its borders.

Provider

During the child's routine physical or encounter, the provider will assess the child's needs and whether he or she will benefit from participating in an obesity counseling intervention program. The provider must bill HCPCS code T1015 for both the provider assessment and the dietitian assessment.

The provider must schedule a follow-up encounter with both child and parent or legal guardian to evaluate the progress the child has made, review their compliance with the exercise and nutritional plan provided by the dietitian, and render all behavioral modification suggestions and plans. Each time the provider and dietitian sees the child, he or she must clearly document the child's progress, activities, and compliance with the treatment plan. The provider must record height and weight percentile in the child's medical records.

Children ages 2 to 7 are at risk for being overweight when they are within the 85th and 95th percentile in weight and age. Children ages 2 to 7 are considered overweight when they are in the 95th percentile for

FQHC Children's Nutritional Counseling Program (Cont'd.)

weight for their age. The provider determining the need for an obesity intervention program must communicate with the child and his or her parents or legal guardian the weight goal and plans that will lead to an incremental decrease in weight loss. The weight loss goals, laboratory work, and exercise plan must be documented in the child's medical records.

It is recommended that overweight children ages 7 to 16 should strive for weight loss of one to two pounds per month; more rapid weight loss may be initiated at the provider's discretion and the child's healthcare needs.

In addition, it is recommended that overweight children who are 16 years old or post pubertal should strive for 10 percent weight loss from baseline over six months. The provider should schedule a reassessment after six months of treatment.

Dietitian

A dietitian is defined as any individual meeting the licensure and educational requirements in the state of South Carolina and/or the border states of Georgia and North Carolina. All services must be rendered within the South Carolina Medicaid Service Area (SCMSA). SCMSA is defined as South Carolina and adjacent areas within 25 miles of its borders.

The dietitian is responsible for reviewing the child's habits, providing education with the child and his or her parent or legal guardian, reinforcing the importance of exercise, developing a nutritional plan, and establishing weight goals. The dietitian must document the child's progress, activities, and compliance with the nutritional and exercise plan. The dietitian must document the child's medical record as to the progress and compliance as stated above.

Billing Requirements

FQHCs must meet the following billing requirements to be reimbursed for Obesity services:

- Providers and dietitians must bill utilizing HCPCS code T1015.
- Providers and dietitians may bill only one T1015 for the combination of their services. Please refer to Section 4 of this manual for additional billing code information.
- Providers and dietitians are allowed a maximum of six encounters in a year for the treatment of obesity.
- Services will be reimbursed for places of service 11 (office) and 22 (clinic).

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Billing Requirements (Cont'd.)

Providers and dietitians are responsible for clearly documenting the child's chart with all information referenced in this policy. All services rendered by both providers and dietitians are subject to review by the Division of Program Integrity. Services not meeting the requirements reflected in this policy may be subject to recoupment by SCDHHS.

Additional Services

A request for services in excess of the limits above requires medical necessity verification by an SCDHHS medical director. The provider must submit a letter of medical necessity and all supporting documentation to:

SCDHHS
ATTN: Medical Director
PO Box 8206
Columbia, SC 29202

Encounter and Ancillary Service Coding

All encounter codes and ancillary services listed in this section must be billed under the FQHC provider number. Only one encounter code may be billed per day, with the exception of the Psychiatry and Counseling Encounter, which can be billed in addition to another encounter on the same day. The most appropriate encounter code must be billed based on the service(s) provided. All supplies, lab work, injections, surgical procedures (unless noted in the "Special Clinic Services" section of this manual), etc., are included in the encounter code reimbursement. The only fragmented services billable on a fee-for-service basis are listed under "Special Clinic Services."

Medical Encounter – T1015

All medical encounters must be billed using the procedure code T1015 unless otherwise specified. A medical "visit" (encounter) is defined as a face-to-face encounter between a patient and the physician, physician assistant, nurse practitioner, chiropractor, or certified nurse midwife during which an FQHC core service is provided. FQHC providers will be reimbursed their contracted encounter rate, and are allowed only one medical encounter per day, even if the patient sees more than one professional at the visit or on that day. The use of this code counts toward the ambulatory visit limit for beneficiaries age 21 or older.

Maternal Encounter – T1015 (With TH Modifier)

All maternal care encounters must be billed with procedure code T1015 with a "TH" modifier. FQHC providers will be reimbursed their contracted rate for all maternal services rendered. The use of this procedure code and a "TH" modifier will not affect the beneficiary's number of allowable ambulatory visits. IUDs, the technical component of ultrasounds, and non-stress tests may be billed separately. Please refer to "Family Planning" and "Special Clinic Services" coding guidelines below.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Psychiatry and Counseling Encounter – T1015 (With HE Modifier)

For Behavioral Health policies and procedures please refer to the "FQHC Behavioral Health Services" provider manual located on our website at http://www.scdhhs.gov/.

Cancer Treatment and HIV/AIDS Encounter – T1015 (With P4 Modifier)

SCDHHS allows FQHCs to bill for HIV/AIDS and cancer-related services using code T1015, with the P4 modifier.

The use of this code and the P4 modifier will not count toward the beneficiary's ambulatory visit limit if the beneficiary is age 21 or older. Charges for such services will be reimbursed at the contract rate.

Family Planning Program

The Family Planning program is a limited Medicaid benefit program available to men and women who meet the appropriate federal poverty level percentage in order to qualify and participate and who are ineligible for full Medicaid benefits under another eligibility category. Family Planning provides coverage for a limited set of services, including biennial physicals, family planning services, and family planning related services. Any services provided to a beneficiary enrolled in Family Planning that is not specifically outlined below are the sole responsibility of the beneficiary.

Covered Services

Section 4 of this manual contains the list of procedure codes, diagnosis codes, and an approved drug list for the Family Planning Program. While there are codes that may be considered Family Planning services other than the ones listed, they are not covered for this eligibility group. The lists will be updated periodically as codes are added or deleted. All services, with the exception of referral codes S0316 and S0320, provided to Family Planning beneficiaries must be billed using a FP modifier and approved family planning diagnosis code.

Encounters

Four types of encounters are covered for beneficiaries enrolled in the Family Planning Program. These encounters include biennial (once every two years) physical examinations, annual family planning encounter, periodic family planning, and contraceptive counseling.

Biennial Physical Encounter

The Family Planning program sponsors adult physical examinations under the following guidelines:

- An FQHC would bill T1015 with a FP modifier appended.
- The biennial encounter is allowed once every two years per beneficiary.
- It is a preventative encounter.
- For dates of service on or before **September 30, 2015**, diagnosis code V70.0 must be used when billing for the Family Planning biennial physical.

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PROGRAM SERVICES

Biennial Physical Encounter (Cont'd.)

For dates of service on or after **October 1, 2015**, diagnosis code Z00.00 or Z00.01must be used when billing for the Family Planning biennial physical.

- The encounter must be performed by a Nurse Practitioner, Physician Assistant or a Physician.
- The encounter must contain the following components at minimum:
  - Family History
  - Social History
  - Surgical History
  - Height, Weight, BMI and Blood Pressure

The adult physical encounter must include a generalized physical overview of the following organ systems:

- Abdomen
- Back
- Breasts (Female)
- Brief Muscular
- Brief Neurological
- Brief Skeletal
- EENT
- External Genitalia
- Heart
- Lungs
- Pelvic (Female)
- Peripheral Vascular
- Prostate (Male)
- Rectal
- Skin

The encounter must include age, gender and risk appropriate preventative health screenings, according to the United States Preventative Services Task Force Recommendations (Grade A & B only).

USPSTF Grade A & B Recommendations as of August 1, 2014

Description	Appropriate for the following Family Planning Beneficiaries	Allowable Codes	Required Modifier	Provider Type Requirements	Notes
Age and Risk-Appropriate Screenings for the Following: • Alcohol Misuse • BRCA Screening Questions • Depression • Intimate Partner Violence • Obesity • Tobacco Use Low-Intensity Counseling for the Following: • Healthy Diet • Skin Cancer Prevention	• All adults	96150 96151 96152	FP	NP, PA or Physician	Must occur during physical exam

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Description	Appropriate for the following Family Planning Beneficiaries	Allowable Codes	Required Modifier	Provider Type Requirements	Notes
Cholesterol Abnormalities Screening	• Men ages 35+ • Men ages 20-35 if at increased risk for coronary heart disease • Women ages 20+ if at increased risk for coronary heart disease	80061 82465 83718	FP	NP, PA or Physician	Must occur during physical exam
Diabetes Screening	• Asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg	82947 82950 82951 83036	FP	NP, PA or Physician	Must occur during physical exam
Hepatitis C Virus Infection Screening	• All adults at high risk for virus infection • One-time screening for all adults born between 1945-1965	86803 86804	FP	NP, PA or Physician	Must occur during physical exam
Breast Cancer Screening (Mammography)	• Women ages 50-74	77067 77066	FP	Physician Only	Can occur outside physical exam
Abdominal Aortic Aneurysm Screening	• Men ages 65-75 who have ever smoked	76706	FP	Physician Only	Can occur outside physical exam
Colorectal Cancer Screening	• Men and Women ages 50-75	45331 45378 82270 82274 88305 G0105	FP	Physician Only	Can occur outside physical exam
Lung Cancer Screening for Smokers	• **Adults ages 55 - 80 who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years**	71250	FP	Physician Only	Can occur outside physical exam
Note: FQHCs must read the entire policy in order to know how to bill for the service located in this chart.					

Family Planning counseling must be offered to Family Planning beneficiaries during the physical encounter.

Portions of the physical may be omitted if the beneficiary is not cooperative and resists specific system examinations (despite encouragement by the physician, nurse practitioner or office staff). A well-documented note must be written in the patient's record explaining why that part of the exam was omitted.

All laboratory procedures are included in the reimbursement for the encounter.

Note: Only one encounter code can be billed in a day.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Annual Family Planning Evaluation/Management Encounters

The Family Planning program sponsors annual family planning encounters. The annual visit is the re-evaluation of an established patient requiring an update to the medical record, interim history, physical examination, appropriate diagnostic laboratory tests and/or procedures, family planning counseling, and adjustment of contraceptive management as indicated. This visit should be billed using T1015 with the FP modifier.

The following services must be provided during the annual encounter:

- Updating the entire history and screening, noting any changes
- Counseling and education, as necessary, regarding pregnancy prevention and/or sexually transmitted diseases
- Laboratory tests
- Issuance of birth control supplies or prescription

Periodic Revisit

The Family Planning Program sponsors periodic revisits for beneficiaries, as needed. The periodic revisit is a follow up of an established patient with a new or existing family planning treatment. These encounters are available for multiple reasons such as change in contraceptive method due to problems with the particular method or issuance of birth control supplies. This visit should be billed using the T1015 with FP modifier. Only one encounter code can be billed in a day.

At a minimum the encounter visit must include:

- Weight and blood pressure check
- Interim history
- Symptom appraisal as needed
- Documentation of any treatment and/or counseling including administration and/or issuance of contraceptive supplies

Family Planning Counseling Encounters

The Family Planning Program sponsors Family Planning Counseling Encounters for beneficiaries. The Family Planning Counseling/ Education visit is a separate and distinct service, using the T1015 with FP modifier. Family Planning counseling/Education is a face-to-face interaction to enhance a beneficiary's comprehension or compliance with, his or her family planning method of choice. These services are for the expressed purpose of providing education/counseling above and beyond the routine contraceptive counseling that are included in the clinic visits.

Note: Only one encounter code can be billed in a day.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

FQHC Reporting Positive Screens

Family Planning beneficiaries have Medicaid coverage for a limited set of services. This coverage does not include treatment, medication, or office visits for many of the conditions that a FQHC provider may identify during the physical examination or annual family planning visit. If a problem or condition is identified during the physical examination or annual family planning visit, the FQHC should schedule a follow-up visit with the patient in order to address the problem. Family Planning patients will be responsible for any fees associated with follow-up visits. All follow-up visits for uninsured Family Planning beneficiaries should follow the FQHC provider's established policies and procedures for treating uninsured patients.

For data collection and monitoring purposes, SCDHHS requests that FQHCs report positive screening results when a problem or condition is identified during the physical examination or annual family planning visit. The instructions that follow describe the process for reporting these positive screenings.

Instructions

When a problem or condition requiring follow-up care is identified, FQHCs should include the Positive Screening Code, **S0320**, along with one or more of the modifiers listed below as a separate line on the Encounter Claim form.

Modifier Instructions

FQHCs must use the appropriate modifier from the list below**. Up to 4 modifiers can be used for the Positive Screening Code** (so if a patient is scheduled to receive a follow-up visit for more than one positive screening, include modifiers for all positive screenings)

1. If scheduling a follow-up visit for a patient for a positive **diabetes screen**, use modifier **P1**
2. If scheduling a follow-up for a patient for a positive **cardiovascular screen**, use modifier **P2**
3. If scheduling a follow-up visit for a patient for any **positive cancer screen**, use modifier **P3**
4. If scheduling a follow-up visit for a patient for any **mental or behavioral health screens**, use modifier **P4**
5. If scheduling a follow-up visit for a patient for any **other condition or problem**, use modifier **P5**

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Covered Medication

During a physical examination encounter or annual family planning encounter, any of the six specific STIs are identified; one course of antibiotic treatment from the approved drug list found in Section 4 of this manual will be allowed per calendar year under the Family Planning. The six STIs are: syphilis, chlamydia, gonorrhea, herpes, candidiasis, and trichomoniasis. Beneficiaries are exempt for copayments for STI treatments as well as all other services under Family Planning. STI testing and treatments are only covered during the beneficiaries' physical examination or annual family planning encounters.

Covered Contraceptive Supplies and Services

The Family Planning Program provides coverage for contraceptive supplies (for example, birth control pills or male condoms) and contraceptive services such as an injection and IUD. When billing for contraceptive services and supplies, all codes must be billed with an FP modifier.

Note: Pregnancy testing (when the test result is negative) is a reimbursable Family Planning service in two situations:

1. The test is provided at the time family planning services are limited for an individual.
2. The test is provided after the initiation of family planning services, when the patient may not have used the method properly, or when the patient is having an unusual response to the family planning method.

Long Acting Reversible Contraceptives (LARCs) are covered under both the pharmacy benefit and under the medical benefit using the traditional "buy and bill" method. Any LARC billed to Medicaid through the pharmacy benefit will be shipped directly to the provider's office for insertion. Providers must only bill Medicaid for the insertion of the device when it is purchased through the pharmacy.

Covered Screenings and Testing

The Family Planning program provides coverage for STI screenings including: Syphilis, chlamydia, gonorrhea, herpes, candidiasis, trichomoniasis and HIV. All laboratory and screenings are covered within the encounter rate and therefore, would not be covered separately and must be completed.

Non-Covered Services

Services beyond those outlined in this section that are required to manage or to treat medical conditions and/or diseases, whether or not such procedures are also related to family planning, are not covered under the Family Planning Program. Services to address side effects or complications (*e.g.*, blood clots, strokes, abnormal Pap smears, etc.)

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Non-Covered Services (Cont'd.)

associated with various family planning methods requiring medical interventions (*e.g.*, blood clots, strokes, abnormal Pap smears, etc.) other than changing the birth control method should not be billed using an FP modifier or Family Planning diagnosis code. When services other than Family Planning are provided during a family planning visit, these services must be billed separately using the appropriate CPT/HCPCS codes and modifiers.

- Sterilization by hysterectomy
- Abortions
- Hospital charges incurred when beneficiary enters an outpatient hospital facility for sterilization purposes, **but then opts not to have the procedure**
- Inpatient hospital services
- Colposcopy and biopsy of cervix/vagina performed to identify and treat medical conditions
- Treatment of medical complications caused by, or following a Family Planning procedure
- Any procedure or service provided to a woman who is known to be pregnant

Note: Beneficiaries are allowed one permanent sterilization procedure per lifetime.

Preventive Services

Preventive measures are defined as any routine service exam for adults or children when the procedures are performed in the absence of an illness or complaint(s). Generally, the South Carolina Medicaid program requires that a complaint or illness be recorded before a service is compensable. The exceptions to this policy are the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program and the Healthy Adult Physical Exams program.

The EPSDT program provides preventive health services to Medicaid-eligible children from birth to age 21 through periodic medical screenings. This includes the application of topical fluoride varnish in a primary care setting. An EPSDT screening is considered an encounter. A screening and an encounter code may not be billed on the same date of service. All EPSDT screenings must be billed using the appropriate CPT codes (99381 – 99385 and 99391 – 99395). EPSDT screening should be billed at the FQHC contract rate. For additional program policy information, please refer to the "EPSDT" heading in this section.

The Medicaid program sponsors adult physical exams under the following guidelines:

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Preventive Services (Cont'd.)

- The exams are allowed once every **two** years per patient.
- The patient must be 21 years of age or older.
- For dates of service on or before **September 30, 2015**, encounter code T1015 should be billed for this service, and diagnosis code V70.9 should be used.

  For dates of service on or after **October 1, 2015**, encounter code T1015 should be billed for this service, and diagnosis code Z00.8 should be used.

This encounter code may also be offered to dually eligible Medicare and Medicaid clients until Medicare covers physicals. If a patient has both Medicare and Medicaid, bill Medicaid directly.

For additional program policy guidelines, please refer to "Adult Physical Exams" under "Preventive Care Services" in this section.

Special Clinic Services

Please refer to Section 4 for a list of procedures that may be billed in addition to an encounter code.

Non-stress tests, EKGs, and x-rays performed in the center must be billed using the appropriate CPT-4 code with a TC modifier indicating the technical component only. The professional component is reimbursed through the encounter code that may be billed (if appropriate). If the patient is referred to a radiologist, cardiologist, etc., for interpretation, the specialist's services are reimbursed fee-for-service following Medicaid policy for their specialty.

Dental Services

For dental program policy guidelines, please contact the DentaQuest Call Center at 1-888-307-6553.

FQHC Crossovers

Crossover claims must be filed initially to the assigned FQHC Medicare intermediary. Upon payment from Medicare, the claim must be filed to Medicaid on the CMS-1500 claim form showing the payment received from Medicare.

PROVIDER ENROLLMENT – MEDICAID

Provider Enrollment procedures have been implemented as follows:

- A NEW SITE for FQHCs and FQHC Look-A-Likes requires the submission of the (1) Health Resources and Services Administrations (HRSA) Notice of Grant Award and (2) CMS Certification Letter, in addition to the enrollment application.
- ADDING A SITE requires the submission of the HRSA Notice of Grant Award, in addition to the enrollment application.

  Note: Information for adding a new site is located in the Terms and Conditions section on the HRSA Notice of Grant Award.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Provider Enrollment – Medicaid (Cont'd.)

FQHCs **must** enroll in Medicare. Providers are encouraged to concurrently enroll in Medicare and Medicaid.

CLINIC-BASED PHYSICIAN POLICY

All hospital services must be billed under the CBP number.

Hospital Services

The Clinic-Based Physician (CBP) program covers the billing for physician, certified nurse midwife, and nurse practitioner services rendered by FQHC providers at a hospital.

All services provided to hospital patients (including emergency room services) by a FQHC provider must be billed under the CBP program. These services must be billed using the Physician's Current Procedural Terminology (CPT) codes and will not be cost-settled.

Providers must bill for these services using the CBP provider number (Section 33) and rendering physician, certified nurse midwife, or nurse practitioner's Medicaid provider number (Section 24K) on the CMS-1500 claim form.

RURAL HEALTH CLINIC (RHC)

Rural Health Clinic (RHC) services are primarily ambulatory, outpatient office type services furnished by physicians and other approved providers at a clinic located in a rural area. When a rural area has been designated as a shortage area by the U.S. Census Bureau and has been certified for participation in Medicare in accordance with 42 CFR Part 405, Subpart X and 42 CFR Part 491, Subpart A, a RHC certified under Medicare will be deemed to have met the standards for certification under Medicaid.

RHCs must be under the medical direction of a physician and have a health care staff that includes one or more physicians and one or more nurse practitioners or physician assistants. The staff may also include ancillary personnel who are supervised by the professional staff. The staff must be sufficient in numbers to provide the services essential to the operation of the clinic or the center. A physician, nurse practitioner, nurse midwife, or physician assistant must be available to furnish patient care services at all times during the RCH's hours of operation. The mid-level nurse practitioner, nurse midwife, or physician assistant must be available at least 50 percent of the RHC's clinical hours.

The RHC and clinical staff must be in compliance with applicable federal, state, and local laws for licensure, certification, and/or registration.

The authority for RHC services is found in Sections 1861(aa), 1102 and 1871, of the Social Security Act, and at 42 CFR Part 405, Subpart X; 42 CFR Section 440.20(b); and 42 CFR Part 491, Subpart A.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Beneficiaries Enrolled in a Managed Care Plan

A beneficiary enrolled in a Medicaid Managed Care Program, such as a Managed Care Organization (MCO) or the Medical Home Network - Medically Complex Children's Waiver (MCCW) program, must receive all health care services through that plan. Each plan specifies services that are covered, those that require prior authorization, the process to request authorization and the conditions for authorization. Please refer to Section 1 of this manual for information on how to verify a beneficiary's enrollment in a managed care plan.

All questions concerning services covered by or payments from a managed care plan must be directed to the appropriate plan. Medicaid does NOT process prior authorization requests for services to be provided to a Medicaid beneficiary who is enrolled in a capitated managed care plan when the services are included in the contract with the plan. Providers requesting prior authorization for services for a beneficiary enrolled in a managed care plan will be referred to that plan. A list of MCOs and the MCCW provider with which Medicaid has a contract to provide health care services is available on our website at http://www.scdhhs.gov/. Please note that Medicaid staff makes every effort to provide complete and accurate information on all inquiries as to a beneficiary's enrollment in a managed care plan. Because eligibility information as to which plan the patient must use is available to providers, a "fee for service" claim will not be paid even when information is given in error by Medicaid staff.

Billing

Services may be billed electronically or on paper, using the CMS-1500 claim form. Medicaid encourages electronic billing. When claims are submitted electronically, mistakes can be corrected immediately, and claims are processed without delays. The following billing procedures apply to the RHC program.

Core Services

Core services are reimbursed through encounter codes using an all-inclusive rate (up to the current year's RHC cap or CMS-approved rate) that reflects the cost of service. RHC core services are outlined in the manual subsections below.

Encounter Services

Currently the definition of a visit is a face-to-face encounter in the RHC setting (or client's home) between a client and the physician, physician assistant, nurse practitioner, certified nurse midwife, chiropractor, clinical psychologist, or clinical social worker, as required by state law, during which an RHC core service is furnished. For billing purposes, SCDHHS has deemed a "visit" an "encounter."

Only one encounter code is allowed per day with the exception of the Psychiatry and Counseling encounter, which can be billed in addition to another encounter on the same day.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Encounter Services (Cont'd.)

RHC services are covered when furnished to clients at the clinic, skilled nursing facility, or the client's place of residence. Services provided to hospital patients, including emergency room services, are not considered RHC services.

Physician Services

Physician services refer to professional services (diagnosis, treatment, therapy, surgery, and consultation) that a physician performs at the clinic, a nursing facility, or the client's place of residence.

Physician Assistant, Nurse Practitioner, and Certified Nurse Midwife

Physician assistant, nurse practitioner, and certified nurse midwife services refer to the professional services performed by one of these providers who meets the following requirements:

- Is employed by or receives payment from the RHC
- Is under a physician's general (or direct, if required by state law) medical supervision
- Provides services according to clinic policies or any physician's medical orders for the care and treatment of the client
- Provides the type of services that Medicare/Medicaid would cover if provided by a physician or incidental to physician services

Screening Brief Intervention and Referral to Treatment Initiative

Effective with dates of service on or after July 1, 2014, the following codes and billing procedures must be utilized in order to receive payment for the Screening, Brief Intervention and Referral to Treatment (SBIRT) services.

SCDHHS began coverage for SBIRT in 2011 to improve birth outcomes and the overall health of moms and babies. SCDHHS has partnered with stakeholders across the state to help identify and treat pregnant beneficiaries who may experience alcohol or other substance abuse issues, depression, tobacco use or domestic violence. SBIRT services (screening and, when applicable, a brief intervention) are reimbursable in addition to an Evaluation and Management (E/M) code for pregnant women and/or those who are in the 12-month postpartum period.

SCDHHS will continue to use the Healthcare Common Procedure Coding System (HCPCS) codes of H0002 for screening and H0004 for intervention. The U1 modifier will no longer be covered as of July 1, 2014. A new modifier, HD, will now be required when the services rendered indicate a positive result and/ or when a referral is completed.

Providers must use the H0002 HCPCS code and the HD modifier when an SBIRT screening result is positive. Additionally, providers must use the H0004 HCPCS code with the HD modifier when a referral to

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Screening Brief Intervention and Referral to Treatment Initiative (Cont'd.)

treatment is made in conjunction with the brief intervention. These changes in billing procedures apply for Healthy Connections Medicaid members enrolled in both the Medicaid Fee-for-Service (FFS) and Medicaid Managed Care program.

- Screening - H0002 reimburses at $24.00 once per fiscal year
- Brief Intervention - H0004 reimburses at $48.00 twice per fiscal year

The Institute for Health and Recovery's Integrated Screening Tool, which is a validated and objective resource, must be used to receive reimbursement for screening and intervention. A copy of this screening tool is located in the "Forms" section of this manual.

When billing for SBIRT services using HCPCS codes H0002 and H0004, providers must bill using both their individual and group NPI numbers on the CMS-1500 form or an electronic claim. The individual provider's NPI number must be entered on line 24J for a paper claim or loop 2310B for an electronic claim. The pay-to-provider must be the group NPI number in field 33A of the CMS-1500 paper claim or on loop 2010AA for an electronic claim. If the provider is the owner, is a sole provider, and does not have a group NPI number; the provider may bill using his or her individual NPI number on both lines 24J and 33A or on both loops 2310B and 2010AA.

Services and Supplies

Supplies, injections, etc., are not billable services. These services and supply costs are included in the encounter rate when provided in the course of a physician, physician assistant, nurse practitioner, certified nurse midwife, chiropractor, clinical psychologist, and/or clinical social worker visit. The types of services and supplies included in the encounter are:

- Commonly provided in a physician's office
- Commonly provided either without charge or included in the RHC's bill
- Provided as incidental, although an integral part of the above provider's services
- Provided under the physician's direct, personal supervision to the extent allowed under written center policies
- Provided by a clinic employee
- Not self-administered (drug, biological)

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Immunizations

Vaccinations are covered as indicated in the Immunization section of this manual.

Application of Fluoride Varnish

Effective for dates of service on or after July 1, 2015, trained staff in a primary care setting must begin billing Current Procedural Terminology (CPT) code 99188 on the CMS-1500 form when applying fluoride varnish. This code replaces the American Dental Association (ADA) code of D1206 when the service is provided in a primary care setting. D1206 will no longer be available for billing in a primary care setting after June 30, 2015. All program requirements and rates applicable to D1206 delivered in a primary care setting are also applicable to the 99188 code.

Healthy Connections children can receive topical fluoride varnish during sick or well child visit from the eruption of their first tooth through the month of their thirteenth birthday. Primary care providers are encouraged to focus their efforts on children through age five, who are at high risk for dental caries. This follows the recommendations of the American Academy of Pediatrics and the United States Preventive Services Task Force.

Laboratory Services

All laboratory services (including the six laboratory tests required for RHC certification) must be billed to Medicaid under your fee-for-service Medicaid provider identification number. Laboratory services cannot be billed using your RHC provider number.

Non-stress tests, EKG's, and x-rays performed in the center must be billed using the appropriate CPT-4 code with a TC modifier indicating the technical component only. The professional component is reimbursed through the encounter code that may be billed (if appropriate). If referred to a radiologist, cardiologist, etc., for interpretation, their services are reimbursed fee-for-service following Medicaid policy for their specialty service.

Hospital Care Services provided by medical professionals of the clinic are compensable under the special clinic service guidelines.

RHC Adult Nutritional Counseling Program

Effective August 1, 2015, SCDHHS will implement the Obesity initiative. This policy currently targets those obese individuals who do not meet the criteria for gastric bypass surgery or related services. Obesity is defined for this program as an adult patient with a body mass index (BMI) of 30 or greater.

Currently, this program will exclude the following categories of beneficiaries:

- Pregnant Women

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

RHC Adult Nutritional Counseling Program (Cont'd.)

- Patients, for whom medication use has significantly contributed to the beneficiary's obesity as determined by the treating physician, are not eligible to participate in the obesity program
- Beneficiaries who have had or scheduled to have bariatric surgery/gastric banding
- Beneficiaries actively being treated with gastric bypass surgery/vertical-banded gastroplasty

There is an exhaustive list of medications that could contribute to obesity. Examples of medications that may cause weight gain are:

- Atypical antipsychotics (aripiprazone, olanzapine, quetiapine, risperidone, ziprasidone)
- Long-term use of oral corticosteroids (prednisone, prednisolone)
- Certain anticonvulsant medications (valproic acid, carbamazepine)
- Tricyclic antidepressants (amitriptyline)

Please note, for Healthy Connections Medicaid members also receiving Medicare benefits, SCDHHS will only pay secondary payments to Medicare.

The program consists of intensive behavioral therapy for obesity and includes three factors:

- Screening for obesity in adults using measurement of BMI calculated by dividing the patient's weight in kilograms by the square of height in meters
- Dietary (nutritional) assessment
- Intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high intensity interventions related to diet and exercise

The following billing instructions apply to Fee for Service only. Providers who submit claims to a Managed Care Organizations (MCOs) should refer to the provider contract with the appropriate MCO for billing instructions.

Provider

For this policy the word "provider" is defined as a physician, physician assistant, or a nurse practitioner meeting the licensure and educational requirements in the state of South Carolina. All services must be within the South Carolina Medicaid Service Area (SCMSA). SCMSA is defined as South Carolina and adjacent areas within 25 miles of its borders.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

RHC Adult Nutritional Counseling Program (Cont'd.)

RHCs must bill for Obesity benefits utilizing their GP legacy/NPI number and not their RHC legacy/NPI number.

During the patient's routine physical exam or office visit, the provider will assess the patient's needs and whether they will benefit from participating in an obesity intervention program. The provider can either schedule the patient for an independent visit or may bill the initial obesity visit on the same day as a routine physical exam or evaluation and management (E&M) service. If the provider chooses to bill for both services on the same day, the provider must append the 25 modifier to the E&M service. This will prevent claim edits due to errors related to the National Correct Coding Initiative. **This policy only applies to the initial obesity visit.**

All obesity visits must be billed utilizing HCPCS code G0447, except for the initial visit. The initial visit must be billed by appending an SC modifier to the HCPCS code G0447. Subsequent visits may be billed as a one-on-one session between the provider and the patient or in a group setting. When billing for a group setting, the provider must append the HB modifier to HCPCS code G0447 indicating that a group session has been rendered. All groups are limited to a maximum of five patients per group. The chart of valid codes and usages are located in Section 4 of this manual.

All obesity visits must include the following components listed below:

- **Assess:** Ask about and assess behavioral health risk and factors affecting behavioral change goals/methods
- **Advise:** Give clear, specific and personalized behavioral advice, including information about personal health, harms, and benefits
- **Agree:** Collaborate with the patient to select appropriate treatment goals and methods based on the patient's interest and willingness to change behavioral patterns and habits
- **Assist:** Use behavioral change techniques (self-help and/or counseling) to aid the patient in achieving agreed upon goals by acquiring the skills, confidence, and social, environmental supports for behavioral change, supplemented with adjunctive medical treatments when appropriate
- **Arrange:** Schedule follow up contacts to provide ongoing assistance and or support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment

The p**rovider must** also emphasize the importance of exercise, developing a realistic exercise plan with goals. The obesity intervention plan must be documented and maintained in the patient's medical

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

RHC Adult Nutritional Counseling Program (Cont'd.)

record. The provider will arrange for an individual nutritional assessment to be provided by a Medicaid enrolled licensed dietitian.

The provider must schedule a follow-up exam with the patient to evaluate the progress the patient has made, reviewing compliance with the exercise plan and nutritional plan provided by the dietitian. Each time the provider sees the patient, he or she must clearly document the patient's progress, activities, and compliance with the treatment plan. The provider must record the patient's BMI in the chart.

Services will be reimbursed for places of service 11 (office) and 22 (clinic). All service information must be written and maintained in the patient's medical record. All services are subject to review and recoupment by the Division of Program Integrity.

Dietitian

A dietitian is defined as any individual meeting the licensure and educational requirements within the state of South Carolina and/or the border states of Georgia and North Carolina. All services must be rendered within the South Carolina Medicaid Service Area (SCMSA). SCMSA is defined as South Carolina and adjacent areas within 25 miles of its borders.

The dietitian is responsible for reviewing the patient's habits, providing education, reinforcing the importance of exercise, developing a nutritional plan, and establishing goals. The dietitian must document the patient's progress, activities and compliance with the nutritional plan, and compliance on exercise. A written report must be submitted to the ordering provider each time the patient is seen individually or in a group/class setting. The records must be sent to the ordering provider within 48 hours after the patient receives the nutritional counseling visit. The dietitian must maintain complete records of the nutritional plan, compliance, and exercise plan in the patient's medical record.

The dietitian must bill the initial nutritional counseling visit utilizing HCPCS code S9470, which is a one-on-one, face-to-face, 30-minute session. All subsequent obesity visits must be billed utilizing HCPCS code S9452, which is a one-on-one, 30-minute session between the dietitian and the patient or in a group setting. When billing for a group setting, the dietitian must append the HB modifier to HCPCS code S9452. All groups are limited to a maximum of five patients per group.

Billing Requirements

All V codes must be billed as secondary diagnosis codes. All providers and dietitians are required to bill with a primary diagnosis code. The following requirements must be met:

- Providers and dietitians must bill utilizing the HCPCS code and modifier combinations as described above.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Billing Requirements (Cont'd.)

- Providers may only bill the **initial obesity visit** on the same day as an evaluation and management (E&M) service or physical exam.
- Providers must not bill for subsequent obesity exams on the same day as an E&M service.
- Providers may only bill for HCPCS code G0447 one unit per day per patient.
- Providers may bill subsequent visits with one-on-one counseling or group counseling.
- Services will be reimbursed for places of service 11 (office) and 22 (clinic).
- Dietitians must bill utilizing the above referenced codes.

Nutritional counseling units are billed based on a 30-minute session and are limited to one unit per day.

All providers and dietitians are responsible for clearly documenting the patient's chart with all information referenced in this policy. All services rendered by both providers and dietitians are subject to review by the Division of Program Integrity. Services not meeting the requirements reflected in this policy may be subject to recoupment by SCDHHS.

Additional Services

If the provider has completed a series of six visits and the patient has been compliant with the treatment plan and the provider has determined that the patient would benefit from additional treatment, the provider must submit documentation of medical necessity to:

SCDHHS
ATTN: Medical Director
Post Office Box 8206
Columbia, SC 29202

In order to receive additional visits not to exceed six additional **provider** visits and six additional **nutritional** counseling sessions within a 12 month period, the following documentation must be submitted to SCDHHS by the physician, nurse practitioner or physician assistant only:

- A letter of Medical Necessity
- Patient notes
- BMI start and end
- A1C

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Additional Services (Cont'd.)

- Dietitian reports
- Exercise plan and notes on adherence

All requests will be reviewed by SCDHHS medical directors for medical necessity and compliance with the Obesity program.

Additional Resources

For additional resources, providers should visit the Department of Health and Environmental Control's Obesity Resources for Community Partners Web page at http://www.scdhec.gov/Health/Obesity/ResourcesforCommunityPartners/SCObesity.

Some examples of current programs include:

- Statewide Obesity Action Plan
- Community Transformation Grant
- Worksite Wellness
- FitnessGram
- ABC Grow Healthy
- Farm to School
- SNAP Education

RHC Children's Nutritional Counseling Program

RHCs must follow all the guidelines listed in both the provider and dietitian sections of the Obesity policy, and are subject to all limitations and benefits. For dates of service on or before **September 30, 2015**, RHCs must bill utilizing the CPT, ICD-9, and HCPCS codes and modifier combinations found in Section 4 of this manual. RHCs must bill utilizing their GP legacy number and NPI combination in order to receive accurate reimbursement. All documentation standards listed in this policy apply.

For dates of service on or after **October 1, 2015**, RHCs must bill utilizing the CPT, ICD-10, and HCPCS codes and modifier combinations found in Section 4 of this manual. RHCs must bill utilizing their GP legacy number and NPI combination in order to receive accurate reimbursement. All documentation standards listed in this policy apply.

Medicaid-eligible children under the age of 21 may receive unlimited evaluation and management (E&M) visits as long as the services are medically necessary. For this policy the word "provider" is defined as a physician, physician assistant, or nurse practitioner meeting the licensure and educational requirements in the state of South Carolina and/or the border states of Georgia and North Carolina. All services

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

RHC Children's Nutritional Counseling Program (Cont'd.)

must be rendered within the South Carolina Medicaid Service Area (SCMSA). SCMSA is defined as South Carolina and adjacent areas within 25 miles of its borders.

Provider

During the child's routine physical or office visit, the provider will assess his or her needs for an obesity counseling intervention program. The provider must schedule the child for an independent visit for an E&M service to treat him or her for obesity. The provider must bill the appropriate level E&M service and document provided services in the child's medical record.

The provider must emphasize the importance of exercise, develop a realistic exercise plan, with goals, and document the visit in the child's medical record. Children must be accompanied by a parent or legal guardian, and all treatment plans must be reviewed with a parent or legal guardian present. The provider will arrange for an individual nutritional assessment to be provided by a licensed and Medicaid-enrolled dietitian, if medically necessary.

The provider must schedule follow-up exams with both child and parent or legal guardian to evaluate the progress the child has made, review compliance with the exercise and nutritional plan provided by the dietitian, and render behavioral modification suggestions and plans. Each time the provider sees the child, he or she must clearly document the child's progress, activities, and compliance with the treatment plan. The provider must record height and weight percentiles in the child's medical records.

Children ages 2 to 7 are at risk for being overweight when they are between the 85th and 95th percentile in weight and age. Children ages 2 to 7 are considered overweight when they are in the 95th percentile for weight for their age. The provider determining a need for an obesity intervention program must communicate with the child and his or her parents or legal guardian the weight loss goal and plans that lead to an incremental decrease in weight loss. The weight loss goals, laboratory work, and exercise plan must be documented in the child's medical records.

It is recommended that overweight children ages 7 to 16 should strive for weight loss of one to two pounds per month; more rapid weight loss may be initiated at the provider's discretion and the child's healthcare needs.

In addition, it is recommended that overweight all children who are 16 years old or post-pubertal should strive for 10 percent weight loss from baseline over six months. The provider should schedule a reassessment after six months of treatment.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

RHC Children's Nutritional Counseling Program (Cont'd.)

Dietitians

A dietitian is defined as any individual meeting the licensure and educational requirements in the state of South Carolina and/or the border states of Georgia and North Carolina. All services must be within the South Carolina Medicaid Service Area (SCMSA). SCMSA is defined as South Carolina and adjacent areas within 25 miles of its borders.

The dietitian is responsible for reviewing the child's habits, providing dietary education for the child and his or her parent or legal guardian, reinforcing of the importance of exercise, developing a nutritional plan, and establishing weight goals. The dietitian must document the child's progress, activities, and compliance with the nutritional and exercise plan. The provider must submit a written progress report to the ordering provider each time the child is seen individually or in a group/class setting. The progress report must be submitted to the ordering provider within 48 hours after the nutritional counseling visit. The dietitian must maintain complete records of the nutritional plan, compliance, and exercise plan in the child's medical records.

The dietitian must bill the initial nutritional counseling visit utilizing HCPCS code 97802, Medical nutrition therapy, assessment and intervention, each 15 minutes. The dietitian may bill a maximum of two units for the initial visit. All subsequent obesity visits must be billed utilizing HCPCS code 97803, Medical nutrition therapy re-assessment and intervention, each 15 minutes. A subsequent nutritional counseling visit is a one-on-one session, with the patient or a session between the dietitian and patient in a group setting. The dietitian may bill 30-minute sessions, if medically necessary, which means that the dietitian would bill a maximum of two units in a day and a maximum of 10 units within a year. When billing for a group setting, the dietitian must append the HB modifier to HCPCS code 97803. Group nutritional counseling sessions are limited to a maximum of five patients per group.

Billing Requirements

RHCs must meet the following billing requirements to be reimbursed for Obesity services:

- For dates of service on or before **September 30, 2015**, providers and dietitians must bill utilizing the Children's Nutritional Counseling CPT, ICD-9, and HCPCS codes and modifier combinations found in Section 4 of this manual.

  For dates of service on or after **October 1, 2015**, providers and dietitians must bill utilizing the Children's Nutritional Counseling ICD-10 and HCPCS codes and modifier combinations found in Section 4 of this manual.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Billing Requirements (Cont'd.)

- Providers must not bill for initial or subsequent obesity exams on the same day as an E&M service.
- Providers may bill subsequent visits with one-on-one counseling or group counseling by appending the HB modifier to the E&M service.
- Services will be reimbursed for places of service 11 (office) and 22 (clinic).
- All groups are limited to five patients per setting.
- Nutritional counseling units billed are based on a 15-minute session and are limited to two units per day, with a maximum of 12 in a year.

Providers and dietitians are responsible for clearly documenting the child's chart with all information referenced in this policy. All services rendered by both providers and dietitians are subject to review by the Division of Program Integrity. Services not meeting the requirements reflected in this policy may be subject to recoupment by SCDHHS.

Providers and dietitians are responsible for clearly documenting the child's chart with all information referenced in this policy. All services rendered by both providers and dietitians are subject to review by the Division of Program Integrity. Services not meeting the requirements reflected in this policy may be subject to recoupment by SCDHHS.

Additional Services

A request for additional services in excess of the limits above requires medical necessity verification by an SCDHHS medical director. Providers must submit a letter of medical necessity and all supporting documentation to:

SCDHHS
ATTN: Medical Director
Post Office Box 8206
Columbia, SC 29202

Encounter and Ancillary Service Coding

The following coding guidelines must be followed for RHC services. All encounter codes and ancillary services listed in this section must be billed under the RHC provider number. Only one encounter code may be billed per day, with the exception of the Psychiatry and Counseling Encounter, which can be billed in addition to another encounter on the same day.

The most appropriate encounter code must be billed based on the service(s) provided. All supplies, injections, surgical procedures, etc., are included in the encounter code reimbursement. The only fragmented services billable on a fee-for-service basis are listed under "Special Clinic Services" below.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Medical Encounter – T1015

All medical encounters must be billed using the procedure code T1015 unless otherwise specified. A medical "visit" (encounter) is defined as a face-to-face encounter between a patient and the physician, physician assistant, nurse practitioner, chiropractor, or certified nurse midwife during which an RHC core service is provided. RHC providers will be reimbursed their contracted encounter rate and are allowed only one medical encounter per day, even if the patient sees more than one professional at the visit or on that day. The use of this code counts toward the ambulatory visit limit for beneficiaries age 21 and older. are allowed 12 ambulatory care visits (ACVs) per year, commencing on July 1st of each year. Beneficiaries under age 21 are exempt from this limitation.

Maternal Encounter – T1015 (With TH Modifier)

All maternal encounters must be billed using code T1015, with a "TH" modifier. RHC providers will be reimbursed their contracted rate for all maternal services rendered. The use of this procedure code and a "TH" modifier will not affect a beneficiary's number of allowable ambulatory visits. The following may be billed separately, please refer to the "Family Planning" and "Special Clinic Services" sections below for coding guidelines.

Psychiatry and Counseling Encounter – T1015 (With HE Modifier)

For Behavioral Health policies and procedures please refer to the "RHC Behavioral Health Services" provider manual located on our website at http://www.scdhhs.gov/.

Cancer Treatment and HIV/AIDS Encounter – T1015 (With P4 Modifier)

SCDHHS allows the RHC to bill for HIV/AIDS cancer-related services using code T1015, with the P4 modifier. The use of this code and the P4 Modifier will not count toward the ambulatory visit limit for beneficiaries aged 21 or older. Charges for such services will be reimbursed at the contract rate.

Family Planning

Family Planning is a **limited benefit program** available to men and women who meet the appropriate federal poverty level percentage in order to be eligible. Family Planning provides coverage for physical examinations, Family Planning services, Family Planning-related services, and some preventive health screenings. Family Planning promotes the increased use of primary medical care; however, beneficiaries enrolled in this program only receive coverage for a **limited set of services**. Services provided to men and women enrolled in Family Planning that are not specifically outlined below are the sole responsibility of the beneficiary.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Covered Services

Section 4 of this manual contains the list of procedure codes, diagnosis codes, and an approved drug list for the Family Planning Program. While there are codes that may be considered Family Planning services other than the ones listed, they are not covered for this eligibility group. The lists will be updated periodically as codes are added or deleted. All services provided to Family Planning beneficiaries must be billed using a FP modifier and one or more of the approved family planning diagnosis codes.

Examinations/Visits

Four types of visits are covered for beneficiaries enrolled in the Family Planning Program. These visits include biennial (once every two years) physical examinations, annual family planning evaluation/management visits, periodic family planning visits, and contraceptive counseling visits.

Biennial Physical Examination

The Family Planning program sponsors adult physical examinations under the following guidelines:

- The examinations are allowed once every two years per beneficiary.
- The examinations are preventive visits.
- Procedure code T1015 must be used for both new and established patients
- A FP modifier must be used when billing these codes for Family Planning beneficiaries
- For dates of service on or before **September 30, 2015**, diagnosis code V70.0 must be used when billing these codes for Family Planning beneficiaries

  For dates of service on or after **October 1, 2015**, diagnosis code Z00.00 or Z00.01 must be used when billing these codes for Family Planning beneficiaries.
- The encounter can be performed by a Nurse Practitioner, Physician Assistant or Physician

The adult physical examination encounter for Family Planning beneficiaries is a preventive, comprehensive visit and should contain the following components, at a minimum:

- A past family, social and surgical history for a new patient or an interval history for an established patient
- Height, weight and BMI
- Blood pressure

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Biennial Physical Examination (Cont'd.)

- A generalized physical overview of the following organ systems:
  - Abdomen
  - Back
  - Breasts (Female)
  - Brief Muscular
  - Brief Neurological
  - Brief Skeletal
  - EENT
  - External Genitalia
  - Heart
  - Lungs
  - Pelvic (Female)
  - Peripheral Vascular
  - Prostate (Male)
  - Rectal
  - Skin
- Age, gender and risk appropriate preventive health screenings, according to the United States Preventive Services Task Force Recommendations (Grade A & B only)

For more information on these recommendations, visit http://www.uspreventiveservicestaskforce.org.

USPSTF Grade A & B Recommendations as of August 1, 2014

Description	Appropriate for the following Family Planning Beneficiaries	Provider Type Requirements	Notes
Age and Risk-Appropriate Screenings for the Following: • Alcohol Misuse • BRCA Screening Questions • Depression • Intimate Partner Violence • Obesity • Tobacco Use	• All adults	NP, PA or Physician	Must occur during physical exam
Low-Intensity Counseling for the Following: • Healthy Diet Skin Cancer Prevention			
Cholesterol Abnormalities Screening	• Men ages 35+ • Men ages 20-35 if at increased risk for coronary heart disease • Women ages 20+ if at increased risk for coronary heart disease	NP, PA or Physician	Must occur during physical exam
Diabetes Screening	• Asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg	NP, PA or Physician	Must occur during physical exam
Hepatitis C Virus Infection Screening	• All adults at high risk for virus infection • One-time screening for all adults born between 1945-1965	NP, PA or Physician	Must occur during physical exam
Breast Cancer Screening (Mammography)	• Women ages 50-74	Physician Only	Can occur outside physical exam

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Description	Appropriate for the following Family Planning Beneficiaries	Provider Type Requirements	Notes
Abdominal Aortic Aneurysm Screening	• Men ages 65-75 who have ever smoked	Physician Only	Can occur outside physical exam
Colorectal Cancer Screening	• Men and Women ages 50-75	Physician Only	Can occur outside physical exam
Lung Cancer Screening for Smokers	• **Adults ages 55 - 80 who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years**	Physician Only	Can occur outside physical exam

Family planning counseling must be offered to Family Planning beneficiaries during the physical examination encounter.

Portions of the physical may be omitted if not medically applicable to the beneficiary's condition or if the beneficiary is not cooperative and resists specific system examinations (despite encouragement by the physician, NP or office staff). A note should be written in the record explaining why that part of the examination was omitted.

Laboratory procedures are included in the reimbursement for a physical exam encounters however; the laboratory portion of the claim must be billed under your fee-for-service Medicaid Provider Legacy identification number in order to be reimbursed. Therefore, when billing for Family Planning services the encounter would be billed under your RHC Medicaid Legacy number and the laboratory services under your GP Medicaid Legacy number resulting in a split claim (two separate claims). The following lab procedures are included in the reimbursement for the physical exam:

- Hemocult
- Urinalysis
- Blood Sugar
- Hemoglobin

Note: **College physicals, DOT physicals, and administrative physicals are not covered.**

Annual Family Planning Evaluation/Management Visit Encounters

The Family Planning program sponsors annual Family Planning Evaluation/Management visit encounters. The annual visit encounter is the re-evaluation of an established patient requiring an update to the medical record, interim history, physical examination, appropriate diagnostic laboratory tests and/or procedures, family planning counseling, and adjustment of contraceptive management as indicated. This encounter should be billed using the T1015 HCPCS code **with an FP modifier**.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Annual Family Planning Evaluation/Management Visit Encounters (Cont'd.)

The following services must be provided during the annual visit encounter:

- Updating of entire history and screening, noting any changes
- Counseling and education, as necessary, regarding pregnancy prevention and/or sexually transmitted diseases
- Laboratory tests
- Issuance of birth control supplies or prescription

Periodic Revisit Encounter

The Family Planning Program sponsors periodic revisit encounters for beneficiaries, as needed. The periodic revisit encounter is a follow-up of an established patient with a new or an existing family planning condition. These visits are available for multiple reasons such as change in contraceptive method due to problems with that particular method (*e.g.*, breakthrough bleeding or the need for additional guidance) or issuance of birth control supplies. This encounter should be billed using the T1015 HCPCS code **with an FP modifier**.

For the T1015 Periodic Revisit Encounter, the following services, at a minimum, must be provided during the revisit:

- Weight and blood pressure check
- Interim history
- Symptom appraisal as needed
- Documentation of any treatment and/or counseling including administration and/or issuance of contraceptive supplies

Family Planning Counseling Visit Encounter

The Family Planning Program sponsors Family Planning Counseling Visit Encounters for beneficiaries. The Family Planning Counseling/ Education visit is a separate and distinct service, but will be billed using HCPCS T1015 **with an FP modifier**. Family Planning Counseling/ Education is a face-to-face interaction to enhance a beneficiary's comprehension of, or compliance with, his or her family planning method of choice. These services are for the expressed purpose of providing education/counseling above and beyond the routine contraceptive counseling that are included in the clinic/office visits.

Note: This service may not be billed on the same day as another encounter.

RHC Reporting Positive Screens

Family Planning beneficiaries have Medicaid coverage for a limited set of services. This coverage does not include treatment, medication, or office visits for many of the conditions that RHCs provider may identify

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

RHC Reporting Positive Screens (Cont'd.)

during the physical examination or annual family planning visit. If a problem or condition is identified during the physical examination or annual family planning visit, the RHC should schedule a follow-up visit with the patient in order to address the problem. Family Planning patients will be responsible for any fees associated with follow-up visits. All follow-up visits for uninsured Family Planning beneficiaries should follow the RHC provider's established policies and procedures for treating uninsured patients.

For data collection and monitoring purposes, SCDHHS requests that RHCs report positive screening results when a problem or condition is identified during the physical examination or annual family planning visit. The instructions that follow describe the process for reporting these positive screenings.

Instructions

When a problem or condition requiring follow-up care is identified, RHCs should include the Positive Screening Code, **S0320**, along with one or more of the modifiers listed below as a separate line on the Encounter Claim form.

Modifier Instructions

RHCs must use the appropriate modifier from the list below. **Up to 4 modifiers can be used for the Positive Screening Code** (if a patient is scheduled to receive a follow-up visit encounter for more than one positive screening, include modifiers for all positive screenings).

1. If scheduling a follow-up visit for a patient for a positive **diabetes screen**, use modifier **P1**
2. If scheduling a follow-up visit for a patient for a positive **cardiovascular screen**, use modifier **P2**
3. If scheduling a follow-up visit for a patient for any positive **cancer screen**, use modifier **P3**
4. If scheduling a follow-up visit for any **mental/behavioral health screens**, use modifier **P4**
5. If scheduling a follow-up visit for a patient for **any other condition or problem**, use modifier **P5**

Covered Contraceptive Supplies and Service

The Family Planning Program provides coverage for contraceptive supplies (for example, birth control pills or male condoms) and contraceptive services such as an injections, IUD, Essure, or sterilization. Please refer to Section 4 of this manual for an approved list of procedure codes and drugs. When billing for contraceptive services and supplies, all claims must bill using a relevant Family Planning diagnosis code.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Long Acting Reversible Contraceptives (LARCs)

Long Acting Reversible Contraceptives (LARCs) are covered under both the pharmacy benefit and under the medical benefit using the traditional "buy and bill" method. Any LARC billed to Medicaid through the pharmacy benefit will be shipped directly to the provider's office for insertion. Providers must only bill Medicaid for the insertion of the device when it is purchased through the pharmacy.

Note: Pregnancy testing (when the test result is negative) is a reimbursable Family Planning service in two situations:

1. The test is provided at the time family planning services are initiated for an individual.
2. The test is provided after the initiation of family planning services, when the patient may not have used the method properly, or when the patient is having an unusual response to the family planning method.

Covered Screenings and Testing

The Family Planning Program provides coverage for STI screenings including: syphilis, chlamydia, gonorrhea, herpes, candidiasis, trichomoniasis and HIV, when performed at the time of the physical examination, initial or annual family planning visits. Please refer to Section 4 of this manual for an approved list of codes for STI testing. All diagnostic tests will require the FP modifier to be appended to the CPT/HCPCS codes. All claims must contain a relevant Family Planning diagnosis code. RHCs must bill these screens under their Medicaid Legacy Provider identification number.

Covered Medication

Effective January 1, 2008, if, during a physical examination or annual family planning evaluation/management visit, any of six specific STIs are identified, one course of antibiotic treatment from the approved drug list found in section 4 of this manual will be allowed per calendar year under the Family Planning Program. The six STIs are: syphilis, chlamydia, gonorrhea, herpes, candidiasis, and trichomoniasis. STI testing and treatment are only covered during the beneficiaries' physical examination or annual family planning visit.

Covered Procedures

For all sterilizations provided in an outpatient hospital setting RHCs must bill utilizing their other Medicaid Provider Legacy identification number beginning with GP.

Sterilization

For all elective sterilizations, SCDHHS requires the provider and beneficiary complete a sterilization consent form located in section 4 of this manual. The Consent for Sterilization form (DHHS Form 687) has been designed to meet all federal requirements associated with elective

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Sterilization (Cont'd.)

sterilizations. Photocopies are accepted if legible. The physician should submit a properly completed consent form with his or her claim so that all providers may also be reimbursed. The Consent for Sterilization form is located in the Forms section of this manual.

Definitions as described in the Code of Federal Regulation

Sterilization – Any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing.

Institutionalized Individual – An individual who is:

- Involuntarily confined or detained under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness or
- Confined, under a voluntary commitment, in a mental hospital or other facility for the care and treatment of mental illness

Mentally Incompetent Individual – Means an individual who has been declared mentally incompetent by a federal, state, or local court. All sections of the Sterilization Consent form (DHHS Form 687) must be completed when submitted with the claim for payment. Each sterilization claim and consent form is reviewed for compliance with federal regulations.

Requirements

In order for Medicaid to reimburse for an elective sterilization the following requirements must be met:

- The Sterilization Consent Form must be signed at least 30 days prior to, but no more than 180 days prior to, the scheduled date of sterilization.
- The individual must be 21 years old at the time the consent form is signed.
- The beneficiary cannot be institutionalized or mentally incompetent.
- If the physician questions the mental competency of the individual, he or she should contact the PSC at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us.
- The individual must voluntarily give consent. All questions must be answered and all topics in the consent form discussed. (A witness of the -beneficiary's choice may be present during the consent interview.) The family planning counseling or family planning education/instruction procedure code may be billed when this service is rendered and documented.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Requirements (Cont'd.)

- A copy of the consent form must be given to the beneficiary after Parts I, II, and III are completed.
- At least 30 days, but not more than 180 days, must pass between the signing of the consent form and the date of the sterilization procedure. The date of the beneficiary's signature is not included in the 30 days (*e.g.*, day one begins the day after the signature). No one can sign the form for the individual.

Exceptions to the 30 day waiting period are:

- Premature Delivery – The informed consent must have been signed at least 30 days prior to the expected date of delivery. In cases involving a Cesarean section, the scheduled date of the C-section is considered the expected date of delivery. At least 72 hours must have elapsed since the informed consent was given.
- Emergency Abdominal Surgery – The emergency does not include the operation to sterilize the beneficiary. At least 72 hours must have elapsed since the informed consent was given. An explanation must accompany the consent form.

Note: If the beneficiary is pregnant, premature delivery is the only exception to the 30-day waiting period. Informed consent may not be obtained while the beneficiary to be sterilized is:

- In labor or childbirth
- Seeking or obtaining an abortion
- Under the influence of alcohol, controlled substances, or other substances which may affect the beneficiary's judgment.

Consent for Sterilization Form

If the consent form was correctly completed and meets all federal regulations, then the claim will be approved for payment. If the consent form does not meet the federal regulations, the claim will reject and a letter sent to the physician explaining the rejection.

If the consent form is not submitted attached to the claim, the claim will be rejected and a new claim will need to be filed complete with the Sterilization Request form attached.

Listed below are explanations of each field that must be completed on the consent form and whether it is a correctable error.

Consent to Sterilization

- Name of the physician or group scheduled to do the sterilization procedure. (If the physician or group is unknown, put the phrase
- "OB on Call"): Correctable Error.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Consent for Sterilization Form (Cont'd.)

- Name of the sterilization procedure (*e.g.,* bilateral tubal ligation): Correctable Error.
- Birth date of the beneficiary (The beneficiary must be 21 years old when he or she gives consent by signing the consent form 30 days prior to the procedure being performed.): Correctable Error.
- Beneficiary's name (Name must match name on CMS-1500 form.): Correctable Error.
- Name of the physician or group scheduled to perform the sterilization or the phrase "OB on call;" Correctable Error.
- Name of the sterilization procedure: Correctable Error.
- Beneficiary's signature. (If the beneficiary signs with an "X," an explanation must accompany the consent form.): Non-correctable error.
- Date of Signature: Non-correctable error without detailed medical record documentation.
- Beneficiary's Medicaid ID number (10 digits): Correctable Error.

Interpreter's Statement

If the beneficiary had an interpreter translate the consent form information into a foreign language (*e.g.,* Spanish, French, etc.), the interpreter must complete this section. If an interpreter was not necessary, put "N/A" in these fields: Correctable Error.

Statement of Person Obtaining Consent

- Beneficiary's name: Correctable Error.
- Name of the sterilization procedure: Correctable Error.
- Signature and date of the person who counseled the beneficiary on the sterilization procedure: This date must be the same date of the beneficiary's signature date.
  - Signature is not a correctable error.
  - Date is not a correctable error without detailed medical record documentation.
  - If the beneficiary signs with an "X," an explanation must accompany the consent form: Not a correctable error without detailed medical record documentation.
- A complete facility address: An address stamp is acceptable if legible.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Consent for Sterilization Form (Cont'd.)

Physicians Statement

- Beneficiary's name: Correctable Error.
- Date of the sterilization procedure (This date must match the date of service that you are billing for on the CMS-1500.): Correctable Error.
- Name of the sterilization procedure: Correctable Error.
- Estimated Date of Confinement (EDC) is required if sterilization is performed within the 30-day waiting period and the beneficiary was pregnant. At least 72 hours are required to pass before the sterilization procedure may be done: Correctable Error.
- An explanation must be attached if emergency abdominal surgery was performed within the 30-day waiting period. At least 72 hours are required to pass before the sterilization, and the sterilization procedure may not be the reason for the emergency surgery.
- Physician signature and date: a physician's stamp is acceptable.

The rendering or attending physician must sign the consent form and bill for the service. The Consent Form must be dated on the same date as the sterilization or after. The date is **not a correctable error** if the date is prior to the sterilization without detailed medical record documentation. In the license number field, put the rendering physician's Medicaid legacy Provider ID or NPI number. Either the group or individual Medicaid legacy Provider ID or NPI is acceptable.

Under the following circumstances, bill the corresponding sterilization procedure codes:

Essure Sterilization Procedure

Effective with dates of service prior to May 31, 2010, SCDHHS will reimburse for the Essure Sterilization procedure only when certain criteria are met. This procedure is available to women who have risk factors that prevent a physician from performing a safe and effective laparoscopic tubal ligation. Reimbursement will be provided for any of the following criteria:

- Morbid Obesity (BMI of 35 or greater)
- Abdominal mesh that mechanically interferers with the laparoscopic tubal ligation
- Permanent colostomy

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Consent for Sterilization Form (Cont'd.)

- Multiple abdominal/pelvic surgeries with documented severe adhesions
- Artificial heart valve requiring continuous anticoagulation
- Any severe medical problems that would contraindicate laparoscopy because of anesthesia considerations. (This must be attested in the request for prior approval that general anesthesia would pose a substantial threat to beneficiaries life.)

Effective with dates of service on or after June 1, 2010, SCDHHS removed the prior authorization and criteria requirements for the Essure sterilization procedure. The procedure will be covered when performed in an inpatient or outpatient hospital setting or in a physician's office. SCDHHS will reimburse for the implantable device by utilizing the Healthcare Common Procedure Coding System (HCPCS) code A4264 with the FP modifier appended, and the professional service will be reimbursed utilizing the CPT code 58565 must also, have the FP modifier appended. Procedure code 58340 (hysterosalpingogram) and 74740 (radiological supervision and interpretation) should be billed as follow-up procedures 90 days after the sterilization. A Sterilization Consent form must be completed and submitted with the claim. Federal guidelines for sterilization procedures will remain a requirement which includes completing and submitting a sterilization consent form.

Sterilization Codes and Services

- **58605** – Tubal ligation following a vaginal delivery by a method except laparoscope
- **58611** – Tubal ligation following C-section or other intra-abdominal (tubal ligation as the minor procedure) surgery
- **58600** – Ligation, transection of fallopian tubes; abdominal or vaginal approach
- **58615** – Occlusion of fallopian tubes by device
- **58670** – Laparoscopic sterilization by fulguration or cauterization
- **58671** – Laparoscopic sterilization by occlusion by device
- **55250** – Vasectomy

Use of procedure codes 55250, 58600, 58605, 58611, 58615, 58670, and 58671 should always be billed hardcopy with a copy of the Consent for Sterilization form attached.

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Non-Covered Services

Services beyond those outlined in this section that are required to manage or to treat medical conditions and/or diseases, whether or not such procedures are also related to family planning, are not covered under the Family Planning Program. Services to address side effects or complications (*e.g.*, blood clots, strokes, abnormal Pap smears, etc.) associated with various family planning methods requiring medical interventions (*e.g.*, blood clots, strokes, abnormal Pap smears, etc.) other than changing the birth control method should not be billed using an FP modifier or Family Planning diagnosis code. When services other than Family Planning are provided during a family planning visit, these services must be billed separately using the appropriate CPT/HCPCS codes and modifiers if applicable. Examples of these services include:

- Sterilization by hysterectomy
- Abortions
- Hospital charges incurred when a beneficiary enters an outpatient hospital/facility for sterilization purposes, but then opts out of the procedure
- Inpatient hospital services
- Colposcopy and biopsy of cervix/vagina performed to identify and treat medical conditions
- Treatment of medical complications (for example, perforated bowel or bladder tear) caused by, or following a Family Planning procedure
- Any procedure or service provided to a woman who is known to be pregnant

Note: Beneficiaries are allowed one permanent sterilization procedure per lifetime.

Preventive Services

Preventive measures are defined as any routine service exam for adults or children when the procedures are performed in the absence of an illness or complaint(s). Generally, the South Carolina Medicaid program requires that a complaint or illness be recorded before a service is compensable. The exceptions to this policy are the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program and the Healthy Adult Physical Exams.

The EPSDT program provides preventive health services to Medicaid-eligible children from birth to age 21 through periodic medical screenings. An EPSDT screening is considered an encounter. A screening and an encounter code may not be billed on the same date of service. All EPSDT screenings must be billed using the appropriate CPT

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Preventive Services (Cont'd.)

codes (99381 – 99385 and 99391 – 99395). EPSDT screening should be billed at the RHC contract rate. For additional program policy information, please refer to "EPSDT" in this section.

The Medicaid program sponsors adult physical exams under the following guidelines:

- The exams are allowed once every **two** years per patient.
- The patient must be 21 years of age or older.
- For dates of service on or before **September 30, 2015**, encounter code T1015 should be billed for this service, and diagnosis code V70.9 should be used.

  For dates of service on or after **October 1, 2015**, encounter code T1015 should be billed for this service, and diagnosis code Z00.8 should be used.

This encounter code may also be offered to dually eligible Medicare and Medicaid clients until Medicare covers physicals. If a patient has both Medicare and Medicaid, bill Medicaid directly.

For additional program policy guidelines, please refer to "Adult Physical Exams" under "Preventive Care Services" in this section.

Special Clinic Services

Please refer to Section 4 for a list of procedures that may be billed in addition to an encounter code.

Non-stress tests, EKGs, and x-rays performed in the center must be billed using the appropriate CPT-4 code with a TC modifier indicating the technical component only. The professional component is reimbursed through the encounter code that may be billed (if appropriate). If referred to a radiologist, cardiologist, etc., for interpretation, their services are reimbursed fee-for-service following Medicaid policy for their specialty service.

RHC Medicare/Medicaid Dual Eligibility Claims

Claims for RHC services must be filed initially to the Medicare intermediary. Upon payment from Medicare, the claim must be filed to Medicaid on the CMS-1500 claim form showing the payment received from Medicare. Medicaid will pay the difference up to the provider's RHC rate.

RHC REIMBURSEMENT METHODOLOGY

Effective January 1, 2001, the South Carolina Medicaid program implemented an alternative payment methodology for the reimbursement of Rural Health Clinics (RHCs). The alternative payment methodology is a cost-based, retrospective, reimbursement system. Reimbursement for medically necessary services shall be made at 100% of the all-inclusive rate per encounter as obtained from the

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

RHC Reimbursement Methodology (Cont'd.)

Medicare intermediary. Actual cost information, to include Medicare annual RHC rate caps, shall be obtained from Medicare Intermediary at the end of the RHC's fiscal reporting period to enable SCDHHS to determine the reimbursement due for the period. Provider-based RHCs with less than 50 beds will receive reimbursement at 100% of Medicare reasonable costs not subject to the RHC rate cap. For provider-based RHCs, actual cost and utilization information based on the RHC's fiscal year shall be obtained from the HCFA-2552-96 actual cost report.

WRAP-AROUND PAYMENT METHODOLOGY

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection ACT (BIPA) of 2000 require 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 months. SCDHHS performs these determinations quarterly and prepares a final reconciliation at the providers year-end. Submission of quarterly and annual MCO encounter data and payment information that is required for these wrap-around payment determinations is the responsibility of each MCO contracting with FQHCs and RHCs. The quarterly and annual reconciliation processes are incorporated into the agency's State Plan for Medical Assistance, Section 4.19-B. MCO responsibilities are contained in the July 2009 MCO Contract (Sections 2.2, 5.1 and 10.2) and the MCO Policies and Procedures Guide.

Questions relating to the RHC Reimbursement Methodology or Wrap-Around payments should be directed to the SCDHHS Division of Ancillary Reimbursements at (803) 898-1040.

SPECIAL COVERAGE GROUPS

Pediatric Anesthesia Services

Effective June 1, 2008, the South Carolina Department of Health and Human Services (SCDHHS) will expand its coverage of anesthesia services to allow board eligible and/or board certified Pediatric Intensivists to be reimbursed for a limited number of anesthesia Current Procedural Terminology (CPT) codes. Board eligible and/or board certified Pediatric Emergency Medicine Physicians may also be reimbursed for this service if they practice in a facility where a board eligible and/or board certified Pediatric Anesthesiologist and/or a board

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Pediatric Anesthesia Services (Cont'd.)

eligible and/or board certified Pediatric Intensivist is on staff. In addition, the Pediatric Intensivist or Pediatric Emergency Medicine Physician must have a current Pediatric Advanced Life Support (PALS) certification.

The physician seeking authorization will be required to enroll with the SCDHHS by submitting an attestation form. All claims must be filed with a "G9" modifier that will identify the claim as reimbursable under this policy. The allowed codes are:

00120	00140	00145	00220	00300
00350	00400	00410	00520	00524
00532	00540	00550	00560	00635
00700	00702	00731	00732	00800
00811	00812	00813	00860	00902
00920	00940	01112	01130	01200
01220	01340	01380	01390	01420
01462	01490	01620	01670	01680
01730	01820	01850	01860	01920
01922	01924	01926	01951	01952
01953				

The Pediatric Sub-Specialist Program

SCDHHS will reimburse an enhanced rate to certain pediatric sub-specialists that meet the enrollment requirements. Reimbursement for certain Evaluation and Management codes will be based on a fee schedule not to exceed 116% of Medicare and 97% of Medicare for most other covered Current Procedural Terminology (CPT) codes. Fee schedules are located on the SCDHHS website at http://www.scdhhs.gov.

Pediatric Sub-Specialist Program Participation Requirements

To be eligible for participation in this program, a physician must meet the following criteria:

- Practice within the South Carolina Medicaid Service Area. The South Carolina service area is defined as within twenty-five miles of the state line.
- At least 85% of total practice, including after-hours patients, is dedicated to children age 18 years or younger.
- Practice in at least one of the following sub-specialties:

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Pediatric Sub-Specialist Program Participation Requirements (Cont'd.)

- Adolescent Medicine
- Allergy
- Cardiology
- Cardiothoracic Surgery
- Child Abuse Pediatrics
- Critical Care
- Developmental – Behavioral
- Emergency Medicine
- Endocrinology
- Gastroenterology/Nutrition
- Genetics
- Hematology/Oncology
- Infectious Disease
- Neonatology
- Eephrology
- Neurology
- Neurological Surgery
- Ophthalmology
- Orthopedic Surgery
- Otolaryngology
- Psychiatry
- Pulmonology
- Radiology
- Rheumatology
- Surgery
- Urology
- Other pediatric subspecialty areas as may be determined by SCDHHS

- Complete and return a copy of the attestation statement found in the Forms section of this manual.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

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SECTION 3

BILLING PROCEDURES

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SECTION 3

BILLING PROCEDURES

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SECTION 3 BILLING PROCEDURES

GENERAL INFORMATION

The South Carolina Department of Health and Human Services (SCDHHS) strives to make billing as simple for providers as possible. This section is a "how-to" manual on billing procedures with information on how to file a claim, what to do with a rejected claim, etc. Also included is information concerning administrative procedures such as adjustments and refunds. This section will help with these issues, but may not answer all of your questions. You should direct any questions to the Provider Service Center (PSC) at 1-888-289-0709. Providers can also submit an online inquiry at http://www.scdhhs.gov/contact-us and a provider service representative will then respond to you directly.

USUAL AND CUSTOMARY RATES

Providers are required to bill their usual and customary rate when filing Medicaid claims. Charges to Medicaid cannot exceed charges to private patients, whether they are self-pay or covered by another carrier. Billing of covered procedures prior to the date of service is prohibited.

CLAIM FILING TIMELINESS

Medicaid policy requires that only "clean" claims received and entered into the claims processing system within one year from the date of service be considered for payment. A "clean" claim is free of errors and can be processed without obtaining additional information from the provider or another third party. Claims with an edit code of 509 or 510 on remittances, or CARC 29 on an electronic Remittance Advice, have not met these criteria. It is the provider's responsibility to follow up on claims in a timely manner to ensure that all claims are filed and corrected within Medicaid policy limits.

DUAL ELIGIBILITY

When a beneficiary has both, Medicare and Medicaid, Medicare is considered to be the primary payer. Services rendered to persons who are certified dually eligible for Medicare/Medicaid must be billed to Medicare first.

MEDICARE CROSSOVER CLAIMS FOR COINSURANCE AND DEDUCTIBLE

All claims not paid in full by Medicare must be filed directly to Medicaid as claims no longer cross over for automatic payment review.

SECTION 3 BILLING PROCEDURES

GENERAL INFORMATION

MEDICARE PRIMARY CLAIM

Claims for payment when Medicare is primary must be received and entered into the claims processing system within two years from the date of service or discharge, or within six months following the date of Medicare payment, whichever is later.

RETROACTIVE ELIGIBILITY

Claims involving retroactive eligibility must meet both of the following criteria to be considered for payment:

- Be received and entered into the claims processing system within **six months** of the beneficiary's eligibility being added to the Medicaid eligibility system **AND**
- Be received within **three years** from the date of service or date of discharge (for hospital claims). Claims for dates of service that are more than three years old will not be considered for payment.

To document retroactive eligibility, the provider is responsible for submitting one of the following documents with each claim within the above time frames:

- DHHS Form 945, which is a statement verifying the retroactive determination furnished by the eligibility worker, or
- The computer-generated Medicaid eligibility approval letter notifying the beneficiary that Medicaid benefits have been approved. This can be furnished by the beneficiary or the eligibility worker. (This is different from the Certificate of Creditable Coverage.)

Claims involving retroactive eligibility that are received more than three years from the date of service will be rejected with edit code 533 (date of service more than three years old) and CARC 29 (the time limit for filing has expired).

SCDHHS will no longer consider claims that exceed the timely filing limits due to the provider being unaware of the beneficiary's coverage.

SECTION 3 BILLING PROCEDURES

GENERAL INFORMATION

BENEFICIARY COPAYMENTS

Section 1902(a)(14) of the Social Security Act permits states to require certain beneficiaries to share some of the costs of Medicaid by imposing copayments upon them. A copayment is the amount of money the beneficiary is expected to pay to the provider at the time services are received.

SC Medicaid has required a copayment from beneficiaries toward the cost of their care since March 2004. Medicaid beneficiaries may not be denied service if they are unable to pay the copayment at the time the service is rendered; however, this does not relieve the beneficiary of the responsibility for the copayment.

It is the provider's responsibility to collect the copayment from the beneficiary to receive full reimbursement for a service. The amount of the copayment will be deducted from the Medicaid payment for all claims involving copayments.

As of July 2011, SCDHHS revised the beneficiary copayment amounts for Medicaid Services. Please refer to Appendix 3 of this manual for the Copayment Schedule. Also, pursuant to this change, persons ages 19 and older who are enrolled in a waiver program through Community Long Term Care or the SC Department of Disabilities and Special Needs must make a copayment for their State Plan services according to established policy. Members of MCOs should contact their individual plan for information about copayments applicable in their plan.

Copayment Exclusions

Pursuant to federal regulations, the following beneficiaries are excluded from copayment requirements: children under the age of 19, pregnant women, institutionalized individuals (such as persons in a nursing facility or ICF/IID, members of a Federally Recognized Indian Tribe (for services rendered by the Catawbas Service Unit in Rock Hill, SC and when referred to a specialist or other medical provider by the Catawbas Service Unit) and members of the Health Opportunity Account (HOA) program. **Additionally, the following services are not subject to a copayment:** Medical equipment and supplies provided by DHEC; Orthodontic services provided by DHEC; Family Planning services, End Stage Renal Disease (ESRD) services, Infusion Center

SECTION 3 BILLING PROCEDURES

GENERAL INFORMATION

Copayment Exclusions (Cont'd.)

services, Emergency services in the hospital emergency room, Hospice benefits and Waiver services**.**

Claim Filing Information

The collection of copayment should not be entered in the Rsvd for NUCC use, field 30, on the CMS-1500 claim form; this would result in an additional reduction in payment.

When a beneficiary has Medicare or private insurance, the Medicaid copayment still applies per the policies outlined in this section. However, if the sum of the copayment and the Medicare/third party payment would exceed the Medicaid-allowed amount, the copayment should be adjusted or eliminated. In other words, though a provider may receive a primary insurance payment higher than what Medicaid would pay, the beneficiary's copayment should not contribute to the excess revenue.

Billing Instructions for Service Provided as the Result of an Emergency

If the service was provided as the result of an emergency, providers should utilize the following billing instructions to exempt co-payment:

CMS-1500

The indicator "Y" must be present in field 24C (unshaded), Emergency Indicator, or the corresponding field on the electronic claim record.

Claims Filed via the Web Tool: Use of Emergency Indicator

If services have been rendered on an emergency basis, that information must be included on your SC Medicaid Web-based Claims Submission Tool (Web Tool) claim.

CMS-1500

Providers submitting a professional claim must select "Emergency?" under the Detail Lines tab. For additional information, please refer to the Web Tool User Guide at http://medicaidelearning.com.

UB

Providers submitting a hospital claim must select the appropriate admission source and type under the Additional Information tab. Please refer to the Web Tool User Guide at http://medicaidelearning.com for additional information.

SECTION 3 BILLING PROCEDURES

GENERAL INFORMATION

Claims Filed via the Web Tool: Use of Emergency Indicator (Cont'd.)

Note: Refer to the ANSI X-12 Implementation Guide and SC Medicaid Companion Guides at http://www.scdhhs.gov for additional information on all electronic transactions.

DENTAL

Dental claims cannot be submitted on the Web Tool. Please contact the dental services vendor at 1-888-307-6553 for billing instructions.

SECTION 3 BILLING PROCEDURES

GENERAL INFORMATION

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SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Providers may choose one or more of the following options for filing claims:

- Paper Claims
- Electronic Claims
  - SC Medicaid Web-based Claims Submission Tool
  - Tapes, Diskettes, CDs, and Zip Files
  - File Transfer Protocol (FTP)

PAPER CLAIMS SUBMISSIONS

Paper claims are mailed to Medicaid Claims Receipt at the following address:

Medicaid Claims Receipt
Post Office Box 1412
Columbia, SC 29202-1412

CMS-1500 Claim Form

Professional Medicaid claims must be filed on the CMS-1500 claim form (02/12 version). Alternate forms are not acceptable. "Super Bills" and Continuous Claims are not acceptable and will be returned to the provider for correction. Use only black or blue ink on the CMS-1500.

Each CMS-1500 submitted to SC Medicaid must show charges totaled. ONLY six lines can be processed on a hard copy CMS-1500 claim form. If more than six lines are submitted, only the first six lines will be processed for payment or the claim may be returned for corrective action.

SCDHHS does not supply the CMS-1500 (form) to providers. Providers should purchase the form in its approved format from the private vendor of their choice. A list of vendors who supply the form can be found in Section 5 of this manual. Examples of the CMS-1500 claim form can be found in the Forms section of this manual.

Providers using computer-generated forms are not exempt from Medicaid claims filing requirements. The SCDHHS data processing personnel should review your proposed format before it is finalized to ensure that it can be processed.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Procedural Coding

SC Medicaid requires that claims be submitted using codes from the current editions of the Healthcare Common Procedure Coding System (HCPCS) and the Current Procedural Terminology (CPT). Providers may also use supplemental codes as outlined in the various sections of this manual.

The Centers for Medicare and Medicaid Services revises the nomenclature within the HCPCS/CPT each quarter. When a HCPCS/CPT code is deleted, the SC Medicaid program discontinues coverage of the deleted code. SC Medicaid will not accept billing of discontinued codes for dates of service after the date on which the code is discontinued. When new codes are added, SCDHHS reviews the new codes to determine if the SC Medicaid program will cover them. Until the results of the review are published, SCDHHS does not guarantee coverage of the new codes.

Providers must adopt the new codes in their billing processes effective January 1 of each year and begin using them for services rendered on or after that time to assure prompt and accurate payment of claims.

The current editions of HCPCS/CPT may be ordered from:

Order Department
American Medical Association
Post Office Box 930876
Atlanta, GA 31193-0876

You may order online at http://www.amabookstore.com/ or call toll free 1-800-621-8335.

Code Limitations

Certain procedures within the HCPCS/CPT may not be covered or may require additional documentation to establish their medical necessity or meet federal guidelines.

Diagnostic Codes

SC Medicaid requires that claims be submitted using the current edition of the *International Classification of Diseases*, Only Volumes I and II are necessary to determine diagnosis codes.

SC Medicaid will not accept billing of discontinued codes for dates of service after the date on which the code is discontinued. Physicians, practitioners, and

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Diagnostic Codes (Cont'd.)

suppliers must bill using the diagnosis code that is valid for that date of service. Providers must adopt the new codes for billing processes effective October 1 of each year and use for services rendered on or after that time to assure prompt and accurate payment of claims.

For dates of service on or before **September 30, 2015**, diagnosis codes must be full ICD-9-CM diagnosis codes.

Medicaid requires the addition of a fourth or fifth digit, if applicable, to an ICD-9 code. Valid diagnosis coding can only be obtained from the most current edition of the ICD-9-CM.

For dates of service on or after **October 1, 2015**, diagnosis codes must be full ICD-10-CM diagnosis codes. Valid diagnosis coding can only be obtained from the most current edition of the ICD-CM.

Supplementary Classification of External Causes of Injury and Poisoning (External Causes of Morbidity) codes are sub-classification codes and are not valid as first-listed or principal diagnosis.

A current edition of the ICD-9-CM may be ordered from:

Practice Management Information Corporation
4727 Wilshire Boulevard, Suite 300
Los Angeles, CA 90010

You may order online at
http://www.pmiconline.com/ or call toll free 1-800-MED-SHOP.

Modifiers

Certain circumstances must be identified by the use of a two-character modifier that follows the procedure code. Failure to use these modifiers according to policy will slow turnaround time and may result in a rejected claim.

Only the first modifier entered is used to process the claim. Failure to use modifiers in the correct combination with the procedure code, or invalid use of modifiers, will result in a rejected claim.

The following modifiers may be used:

Modifier	Description
24	Unrelated Evaluation and Management service by the same physician or other

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Modifiers (Cont'd.)

	qualified health care professional during a postoperative period
25	Significant, separately identifiable Evaluation and Management service by the same physician or other qualified health care professional on the same day of the procedure or other Service
26	Professional component
50	Bilateral procedure
51	Multiple procedures
52	Reduced Service
53	Discontinued Procedure
54	Surgical Care Only
55	Postoperative Management Only
76	Repeat procedure or service by same physician or other qualified health care professional
78	Unplanned return to the operating/procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period
79	Unrelated procedure or service by the same physician or other qualified health care professional during the postoperative period
80	Assistant Surgeon
81	Minimum Assistant Surgeon
82	Assistant Surgeon (when qualified resident surgeon not available)
99	Multiple Modifiers
TC	Technical component. Under certain circumstances, a charge may be made for the technical component alone. Under those circumstances the technical component charge is identified by adding modifier 'TC' to the usual procedure number. Technical component charges are institutional charges

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Modifiers (Cont'd.)

and not billed separately by physicians. However, portable x-ray suppliers only bill for technical component and should utilize modifier TC. The charge data from portable x-ray suppliers will then be used to build customary and prevailing profiles.

AA	Anesthesia services performed personally by anesthesiologist
AD	Medical supervision by a physician: more than four concurrent anesthesia procedures
LT	Left side (used to identify procedures performed on the left side of the body)
RT	Right side (used to identify procedures performed on the right side of the body)
QK	Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals
QS	Monitored anesthesiology care services (can be billed by a qualified nonphysician anesthetist or a physician)
QX	Qualified nonphysician anesthetist with medical direction by a physician
QY	Medical direction of one qualified nonphysician anesthetist by an anesthesiologist.
QZ	Unsupervised CRNA
SB	Nurse Midwife
FP	Service provided as part of family planning program

Modifiers for Family Planning

Modifier	**Description**
P1	A patient with mild systemic disease
P2	A patient with severe systemic disease
P3	A patient with severe systemic disease that is a constant threat to life
P4	A moribund patient who is not expected to survive without the operation

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Modifiers for Family Planning (Cont'd.)

P5	Repeat procedure or service by same physician or other qualified health care professional

Place of Service Key

Place of Service Codes

Code	Description
00	Unassigned
01	Pharmacy
02	Unassigned
03	School
04	Homeless Shelter
05	Indian Health Service Free-standing Facility
06	Indian Health Service Provider-based Facility
07	Tribal 638 Free-standing Facility
08	Tribal 638 Provider-based Facility
09	Prison/Correctional Facility
10	Unassigned
11	Office (Outpatient Pediatric AIDS Clinic)
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
16	Temporary Lodging
17	Walk-in Retail Health Clinic
18	Unassigned
19	Off Campus Hospital
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
24	Ambulatory Surgical Center

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Place of Service Key (Cont'd.)

25	Birthing Center
26	Military Treatment Center
27–30	Unassigned
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
35–40	Unassigned
41	Ambulance – Land
42	Ambulance – Air or Water
43–48	Unassigned
49	Independent Clinic
50	Federally Qualified Health Center (FQHC)
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Intellectually Disabled
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
57	Non-Residential Substance Abuse Treatment Facility
58–59	Unassigned
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
63–64	Unassigned
65	End Stage Renal Disease Treatment Facility

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Place of Service Key (Cont'd.)

66–70	Unassigned
71	Public Health Clinic
72	Rural Health Clinic
73–80	Unassigned
81	Independent Laboratory
82–98	Unassigned
99	Other Unlisted Facility (Infusion Center)

National Provider Identifier and Medicaid Provider Number

Providers who are covered entities under HIPAA are required to obtain a National Provider Identifier (NPI). These "typical" providers must apply for an NPI and share it with SC Medicaid. to obtain an NPI and taxonomy code, please visit http://www1.scdhhs.gov/openpublic/serviceproviders/npi%info.asp for more information on the application process.

When submitting claims to SC Medicaid, typical providers must use the NPI of the ordering/referring provider and the NPI and taxonomy code for each rendering, pay-to, and billing provider.

Atypical providers (non-covered entities under HIPAA) identify themselves on claims submitted to SC Medicaid by using their six-character legacy Medicaid provider number.

CMS-1500 Form Completion Instructions

Effective on and after April 1, 2014, all claims, regardless of the date of service, must be submitted on the CMS 1500 claim form 02/12 version. Please use the instructions provided in this section to complete the form (see the Forms section of this manual for sample claims). Use only black or blue ink on the claim form.

Field	Description
*	Required for claim to process
**	Required if applicable (based upon the specific program area requirements)

1 Health Insurance Coverage

Show all types of coverage applicable to this claim by checking the appropriate box(es). If Group Health Plan is checked and the patient has

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

CMS-1500 Form Completion Instructions (Cont'd.)

Field	Description
*	Required for claim to process
**	Required if applicable (based upon the specific program area requirements)

only one primary health insurance policy, complete either block 9 (fields 9, 9a, and 9d) **or** block 11 (fields 11, 11b, and 11c). If the beneficiary has two policies, complete both blocks, one for each policy.

IMPORTANT: Check the **"MEDICAID"** field at the top of the form.

1a* Insured's ID Number

Enter the patient's Medicaid ID number, exactly as it appears on the South Carolina Healthy Connections Medicaid card (10 digits, no letters).

2 Patient's Name

Enter the patient's last name, first name, and middle initial.

3 Patient's Birth Date

Enter the date of birth of the patient written as month, day, and year.

Sex

Check "M" for male or "F" for female.

4 Insured's Name

Not applicable

5 Patient's Address

Enter the full address and telephone number of the patient.

6 Patient Relationship to Insured

Not applicable

7 Insured's Address

Not applicable

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

CMS-1500 Form Completion Instructions (Cont'd.)

Field	Description
*	Required for claim to process
**	Required if applicable (based upon the specific program area requirements)

8 Reserved for NUCC Use

Not applicable

9 Other Insured's Name

When applicable, enter the name of the other insured.

If 11d is marked "YES," complete fields 9, 9a, and 9d.

9a ** **Other Insured's Policy or Group Number**

When applicable, enter the policy or group number of the other insured.

9b Reserved for NUCC Use

When applicable, enter the date of birth of the other insured.

9c ** **Reserved for NUCC Use**

If the insurance has paid, indicate the amount paid in this field. If the insurance has denied payment, enter "0.00" in this field.

9d ** **Insurance Plan Name or Program Name**

When applicable, enter the three-character carrier code. A list of the carrier codes can be found in Appendix 2.

10a Is Patient's Condition Related to Employment?

Check "YES" or "NO."

10b Is Patient's Condition Related to an Auto Accident?

Check "YES" or "NO." If "YES," enter the two-character state postal code in the Place (State) field (*e.g.,* "SC").

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

CMS-1500 Form Completion Instructions (Cont'd.)

Field	Description
*	Required for claim to process
**	Required if applicable (based upon the specific program area requirements)

10c Is Patient's Condition Related to an Other Accident?

Check "YES" or "NO."

10d Claim Codes (Designated by NUCC)**

When applicable, enter the appropriate TPL indicator for this claim. Valid indicators are as follows:

Code	Description
1	Insurance denied
6	Crime victim
8	Uncooperative beneficiary

11 Insured's Policy Group or FECA Number**

If the beneficiary is covered by health insurance, enter the insured's policy number.

11a Insured's Date of Birth

When applicable, enter the insured's date of birth.

Sex

Check "M" for male or "F" for female.

11b Other Claim ID (Designated by NUCC)**

If payment has been made by the patient's health insurance, indicate the payment in this field. If the health insurance has denied payment, enter "0.00" in this field. **The payment information should be entered on the right-hand side of the vertical, dotted line.**

11c Insurance Plan Name or Program Name**

When applicable, enter the three-character carrier code. A list of the carrier codes can be found in Appendix 2.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

CMS-1500 Form Completion Instructions (Cont'd.)

Field	Description
*	Required for claim to process
**	Required if applicable (based upon the specific program area requirements)

11d Is There Another Health Benefit Plan?

Check "YES" or "NO" to indicate whether or not there is another health insurance policy. If "YES," items 9, 9a, and 9d **or** 11, 11b, and 11c must be completed. (If there are two policies, complete both.)

12 Patient's or Authorized Person's Signature

"Signature on File" or patient's signature is required.

13 Insured's or Authorized Person's Signature

Not applicable

14 Date of Current Illness, Injury, or Pregnancy

Not applicable

15 Other Date

Not applicable

16 Dates Patient Unable to Work in Current Occupation

Not applicable

Fields 17, 17a, and 17b are used to enter the referring, ordering, and/or supervising provider(s). Field values are a combination of a two-byte qualifier followed by the NPI of the applicable provider. Valid qualifiers are DN = Referring; DK = Ordering; DQ = Supervising.

17 ** **Name of Referring Provider or Other Source**

Enter the two-byte qualifier to the left of the vertical, dotted line.

Enter the name of the referring, ordering, or supervising provider to the right of the vertical, dotted line.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

CMS-1500 Form Completion Instructions (Cont'd.)

Field	Description
*	Required for claim to process
**	Required if applicable (based upon the specific program area requirements)

17a Shaded**

Enter the provider's license number if applicable.

17b Unshaded**

NPI
Enter the NPI of the referring, ordering, or supervising provider listed in field 17.

18 Hospitalization Dates Related to Current Services

Complete this field when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

19 Additional Claim Information (Designated by NUCC)**

For beneficiaries participating in special programs (*i.e.*, CLTC, MCCW, Hospice, etc.), enter the primary care provider's referral number.

20 Outside Lab?

Not applicable

21* Diagnosis or Nature of Illness or Injury

ICD Ind.

The "ICD Indicator" identifies the ICD code set being reported. Enter the applicable 1-byte ICD indicator between the vertical, dotted lines in the upper right-hand portion of the field.

Indicator	Code Set
9	ICD-9-CM diagnosis
0	ICD-10-CM diagnosis

Diagnosis Codes

For dates of service on or before **September 30,**

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

CMS-1500 Form Completion Instructions (Cont'd.)

Field	Description
*	Required for claim to process
**	Required if applicable (based upon the specific program area requirements)

2015, enter the diagnosis codes of the patient as indicated in the ICD-9-CM, Volume I. SC Medicaid requires full ICD-9-CM diagnosis codes. Enter the diagnosis codes in priority order (primary, then secondary condition). Only one diagnosis is necessary to process the claim.

For dates of services on or after **October 1, 2015**, enter the diagnosis codes of the patient as indicated in the ICD-10-CM. SC Medicaid requires full ICD-10-CM diagnosis codes. Enter the diagnosis codes in priority order (primary, then secondary condition). Only one diagnosis is necessary to process the claim.

22 Resubmission Code

Not applicable

23 Prior Authorization Number**

If applicable, enter the prior authorization number for this claim.

Fields 24A through 24J pertain to line item information. There are six billable lines on this claim. Each of the six lines contains a shaded and unshaded portion. The shaded portion of the line is used to report supplemental information.

24A Shaded**

NDC Qualifier/NDC Number

If applicable, enter the NDC qualifier of N4, followed by an 11-digit NDC. Do not enter a space between the qualifier and the NDC.

24A* Unshaded

Date(s) of Service

Enter the month, day, and year for each procedure, service, or supply that was provided.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

CMS-1500 Form Completion Instructions (Cont'd.)

Field	Description
*	Required for claim to process
**	Required if applicable (based upon the specific program area requirements)

24B* Unshaded

Place of Service

Enter the appropriate two-character place of service code. See "Place of Service Key" earlier in this section for a listing of place of service codes.

24C Unshaded**

EMG

If applicable, enter an "E" in this field to indicate that the service rendered was on an emergency basis.

24D* Unshaded

Procedures, Services, or Supplies

Enter the procedure code and, if applicable, the two-character modifier in the appropriate field. If two modifiers are entered, the first modifier entered will be used to process the claim. For unusual circumstances and for unlisted procedures, an attachment with a description of each procedure must be included with the claim.

When more than one service of the same kind is rendered to the **same** patient by the **same** provider on the **same** day, the second service must be billed with the 76 modifier (repeat procedure or service by same physician or other qualified health care professional). No more than two services for the same provider and date of service may be billed. Documentation to support billing of repeat procedures to the same patient by the same provider on the same day must be contained in the record.

24E Diagnosis Pointer

Not applicable

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

CMS-1500 Form Completion Instructions (Cont'd.)

Field	Description
*	Required for claim to process
**	Required if applicable (based upon the specific program area requirements)

24F* Unshaded

Charges

Enter the charge for each listed service. Do not use dollar signs or commas when reporting dollar amounts. Enter "00" in the cents area if the amount is a whole number.

24G Unshaded**

Days or Units

If applicable, enter the number of days or units provided for each procedure listed.

24H Unshaded**

EPSDT/Family Plan

If applicable, if this claim is for EPSDT services or a referral from an EPSDT Screening, enter a "Y."

This field should be coded as follows:

N = No problems found during visit

1 = Well child care with treatment of an identified problem treated by the physician

2 = Well child care with a referral made for an identified problem to another provider

24I* Shaded

ID Qualifier

Typical Providers:

Enter ZZ for the taxonomy qualifier.

Atypical Providers:

Enter 1D for the Medicaid qualifier.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

CMS-1500 Form Completion Instructions (Cont'd.)

Field	Description
*	Required for claim to process
**	Required if applicable (based upon the specific program area requirements)

24J Shaded**

Rendering Provider ID #

Enter the six-character legacy Medicaid provider number or taxonomy code of the rendering provider/individual who performed the service(s).

Typical Providers:

Enter the provider's taxonomy code.

Atypical Providers:

Enter the six-character legacy Medicaid provider number.

24J Unshaded**

Rendering Provider ID #

Typical Providers:

Enter the NPI of the rendering individual provider. If the provider is billing as a member of a group, the rendering individual provider's 10-character NPI may be entered.

Atypical Providers:

Not applicable

25 Federal Tax ID Number

Enter the provider's federal tax ID number (Employer Identification Number) or Social Security Number.

26 Patient's Account Number

Enter the patient's account number as assigned by the provider. Only the first nine characters will be keyed. The account number is helpful in tracking the claim in case the beneficiary's Medicaid ID number is invalid. The patient's account number will be listed as the "Own Reference Number" on the Remittance Advice.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

CMS-1500 Form Completion Instructions (Cont'd.)

Field	Description
*	Required for claim to process
**	Required if applicable (based upon the specific program area requirements)

27 Accept Assignment?

Complete this field to indicate that the provider accepts assignment of Medicaid benefits. Submitting a claim to SC Medicaid automatically indicates the provider accepts assignment.

28* Total Charge

Enter the total charge for the services.

29 Amount Paid**

If applicable, enter the total amount paid from all insurance sources on the submitted charges in item 28. This amount is the sum of 9c and 11b.

30* Rsvd for NUCC Use

Enter the balance due.

When a beneficiary has third party coverage, including Medicare, this is where the patient responsibility amount is entered. The third party payment plus the patient responsibility cannot exceed the amount the provider has agreed to accept as payment in full from the third-party payer, including Medicare.

31 Signature of Physician or Supplier

Not applicable

32 Service Facility Location Information**

Note: Use field 32 only if the address is different from the address in field 33.

If applicable, enter the name, address and ZIP+4 code of the facility if the services were rendered in a facility other than the patient's home or provider's office.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

CMS-1500 Form Completion Instructions (Cont'd.)

Field **Description**

* Required for claim to process

** Required if applicable (based upon the specific program area requirements)

32a Service Facility Location Information**

Typical Providers:

Enter the NPI of the service facility.

Atypical Providers:

Not applicable

32b Service Facility Location Information**

Typical Providers:

Enter the two-byte qualifier ZZ followed by the taxonomy code (no spaces).

Atypical Providers:

Enter the two-byte qualifier 1D followed by the six-character legacy Medicaid provider number (no spaces).

33* Billing Provider Info & PH #

Enter the provider of service/supplier's billing name, address, ZIP+4 code, and telephone number.

Note: Do not use commas, periods, or other punctuation in the address. When entering a ZIP+4 code, include the hyphen. Do not use a hyphen or space as a separator within the telephone number. Claims will be paid to the provider number submitted in field 33 of the CMS-1500 form. This pay-to-provider number is indicated on the Remittance Advice and payment.

33a* Billing Provider Info

Typical Providers:

Enter the NPI of the billing provider or group. If the provider rendering the services is a member of a group, the 10-character NPI group/organization number must be entered. If not billing as a

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

CMS-1500 Form Completion Instructions (Cont'd.)

Field	Description
*	Required for claim to process
**	Required if applicable (based upon the specific program area requirements)

member of a group, enter the 10-character individual NPI in the field.

Atypical Providers:

Not applicable

33b* **Billing Provider Info**

Typical Providers:

Enter the two-byte qualifier ZZ followed by the taxonomy code (no spaces).

Atypical Providers:

Enter the two-byte qualifier 1D followed by the six-character legacy Medicaid provider number (no spaces).

ELECTRONIC CLAIMS SUBMISSIONS

Trading Partner Agreement

SCDHHS encourages electronic claims submissions. All Medicaid providers who elect to submit or receive electronic transactions are required to complete a SC Medicaid Trading Partner Agreement (TPA) with SCDHHS. The TPA outlines the basic requirements for receiving and sending electronic transactions with SCDHHS. For specifications and instructions on electronic claims submission or to obtain a TPA, visit http://www1.scdhhs.gov/openpublic/hipaa/Trading%20Partner%20Enrollment.asp or contact the EDI Support Center via the SCDHHS Medicaid Provider Service Center at 1-888-289-0709.

Providers should return the completed and signed SC Medicaid TPA Enrollment Form by mail or fax to:

SC Medicaid TPA
Post Office Box 17
Columbia, SC 29202
Fax: (803) 870-9021

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Trading Partner Agreement (Cont'd.)

If a provider utilizes a billing agent and elects to have the billing agent access their electronic remittance advice, both the provider and the billing agent must have a TPA on file.

Note: SCDHHS distributes remittance advices electronically through the Web Tool. **All providers must complete a TPA in order to receive these transactions electronically.** Providers that currently use the Web Tool do not need to complete another TPA. Providers who have previously completed a TPA, but are not current users of the Web Tool, must register for a Web Tool User ID by contacting the SC Medicaid EDI Support Center via the SCDHHS Provider Service Center at 1-888-289-0709.

Companion Guides

Providers submitting electronic transactions must comply with all federal guidelines as contained in the HIPAA-required ANSI X-12 Implementation Guide, and with SCDHHS guidelines as contained in the SC Medicaid Companion Guides. The Companion Guides explain the situational and optional data required by SC Medicaid. Please visit the SC Medicaid Companion Guides webpage at http://www.scdhhs.gov/resource/sc-medicaid-companion-guides to download the Companion Guides. Information regarding placement of NPIs, taxonomy codes, and six-character legacy Medicaid provider numbers on electronic claims can also be found here.

Companion Guides are available for the following transactions:

- 837P Professional Health Care Claim
- 837I Institutional Health Care Claim
- 835 Claim Payment/Advice
- 276/277 Claim Status Inquiry/Response
- 270/271 Eligibility Verification Request/Response
- 278 Prior Authorization

Transmission Methods

An Electronic Data Interchange (EDI) transaction is the movement of data between two entities. EDI software enables providers to submit claims directly to South Carolina Medicaid.

The following options may be used also to submit claims electronically:

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Tapes, Diskettes, CDs, and Zip Files

A biller using this option records transactions on the specified media and mails them to:

SC Medicaid Claims Control System
Post Office Box 2765
Columbia, SC 29202-2765

File Transfer Protocol

A biller using this option exchanges electronic transactions with SC Medicaid over the Internet.

SC Medicaid Web-based Claims Submission Tool

The SC Medicaid Web-based Claims Submission Tool is a free, online Web-based application for submitting HIPAA-compliant professional claims, institutional claims, and associated adjustments to SC Medicaid. The Web Tool offers the following features:

- Providers can attach supporting documentation to associated claims.
- The Lists feature allows users to develop their own list of frequently used information (*e.g.*, beneficiaries, procedure codes, diagnosis codes, etc.). During claims entry the user has the ability to select information from lists rather than repetitively keying, thus saving valuable time and increasing accuracy.
- Providers can check the status of claims.
- No additional software is required to use this application.
- Data is automatically archived.
- Providers can verify beneficiary eligibility online by entering Medicaid ID, Social Security Number, or a combination of name and date of birth.
- Providers can view, save and print their own remittance advices.
- Providers can change their own passwords.

The minimum requirements necessary for using the Web Tool are:

- Signed SC Medicaid Trading Partner Agreement (TPA) Enrollment Form
- Microsoft Internet Explorer (version 9.0, 10, 11); Firefox; Safari; or Google Chrome

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

SC Medicaid Web-based Claims Submission Tool (Cont'd.)

- Internet Service Provider (ISP)
- Pentium series processor or better processor (recommended)
- Minimum of 1 gigabyte of memory
- Minimum of 20 gigabytes of hard drive storage

Note: In order to access the Web Tool, all users must have individual login IDs and passwords.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

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SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

REMITTANCE ADVICE

The Remittance Advice is an explanation of payments and actions taken on all processed claim forms and adjustments. The information on the Remittance Advice is drawn from the original claim submitted by the provider.

Processed claims and/or lines are assigned one of four statuses in field 10 on the Remittance Advice:

- **Status "P"** – Paid claims or lines
- **Status "S"** – Claims in process that require medical or technical review are suspended pending further action.
- **Status "R"** – Rejected claims or lines
- **Status "E"** – Encounter data (line contains service provided by the PCP). No action required.

Please refer to the Forms section of this manual for a sample Remittance Advice.

If a claim is rejected or suspended, the Remittance Advice will display the claim without payment. If some lines on the claim have paid and others are rejected, evaluate the reason for the rejection and file a new claim with the corrected information for the rejected lines only, if appropriate. For some rejected claims, it may also be necessary to attach applicable documentation to the new claim for review and consideration for payment.

Note: Corrections cannot be processed from the Remittance Advice.

SCDHHS generates electronic Remittance Advices every Friday for all providers who had claims processed during the previous week. Unless an adjustment has been made, a reimbursement payment equaling the sum total of all claims on the Remittance Advice with status P (paid) will be deposited by electronic funds transfer (EFT) into the provider's account. (See "Electronic Funds Transfer (EFT)" later in this section. **Providers must access their Remittance Advices electronically through the SC Medicaid Web-Based Claims Submission Tool (Web Tool).** Providers can view, save, and print their remittance advice(s), but not a Remittance Advice belonging to

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

REMITTANCE ADVICE (CONT'D.)

another provider. Remittance Advices for current and previous weeks are retrievable on the Web Tool.

Suspended Claims

Provider response is not required for resolution of suspended claims unless it is requested by SCDHHS. If the claim is not resolved within 30 days, check it for errors and refile. For information regarding your suspended claim, please contact the PSC or submit an online inquiry at http://scdhhs.gov/contact-us.

Rejected Claims

For a claim or line that is rejected, edit codes will be listed on the Remittance Advice under the Recipient Name column. The edit code sequence displayed in the column is a combination of an edit type (beginning with the letter "L" followed by "00" or "01," "02," etc.) and a three-digit edit code.

The following three types of edits will appear on the Remittance Advice:

Insurance Edits

These edit codes apply to third-party coverage information. They can stand alone ("L00") or include a claim line number ("L01," "L02," etc.). Always resolve insurance edit codes first.

Claim Edits

These edit codes apply to the body of the claim (not the line items) and have rejected the entire claim from payment. Such edits are prefaced by "L00."

Line Edits

These edit codes are line specific and are always prefaced by a claim line number ("L01," "L02," etc.). They apply to only the line indicated by the number.

The three-digit edit code has associated instructions to assist the providers in resolving their claims. Edit resolution instructions can be found in Appendix 1 of this manual.

If you are unable to resolve an unpaid line or claim, contact the PSC or submit an online inquiry at http://scdhhs.gov/contact-us for assistance before resubmitting another claim.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Rejected Claims (Cont'd.)

Note: Medicaid will pay claims that are up to one year old. If the date of service is greater than one year old, Medicaid will not make payment. The one-year time limit does not apply to **retroactive eligibility** for beneficiaries. Refer to "Retroactive Eligibility" earlier in this section for more information. Timeliness standards for the submission and resubmission of claims are also found in Section 1 of this manual.

Rejections for Duplicate Billing

When a claim or line is rejected for duplicate billing, the payment date of the original claim appears beside the duplicate edit code on the Remittance Advice under the Recipient Name column (*e.g.*, "L00 852 01/24/14"). This eliminates the need for contacting the PSC for the original reimbursement date.

Claim Reconsideration Policy — Fee-for-Service Medicaid

Effective January 1, 2015, SCDHHS will implement a Claim Reconsideration policy. The Claim Reconsideration process is an informal claim review, and is not a substitute for an appeal of a final agency decision. When requesting a reconsideration, providers must adhere to all applicable policies, timely filing limits, and must comply with the following procedures:

1. Submit a completed SCDHHS-CR Form within 30 days of receipt of the remittance advice reflecting the denial of the claim(s). The SCDHHS-CR Form is located in the Forms section of this provider manual.
2. Complete the SCDHHS-CR Form and attach all documentation in support of your request for reconsideration.

The provider will receive a written response from SCDHHS within 60 days notifying them of the decision of the reconsideration request provided the SCDHHS-CR Form has been fully completed and all supporting documentation was attached for review. If the denial is upheld as a result of the Claim Reconsideration review, the provider has 30 days from receipt of the decision to file an appeal in accordance with the Appeal policy in Section 1 of this provider manual.

Providers should submit Claim Reconsiderations to the following mailing address or fax number:

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CLAIM PROCESSING

Claim Reconsideration Policy — Fee-for-Service Medicaid (Cont'd.)

South Carolina Healthy Connections Medicaid
ATTN: Claim Reconsiderations
Post Office Box 8809
Columbia, SC 29202-8809

OR

Fax: 1-855-563-7086

Requests that **do not** qualify for SCDHHS claim reconsiderations:

1. Claim denials resulting from failure to submit documentation during the claim adjudication process do not qualify for a Claim Reconsideration. Providers should submit a new claim and attach documentation.
2. Providers who receive a denial of service for Prior Authorization (PA) through one of SCDHHS contracted agents (*e.g.*, KEPRO, LogistiCare, ICORE, Magellan, DentaQuest) will not qualify for a Claim Reconsideration. The provider must pursue a reconsideration or appeal request through the contracted agent, and if the denial is upheld the provider has the right to a SCDHHS formal Appeal of a final agency decision.
3. Providers who receive a denied claim or denial of service through one of SCDHHS' Managed Care Organizations (MCOs) must pursue a reconsideration or appeal through the MCO, and will not qualify for a Claim Reconsideration.
4. Claim payments suspended for a credible allegation of fraud and pending an investigation do not qualify for Claim Reconsideration.
5. Submission of a new claim with a Claim Reconsideration is not an acceptable method to correct claim disputes in the informal Claim Reconsideration review process, and will not be adjudicated or reviewed. For Claim Reconsideration requests that do not qualify for review, providers will be sent a written response notifying them that a Claim Reconsideration will not be conducted due to failure to meet Claim Reconsideration qualifications and/or procedures.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Claim Reconsideration Policy — Fee-for-Service Medicaid (Cont'd.)

If you have any questions regarding this process, please contact the PSC at 1-888-289-0709. For any Medicaid participants enrolled in a managed care plan, the member's MCO is responsible for claims payment and claims redetermination. Please refer all questions regarding claim payment and redeterminations to the Medicaid member's MCO.

EDI Remittance Advice - 835 Transactions

Providers who file electronically using EDI Software can elect to receive their Remittance Advice via the ASC X12 835 (005010X221A1) transaction set or a subsequent version. These electronic 835 EDI Remittance Advices contain Claim Adjustment Reason Codes (CARCs), broad definitions of why claims did not pay as billed, and Remittance Advice Remark Codes (RARCs), more detailed reasons for why claims did not pay as billed. (See Appendix 1 for a listing of CARCs and RARCs.) The electronic 835 EDI Remittance Advice will only report items that are returned with P (paid) or R (rejected) statuses.

Providers interested in utilizing this electronic transaction should contact the EDI Support Center via the SCDHHS Medicaid Provider Service Center at 1-888-289-0709.

Duplicate Remittance Advice

Providers must use the Remittance Advice Request Form located in the Forms Section of this manual to submit requests for duplicate remittance advices. Charges associated with these requests will be deducted from a future Remittance Advice and will appear as a debit adjustment. Please check the Web Tool for the availability of the remittance advice date before submitting your request.

Reimbursement Payment

SCDHHS no longer issues hard copy checks for Medicaid payments. Providers receive reimbursement from SC Medicaid via electronic funds transfer (EFT). (See "Electronic Funds Transfer" later in this section.)

The reimbursement payment is the sum total of all claims on the Remittance Advice with status P. If an adjustment request has been completed, it will appear on the Remittance Advice. (See "Claim Adjustments" later in this section.)

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Reimbursement Payment (Cont'd.)

Note: Newly enrolled providers will receive a hard copy check until the electronic funds transfer process is successfully completed.

Electronic Funds Transfer (EFT)

Upon enrollment, SC Medicaid providers must register for Electronic Funds Transfer (EFT) in order to receive reimbursement. SCDHHS will not provide any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside the United States.

Prior to revoking or revising the EFT authorization agreement, the provider must provide 30 days written notice to:

Medicaid Provider Enrollment
Post Office Box 8809
Columbia, SC 29202-8809

The provider is required to submit a completed and signed EFT Authorization Agreement Form to confirm new and/or updated banking information. Refer to the Forms section for a copy of the EFT Authorization form.

All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any SC Medicaid direct deposits are made.

During the pre-certification period, the provider will receive reimbursement via hard copy checks.

If the bank account cannot be verified during the pre-certification period, the provider will be notified and will be required to submit an EFT form and bank account verification from their financial institution.

Upon completion of the pre-certification period, reimbursement payment will be deposited directly into the provider's bank account. The last four digits of the bank account are reflected on the Remittance Advice. Providers may view their Remittance Advice (RA) on the Web Tool for payment information.

When SCDHHS is notified that the provider's bank account is closed or the routing and/or bank account number is no longer valid, the provider will be notified and will be required to submit an EFT form and bank account verification from their financial institution.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Electronic Funds Transfer (EFT) (Cont'd.)

Each time banking information changes, the 15-day pre-certification period will occur and the provider will receive reimbursement via hard copy checks.

Uncashed Medicaid Checks

SCDHHS may, under special circumstances, issue a hard copy reimbursement check. In instances where Medicaid checks to providers remain outstanding 180 days or longer from the date of check issue, SCDHHS is required by federal regulations to refund to the federal government the federal share of those Medicaid checks. Therefore, SCDHHS will have the bank return (or not honor) Medicaid checks presented for payments that are 180 days old or older.

THIRD-PARTY LIABILITY (TPL)

The SCDHHS Health Insurance Information Referral Form is used to document third-party insurance coverage, policy changes, beneficiary coverage changes, carrier changes, and policy lapse information. A copy of this form is included in the Forms section of this manual. Completed forms should be mailed or faxed directly to Medicaid Insurance Verification Services at the following address:

South Carolina Healthy Connections
Post Office Box 101110
Columbia, SC 29211-9804
Fax: (803) 252-0870

Cost Avoidance

Under the cost avoidance program, claims billed primary to Medicaid for many providers will automatically be rejected for those beneficiaries who have other resources available for payment that are responsible as the primary payer.

Providers should not submit claims to Medicaid until payment or notice of denial has been received from any liable third party. However, the time limit for filing claims cannot be extended on the basis of third-party liability requirements.

If a claim or line is rejected for primary payer(s) or failure to bill third-party coverage, providers should submit a new claim and include the insurance carrier code, the policy number, and the name of the policyholder found in third-party payer information on the Web Tool. Information about the insurance carrier address and telephone number may be found in Appendix 2 of this manual. Providers can

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Cost Avoidance (Cont'd.)

also view carrier codes on the Provider Information page at http://provider.scdhhs.gov.

Reporting Third-Party Insurance On a CMS-1500 Claim Form

After the claim has been submitted to the third-party payer, and the third-party payer denies payment or the third-party payment is less than the Medicaid allowed amount, the provider may submit the claim to Medicaid. To indicate that a claim has been submitted to a third-party insurance carrier, include the carrier code, the policy number, and the amount paid. Instructions are provided earlier in this section on coding the CMS-1500 claim for third-party insurance information.

If the third party denies payment, the TPL indicator for "insurance denied" should be entered in the appropriate field on the CMS-1500 claim form. For the CMS-1500 the appropriate field for TPL coding is field 10d. The TPL indicators accepted are:

Code	Description
1	Insurance denied
6	Crime victim
8	Uncooperative beneficiary

If the third-party payment is equal to or greater than the SC Medicaid established rate, Medicaid will not reimburse the balance. The Medicaid beneficiary **is not liable** for the balance.

Third-Party Liability Exceptions

Providers may occasionally encounter difficulties in obtaining documentation and payment from third parties and beneficiaries. For example, the third-party insurer may refuse to send a written denial or explanation of benefits, or a beneficiary may be missing or uncooperative. In such cases it is the provider's responsibility to seek a solution to the problem.

Providers have many resources available to them for pursuing third party payments. Program areas will work with providers to explore these options.

As a measure, providers may submit a reasonable effort document along with a claim filed as a denial. This document can be found in the Forms section of this manual. The reasonable effort document must demonstrate

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Third-Party Liability Exceptions (Cont'd.)

sustained efforts of claim submission and/or adequate follow-up to obtain the needed action from the insurance company or beneficiary. This document should be used only as a last resort, when all other attempts at contact and payment collection have failed.

The reasonable effort documentation process does not exempt providers from timely filing requirements for claims. Please refer to "Time Limit for Submitting Claims" in Section 1.

If the provider is filing a hard copy claim, the reasonable effort document should be attached to the claim form and returned to Medicaid Claims Receipt.

If a claim is rejected for failure to bill third-party coverage, the provider must submit a new claim with the correctly coded information that documents payment or denial of payment by the third-party carrier. Please refer to the Web Tool for the insurance information of the third-party payer.

Dually Eligible Beneficiaries

When a dually eligible beneficiary also has a commercial payer, the provider should file to all payers before filing to Medicaid. If the provider chooses to submit a CMS-1500 claim form for consideration of payment, he or she must declare all payments and denials. If the combined payments of Medicare and the other payer add up to less than Medicaid's allowable, Medicaid will make an additional payment up to that allowable not to exceed the remaining patient responsibility. If the sum of Medicare and other payers is greater than Medicaid's allowable, the claim will reject with the 690 edit (payment from other sources is more than Medicaid allowable).

TPL Refunds

When reimbursed by both Medicaid and third-party insurance, the provider must refund the lesser of either the amount paid by Medicaid or the full amount paid by the insurance company. See "Claim Adjustments" and "Refunds" later in this section.

Medicaid Recovery Initiatives

Retro-Health Insurance

Where SCDHHS discovers a primary payer for a claim Medicaid has already paid, SCDHHS will pursue recovery. Once an insurance policy is added to the TPL policy file,

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Retro-Health Insurance (Cont'd.)

claims that have services in the current and prior calendar years are invoiced directly to the third party.

As new policies are added each month to the TPL policy file, claims history is reviewed to identify claims paid by Medicaid for which the third party may be liable. A detailed claims listing is generated and mailed to providers in a format similar to the Retro Medicare claims listing. The listing identifies relevant beneficiaries, claim control numbers, dates of service, and insurance information. Three notices over a period of three months are provided. Claims will be recouped approximately 90 days after the first letter if no response is received. If you have questions about this process, please contact Medicaid Insurance Verification Services (MIVS) at 1-888-289-0709 option 5.

Retro-Medicare

Every month, providers are notified by letter of claims Medicaid paid primary for beneficiaries with Medicare coverage (Retro Medicare). The letter provides the beneficiary's Medicare number to file the claim with Medicare. The Medicaid payments will be recouped within 30 days of the date of the letter. Please retain the letter for accurate accounting of the recoupment. Questions about this letter may be referred to Medicaid Insurance Verification Services (MIVS) at 1-888-289-0709 option 5.

Where claims have been pulled into Retro Medicare and Retro Health for institutional providers, the provider should not attempt to refund the claim with a void or void/replacement claim. Should they do so, they will incur edits 561, 562, and 563.

Carrier Codes

All third-party payers are assigned a three-character code referred to as a carrier code. The appropriate carrier code must be entered on the CMS-1500 form when reporting third-party liability.

The list of carrier codes (Appendix 2) contained in this manual is categorized both alphabetically by the names of the insurance companies and numerically by the carrier code assigned to each company. These codes are current at the time of publication of this manual; however, they are subject to change.

If a particular carrier or carrier code cannot be found in this manual, providers should visit the Provider Information

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Carrier Codes (Cont'd.)

page on the SCDHHS Web site at http://provider.scdhhs.gov to view and/or download the most current carrier codes. Carrier codes are updated each quarter on the Web site.

If a particular carrier code is neither listed in the manual nor on the SCDHHS Web site, providers may use the generic carrier code 199 for billing purposes. Contact the PSC or submit an online inquiry for assistance should the Web Tool list a numerical code that cannot be located in the carrier codes either in this manual or online.

CLAIM ADJUSTMENTS

Adjustments can be made to paid claims only. A request may be initiated by the provider or SCDHHS. SCDHHS-initiated adjustments are used when the agency determines that an overpayment or underpayment has been made to a provider; SCDHHS will notify the provider when this occurs. Questions regarding an adjustment should be directed to the PSC or submit an online inquiry for assistance. It is important to note that discontinuation of participation in Medicaid will **NOT** eliminate an existing overpayment debt.

A **claim-level adjustment** is a **detail-level** Void (debit) or Void/Replacement that is used to correct both the payment history **and** the actual claim record. It is limited to one claim per adjustment request. A Void claim will always result in an account debit for the total amount of the original claim. A Void/Replacement claim will generate an account debit for the original claim and refile the claim with the corrected information.

A **gross-level adjustment** is defined as a **provider-level** adjustment that is a debit or credit that will affect the financial account history for the provider; however, the patient claim history in the Medicaid Management Information System (MMIS) will not be altered, and the Remittance Advice will not be able to provide claim-specific information.

Claim-Level Adjustments

All Medicaid providers are able to initiate claim-level adjustments. Please note: gross-level adjustments may still be used as discussed in "Gross-Level Adjustments." The process for claim-level adjustments gives providers the option of initiating their own corrections to individual claim records. This process allows providers to submit

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Claim-Level Adjustments (Cont'd.)

adjustments directly to SC Medicaid. Claim-level adjustments should only be submitted for claims that have been paid (status "P").

Claim-level adjustments should be initiated when:

- The provider has identified the need for a **Void/Replacement** of an original claim. This process should be used when the information reported on the original claim needs to be amended. **The original claim must have a date of service that is less than 12 months old.** (See "Claim Filing Timeliness" in this section for more information.)
- The provider has identified the need for a **Void Only** of a claim that was paid within the last 18 months. This process should be used when the provider wishes to withdraw the original claim entirely.

Claim-level adjustments can be submitted in several ways:

- Providers who submit claims using a HIPAA-compliant electronic claims submission format must use the void or replacement option provided by their system. (See "Void and Replacement Claims for HIPAA-Compliant Electronic Submissions" below.)
- Providers who submit claims on paper using CMS-1500, or Transportation forms can use the Claim Adjustment Form 130 (DHHS Form 130, revised 03-13-2007). They can also use the Web Tool to initiate claim-level adjustments in a HIPAA-compliant electronic format, even if they continue using paper forms for regular billing. See "Electronic Claims Submissions" in this section for more information about the Web Tool.

Providers who use an electronic format that is not compliant with HIPAA standards to submit CMS-1500 or Transportation claims can use DHHS Form 130; they may also use the Web Tool to submit adjustments.

Note: When submitting a Form 130 to void or void/replace a claim, it is not necessary for the provider to also submit a refund check.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Claim-Level Adjustments (Cont'd.)

Void and Replacement Claims (HIPAA-Compliant Electronic Submissions)

Providers may use a HIPAA-compliant electronic format to void a claim that has been filed in error, processed, and for which payment has been received. Submitting a **Void claim** with the original Claim Control Number will alert SCDHHS that claim payment has been made in error. The amount paid for the original claim will be deducted from the next Remittance Advice**.**

Alternatively, these providers may submit a **Replacement claim** to change information on a claim that has been filed, processed, and for which payment has been received. Submitting a Replacement claim automatically voids the original claim and processes the Replacement claim. The Void and Replacement claims must have the same beneficiary and provider numbers.

Void Only and Void/Replacement Claims

Providers who file claims on paper or who submit electronic claims that are not in a HIPAA-compliant electronic format may use DHHS Form 130 to submit claim-level adjustments. (A sample DHHS Form 130 can be found in the Forms section of this manual.) Once a provider has determined that a claim-level adjustment is warranted, there are two options:

- Submitting a **Void Only** claim will generate an account debit for the amount that was reimbursed. A Void Only claim should be used to retract a claim that was paid in error. To initiate a Void Only claim, complete DHHS Form 130 and attach a copy of the original Remittance Advice.
- Submitting a **Void/Replacement** claim will generate an account debit for the original claim and refile the claim with the corrected information. A Void/Replacement claim should be used to:
  - Correct a keying or billing error on a paid claim
  - Add new or additional information to a claim
  - Add information about a third party insurer or payment

To initiate a Void/Replacement claim, complete DHHS Form 130 and attach a copy of the original Remittance

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Void Only and Void/Replacement Claims

Advice, as well as the new Replacement claim. Also attach any documentation relevant to the claim.

Form 130 Instructions

The completed DHHS Form 130 and any other documents specified above should be sent directly to SC Medicaid at the same address used for regular claims submission. All fields are required with the exception of field 13, "Comments."

1 Provider Name

Enter the provider's name.

2 Provider Address

Enter the provider's address.

3 Provider City, State, Zip

Enter the provider's city, state, and zip code.

4 Total amount paid on the original claim

Enter the total amount that was paid on the original claim that is to be voided or replaced.

5 Original CCN

Enter the Claim Control Number of the original claim you wish to Void or Void/Replace. The CCN is 17 characters long; the first 16 characters are numeric, and the 17th is alpha, indicating the claim type.

6 Provider ID/NPI

Enter the six-character Medicaid legacy provider number and/or NPI of the provider reimbursed on the original claim.

7 Recipient ID

Enter the beneficiary's Medicaid ID as submitted on the original claim.

8 Adjustment Type

Fill in the appropriate bubble to indicate Void or Void/Replace.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Form 130 Instructions (Cont'd.)

9 Originator

Fill in the "Provider" bubble.

10 Reason for Adjustment

Select only **one** reason for the adjustment and fill in the appropriate bubble.

11 Analyst ID

This field is for agency use only.

12 For Agency Use Only

These adjustment reasons are for agency use only.

13 Comments

Include any relevant comments in this field. Comments are not required.

14 Signature

The person completing the form must sign on this line.

15 Date

Enter the date the form was completed.

16 Phone

Enter the contact phone number of the person completing the form.

Visit Counts

Because visit counts are stored on the claim record for beneficiaries, the claim-level adjustment process can affect the visit count for services that have a limitation on the number of visits allowed within a specific time frame (typically the state fiscal year). Those services include Ambulatory, Home Health, and Chiropractic visits.

In the case of a **Void Only** adjustment, the visit count for a beneficiary will be restored by the same number and type of visits on the original claim. Once the Void Only adjustment has been processed, those allowed visits are returned to the beneficiary's record and are available for use.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Visit Counts (Cont'd.)

In the case of a **Void/Replacement** adjustment, a new visit count will be applied to the beneficiary record after the replacement claim has completed processing.

There are two factors to note here:

- If the recalculated visit count exceeds that beneficiary's limits, reimbursement for the excess visits on the Replacement claim will be denied.
- There may be cases when a Void/Replacement adjustment is submitted, the Void of the old claim is processed, and the Replacement claim is suspended. In such cases, the allowable visits on the original claim are "held" until the suspension is resolved. If the resolution results in "Paid" status for the Replacement claim, the allowable visits are applied to it. However, if the Replacement claim is denied ("R" status), then those allowable visits again become active in the beneficiary's record and can be applied to other visits.

Gross-Level Adjustments

Gross-level adjustments will be initiated when:

- A claim is no longer in Medicaid's active history file (the claim payment date is more than 18 months old.)
- The adjustment request is not "claim-specific" (cost settlements, disproportionate share, etc.). SCDHHS will initiate this type of gross adjustment.
- A claim in TPL Recovery will not be taken back in full.

Provider requests for credit adjustments (where the provider can substantiate that additional reimbursement is appropriate) or debit adjustments (where the provider wishes to make a voluntary refund of an overpayment) should be directed to the Medicaid program manager within 90 days of receipt of payment. Requests for gross-level **credit** adjustments for dates of service that are more than one year old typically cannot be processed by SCDHHS without documentation justifying an exception. Providers may send TPL-related adjustments directly to Medicaid Insurance Verification Services (MIVS) at the following address:

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Gross-Level Adjustments (Cont'd.)

South Carolina Healthy Connections
Post Office Box 101110
Columbia, SC 29211-9804

Fax: (803) 462-2582
Phone: 1-888-289-0709 option 5

In the event of a debit adjustment, the provider should not send a check. Appropriate deductions will be made from the provider's account, if necessary. Providers may inquire directly to Medicaid Insurance Verification Services about debit or credit adjustments resulting from private health insurance or retroactive Medicare coverage.

To request a gross-level adjustment, the provider should submit a letter on letterhead stationery to SCDHHS providing a brief description of the problem, the action that the provider wishes SCDHHS to take on the claim, and the amount of the adjustment, if known. If the problem involves an individual claim, the letter should also provide the beneficiary's name and Medicaid number, the date of service involved, and the procedure code for the service to be adjusted. The provider's authorized representative must sign the letter. For problems involving individual claims, copies of the pertinent Medicaid Remittance Advices with the beneficiary's name and Medicaid number, date of service, procedure code, and payment amount **highlighted** should also be included.

The provider will be notified of the adjustment via a letter or a copy of an Adjustment/Alternate Claim Form (DHHS Form 115). After it is processed by SCDHHS, the gross-level adjustment will appear on the last page of the provider's next Remittance Advice. Each adjustment will be assigned a unique identification number ("Own Reference Number" on the adjustment form), which will appear in the first column of the Remittance Advice. The identification number will be up to nine alphanumeric characters in length. A sample Remittance Advice can be found in the Forms section of this manual. Gross-level adjustments are shown on page 3 of the sample.

Adjustments on the Remittance Advice

If a Void claim and its Replacement process in the same payment cycle, they are reported together on the Remittance Advice along with other paid claims. The original Claim Control Number (CCN) and other claim

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Adjustments on the Remittance Advice (Cont'd.)

details will appear on both the Void and the Replacement lines.

Void Only claim adjustments are reported on a separate page of the Remittance Advice; they will also show the original CCN and other claim details. If the Replacement claim for a Void/Replacement processes in a subsequent payment cycle, it will appear with other paid claims.

Gross-level adjustments are reported on the last page of the Remittance Advice, and show only a reference number and debit/credit information.

A sample Remittance Advice that shows Void Only, Void/Replacement, and gross-level adjustments can be found in the Forms section of this manual.

Refund Checks

Providers who are instructed to send a refund check should complete the Form for Medicaid Refunds (DHHS Form 205) and send it along with the check to the following address:

South Carolina Healthy Connections
Cash Receipts
Post Office Box 8355
Columbia, SC 29202-8355

All refund checks should be made payable to the SC Department of Health and Human Services. A sample of the Form for Medicaid Refunds, along with instructions for its completion, can be found in the Forms section of this manual. SCDHHS must be able to identify the reason for the refund, the beneficiary's name and Medicaid number, the provider's number, and the date of service in order to post the refund correctly.

If you submit a refund to SCDHHS and subsequently discover that it was in error, SCDHHS must receive your credit adjustment request within 90 days of the refund.

SECTION 4

PROCEDURE CODES

TABLE OF CONTENTS

Note: ICD-9 codes for dates of service on or before **September 30, 2015** are located on the SCDHHS website on the Physicians Services Provider Manual webpage.

SECTION 4

PROCEDURE CODES

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SECTION 4 PROCEDURE CODES

ASSISTANT SURGEON CODES

Please refer to the Physicians Services Provider Manual webpage on the SCDHHS website for eligible assistant surgeon codes.

PAYMENT CATEGORY

A two-digit numeric code indicating the category under which assistance is being received.

PAYMENT CATEGORY A. MEDICAL ASSISTANCE ONLY (MAO)		ALLOWABLE QUALIFYING CATEGORIES
10	MAO (NURSING HOMES)	10, 20, 30, 40, 50, 70
11	MAO TRANSITIONAL MEDICAID	30
12	OPTIONAL COVERAGE FOR WOMEN AND INFANTS (OCWI) INFANTS UP TO AGE 1	30
13	MAO (FOSTER CARE)	60
14	MAO (GENERAL HOSPITAL)	10, 20, 30, 50
15	MAO (OTHER) – SEE CS-2 FOR COVERAGE GROUPS (FOR WAIVERS)	10, 20, 30, 50, 70
16	PASS-ALONG ELIGIBLES	10, 20, 50
31	TITLE IV-E FOSTER CARE	31
32	AGED, BLIND AND DISABLED	10, 20, 30
40	WORKING DISABLED	50
50	QUALIFIED WORKING DISABLED INDIVIDUALS (QWDI)	50
51	TITLE IV-E ADOPTIONS	31
52	SPECIFIED LOW INCOME MEDICARE BENEFICIARY (SLMB)	10, 20, 50
54	SSI NURSING HOMES	10, 20, 30, 50, 70
55	FAMILY PLANNING	30
56	COSY/ISCEDC	50
57	TEFRA/KATIE BECKETT	50
58	FAMILY INDEPENDENCE (MAO)	30

SECTION 4 PROCEDURE CODES

PAYMENT CATEGORY

PAYMENT CATEGORY		ALLOWABLE QUALIFYING CATEGORIES
A. MEDICAL ASSISTANCE ONLY (MAO)		
59	LOW INCOME FAMILIES	30
60	REGULAR FOSTER CARE	60
70	REFUGEE/ENTRANT	70
71	BREAST & CERVICAL CANCER PROGRAM	30
80	SSI (INCLUDING SSI INSTITUTIONAL CASES)	10, 20, 50
81	SSI WITH ESSENTIAL SPOUSE	10, 20, 50
85	OPTIONAL STATE SUPPLEMENTATION (OSS)/OSS ADULT FOSTER CARE	10, 20, 50
86	OSS & SSI/OSS & SSI ADULT FOSTER CARE	10, 20, 50
87	OPTIONAL COVERAGE FOR WOMEN AND INFANTS (OCWI) – PREGNANT WOMEN	30
88	PARTNERS FOR HEALTHY CHILDREN (CHILDREN UP TO AGE 19)	30
90	QUALIFIED MEDICARE BENEFICIARY (QMB)	10, 20, 30, 50
91	RIBICOFF CHILDREN	30
92+	SILVERXCARD RECIPIENT/PHARMACY SERVICES ONLY	

SECTION 4 PROCEDURE CODES

PROCEDURE CODES REQUIRING SUPPORTING DOCUMENTATION

ICD-10-PCS SURGICAL CODES AND CPT CODES REQUIRING SUPPORTING DOCUMENTATION

October 2017 Update

For dates of service on or after **October 1, 2017,** the following ICD-10 PCS codes require supporting documentation for KEPRO and SCDHHS Physicians Services. For dates of service prior to October 1, 2017, refer to the October 2015 Update included in this section.

ICD-10 CODE	DESCRIPTION
00Q00ZZ	REPAIR BRAIN, OPEN APPROACH
00Q03ZZ	REPAIR BRAIN, PERCUTANEOUS APPROACH
00Q04ZZ	REPAIR BRAIN, PERCUTANEOUS ENDOSCOPIC APPROACH
08SN0ZZ	REPOSITION RIGHT UPPER EYELID, OPEN APPROACH
08SN3ZZ	REPOSITION RIGHT UPPER EYELID, PERCUTANEOUS APPROACH
08SP0ZZ	REPOSITION LEFT UPPER EYELID, OPEN APPROACH
08SP3ZZ	REPOSITION LEFT UPPER EYELID, PERCUTANEOUS APPROACH
08SQ0ZZ	REPOSITION RIGHT LOWER EYELID, OPEN APPROACH
08SQ3ZZ	REPOSITION RIGHT LOWER EYELID, PERCUTANEOUS APPROACH
08SR0ZZ	REPOSITION LEFT LOWER EYELID, OPEN APPROACH
08SR3ZZ	REPOSITION LEFT LOWER EYELID, PERCUTANEOUS APPROACH
0D16079	BYPASS STOMACH TO DUODENUM WITH AUTOLOGOUS TISSUE SUBSTITUTE, OPEN APPROACH
0D1607B	BYPASS STOMACH TO ILEUM WITH AUTOL SUB, OPEN APPROACH
0D1607L	BYPASS STOMACH TO TRANS COLON WITH AUTOL SUB, OPEN APPROACH
0D160J9	BYPASS STOMACH TO DUODENUM WITH SYNTH SUB, OPEN APPROACH
0D160JB	BYPASS STOMACH TO ILEUM WITH SYNTH SUB, OPEN APPROACH
0D160JL	BYPASS STOMACH TO TRANS COLON WITH SYNTH SUB, OPEN APPROACH
0D160K9	BYPASS STOMACH TO DUODENUM WITH NONAUT SUB, OPEN APPROACH
0D160KB	BYPASS STOMACH TO ILEUM WITH NONAUT SUB, OPEN APPROACH

SECTION 4 PROCEDURE CODES

PROCEDURE CODES REQUIRING SUPPORTING DOCUMENTATION

ICD-10 CODE	DESCRIPTION
0D160KL	BYPASS STOMACH TO TRANS COLON WITH NONAUT SUB, OPEN APPROACH
0D160Z9	BYPASS STOMACH TO DUODENUM, OPEN APPROACH
0D160ZB	BYPASS STOMACH TO ILEUM, OPEN APPROACH
0D160ZL	BYPASS STOMACH TO TRANSVERSE COLON, OPEN APPROACH
0D16879	BYPASS STOMACH TO DUODENUM WITH AUTOL SUB, ENDO
0D1687B	BYPASS STOMACH TO ILEUM WITH AUTOL SUB, ENDO
0D1687L	BYPASS STOMACH TO TRANSVERSE COLON WITH AUTOL SUB, ENDO
0D168J9	BYPASS STOMACH TO DUODENUM WITH SYNTHETIC SUBSTITUTE, ENDO
0D168JB	BYPASS STOMACH TO ILEUM WITH SYNTHETIC SUBSTITUTE, ENDO
0D168JL	BYPASS STOMACH TO TRANSVERSE COLON WITH SYNTH SUB, ENDO
0D168K9	BYPASS STOMACH TO DUODENUM WITH NONAUT SUB, ENDO
0D168KB	BYPASS STOMACH TO ILEUM WITH NONAUT SUB, ENDO
0D168KL	BYPASS STOMACH TO TRANSVERSE COLON WITH NONAUT SUB, ENDO
0D168Z9	BYPASS STOMACH TO DUODENUM, ENDO
0D168ZB	BYPASS STOMACH TO ILEUM, ENDO
0D168ZL	BYPASS STOMACH TO TRANSVERSE COLON, ENDO
0VLN0DZ	OCCLUSION OF R VAS DEFERENS WITH INTRALUM DEV, OPEN APPROACH
0VLN3DZ	OCCLUSION OF R VAS DEFERENS WITH INTRALUM DEV, PERC APPROACH
0VLN4DZ	OCCLUSION R VAS DEFERENS W INTRALUM DEV, PERC ENDO
0VLN8DZ	OCCLUSION OF RIGHT VAS DEFERENS WITH INTRALUMINAL DEVICE, VIA NATURAL OR ARTIFICIAL OPENING ENDOSCOPIC
0VLP0DZ	OCCLUSION OF L VAS DEFERENS WITH INTRALUM DEV, OPEN APPROACH
0VLP3DZ	OCCLUSION OF L VAS DEFERENS WITH INTRALUM DEV, PERC APPROACH
0VLP4DZ	OCCLUSION L VAS DEFERENS W INTRALUM DEV, PERC ENDO
0VLP8DZ	OCCLUSION OF LEFT VAS DEFERENS WITH INTRALUMINAL DEVICE, VIA NATURAL OR ARTIFICIAL OPENING ENDOSCOPIC
0VLQ0DZ	OCCLUSION BI VAS DEFERENS W INTRALUM DEV, OPEN
0VLQ3DZ	OCCLUSION BI VAS DEFERENS W INTRALUM DEV, PERC
0VLQ4DZ	OCCLUSION BI VAS DEFERENS W INTRALUM DEV, PERC ENDO
0VLQ8DZ	OCCLUSION OF BILATERAL VAS DEFERENS WITH INTRALUMINAL DEVICE, VIA NATURAL OR ARTIFICIAL OPENING ENDOSCOPIC
0VNJ0ZZ	RELEASE RIGHT EPIDIDYMIS, OPEN APPROACH
0VNJ3ZZ	RELEASE RIGHT EPIDIDYMIS, PERCUTANEOUS APPROACH
0VNJ4ZZ	RELEASE RIGHT EPIDIDYMIS, PERCUTANEOUS ENDOSCOPIC APPROACH
0VNJ8ZZ	RELEASE RIGHT EPIDIDYMIS, VIA NATURAL OR ARTIFICIAL OPENING ENDOSCOPIC
0VNK0ZZ	RELEASE LEFT EPIDIDYMIS, OPEN APPROACH
0VNK3ZZ	RELEASE LEFT EPIDIDYMIS, PERCUTANEOUS APPROACH
0VNK4ZZ	RELEASE LEFT EPIDIDYMIS, PERCUTANEOUS ENDOSCOPIC APPROACH

SECTION 4 PROCEDURE CODES

PROCEDURE CODES REQUIRING SUPPORTING DOCUMENTATION

ICD-10 CODE	DESCRIPTION
0VNK8ZZ	RELEASE LEFT EPIDIDYMIS, VIA NATURAL OR ARTIFICIAL OPENING ENDOSCOPIC
0VNL0ZZ	RELEASE BILATERAL EPIDIDYMIS, OPEN APPROACH
0VNL3ZZ	RELEASE BILATERAL EPIDIDYMIS, PERCUTANEOUS APPROACH
0VNL4ZZ	RELEASE BILATERAL EPIDIDYMIS, PERC ENDO APPROACH
0VNL8ZZ	RELEASE BILATERAL EPIDIDYMIS, VIA NATURAL OR ARTIFICIAL OPENING ENDOSCOPIC
0VQF0ZZ	REPAIR RIGHT SPERMATIC CORD, OPEN APPROACH
0VQF3ZZ	REPAIR RIGHT SPERMATIC CORD, PERCUTANEOUS APPROACH
0VQF4ZZ	REPAIR RIGHT SPERMATIC CORD, PERCUTANEOUS ENDOSCOPIC APPROACH
0VQF8ZZ	REPAIR RIGHT SPERMATIC CORD, VIA NATURAL OR ARTIFICIAL OPENING ENDOSCOPIC
0VQG0ZZ	REPAIR LEFT SPERMATIC CORD, OPEN APPROACH
0VQG3ZZ	REPAIR LEFT SPERMATIC CORD, PERCUTANEOUS APPROACH
0VQG4ZZ	REPAIR LEFT SPERMATIC CORD, PERCUTANEOUS ENDOSCOPIC APPROACH
0VQG8ZZ	REPAIR LEFT SPERMATIC CORD, VIA NATURAL OR ARTIFICIAL OPENING ENDOSCOPIC
0VQH0ZZ	REPAIR BILATERAL SPERMATIC CORDS, OPEN APPROACH
0VQH3ZZ	REPAIR BILATERAL SPERMATIC CORDS, PERCUTANEOUS APPROACH
0VQH4ZZ	REPAIR BILATERAL SPERMATIC CORDS, PERCUTANEOUS ENDOSCOPIC APPROACH
0VQH8ZZ	REPAIR BILATERAL SPERMATIC CORDS, VIA NATURAL OR ARTIFICIAL OPENING ENDOSCOPIC
0VQJ0ZZ	REPAIR RIGHT EPIDIDYMIS, OPEN APPROACH
0VQJ3ZZ	REPAIR RIGHT EPIDIDYMIS, PERCUTANEOUS APPROACH
0VQJ4ZZ	REPAIR RIGHT EPIDIDYMIS, PERCUTANEOUS ENDOSCOPIC APPROACH
0VQJ8ZZ	REPAIR RIGHT EPIDIDYMIS, VIA NATURAL OR ARTIFICIAL OPENING ENDOSCOPIC
0VQK0ZZ	REPAIR LEFT EPIDIDYMIS, OPEN APPROACH
0VQK3ZZ	REPAIR LEFT EPIDIDYMIS, PERCUTANEOUS APPROACH
0VQK4ZZ	REPAIR LEFT EPIDIDYMIS, PERCUTANEOUS ENDOSCOPIC APPROACH
0VQK8ZZ	REPAIR LEFT EPIDIDYMIS, VIA NATURAL OR ARTIFICIAL OPENING ENDOSCOPIC
0VQL0ZZ	REPAIR BILATERAL EPIDIDYMIS, OPEN APPROACH
0VQL3ZZ	REPAIR BILATERAL EPIDIDYMIS, PERCUTANEOUS APPROACH
0VQL4ZZ	REPAIR BILATERAL EPIDIDYMIS, PERCUTANEOUS ENDOSCOPIC APPROACH
0VQL8ZZ	REPAIR BILATERAL EPIDIDYMIS, VIA NATURAL OR ARTIFICIAL OPENING ENDOSCOPIC
0VQN0ZZ	REPAIR RIGHT VAS DEFERENS, OPEN APPROACH
0VQN3ZZ	REPAIR RIGHT VAS DEFERENS, PERCUTANEOUS APPROACH
0VQN4ZZ	REPAIR RIGHT VAS DEFERENS, PERCUTANEOUS ENDOSCOPIC APPROACH

SECTION 4 PROCEDURE CODES

PROCEDURE CODES REQUIRING SUPPORTING DOCUMENTATION

ICD-10 CODE	DESCRIPTION
0VQN8ZZ	REPAIR RIGHT VAS DEFERENS, VIA NATURAL OR ARTIFICIAL OPENING ENDOSCOPIC
0VQP0ZZ	REPAIR LEFT VAS DEFERENS, OPEN APPROACH
0VQP3ZZ	REPAIR LEFT VAS DEFERENS, PERCUTANEOUS APPROACH
0VQP4ZZ	REPAIR LEFT VAS DEFERENS, PERCUTANEOUS ENDOSCOPIC APPROACH
0VQP8ZZ	REPAIR LEFT VAS DEFERENS, VIA NATURAL OR ARTIFICIAL OPENING ENDOSCOPIC
0VQQ0ZZ	REPAIR BILATERAL VAS DEFERENS, OPEN APPROACH
0VQQ3ZZ	REPAIR BILATERAL VAS DEFERENS, PERCUTANEOUS APPROACH
0VQQ4ZZ	REPAIR BILATERAL VAS DEFERENS, PERCUTANEOUS ENDOSCOPIC APPROACH
0VQQ8ZZ	REPAIR BILATERAL VAS DEFERENS, VIA NATURAL OR ARTIFICIAL OPENING ENDOSCOPIC
0UL50ZZ	OCCLUSION OF RIGHT FALLOPIAN TUBE, OPEN APPROACH
0UL53ZZ	OCCLUSION OF RIGHT FALLOPIAN TUBE, PERCUTANEOUS APPROACH
0UL54ZZ	OCCLUSION OF RIGHT FALLOPIAN TUBE, PERCUTANEOUS ENDOSCOPIC APPROACH
0UL60ZZ	OCCLUSION OF LEFT FALLOPIAN TUBE, OPEN APPROACH
0UL63ZZ	OCCLUSION OF LEFT FALLOPIAN TUBE, PERCUTANEOUS APPROACH
0UL64ZZ	OCCLUSION OF LEFT FALLOPIAN TUBE, PERCUTANEOUS ENDOSCOPIC APPROACH
0UL70ZZ	OCCLUSION OF BILATERAL FALLOPIAN TUBES, OPEN APPROACH
0UL73ZZ	OCCLUSION OF BILATERAL FALLOPIAN TUBES, PERCUTANEOUS APPROACH
0UL74ZZ	OCCLUSION OF BILATERAL FALLOPIAN TUBES, PERCUTANEOUS ENDOSCOPIC APPROACH
10A07ZZ	ABORTION OF PRODUCTS OF CONCEPTION, VIA OPENING
10A08ZZ	ABORTION OF PRODUCTS OF CONCEPTION, ENDO
10A07ZW	ABORTION OF PRODUCTS OF CONCEPTION, LAMINARIA, VIA NATURAL OR ARTIFICIAL OPENING
10A00ZZ	ABORTION OF PRODUCTS OF CONCEPTION, OPEN APPROACH
10A03ZZ	ABORTION OF PRODUCTS OF CONCEPTION, PERCUTANEOUS APPROACH
10A04ZZ	ABORTION OF PRODUCTS OF CONCEPTION, PERCUTANEOUS ENDOSCOPIC APPROACH
10A07Z6	ABORTION OF PRODUCTS OF CONCEPTION, VACUUM, VIA OPENING
10A07ZX	ABORTION OF PRODUCTS OF CONCEPTION, ABORTIFACIENT, VIA NATURAL OR ARTIFICIAL OPENING
0NNC0ZZ	RELEASE SPHENOID BONE, OPEN APPROACH
0NNC3ZZ	RELEASE SPHENOID BONE, PERCUTANEOUS APPROACH
0NNC4ZZ	RELEASE SPHENOID BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNF0ZZ	RELEASE RIGHT ETHMOID BONE, OPEN APPROACH
0NNF3ZZ	RELEASE RIGHT ETHMOID BONE, PERCUTANEOUS APPROACH
0NNF4ZZ	RELEASE RIGHT ETHMOID BONE, PERCUTANEOUS ENDOSCOPIC APPROACH

SECTION 4 PROCEDURE CODES

PROCEDURE CODES REQUIRING SUPPORTING DOCUMENTATION

ICD-10 CODE	DESCRIPTION
0NNG0ZZ	RELEASE LEFT ETHMOID BONE, OPEN APPROACH
0NNG3ZZ	RELEASE LEFT ETHMOID BONE, PERCUTANEOUS APPROACH
0NNG4ZZ	RELEASE LEFT ETHMOID BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNH0ZZ	RELEASE RIGHT LACRIMAL BONE, OPEN APPROACH
0NNH3ZZ	RELEASE RIGHT LACRIMAL BONE, PERCUTANEOUS APPROACH
0NNH4ZZ	RELEASE RIGHT LACRIMAL BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNJ0ZZ	RELEASE LEFT LACRIMAL BONE, OPEN APPROACH
0NNJ3ZZ	RELEASE LEFT LACRIMAL BONE, PERCUTANEOUS APPROACH
0NNJ4ZZ	RELEASE LEFT LACRIMAL BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNK0ZZ	RELEASE RIGHT PALATINE BONE, OPEN APPROACH
0NNK3ZZ	RELEASE RIGHT PALATINE BONE, PERCUTANEOUS APPROACH
0NNK4ZZ	RELEASE RIGHT PALATINE BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNL0ZZ	RELEASE LEFT PALATINE BONE, OPEN APPROACH
0NNL3ZZ	RELEASE LEFT PALATINE BONE, PERCUTANEOUS APPROACH
0NNL4ZZ	RELEASE LEFT PALATINE BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNM0ZZ	RELEASE RIGHT ZYGOMATIC BONE, OPEN APPROACH
0NNM3ZZ	RELEASE RIGHT ZYGOMATIC BONE, PERCUTANEOUS APPROACH
0NNM4ZZ	RELEASE RIGHT ZYGOMATIC BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNN0ZZ	RELEASE LEFT ZYGOMATIC BONE, OPEN APPROACH
0NNN3ZZ	RELEASE LEFT ZYGOMATIC BONE, PERCUTANEOUS APPROACH
0NNN4ZZ	RELEASE LEFT ZYGOMATIC BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNP0ZZ	RELEASE RIGHT ORBIT, OPEN APPROACH
0NNP3ZZ	RELEASE RIGHT ORBIT, PERCUTANEOUS APPROACH
0NNP4ZZ	RELEASE RIGHT ORBIT, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNQ0ZZ	RELEASE LEFT ORBIT, OPEN APPROACH
0NNQ3ZZ	RELEASE LEFT ORBIT, PERCUTANEOUS APPROACH
0NNQ4ZZ	RELEASE LEFT ORBIT, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNR0ZZ	RELEASE MAXILLA, OPEN APPROACH
0NNR3ZZ	RELEASE MAXILLA, PERCUTANEOUS APPROACH
0NNR4ZZ	RELEASE MAXILLA, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNT0ZZ	RELEASE RIGHT MANDIBLE, OPEN APPROACH
0NNT3ZZ	RELEASE RIGHT MANDIBLE, PERCUTANEOUS APPROACH
0NNT4ZZ	RELEASE RIGHT MANDIBLE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNV0ZZ	RELEASE LEFT MANDIBLE, OPEN APPROACH
0NNV3ZZ	RELEASE LEFT MANDIBLE, PERCUTANEOUS APPROACH
0NNV4ZZ	RELEASE LEFT MANDIBLE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NQC0ZZ	REPAIR SPHENOID BONE, OPEN APPROACH
0NQC3ZZ	REPAIR SPHENOID BONE, PERCUTANEOUS APPROACH
0NQC4ZZ	REPAIR SPHENOID BONE, PERCUTANEOUS ENDOSCOPIC APPROACH

SECTION 4 PROCEDURE CODES

PROCEDURE CODES REQUIRING SUPPORTING DOCUMENTATION

ICD-10 CODE	DESCRIPTION
0NQCXZZ	REPAIR SPHENOID BONE, EXTERNAL APPROACH
0NQF0ZZ	REPAIR RIGHT ETHMOID BONE, OPEN APPROACH
0NQF3ZZ	REPAIR RIGHT ETHMOID BONE, PERCUTANEOUS APPROACH
0NQF4ZZ	REPAIR RIGHT ETHMOID BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NQFXZZ	REPAIR RIGHT ETHMOID BONE, EXTERNAL APPROACH
0NQG0ZZ	REPAIR LEFT ETHMOID BONE, OPEN APPROACH
0NQG3ZZ	REPAIR LEFT ETHMOID BONE, PERCUTANEOUS APPROACH
0NQG4ZZ	REPAIR LEFT ETHMOID BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NQGXZZ	REPAIR LEFT ETHMOID BONE, EXTERNAL APPROACH
0NQH0ZZ	REPAIR RIGHT LACRIMAL BONE, OPEN APPROACH
0NQH3ZZ	REPAIR RIGHT LACRIMAL BONE, PERCUTANEOUS APPROACH
0NQH4ZZ	REPAIR RIGHT LACRIMAL BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NQHXZZ	REPAIR RIGHT LACRIMAL BONE, EXTERNAL APPROACH
0NQJ0ZZ	REPAIR LEFT LACRIMAL BONE, OPEN APPROACH
0NQJ3ZZ	REPAIR LEFT LACRIMAL BONE, PERCUTANEOUS APPROACH
0NQJ4ZZ	REPAIR LEFT LACRIMAL BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NQJXZZ	REPAIR LEFT LACRIMAL BONE, EXTERNAL APPROACH
0NQK0ZZ	REPAIR RIGHT PALATINE BONE, OPEN APPROACH
0NQK3ZZ	REPAIR RIGHT PALATINE BONE, PERCUTANEOUS APPROACH
0NQK4ZZ	REPAIR RIGHT PALATINE BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NQKXZZ	REPAIR RIGHT PALATINE BONE, EXTERNAL APPROACH
0NQL0ZZ	REPAIR LEFT PALATINE BONE, OPEN APPROACH
0NQL3ZZ	REPAIR LEFT PALATINE BONE, PERCUTANEOUS APPROACH
0NQL4ZZ	REPAIR LEFT PALATINE BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NQLXZZ	REPAIR LEFT PALATINE BONE, EXTERNAL APPROACH
0NQM0ZZ	REPAIR RIGHT ZYGOMATIC BONE, OPEN APPROACH
0NQM3ZZ	REPAIR RIGHT ZYGOMATIC BONE, PERCUTANEOUS APPROACH
0NQM4ZZ	REPAIR RIGHT ZYGOMATIC BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NQMXZZ	REPAIR RIGHT ZYGOMATIC BONE, EXTERNAL APPROACH
0NQN0ZZ	REPAIR LEFT ZYGOMATIC BONE, OPEN APPROACH
0NQN3ZZ	REPAIR LEFT ZYGOMATIC BONE, PERCUTANEOUS APPROACH
0NQN4ZZ	REPAIR LEFT ZYGOMATIC BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NQNXZZ	REPAIR LEFT ZYGOMATIC BONE, EXTERNAL APPROACH
0NQX0ZZ	REPAIR HYOID BONE, OPEN APPROACH
0NQX3ZZ	REPAIR HYOID BONE, PERCUTANEOUS APPROACH
0NQX4ZZ	REPAIR HYOID BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NQXXZZ	REPAIR HYOID BONE, EXTERNAL APPROACH

SECTION 4 PROCEDURE CODES

PROCEDURE CODES REQUIRING SUPPORTING DOCUMENTATION

ICD-10 CODE	DESCRIPTION
0NRR07Z	REPLACEMENT OF MAXILLA WITH AUTOLOGOUS TISSUE SUBSTITUTE, OPEN APPROACH
0NRR0JZ	REPLACEMENT OF MAXILLA WITH SYNTHETIC SUBSTITUTE, OPEN APPROACH
0NRR0KZ	REPLACEMENT OF MAXILLA WITH NONAUTOLOGOUS TISSUE SUBSTITUTE, OPEN APPROACH
0NRR37Z	REPLACEMENT OF MAXILLA WITH AUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS APPROACH
0NRR3JZ	REPLACEMENT OF MAXILLA WITH SYNTHETIC SUBSTITUTE, PERCUTANEOUS APPROACH
0NRR3KZ	REPLACEMENT OF MAXILLA WITH NONAUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS APPROACH
0NRR47Z	REPLACEMENT OF MAXILLA WITH AUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NRR4JZ	REPLACEMENT OF MAXILLA WITH SYNTHETIC SUBSTITUTE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NRR4KZ	REPLACEMENT OF MAXILLA WITH NONAUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NUR07Z	SUPPLEMENT MAXILLA WITH AUTOLOGOUS TISSUE SUBSTITUTE, OPEN APPROACH
0NUR0JZ	SUPPLEMENT MAXILLA WITH SYNTHETIC SUBSTITUTE, OPEN APPROACH
0NUR0KZ	SUPPLEMENT MAXILLA WITH NONAUTOLOGOUS TISSUE SUBSTITUTE, OPEN APPROACH
0NUR37Z	SUPPLEMENT MAXILLA WITH AUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS APPROACH
0NUR3JZ	SUPPLEMENT MAXILLA WITH SYNTHETIC SUBSTITUTE, PERCUTANEOUS APPROACH
0NUR3KZ	SUPPLEMENT MAXILLA WITH NONAUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS APPROACH
0NUR47Z	SUPPLEMENT MAXILLA WITH AUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NUR4JZ	SUPPLEMENT MAXILLA WITH SYNTHETIC SUBSTITUTE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NUR4KZ	SUPPLEMENT MAXILLA WITH NONAUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS ENDOSCOPIC APPROACH
0RNC0ZZ	RELEASE RIGHT TEMPOROMANDIBULAR JOINT, OPEN APPROACH
0RNC3ZZ	RELEASE RIGHT TEMPOROMANDIBULAR JOINT, PERCUTANEOUS APPROACH
0RNC4ZZ	RELEASE RIGHT TEMPOROMANDIBULAR JOINT, PERCUTANEOUS ENDOSCOPIC APPROACH
0RND0ZZ	RELEASE LEFT TEMPOROMANDIBULAR JOINT, OPEN APPROACH
0RND3ZZ	RELEASE LEFT TEMPOROMANDIBULAR JOINT, PERCUTANEOUS APPROACH
0RND4ZZ	RELEASE LEFT TEMPOROMANDIBULAR JOINT, PERCUTANEOUS ENDOSCOPIC APPROACH

SECTION 4 PROCEDURE CODES

PROCEDURE CODES REQUIRING SUPPORTING DOCUMENTATION

October 2015 Update

For dates of service on or after **October 1, 2015**, the following ICD-10 codes require supporting documentation for KEPRO and SCDHHS Physicians Services. For dates of service on or after October 1, 2017, refer to the October 2017 Update included in this section.

ICD-10 CODE	DESCRIPTION
00Q00ZZ	REPAIR BRAIN, OPEN APPROACH
00Q03ZZ	REPAIR BRAIN, PERCUTANEOUS APPROACH
00Q04ZZ	REPAIR BRAIN, PERCUTANEOUS ENDOSCOPIC APPROACH
08SN0ZZ	REPOSITION RIGHT UPPER EYELID, OPEN APPROACH
08SN3ZZ	REPOSITION RIGHT UPPER EYELID, PERCUTANEOUS APPROACH
08SP0ZZ	REPOSITION LEFT UPPER EYELID, OPEN APPROACH
08SP3ZZ	REPOSITION LEFT UPPER EYELID, PERCUTANEOUS APPROACH
08SQ0ZZ	REPOSITION RIGHT LOWER EYELID, OPEN APPROACH
08SQ3ZZ	REPOSITION RIGHT LOWER EYELID, PERCUTANEOUS APPROACH
08SR0ZZ	REPOSITION LEFT LOWER EYELID, OPEN APPROACH
08SR3ZZ	REPOSITION LEFT LOWER EYELID, PERCUTANEOUS APPROACH
0D16079	BYPASS STOMACH TO DUODENUM WITH AUTOLOGOUS TISSUE SUBSTITUTE, OPEN APPROACH
0D1607B	BYPASS STOMACH TO ILEUM WITH AUTOL SUB, OPEN APPROACH
0D1607L	BYPASS STOMACH TO TRANS COLON WITH AUTOL SUB, OPEN APPROACH
0D160J9	BYPASS STOMACH TO DUODENUM WITH SYNTH SUB, OPEN APPROACH
0D160JB	BYPASS STOMACH TO ILEUM WITH SYNTH SUB, OPEN APPROACH
0D160JL	BYPASS STOMACH TO TRANS COLON WITH SYNTH SUB, OPEN APPROACH
0D160K9	BYPASS STOMACH TO DUODENUM WITH NONAUT SUB, OPEN APPROACH
0D160KB	BYPASS STOMACH TO ILEUM WITH NONAUT SUB, OPEN APPROACH
0D160KL	BYPASS STOMACH TO TRANS COLON WITH NONAUT SUB, OPEN APPROACH
0D160Z9	BYPASS STOMACH TO DUODENUM, OPEN APPROACH

SECTION 4 PROCEDURE CODES

PROCEDURE CODES REQUIRING SUPPORTING DOCUMENTATION

ICD-10 CODE	DESCRIPTION
0D160ZB	BYPASS STOMACH TO ILEUM, OPEN APPROACH
0D160ZL	BYPASS STOMACH TO TRANSVERSE COLON, OPEN APPROACH
0D16879	BYPASS STOMACH TO DUODENUM WITH AUTOL SUB, ENDO
0D1687B	BYPASS STOMACH TO ILEUM WITH AUTOL SUB, ENDO
0D1687L	BYPASS STOMACH TO TRANSVERSE COLON WITH AUTOL SUB, ENDO
0D168J9	BYPASS STOMACH TO DUODENUM WITH SYNTHETIC SUBSTITUTE, ENDO
0D168JB	BYPASS STOMACH TO ILEUM WITH SYNTHETIC SUBSTITUTE, ENDO
0D168JL	BYPASS STOMACH TO TRANSVERSE COLON WITH SYNTH SUB, ENDO
0D168K9	BYPASS STOMACH TO DUODENUM WITH NONAUT SUB, ENDO
0D168KB	BYPASS STOMACH TO ILEUM WITH NONAUT SUB, ENDO
0D168KL	BYPASS STOMACH TO TRANSVERSE COLON WITH NONAUT SUB, ENDO
0D168Z9	BYPASS STOMACH TO DUODENUM, ENDO
0D168ZB	BYPASS STOMACH TO ILEUM, ENDO
0D168ZL	BYPASS STOMACH TO TRANSVERSE COLON, ENDO
0VLN0DZ	OCCLUSION OF R VAS DEFERENS WITH INTRALUM DEV, OPEN APPROACH
0VLN3DZ	OCCLUSION OF R VAS DEFERENS WITH INTRALUM DEV, PERC APPROACH
0VLN4DZ	OCCLUSION R VAS DEFERENS W INTRALUM DEV, PERC ENDO
0VLP0DZ	OCCLUSION OF L VAS DEFERENS WITH INTRALUM DEV, OPEN APPROACH
0VLP3DZ	OCCLUSION OF L VAS DEFERENS WITH INTRALUM DEV, PERC APPROACH
0VLP4DZ	OCCLUSION L VAS DEFERENS W INTRALUM DEV, PERC ENDO
0VLQ0DZ	OCCLUSION BI VAS DEFERENS W INTRALUM DEV, OPEN
0VLQ3DZ	OCCLUSION BI VAS DEFERENS W INTRALUM DEV, PERC
0VLQ4DZ	OCCLUSION BI VAS DEFERENS W INTRALUM DEV, PERC ENDO
0VNJ0ZZ	RELEASE RIGHT EPIDIDYMIS, OPEN APPROACH
0VNJ3ZZ	RELEASE RIGHT EPIDIDYMIS, PERCUTANEOUS APPROACH
0VNJ4ZZ	RELEASE RIGHT EPIDIDYMIS, PERCUTANEOUS ENDOSCOPIC APPROACH
0VNK0ZZ	RELEASE LEFT EPIDIDYMIS, OPEN APPROACH

SECTION 4 PROCEDURE CODES

PROCEDURE CODES REQUIRING SUPPORTING DOCUMENTATION

ICD-10 CODE	DESCRIPTION
0VNK3ZZ	RELEASE LEFT EPIDIDYMIS, PERCUTANEOUS APPROACH
0VNK4ZZ	RELEASE LEFT EPIDIDYMIS, PERCUTANEOUS ENDOSCOPIC APPROACH
0VNL0ZZ	RELEASE BILATERAL EPIDIDYMIS, OPEN APPROACH
0VNL3ZZ	RELEASE BILATERAL EPIDIDYMIS, PERCUTANEOUS APPROACH
0VNL4ZZ	RELEASE BILATERAL EPIDIDYMIS, PERC ENDO APPROACH
0VQF0ZZ	REPAIR RIGHT SPERMATIC CORD, OPEN APPROACH
0VQF3ZZ	REPAIR RIGHT SPERMATIC CORD, PERCUTANEOUS APPROACH
0VQF4ZZ	REPAIR RIGHT SPERMATIC CORD, PERCUTANEOUS ENDOSCOPIC APPROACH
0VQG0ZZ	REPAIR LEFT SPERMATIC CORD, OPEN APPROACH
0VQG3ZZ	REPAIR LEFT SPERMATIC CORD, PERCUTANEOUS APPROACH
0VQG4ZZ	REPAIR LEFT SPERMATIC CORD, PERCUTANEOUS ENDOSCOPIC APPROACH
0VQH0ZZ	REPAIR BILATERAL SPERMATIC CORDS, OPEN APPROACH
0VQH3ZZ	REPAIR BILATERAL SPERMATIC CORDS, PERCUTANEOUS APPROACH
0VQH4ZZ	REPAIR BILATERAL SPERMATIC CORDS, PERCUTANEOUS ENDOSCOPIC APPROACH
0VQJ0ZZ	REPAIR RIGHT EPIDIDYMIS, OPEN APPROACH
0VQJ3ZZ	REPAIR RIGHT EPIDIDYMIS, PERCUTANEOUS APPROACH
0VQJ4ZZ	REPAIR RIGHT EPIDIDYMIS, PERCUTANEOUS ENDOSCOPIC APPROACH
0VQK0ZZ	REPAIR LEFT EPIDIDYMIS, OPEN APPROACH
0VQK3ZZ	REPAIR LEFT EPIDIDYMIS, PERCUTANEOUS APPROACH
0VQK4ZZ	REPAIR LEFT EPIDIDYMIS, PERCUTANEOUS ENDOSCOPIC APPROACH
0VQL0ZZ	REPAIR BILATERAL EPIDIDYMIS, OPEN APPROACH
0VQL3ZZ	REPAIR BILATERAL EPIDIDYMIS, PERCUTANEOUS APPROACH
0VQL4ZZ	REPAIR BILATERAL EPIDIDYMIS, PERCUTANEOUS ENDOSCOPIC APPROACH
0VQN0ZZ	REPAIR RIGHT VAS DEFERENS, OPEN APPROACH
0VQN3ZZ	REPAIR RIGHT VAS DEFERENS, PERCUTANEOUS APPROACH
0VQN4ZZ	REPAIR RIGHT VAS DEFERENS, PERCUTANEOUS ENDOSCOPIC APPROACH
0VQP0ZZ	REPAIR LEFT VAS DEFERENS, OPEN APPROACH
0VQP3ZZ	REPAIR LEFT VAS DEFERENS, PERCUTANEOUS APPROACH
0VQP4ZZ	REPAIR LEFT VAS DEFERENS, PERCUTANEOUS ENDOSCOPIC

SECTION 4 PROCEDURE CODES

PROCEDURE CODES REQUIRING SUPPORTING DOCUMENTATION

ICD-10 CODE	DESCRIPTION
	APPROACH
0VQQ0ZZ	REPAIR BILATERAL VAS DEFERENS, OPEN APPROACH
0VQQ3ZZ	REPAIR BILATERAL VAS DEFERENS, PERCUTANEOUS APPROACH
0VQQ4ZZ	REPAIR BILATERAL VAS DEFERENS, PERCUTANEOUS ENDOSCOPIC APPROACH
0UL50ZZ	OCCLUSION OF RIGHT FALLOPIAN TUBE, OPEN APPROACH
0UL53ZZ	OCCLUSION OF RIGHT FALLOPIAN TUBE, PERCUTANEOUS APPROACH
0UL54ZZ	OCCLUSION OF RIGHT FALLOPIAN TUBE, PERCUTANEOUS ENDOSCOPIC APPROACH
0UL60ZZ	OCCLUSION OF LEFT FALLOPIAN TUBE, OPEN APPROACH
0UL63ZZ	OCCLUSION OF LEFT FALLOPIAN TUBE, PERCUTANEOUS APPROACH
0UL64ZZ	OCCLUSION OF LEFT FALLOPIAN TUBE, PERCUTANEOUS ENDOSCOPIC APPROACH
0UL70ZZ	OCCLUSION OF BILATERAL FALLOPIAN TUBES, OPEN APPROACH
0UL73ZZ	OCCLUSION OF BILATERAL FALLOPIAN TUBES, PERCUTANEOUS APPROACH
0UL74ZZ	OCCLUSION OF BILATERAL FALLOPIAN TUBES, PERCUTANEOUS ENDOSCOPIC APPROACH
10A07ZZ	ABORTION OF PRODUCTS OF CONCEPTION, VIA OPENING
10A08ZZ	ABORTION OF PRODUCTS OF CONCEPTION, ENDO
10A07ZW	ABORTION OF PRODUCTS OF CONCEPTION, LAMINARIA, VIA NATURAL OR ARTIFICIAL OPENING
10A00ZZ	ABORTION OF PRODUCTS OF CONCEPTION, OPEN APPROACH
10A03ZZ	ABORTION OF PRODUCTS OF CONCEPTION, PERCUTANEOUS APPROACH
10A04ZZ	ABORTION OF PRODUCTS OF CONCEPTION, PERCUTANEOUS ENDOSCOPIC APPROACH
10A07Z6	ABORTION OF PRODUCTS OF CONCEPTION, VACUUM, VIA OPENING
10A07ZX	ABORTION OF PRODUCTS OF CONCEPTION, ABORTIFACIENT, VIA NATURAL OR ARTIFICIAL OPENING
0NNC0ZZ	RELEASE RIGHT SPHENOID BONE, OPEN APPROACH
0NNC3ZZ	RELEASE RIGHT SPHENOID BONE, PERCUTANEOUS APPROACH
0NNC4ZZ	RELEASE RIGHT SPHENOID BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NND0ZZ	RELEASE LEFT SPHENOID BONE, OPEN APPROACH
0NND3ZZ	RELEASE LEFT SPHENOID BONE, PERCUTANEOUS APPROACH

SECTION 4 PROCEDURE CODES

PROCEDURE CODES REQUIRING SUPPORTING DOCUMENTATION

ICD-10 CODE	DESCRIPTION
0NND4ZZ	RELEASE LEFT SPHENOID BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNF0ZZ	RELEASE RIGHT ETHMOID BONE, OPEN APPROACH
0NNF3ZZ	RELEASE RIGHT ETHMOID BONE, PERCUTANEOUS APPROACH
0NNF4ZZ	RELEASE RIGHT ETHMOID BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNG0ZZ	RELEASE LEFT ETHMOID BONE, OPEN APPROACH
0NNG3ZZ	RELEASE LEFT ETHMOID BONE, PERCUTANEOUS APPROACH
0NNG4ZZ	RELEASE LEFT ETHMOID BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNH0ZZ	RELEASE RIGHT LACRIMAL BONE, OPEN APPROACH
0NNH3ZZ	RELEASE RIGHT LACRIMAL BONE, PERCUTANEOUS APPROACH
0NNH4ZZ	RELEASE RIGHT LACRIMAL BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNJ0ZZ	RELEASE LEFT LACRIMAL BONE, OPEN APPROACH
0NNJ3ZZ	RELEASE LEFT LACRIMAL BONE, PERCUTANEOUS APPROACH
0NNJ4ZZ	RELEASE LEFT LACRIMAL BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNK0ZZ	RELEASE RIGHT PALATINE BONE, OPEN APPROACH
0NNK3ZZ	RELEASE RIGHT PALATINE BONE, PERCUTANEOUS APPROACH
0NNK4ZZ	RELEASE RIGHT PALATINE BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNL0ZZ	RELEASE LEFT PALATINE BONE, OPEN APPROACH
0NNL3ZZ	RELEASE LEFT PALATINE BONE, PERCUTANEOUS APPROACH
0NNL4ZZ	RELEASE LEFT PALATINE BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNM0ZZ	RELEASE RIGHT ZYGOMATIC BONE, OPEN APPROACH
0NNM3ZZ	RELEASE RIGHT ZYGOMATIC BONE, PERCUTANEOUS APPROACH
0NNM4ZZ	RELEASE RIGHT ZYGOMATIC BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNN0ZZ	RELEASE LEFT ZYGOMATIC BONE, OPEN APPROACH
0NNN3ZZ	RELEASE LEFT ZYGOMATIC BONE, PERCUTANEOUS APPROACH
0NNN4ZZ	RELEASE LEFT ZYGOMATIC BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNP0ZZ	RELEASE RIGHT ORBIT, OPEN APPROACH

SECTION 4 PROCEDURE CODES

PROCEDURE CODES REQUIRING SUPPORTING DOCUMENTATION

ICD-10 CODE	DESCRIPTION
0NNP3ZZ	RELEASE RIGHT ORBIT, PERCUTANEOUS APPROACH
0NNP4ZZ	RELEASE RIGHT ORBIT, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNQ0ZZ	RELEASE LEFT ORBIT, OPEN APPROACH
0NNQ3ZZ	RELEASE LEFT ORBIT, PERCUTANEOUS APPROACH
0NNQ4ZZ	RELEASE LEFT ORBIT, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNR0ZZ	RELEASE RIGHT MAXILLA, OPEN APPROACH
0NNR3ZZ	RELEASE RIGHT MAXILLA, PERCUTANEOUS APPROACH
0NNR4ZZ	RELEASE RIGHT MAXILLA, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNS0ZZ	RELEASE LEFT MAXILLA, OPEN APPROACH
0NNS3ZZ	RELEASE LEFT MAXILLA, PERCUTANEOUS APPROACH
0NNS4ZZ	RELEASE LEFT MAXILLA, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNT0ZZ	RELEASE RIGHT MANDIBLE, OPEN APPROACH
0NNT3ZZ	RELEASE RIGHT MANDIBLE, PERCUTANEOUS APPROACH
0NNT4ZZ	RELEASE RIGHT MANDIBLE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNV0ZZ	RELEASE LEFT MANDIBLE, OPEN APPROACH
0NNV3ZZ	RELEASE LEFT MANDIBLE, PERCUTANEOUS APPROACH
0NNV4ZZ	RELEASE LEFT MANDIBLE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NQC0ZZ	REPAIR RIGHT SPHENOID BONE, OPEN APPROACH
0NQC3ZZ	REPAIR RIGHT SPHENOID BONE, PERCUTANEOUS APPROACH
0NQC4ZZ	REPAIR RIGHT SPHENOID BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NQCXZZ	REPAIR RIGHT SPHENOID BONE, EXTERNAL APPROACH
0NQD0ZZ	REPAIR LEFT SPHENOID BONE, OPEN APPROACH
0NQD3ZZ	REPAIR LEFT SPHENOID BONE, PERCUTANEOUS APPROACH
0NQD4ZZ	REPAIR LEFT SPHENOID BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NQDXZZ	REPAIR LEFT SPHENOID BONE, EXTERNAL APPROACH
0NQF0ZZ	REPAIR RIGHT ETHMOID BONE, OPEN APPROACH
0NQF3ZZ	REPAIR RIGHT ETHMOID BONE, PERCUTANEOUS APPROACH
0NQF4ZZ	REPAIR RIGHT ETHMOID BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NQFXZZ	REPAIR RIGHT ETHMOID BONE, EXTERNAL APPROACH
0NQG0ZZ	REPAIR LEFT ETHMOID BONE, OPEN APPROACH

SECTION 4 PROCEDURE CODES

PROCEDURE CODES REQUIRING SUPPORTING DOCUMENTATION

ICD-10 CODE	DESCRIPTION
0NQG3ZZ	REPAIR LEFT ETHMOID BONE, PERCUTANEOUS APPROACH
0NQG4ZZ	REPAIR LEFT ETHMOID BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NQGXZZ	REPAIR LEFT ETHMOID BONE, EXTERNAL APPROACH
0NQH0ZZ	REPAIR RIGHT LACRIMAL BONE, OPEN APPROACH
0NQH3ZZ	REPAIR RIGHT LACRIMAL BONE, PERCUTANEOUS APPROACH
0NQH4ZZ	REPAIR RIGHT LACRIMAL BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NQHXZZ	REPAIR RIGHT LACRIMAL BONE, EXTERNAL APPROACH
0NQJ0ZZ	REPAIR LEFT LACRIMAL BONE, OPEN APPROACH
0NQJ3ZZ	REPAIR LEFT LACRIMAL BONE, PERCUTANEOUS APPROACH
0NQJ4ZZ	REPAIR LEFT LACRIMAL BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NQJXZZ	REPAIR LEFT LACRIMAL BONE, EXTERNAL APPROACH
0NQK0ZZ	REPAIR RIGHT PALATINE BONE, OPEN APPROACH
0NQK3ZZ	REPAIR RIGHT PALATINE BONE, PERCUTANEOUS APPROACH
0NQK4ZZ	REPAIR RIGHT PALATINE BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NQKXZZ	REPAIR RIGHT PALATINE BONE, EXTERNAL APPROACH
0NQL0ZZ	REPAIR LEFT PALATINE BONE, OPEN APPROACH
0NQL3ZZ	REPAIR LEFT PALATINE BONE, PERCUTANEOUS APPROACH
0NQL4ZZ	REPAIR LEFT PALATINE BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NQLXZZ	REPAIR LEFT PALATINE BONE, EXTERNAL APPROACH
0NQM0ZZ	REPAIR RIGHT ZYGOMATIC BONE, OPEN APPROACH
0NQM3ZZ	REPAIR RIGHT ZYGOMATIC BONE, PERCUTANEOUS APPROACH
0NQM4ZZ	REPAIR RIGHT ZYGOMATIC BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NQMXZZ	REPAIR RIGHT ZYGOMATIC BONE, EXTERNAL APPROACH
0NQN0ZZ	REPAIR LEFT ZYGOMATIC BONE, OPEN APPROACH
0NQN3ZZ	REPAIR LEFT ZYGOMATIC BONE, PERCUTANEOUS APPROACH
0NQN4ZZ	REPAIR LEFT ZYGOMATIC BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NQNXZZ	REPAIR LEFT ZYGOMATIC BONE, EXTERNAL APPROACH

SECTION 4 PROCEDURE CODES

PROCEDURE CODES REQUIRING SUPPORTING DOCUMENTATION

ICD-10 CODE	DESCRIPTION
0NQX0ZZ	REPAIR HYOID BONE, OPEN APPROACH
0NQX3ZZ	REPAIR HYOID BONE, PERCUTANEOUS APPROACH
0NQX4ZZ	REPAIR HYOID BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NQXXZZ	REPAIR HYOID BONE, EXTERNAL APPROACH
0NRR07Z	REPLACEMENT OF RIGHT MAXILLA WITH AUTOLOGOUS TISSUE SUBSTITUTE, OPEN APPROACH
0NRR0JZ	REPLACEMENT OF RIGHT MAXILLA WITH SYNTHETIC SUBSTITUTE, OPEN APPROACH
0NRR0KZ	REPLACEMENT OF RIGHT MAXILLA WITH NONAUTOLOGOUS TISSUE SUBSTITUTE, OPEN APPROACH
0NRR37Z	REPLACEMENT OF RIGHT MAXILLA WITH AUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS APPROACH
0NRR3JZ	REPLACEMENT OF RIGHT MAXILLA WITH SYNTHETIC SUBSTITUTE, PERCUTANEOUS APPROACH
0NRR3KZ	REPLACEMENT OF RIGHT MAXILLA WITH NONAUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS APPROACH
0NRR47Z	REPLACEMENT OF RIGHT MAXILLA WITH AUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NRR4JZ	REPLACEMENT OF RIGHT MAXILLA WITH SYNTHETIC SUBSTITUTE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NRR4KZ	REPLACEMENT OF RIGHT MAXILLA WITH NONAUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NRS07Z	REPLACEMENT OF LEFT MAXILLA WITH AUTOLOGOUS TISSUE SUBSTITUTE, OPEN APPROACH
0NRS0JZ	REPLACEMENT OF LEFT MAXILLA WITH SYNTHETIC SUBSTITUTE, OPEN APPROACH
0NRS0KZ	REPLACEMENT OF LEFT MAXILLA WITH NONAUTOLOGOUS TISSUE SUBSTITUTE, OPEN APPROACH
0NRS37Z	REPLACEMENT OF LEFT MAXILLA WITH AUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS APPROACH
0NRS3JZ	REPLACEMENT OF LEFT MAXILLA WITH SYNTHETIC SUBSTITUTE, PERCUTANEOUS APPROACH
0NRS3KZ	REPLACEMENT OF LEFT MAXILLA WITH NONAUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS APPROACH
0NRS47Z	REPLACEMENT OF LEFT MAXILLA WITH AUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NRS4JZ	REPLACEMENT OF LEFT MAXILLA WITH SYNTHETIC SUBSTITUTE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NRS4KZ	REPLACEMENT OF LEFT MAXILLA WITH NONAUTOLOGOUS TISSUE

SECTION 4 PROCEDURE CODES

PROCEDURE CODES REQUIRING SUPPORTING DOCUMENTATION

ICD-10 CODE	DESCRIPTION
	SUBSTITUTE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NUR07Z	SUPPLEMENT RIGHT MAXILLA WITH AUTOLOGOUS TISSUE SUBSTITUTE, OPEN APPROACH
0NUR0JZ	SUPPLEMENT RIGHT MAXILLA WITH SYNTHETIC SUBSTITUTE, OPEN APPROACH
0NUR0KZ	SUPPLEMENT RIGHT MAXILLA WITH NONAUTOLOGOUS TISSUE SUBSTITUTE, OPEN APPROACH
0NUR37Z	SUPPLEMENT RIGHT MAXILLA WITH AUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS APPROACH
0NUR3JZ	SUPPLEMENT RIGHT MAXILLA WITH SYNTHETIC SUBSTITUTE, PERCUTANEOUS APPROACH
0NUR3KZ	SUPPLEMENT RIGHT MAXILLA WITH NONAUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS APPROACH
0NUR47Z	SUPPLEMENT RIGHT MAXILLA WITH AUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NUR4JZ	SUPPLEMENT RIGHT MAXILLA WITH SYNTHETIC SUBSTITUTE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NUR4KZ	SUPPLEMENT RIGHT MAXILLA WITH NONAUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NUS07Z	SUPPLEMENT LEFT MAXILLA WITH AUTOLOGOUS TISSUE SUBSTITUTE, OPEN APPROACH
0NUS0JZ	SUPPLEMENT LEFT MAXILLA WITH SYNTHETIC SUBSTITUTE, OPEN APPROACH
0NUS0KZ	SUPPLEMENT LEFT MAXILLA WITH NONAUTOLOGOUS TISSUE SUBSTITUTE, OPEN APPROACH
0NUS37Z	SUPPLEMENT LEFT MAXILLA WITH AUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS APPROACH
0NUS3JZ	SUPPLEMENT LEFT MAXILLA WITH SYNTHETIC SUBSTITUTE, PERCUTANEOUS APPROACH
0NUS3KZ	SUPPLEMENT LEFT MAXILLA WITH NONAUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS APPROACH
0NUS47Z	SUPPLEMENT LEFT MAXILLA WITH AUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NUS4JZ	SUPPLEMENT LEFT MAXILLA WITH SYNTHETIC SUBSTITUTE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NUS4KZ	SUPPLEMENT LEFT MAXILLA WITH NONAUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS ENDOSCOPIC APPROACH
0RNC0ZZ	RELEASE RIGHT TEMPOROMANDIBULAR JOINT, OPEN APPROACH
0RNC3ZZ	RELEASE RIGHT TEMPOROMANDIBULAR JOINT, PERCUTANEOUS APPROACH

SECTION 4 PROCEDURE CODES

PROCEDURE CODES REQUIRING SUPPORTING DOCUMENTATION

ICD-10 CODE	DESCRIPTION
0RNC4ZZ	RELEASE RIGHT TEMPOROMANDIBULAR JOINT, PERCUTANEOUS ENDOSCOPIC APPROACH
0RND0ZZ	RELEASE LEFT TEMPOROMANDIBULAR JOINT, OPEN APPROACH
0RND3ZZ	RELEASE LEFT TEMPOROMANDIBULAR JOINT, PERCUTANEOUS APPROACH
0RND4ZZ	RELEASE LEFT TEMPOROMANDIBULAR JOINT, PERCUTANEOUS ENDOSCOPIC APPROACH

SECTION 4 PROCEDURE CODES

PROCEDURE CODES REQUIRING SUPPORTING DOCUMENTATION

CPT CODES REQUIRING SUPPORTING DOCUMENTATION FOR KEPRO

The codes listed below must be reviewed by KEPRO. Please attach all supporting documentation to your claim when submitting.

CODE	CODE	CODE
36593	58661	59841
55200	58670	59850
55250	58671	59851
58600	58673	59852
58605	58700	59855
58611	58720	59856
58615	59135	59857
58660	59840	67912

SECTION 4 PROCEDURE CODES

PROCEDURE CODES REQUIRING SUPPORTING DOCUMENTATION

CPT CODES REQUIRING SUPPORTING DOCUMENTATION FOR SCDHHS

The codes listed below must be reviewed by the SCDHHS. Please attach all supporting documentation to your claim when submitting.

CODE	CODE	CODE	CODE	CODE	CODE
15999	21295	39499	53899	76499	92499
17999	21296	40799	54699	76999	93799
19499	21499	40899	55899	77299	94799
20999	22999	41599	58340	77499	95199
21159	23929	41899	58578	77799	95999
21172	24999	42299	58579	78099	96549
21175	25999	42699	58679	78199	96999
21180	26989	42999	58999	78299	97139
21188	27299	43289	59200	78399	97799
21206	27599	43499	59899	78499	99082
21208	27899	43999	60659	78599	99199
21209	28899	44799	60699	78699	99499
21210	29799	44899	64590	78799	A9604
21215	29999	44979	64999	78999	J0598
21235	30999	45499	66999	79999	J1680
21243	31299	45999	67299	81099	J2185
21246	31599	46999	67399	84999	J2796
21249	31899	47399	67599	85999	J3490
21256	32999	47579	67999	86999	J9999
21260	33999	47999	68399	87999	Q4101
21261	36299	48999	68899	88199	Q4104
21263	36592	49329	69399	88299	Q4105
21267	36593	49659	69799	88399	V2599
21270	37799	49999	69949	90899	
21275	38589	50549	69979	90999	
21282	38999	51999	74740	91299	

SECTION 4 PROCEDURE CODES

PROCEDURE CODES REQUIRING PRIOR AUTHORIZATION

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SECTION 4 PROCEDURE CODES

PROCEDURE CODES REQUIRING PRIOR AUTHORIZATION BY ICORE

Effective with date of service September 9, 2013, J-code drug prior authorization requests for beneficiaries enrolled in FFS Medicaid or the Medicaid Medical Home Network - Medically Complex Children's Waiver (MCCW) will be processed by ICORE. Prior authorization requests may be submitted online at www.icorehealthcare.com, or by telephone at 1-800-424-8219, Monday through Friday, 8:00 a.m. to 5:00 p.m. Detailed information about the J-code drug prior authorization process can be found in the Medicaid bulletin dated August 8, 2013.

Prior authorization is required for the following CPT codes:

J-CODES REQUIRING PRIOR AUTHORIZATION

J-CODE	DRUG NAME	CATEGORY
J2505	NEULASTA	NEUTROPENIA
J9035	AVASTIN	ONCOLOGY
J1745	REMICADE	INFLAMMATORY CONDITIONS
J9263	ELOXATIN	ONCOLOGY
J9305	ALIMTA	ONCOLOGY
J9055	ERBITUX	ONCOLOGY
J9312	RITUXIMAB	INFLAMMATORY CONDITIONS
J2323	TYSABRI	MULTIPLE SCLEROSIS
J2469	ALOXI	ANTI-EMETICS
J9264	ABRAXANE	ONCOLOGY
J0881	ARANESP	ANEMIA
J0885	PROCRIT	ANEMIA
J0129	ORENCIA	INFLAMMATORY CONDITIONS
J1442	NEUPOGEN	NEUTROPENIA

SECTION 4 PROCEDURE CODES

PROCEDURE CODES REQUIRING PRIOR AUTHORIZATION BY ICORE

J-CODES REQUIRING PRIOR AUTHORIZATION

J-CODE	DRUG NAME	CATEGORY
J9303	VECTIBIX	ONCOLOGY
J9228	YERVOY	ONCOLOGY
J9179	HALAVAN	ONCOLOGY
J2507	KRYSTEXXA	INFLAMMATORY CONDITIONS
J9354	KADCYLA	ONCOLOGY
Q2043	PROVENGE	ONCOLOGY
J3262	ACTEMRA	INFLAMMATORY CONDITIONS
J0800	ACTHAR_HP	ENDOCRINE DISORDERS
J0717	CIMZIA	INFLAMMATORY CONDITIONS
J3380	ENTYVIO	INFLAMMATORY CONDITIONS
J9355	HERCEPTIN	ONCOLOGY
J9306	PERJETA	ONCOLOGY
J1602	SIMPONI_ARIA	INFLAMMATORY CONDITIONS
J1300	SOLIRIS	HEMATOLOGICAL CONDITIONS
J3357	STELARA	PSORIASIS
J3358	STELARA	INFLAMMATORY CONDITIONS
Q5101	ZARXIO	ONCOLOGY
J9271	KEYTRUDA	ONCOLOGY
J9299	OPDIVO	ONCOLOGY
J0585	BOTOX	BOTOX
J0586	DYSPORT	BOTOX
J0587	MYOBLOC	BOTOX
J0588	XEOMIN	BOTOX

SECTION 4 PROCEDURE CODES

PROCEDURE CODES REQUIRING PRIOR AUTHORIZATION BY KEPRO

ICD-10-PCS SURGICAL CODES AND CPT CODES REQUIRING PRIOR AUTHORIZATION BY KEPRO

ICD-10-PCS and CPT codes that require prior authorization by KEPRO are located on the SCDHHS website on the Physicians Services Provider Manual webpage.

CPT CODES REQUIRING PRIOR AUTHORIZATION REVIEW

KEPRO will preauthorize all CPT codes listed below and may be reached at 1-855-326-5219.

CODE	CODE	CODE	CODE
15823	19342	22552	22808
15830	19350	22554	22810
15847	19355	22556	22812
19300	19357	22558	22830
19301	19361	22585	22840
19302	19364	22590	22841
19303	19366	22595	22842
19304	19367	22600	22843
19305	19368	22610	22844
19306	19369	22612	22845
19307	19370	22614	22846
19316	19371	22630	22847
19318	19380	22632	22848
19328	21899	22800	22849
19330	22548	22802	22853
19340	22551	22804	22854

SECTION 4 PROCEDURE CODES

PROCEDURE CODES REQUIRING PRIOR AUTHORIZATION BY KEPRO

CODE	CODE	CODE	CODE
22859	58262	59525	63077
22899	58263	61885	63078
37788	58267	61886	63081
43644	58270	63001	63082
43645	58275	63003	63085
43770	58280	63005	63086
43771	58285	63011	63087
43773	58290	63012	63088
43842	58291	63015	63090
43846	58292	63016	63091
43847	58293	63017	63170
43848	58294	63020	63172
43886	58541	63030	63173
43887	58542	63035	63180
43888	58543	63040	63182
51925	58544	63042	63185
54235	58548	63043	63190
54400	58550	63044	63191
54401	58552	63045	63194
54405	58553	63046	63195
54690	58554	63047	63196
57291	58570	63048	63197
57292	58571	63050	63198
57295	58572	63051	63199
58150	58573	63055	63200
58152	58575	63056	63650
58180	58952	63057	63655
58200	58953	63064	63661
58210	58954	63066	63662
58240	58956	63075	63663
58260	58957	63076	63664

SECTION 4 PROCEDURE CODES

PROCEDURE CODES REQUIRING PRIOR AUTHORIZATION BY KEPRO

CODE	CODE	CODE	CODE
63685	69300	69714	69718
63688	69710	69715	69930

CPT CODES (PT, OT, ST) REQUIRING PRIOR AUTHORIZATION REVIEW

KEPRO will preauthorize physical, occupational or speech therapy (PT, OT, ST), CPT codes listed below and may be reached at 1-855-326-5219.

CODE	DESCRIPTION
92507	TREATMENT OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AND/OR HEARING PROCESSING DISORDER
92508	GROUP TREATMENT OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AND/OR HEARING PROCESSING DISORDER
92607	EVALUATION FOR PRESCRIPTION FOR SPEECH-GENERATING AUGMENTATIVE AND ALTERNATIVE COMMUNICATION DEVICE, FACE-TO-FACE WITH THE PATIENT; FIRST HOUR
92608	EVALUATION FOR PRESCRIPTION FOR SPEECH-GENERATING AUGMENTATIVE AND ALTERNATIVE COMMUNICATION DEVICE, FACE-TO-FACE WITH THE PATIENT; EACH ADDITIONAL 30 MINUTES
92609	THERAPEUTIC SERVICES FOR THE USE OF SPEECH-GENERATING DEVICE, INCLUDING PROGRAMMING AND MODIFICATION
92610	EVALUATION OF ORAL AND PHARYNGEAL SWALLOWING FUNCTION
97012	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; TRACTION, MECHANICAL
97016	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; VASOPNEUMATIC DEVICES
97018	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; PARAFFIN BATH
97022	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; WHIRLPOOL
97024	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; DIATHERMY (E.G., MICROWAVE)
97026	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; INFRARED
97028	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; ULTRAVIOLET
97032	APPLICATION OF ELECTRICAL STIMULATION TO 1 OR MORE AREAS, EACH 15 MINUTES

SECTION 4 PROCEDURE CODES

PROCEDURE CODES REQUIRING PRIOR AUTHORIZATION BY KEPRO

CODE	DESCRIPTION
97033	APPLICATION OF MEDICATION THROUGH SKIN USING ELECTRICAL CURRENT, EACH 15 MINUTES
97034	THERAPEUTIC HOT AND COLD BATHS TO 1 OR MORE AREAS, EACH 15 MINUTES
97035	APPLICATION OF ULTRASOUND TO 1 OR MORE AREAS, EACH 15 MINUTES
97036	PHYSICAL THERAPY TREATMENT TO 1 OR MORE AREAS, HUBBARD TANK, EACH 15 MINUTES
97110	THERAPEUTIC EXERCISE TO DEVELOP STRENGTH, ENDURANCE, RANGE OF MOTION, AND FLEXIBILITY, EACH 15 MINUTES
97112	THERAPEUTIC PROCEDURE TO RE-EDUCATE BRAIN-TO-NERVE-TO-MUSCLE FUNCTION, EACH 15 MINUTES
97113	WATER POOL THERAPY WITH THERAPEUTIC EXERCISES TO 1 OR MORE AREAS, EACH 15 MINUTES
97116	WALKING TRAINING TO 1 OR MORE AREAS, EACH 15 MINUTES
97124	THERAPEUTIC MASSAGE TO 1 OR MORE AREAS, EACH 15 MINUTES
97127	ONE-ON-ONE THERAPEUTIC INTERVENTIONS FOCUSED ON THOUGHT PROCESSING AND STRATEGIES TO MANAGE ACTIVITIES
97140	MANUAL (PHYSICAL) THERAPY TECHNIQUES TO 1 OR MORE REGIONS, EACH 15 MINUTES
97150	THERAPEUTIC PROCEDURE(S), GROUP (2 OR MORE INDIVIDUALS)
97161	EVALUATION OF PHYSICAL THERAPY, TYPICALLY 20 MINUTES
97162	EVALUATION OF PHYSICAL THERAPY, TYPICALLY 30 MINUTES
97163	EVALUATION OF PHYSICAL THERAPY, TYPICALLY 45 MINUTES
97164	RE-EVALUATION OF PHYSICAL THERAPY, TYPICALLY 20 MINUTES
97165	EVALUATION OF OCCUPATIONAL THERAPY, TYPICALLY 30 MINUTES
97166	EVALUATION OF OCCUPATIONAL THERAPY, TYPICALLY 45 MINUTES
97167	EVALUATION OF OCCUPATIONAL THERAPY ESTABLISHED PLAN OF CARE, TYPICALLY 60 MINUTES
97168	RE-EVALUATION OF OCCUPATIONAL THERAPY ESTABLISHED PLAN OF CARE, TYPICALLY 30 MINUTES
97530	THERAPEUTIC ACTIVITIES TO IMPROVE FUNCTION, WITH ONE-ON-ONE CONTACT BETWEEN PATIENT AND PROVIDER, EACH 15 MINUTES

SECTION 4 PROCEDURE CODES

PROCEDURE CODES REQUIRING PRIOR AUTHORIZATION BY KEPRO

CODE	DESCRIPTION
97533	SENSORY TECHNIQUE TO ENHANCE PROCESSING AND ADAPTATION TO ENVIRONMENTAL DEMANDS, EACH 15 MINUTES
97535	SELF-CARE OR HOME MANAGEMENT TRAINING, EACH 15 MINUTES
97537	COMMUNITY OR WORK REINTEGRATION TRAINING, EACH 15 MINUTES
97542	WHEELCHAIR MANAGEMENT, EACH 15 MINUTES
97597	DEBRIDEMENT (EG, HIGH PRESSURE WATERJET WITH/WITHOUT SUCTION, SHARP SELECTIVE DEBRIDEMENT WITH SCISSORS, SCALPEL AND FORCEPS), OPEN WOUND, (EG, FIBRIN, DEVITALIZED EPIDERMIS AND/OR DERMIS, EXUDATE, DEBRIS, BIOFILM), INCLUDING TOPICAL APPLICATION(S), WOUND ASSESSMENT, USE OF A WHIRLPOOL, WHEN PERFORMED AND INSTRUCTION(S) FOR ONGOING CARE, PER SESSION, TOTAL WOUND(S) SURFACE AREA; FIRST 20 SQ CM OR LESS
97598	DEBRIDEMENT (EG, HIGH PRESSURE WATERJET WITH/WITHOUT SUCTION, SHARP SELECTIVE DEBRIDEMENT WITH SCISSORS, SCALPEL AND FORCEPS), OPEN WOUND, (EG, FIBRIN, DEVITALIZED EPIDERMIS AND/OR DERMIS, EXUDATE, DEBRIS BIOFILM), INCLUDING TOPICAL APPLICATION(S), WOUND ASSESSMENT, USE OF A WHIRLPOOL, WHEN PERFORMED AND INSTRUCTION(S) FOR ONGOING CARE, PER SESSION, TOTAL WOUND(S) SURFACE AREA; EACH ADDITIONAL 20 SQ CM, OR PART THEREOF
97605	NEGATIVE PRESSURE WOUND THERAPY, SURFACE AREA LESS THAN OR EQUAL TO 50 SQUARE CENTIMETERS, PER SESSION
97606	NEGATIVE PRESSURE WOUND THERAPY, SURFACE AREA GREATER THAN 50 SQUARE CENTIMETERS, PER SESSION
97750	PHYSICAL PERFORMANCE TEST OR MEASUREMENT WITH REPORT, EACH 15 MINUTES
97755	ASSISTIVE TECHNOLOGY ASSESSMENT TO ENHANCE FUNCTIONAL PERFORMANCE, EACH 15 MINUTES
97760	TRAINING IN USE OF ORTHOTICS (SUPPORTS, BRACES, OR SPLINTS) FOR ARMS, LEGS AND/OR TRUNK, PER 15 MINUTES
97761	TRAINING IN USE OF PROSTHESIS FOR ARMS AND/OR LEGS, PER 15 MINUTES
97763	MANAGEMENT AND/OR TRAINING IN USE OF ORTHOTICS (SUPPORTS, BRACES, OR SPLINTS) FOR ARMS, LEGS, AND/OR TRUNK, PER 15 MINUTES

SECTION 4 PROCEDURE CODES

PROCEDURE CODES REQUIRING PRIOR AUTHORIZATION BY KEPRO

TRANSPLANT CODES REQUIRING PRIOR AUTHORIZATION BY KEPRO

The following transplant procedure codes require prior authorization from KEPRO. Providers should contact KEPRO at 1-855-326-5219.

CODE	CODE
32851	44715
32852	44720
32853	44721
32854	47125
32855	47130
32856	47133
33927	47135
33928	47143
33929	47144
33933	47145
33935	47146
33944	47147
33945	48160
33975	48550
33976	48551
33977	48552
33978	48554
33979	48556

SECTION 4 PROCEDURE CODES

PROCEDURE CODES FOR FAMILY PLANNING

FAMILY PLANNING ICD-10-CM DIAGNOSIS CODES

October 2016 Update

For dates of service on or after **October 1, 2016**, please use the following ICD-10-CM diagnosis codes. For dates of service prior to October 1, 2016, refer to the October 2015 Update included in this section.

ICD-10 CODE	DESCRIPTION
Z30.011	ENCOUNTER FOR INITIAL PRESCRIPTION OF CONTRACEPTIVE PILLS
Z30.013	ENCOUNTER FOR INITIAL PRESCRIPTION OF INJECTABLE CONTRACEPTIVE
Z30.014	ENCOUNTER FOR INITIAL PRESCRIPTION OF INTRAUTERINE CONTRACEPTIVE DEVICE
Z30.015	ENCOUNTER FOR INITIAL PRESCRIPTION OF VAGINAL RING HORMONAL CONTRACEPTIVE
Z30.016	ENCOUNTER FOR INITIAL PRESCRIPTION OF TRANSDERMAL PATCH HORMONAL CONTRACEPTIVE DEVICE
Z30.017	ENCOUNTER FOR INITIAL PRESCRIPTION OF IMPLANTABLE SUBDERMAL CONTRACEPTIVE
Z30.018	ENCOUNTER FOR INITIAL PRESCRIPTION OF OTHER CONTRACEPTIVES
Z30.019	ENCOUNTER FOR INITIAL PRESCRIPTION OF CONTRACEPTIVES, UNSPECIFIED
Z30.09	ENCOUNTER FOR OTHER GENERAL COUNSELING AND ADVICE ON CONTRACEPTION
Z30.2	ENCOUNTER FOR STERILIZATION
Z30.430	ENCOUNTER FOR INSERTION OF INTRAUTERINE CONTRACEPTIVE DEVICE
Z30.432	ENCOUNTER FOR REMOVAL OF INTRAUTERINE CONTRACEPTIVE DEVICE

SECTION 4 PROCEDURE CODES

PROCEDURE CODES FOR FAMILY PLANNING

ICD-10 CODE	DESCRIPTION
Z30.433	ENCOUNTER FOR REMOVAL AND REINSERTION OF INTRAUTERINE CONTRACEPTIVE DEVICE
Z30.40	ENCOUNTER FOR SURVEILLANCE OF CONTRACEPTIVES, UNSPECIFIED
Z30.41	ENCOUNTER FOR SURVEILLANCE OF CONTRACEPTIVE PILLS
Z30.431	ENCOUNTER FOR ROUTINE CHECKING OF INTRAUTERINE CONTRACEPTIVE DEVICE
Z30.49	ENCOUNTER FOR SURVEILLANCE OF OTHER CONTRACEPTIVES
Z30.42	ENCOUNTER FOR SURVEILLANCE OF INJECTABLE CONTRACEPTIVE
Z30.44	ENCOUNTER FOR SURVEILLANCE OF VAGINAL RING HORMONAL CONTRACEPTIVE DEVICE
Z30.45	ENCOUNTER FOR SURVEILLANCE OF TRANSDERMAL PATCH HORMONAL CONTRACEPTIVE DEVICE
Z30.46	ENCOUNTER FOR SURVEILLANCE OF IMPLANTABLE SUBDERMAL CONTRACEPTIVE
Z30.8	ENCOUNTER FOR OTHER CONTRACEPTIVE MANAGEMENT
Z30.9	ENCOUNTER FOR CONTRACEPTIVE MANAGEMENT, UNSPECIFIED
Z00.00	ENCOUNTER FOR GENERAL ADULT MEDICAL EXAMINATION WITHOUT ABNORMAL FINDINGS
Z00.01	ENCOUNTER FOR GENERAL ADULT MEDICAL EXAMINATION WITH ABNORMAL FINDINGS

October 2015 Update

For dates of service on or after **October 1, 2015**, please use the following ICD-10-CM diagnosis codes. For dates of service on or after October 1, 2016, refer to the October 2016 Update included in this section.

ICD-10 CODE	DESCRIPTION
Z30.011	ENCOUNTER FOR INITIAL PRESCRIPTION OF CONTRACEPTIVE PILLS
Z30.013	ENCOUNTER FOR INITIAL PRESCRIPTION OF INJECTABLE CONTRACEPTIVE

SECTION 4 PROCEDURE CODES

PROCEDURE CODES FOR FAMILY PLANNING

ICD-10 CODE	DESCRIPTION
Z30.014	ENCOUNTER FOR INITIAL PRESCRIPTION OF INTRAUTERINE CONTRACEPTIVE DEVICE
Z30.018	ENCOUNTER FOR INITIAL PRESCRIPTION OF OTHER CONTRACEPTIVES
Z30.019	ENCOUNTER FOR INITIAL PRESCRIPTION OF CONTRACEPTIVES, UNSPECIFIED
Z30.09	ENCOUNTER FOR OTH GENERAL CNSL AND ADVICE ON CONTRACEPTION
Z30.2	ENCOUNTER FOR STERILIZATION
Z30.430	ENCOUNTER FOR INSERTION OF INTRAUTERINE CONTRACEPTIVE DEVICE
Z30.432	ENCOUNTER FOR REMOVAL OF INTRAUTERINE CONTRACEPTIVE DEVICE
Z30.433	ENCOUNTER FOR REMOVAL AND REINSERTION OF INTRAUTERINE CONTRACEPTIVE DEVICE
Z30.40	ENCOUNTER FOR SURVEILLANCE OF CONTRACEPTIVES, UNSPECIFIED
Z30.41	ENCOUNTER FOR SURVEILLANCE OF CONTRACEPTIVE PILLS
Z30.431	ENCOUNTER FOR ROUTINE CHECKING OF INTRAUTERINE CONTRACEPTIVE DEVICE
Z30.49	ENCOUNTER FOR SURVEILLANCE OF OTHER CONTRACEPTIVES
Z30.42	ENCOUNTER FOR SURVEILLANCE OF INJECTABLE CONTRACEPTIVE
Z30.8	ENCOUNTER FOR OTHER CONTRACEPTIVE MANAGEMENT
Z30.9	ENCOUNTER FOR CONTRACEPTIVE MANAGEMENT, UNSPECIFIED
Z00.00	ENCOUNTER FOR GENERAL ADULT MEDICAL EXAMINATION WITHOUT ABNORMAL FINDINGS
Z00.01	ENCOUNTER FOR GENERAL ADULT MEDICAL EXAMINATION WITH ABNORMAL FINDINGS

SECTION 4 PROCEDURE CODES

PROCEDURE CODES FOR FAMILY PLANNING

CPT/HCPCS SERVICES

FAMILY PLANNING CPT / HCPCS SERVICES

CPT/ HCPCS CODE	DESCRIPTION	REQUIRES FP	FAMILY PLANNING CODES THAT ARE NOT TO BE CODED WITH FP MODIFIER	COMMENTS
00851	ANESTHESIA FOR INTRAPERITONEAL PROCEDURES IN LOWER ABDOMEN INCLUDING LAPAROSCOPY; TUBAL LIGATION/TRANSECTION			MAY ONLY BE BILLED WITH STERILIZATION PROCEDURE
00952	ANESTHESIA FOR VAGINAL PROCEDURES (INCLUDING BIOPSY OF LABIA, VAGINA, CERVIX, OR ENDOMETRIUM); HYSTEROSCOPY AND/OR HYSTEROSALPINGOGRAPHY			MAY ONLY BE BILLED WITH STERILIZATION PROCEDURE
11976	REMOVAL, IMPLANTABLE CONTRACEPTIVE CAPSULES	X		
11981	INSERTION, NON-BIODEGRADABLE DRUG DELIVERY IMPLANT	X		MAY BE BILLED WITH IMPLANON
11982	REMOVAL, NON BIODEGRADABLE DRUG DELIVERY	X		MAY BE BILLED WITH IMPLANON
11983	REMOVAL, WITH REINSERTION, NON-BIODEGRADABLE DRUG DELIVERY IMPLANT	X		MAY BE BILLED WITH IMPLANON
36415	COLLECTION OF VENOUS BLOOD BY VENIPUNCTURE	X		
45331	SIGMOIDOSCOPY, FLEX; W/BIOP, SINGLE/MULTI	X		
45378	COLONOSCOPY, FLEXIBLE, DIAGNOSTIC, WITH/ WITHOUT SPECIMEN			
55250	VASECTOMY, UNILATERAL OR BILATERAL (SEPARATE PROCEDURE), INCLUDING POSTOPERATIVE SEMEN EXAMINATION(S)			
57170	DIAPHRAGM OR CERVICAL CAP FITTING W/INSTRUCTIONS	X		
58300	INSERTION OF INTRAUTERINE DEVICE	X		

SECTION 4 PROCEDURE CODES

PROCEDURE CODES FOR FAMILY PLANNING

FAMILY PLANNING CPT / HCPCS SERVICES

CPT/ HCPCS CODE	DESCRIPTION	REQUIRES FP	FAMILY PLANNING CODES THAT ARE NOT TO BE CODED WITH FP MODIFIER	COMMENTS
58301	REMOVAL OF INTRAUTERINE DEVICE	X		
58340	CATHETERIZATION AND INDUCTION OF SALINE OR CONTRAST MATERIAL FOR SALINE INFUSION SONOHYSTEROGRAPHY OR HYSTEROSALPINGOGRAPHY	X		MAY ONLY BE BILLED WITH ESSURE PROCEDURE
58565	CATHETERIZATION AND INDUCTION OF SALINE OR CONTRAST MATERIAL FOR SALINE INFUSION SONOHYSTEROGRAPHY OR HYSTEROSALPINGOGRAPHY	X		REQUIRES COMPLETED STERILIZATION FORM PRIOR TO PROCEDURE
58600	HYSTEROSCOPY, SURGICAL; WITH BILATERAL FALLOPIAN TUBE CANNULATION TO INDUCE OCCLUSION BY PLACEMENT OF PERMANENT IMPLANTS	X		REQUIRES COMPLETED STERILIZATION FORM PRIOR TO PROCEDURE
58615	LIGATION OR TRANSACTION OF FALLOPIAN TUBE(S), AND OR VAGINAL UNILATERAL OR BILATERAL	X		REQUIRES COMPLETED STERILIZATION FORM PRIOR TO PROCEDURE
58670	OCCLUSION OF FALLOPIAN TUBE(S) BY DEVICE (E.G., BAND, CLIP VAGINAL OR SUPRAPUBIC APPROACH	X		REQUIRES COMPLETED STERILIZATION FORM PRIOR TO PROCEDURE
58671	LAPAROSCOPY, SURGICAL; WITH FULGURATION OF OVIDUCTS (WITH OR WITHOUT TRANSECTION)	X		REQUIRES COMPLETED STERILIZATION FORM PRIOR TO PROCEDURE
71045	X-RAY OF CHEST, 1 VIEW	X		
71250	COMPUTER TOMOGRAPHY THORAX W/O CONTRAST	X		
74740	HYSTEROSALPINGOGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION	X		MAY ONLY BE BILLED AFTER ESSURE PROCEDURE
76706	ULTRASOUND, ABDOMINAL AORTA, REAL TIME WITH IMAGE DOCUMENTATION, SCREENING STUDY FOR ABDOMINAL AORTIC ANEURYSM (AAA)		X	
76830	ULTRASOUND, TRANSVAGINAL	X		

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76856	ULTRASOUND, PELVIC (NONOBSTETRIC), REAL TIME WITH IMAGE DOCUMENTATION; COMPLETE	X		
76857	LIMITED OR FOLLOW-UP (E.G., FOR FOLLICLES)	X		
77065	DX MAMMO INCL CAD UNI	X		
77066	DX MAMMO INCL CAD BI	X		
77067	SCR MAMMO BI INCL CAD	X		
80048	BLOOD TEST, BASIC GROUP OF BLOOD CHEMICALS	X		MAY BE BILLED WITH STERILIZATION PROCEDURE ONLY
80061	LIPID PANEL	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
81000	URINALYSIS, BY DIP STICK OR TABLET REAGENT FOR BILIRUBIN, GLUCOSE, HEMOGLOBIN, KETONES, LEUKOCYTES, NITRITE, PH, PROTEIN, SPECIFIC GRAVITY, UROBILINOGEN, ANY NUMBER OF THESE CONSTITUENTS; NON-AUTOMATED, WITH MICROSCOPY	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
81001	AUTOMATED, WITH MICROSCOPY	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
81002	URINALYSIS, MANUAL TEST	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
81003	AUTOMATED, WITH MICROSCOPY	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
81005	URINALYSIS; QUALITATIVE OR SEMIQUANTITATIVE, EXCEPT IMMUNOASSAY KIT	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
81007	BACTERIURIA SCREEN, BY NON-CULTURE TECHNIQUE, COMMERCIAL KIT	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY

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81015	MICROSCOPIC ONLY	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
81020	URINALYSIS, 2 OR 3 GLASS TEST	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
81025	URINE PREGNANCY TES, BY VISUAL COLOR COMPARISON METHODS	X		
82270	BLOOD, OCULT/PEROXIDAS ACTIVTY, QUAL; FECES	X		
82274	BLOOD OCCULT, FECAL HEMOG; 1-3 DETERMIN	X		
82465	CHOLESTEROL SERUM OR WHOLE BLOOD, TOTAL	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
82947	GLUCOSE;QUANTITA BLOOD EXCP REAGNT STRIP	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
82950	GLUCOSE POST GLUCOSE DOSE (INC GLUCOSE)	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
82951	GLUCOSE TOLERANCE TEST(GTT)3SPEC(INC GL)	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
83036	HEMOGLOBIN; GLYCOSYLATED (A1C)	X		
83718	LIPOPRO, DIR MSRMNT; HGH DNSTY CHLSTR(HDL)	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
84702	GONADOTROPIN, CHORIONIC (REPRODUCTIVE HORMONE) LEVEL	X		
84703	QUALITATIVE	X		
85007	BLOOD COUNT; BLOOD SMEAR, MICROSCOPIC EXAMINATION WITH MANUAL DIFFERENTIAL WBC COUNT	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY

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85008	BLOOD SMEAR, MICROSCOPIC EXAMINATION WITHOUT DIFFERENTIAL WBC COUNT	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
85009	MANUAL DIFFERENTIAL WBC COUNT, BUFFY COAT	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
85013	SPUN MICROHEMATOCRIT	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
85014	HEMATOCRIT (HCT)	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
85018	HEMAGLOBIN (HGB)	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
85025	COMPLETE BLOOD CELL COUNT (RED CELLS, WHITE BLOOD CELL, PLATELETS), AUTOMATED TEST	X		MAY BE BILLED WITH STERILIZATION PROCEDURE ONLY
85027	COMPLETE BLOOD CELL COUNT (RED CELLS, WHITE BLOOD CELL, PLATELETS), AUTOMATED TEST	X		MAY BE BILLED WITH STERILIZATION PROCEDURE ONLY
85032	MANUAL CELL COUNT (ERYTHROCYTE, LEUKOCYTE OR PLATELET)EACH	X		MAY BE BILLED WITH STERILIZATION PROCEDURE ONLY
86255	FLOURESCENT NONINFECTIOUS AGENT ANTIBODY: SCREEN, EACH ANTIBODY	X		MAY BE BILLED WITH STERILIZATION PROCEDURE ONLY
86592	SYPHILIS TEST, NON-TREPONEMAL ANTIBODY; QUALITATIVE (EG, VDRL, RPR, ART)	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
86593	QUANTITATIVE	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
86689	ANTIBODY, HTLV OR HIV ANTIBODY, CONFIRMATORY TEST (E.G., WESTERN BLOT)	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
86694	ANTIBODY; HERPES SIMPLEX, NON-SPECIFIC TYPE TEST	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY

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86695	ANALYSIS FOR ANTIBODY TO HERPES SIMPLEX VIRUS, TYPE 1	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
86696	ANALYSIS FOR ANTIBODY TO HERPES SIMPLEX VIRUS, TYPE 2	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
86701	ANTIBODY, HIV-1	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
86702	HIV-2	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
86703	HIV-1 AND HIV-2, SINGLE ASSAY	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
86780	ANALYSIS FOR ANTIBODY, TREPONEMA PALLIDUM	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
86803	HEPATITIS C ANTIBODY	X		
86804	HEPATITIS C ANTIBODY; CONFIRM TST (IMMUNOB)	X		
87081	CULTURE, PRESUMPTIVE, PATHOGENIC ORGANISMS, SCREENING ONLY	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87110	CULTURE, CHLAMYDIA, ANY SOURCE	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87140	CULTURE; TYPING; IMMUNOFLUORESCENT METHOD; EACH ANTISERUM	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87164	DARK FIELD EXAMINATION, ANY SOURCE (E.G., PENILE, VAGINAL, ORAL, SKIN); INCLUDES SPECIMEN COLLECTION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87177	OVA AND PARASITES, DIRECT SMEARS, CONCENTRATION AND IDENTIFICATION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY

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87205	SMEAR, PRIMARY SOURCE WITH INTERPRETATION; GRAM OR GIEMSA STAIN FOR BACTERIA, FUNGI, OR CELL TYPES	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87206	FLUORESCENT AND/OR ACID FAST STAIN FOR BACTERIA, FUNGI, PARASITES, VIRUSES, OR CELL TYPES	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87207	SPECIAL STAIN FOR INCLUSION BODIES OR PARASITES (E.G.,MALARIA COCCIDIA, MICROSPORIDIA, TRYPANOSOMES, HERPES VIRUS)	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87209	COMPLEX SPECIAL STAIN (E.G., TRICHROME, IRON HEMOTOXYLIN) FOR OVA AND PARASITES	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87210	WET MOUNT FOR INFECTIOUS AGENTS (E.G., SALINE, INDIA INK, KOH PREPS)	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87220	TISSUE EXAMINATION BY KOH SLIDE OF SAMPLES FROM SKIN, HAIR OR NAILS FOR FUNGI OR ECTOPARASITE OVA OR MITES (E.G., SCABIES)	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87270	INFECTIOUS AGENT ANTIGEN DETECTION BY IMMUNOFLUORESCENT TECHNIQUE; CHLAMYDIA TRACHOMATIS	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87480	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); CANDIDA SPECIES, DIRECT PROBE TECHNIQUE	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87481	CANDIDA SPECIES, AMPLIFIED PROBE TECHNIQUE	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87482	CANDIDA SPECIES, QUANTIFICATION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87490	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); CHLAMYDIA TRACHMOATIS, DIRECT PROBE TECHNIQUE	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY

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87491	CHLAMYDIA TRACHOMATIS, AMPLIFIED PROBE TECHNIQUE	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87510	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); GARDNERELLA VAGINALIS, AMPLIFIED PROBE TECHNIQUE	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87511	GARDNERELLA VAGINALIS, AMPLIFIED PROBE TECHNIQUE	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87512	GARDNERELLA VAGINALIS, QUANTIFICATION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87528	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); HERPES SIMPLEX VIRUS, DIRECT PROBE TECHNIQUE	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87529	HERPES SIMPLEX VIRUS, AMPLIFIED PROBE TECHNIQUE	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87530	HERPES SIMPLEX VIRUS, QUANTIFICATION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87531	HERPES VIRUS-6, DIRECT PROBE TECHNIQUE	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87532	HERPES VIRUS-6, AMPLIFIED PROBE TECHNIQUE	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87533	HERPES VIRUS -6, QUANTIFICATION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87534	HIV-1, DIRECT PROBE TECHNIQUE	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87535	HIV-1, AMPLIFIED PROBE TECHNIQUE	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY

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87536	HIV-1 QUANTIFICATION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87537	HIV-2, DIRECT PROBE TECHNIQUE	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87538	HIV-2 AMPLIFIED PROBE TECHNIQUE	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87539	HIV-2, QUANTIFICATION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87590	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); NEISSERIA GONORRHOEAE, DIRECT PROBE TECHNIQUE	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87591	NEISSERIA GONORRHOEAE, AMPLIFIED PROBE TECHNIQUE	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87592	NEISSERIA GONORRHEA, QUANTIFICATION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87660	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); TRICHOMONAS VAGINALIS, DIRECT PROBE TECHNIQUE	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87797	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); NOT OTHERWISE SPECIFIED; DIRECT PROBE TECHNIQUE, EACH ORGANISM	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87850	INFECTIOUS AGENT ANTIGEN DETECTION BY IMMUNOASSAY WITH DIRECT OPTICAL OBSERVATION; NEISSERIA GONORRHEA	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
88108	CYTOPATHOLOGY, CONCENTRATION TECHNIQUE, SMEARS AND INTERPRETATION (E.G., SACCOMANNO TECHNIQUE	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY

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88141	CYTOPATHOLOGY, CERVICAL OR VAGINAL (ANY REPORTING SYSTEM), REQUIRING INTERPRETATION BY PHYSICIAN	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
88142	CYTOPATHOLOGY, CERVICAL OR VAGINAL (ANY REPORTING SYSTEM), COLLECTED IN PRESERVATIVE FLUID, AUTOMATED THIN LAYER PREPARATION; MANUAL SCREENING UNDER PHYSICIAN SUPERVISION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
88143	WITH MANUAL SCREENING AND RESCREENING UNDER PHYSICIAN SUPERVISION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
88147	CYTOPATHOLOGY SMEARS, CERVICAL OR VAGINAL; SCREENING BY AUTOMATED SYSTEM UNDER PHYSICIAN SUPERVISION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
88148	SCREENING BY AUTOMATED SYSTEM WITH MANUAL RESCREENING UNDER PHYSICIAN SUPERVISION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
88150	CYTOPATHOLOGY, SLIDES, CERVICAL OR VAGINAL; MANUAL SCREENING UNDER PHYSICIAN SUPERVISION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
88152	WITH MANUAL SCREENING AND COMPUTER ASSISTED RESCREENING UNDER PHYSICIAN SUPERVISION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
88153	WITH MANUAL SCREENING AND RESCREENING UNDER PHYSICIAN SUPERVISION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
88155	CYTOPATHOLOGY, SLIDES, CERVICAL OR VAGINAL, DEFINITIVE HORMONAL EVALUATION (EG., MATURATION INDEX, KARYOPYKNOTIC INDEX ESTROGENIC INDEX)(LIST SEPARATELY IN ADDITION TO CODE 9S) FOR OTHER TECHNICAL AND INTERPRETATION SERVICES)	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
88160	CYTOPATHOLOGY, SMEARS, ANY OTHER SOURCE; SCREENING AND INTERPRETATION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY

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88161	PREPARATION, SCREENING, AND INTERPRETATION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
88162	EXTENDED STUDY INVOLVING OVER 5 SLIDES AND/OR MULTIPLE STAINS	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
88164	CYTOPATHOLOGY, SLIDES, CERVICAL OR VAGINAL (THE BETHESDA SYSTEM); MANUAL SCREENING UNDER PHYSICIAN SUPERVISION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
88165	WITH MANUAL SCREENING AND RESCREENING UNDER PHYSICIAN SUPERVISION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
88166	WITH MANUAL SCREENING AND COMPUTER ASSISTED RESCREENING UNDER PHYSICIAN SUPERVISION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
88167	WITH MANUAL SCREENING AND COMPUTER ASSISTED RESCREENING USING CELL SELECTION AND REVIEW UNDER PHYSICIAN SUPERVISION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
88172	CYTOPATHOLOGY, EVALUATION OF FINE NEEDLE ASPIRATE; IMMEDIATE CYTOHISTOLOGIC	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
88173	INTERPRETATION AND REPORT	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
88174	CYTOPATHOLOGY, CERVICAL OR VAGINAL (ANY REPORTING SYSTEM), COLLECTED IN PRESERVATIVE FLUID, AUTOMATED THIN LAYER PREPARATION; SCREENING BY AUTOMATED SYSTEM, UNDER PHYSICIAN SUPERVISION	X		
88175	WITH SCREENING BY AUTOMATED SYSTEM AND MANUAL RESCREENING OR REVIEW, UNDER PHYSICIAN SUPERVISION	X		MAY BE BILLED WITH STERILIZATION PROCEDURE ONLY

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88300	PATHOLOGY EXAMINATION OF TISSUE USING A MICROSCOPE, LIMITED EXAMINATION	X		MAY BE BILLED WITH STERILIZATION PROCEDURE ONLY
88302	LEVEL II SURGICAL PATHOLOGY, GROSS AND MICROSCOPIC EXAMINATION	X		MAY BE BILLED WITH STERILIZATION PROCEDURE ONLY
88305	PATHOLOGY EXAMINATION OF TISSUE USING A MICROSCOPE, INTERMEDIATE COMPLEXITY	X		STERILIZATION, COLONOSCOPY POLYPS AND BIOPSY
96372	INJECTION BENEATH THE SKIN OR INTO MUSCLE FOR THERAPY, DIAGNOSIS, OR PREVENTION	X		MAY BE BILLED WITH STERILIZATION PROCEDURE ONLY
99000	HANDLING AND OR CONVEYANCE OF SPECIMEN FOR TRANSFER FROM THE PHYSICIANS OFFICE TO THE LABORATORY	X		MAY BE BILLED WITH STERILIZATION PROCEDURE ONLY
99071	EDUCATIONAL SUPPLIES, SUCH AS BOOKS, TAPES, AND PAMPHLETS, PROVIDED BY THE PHYSICIAN FOR THE PATIENT'S EDUCATION AT COST TO THE PHYSICIAN	X		MAY BE BILLED WITH STERILIZATION PROCEDURE ONLY
99201	NEW PATIENT OFFICE OR OTHER OUTPATIENT VISIT, TYPICALLY 10 MINUTES	X		TO BE USED FOR A NEW PATIENT ALSO, MUST FOLLOW CPT GUIDELINES FOR COMPONENTS
99202	NEW PATIENT OFFICE OR OTHER OUTPATIENT VISIT, TYPICALLY 20 MINUTES	X		TO BE USED FOR A NEW PATIENT ALSO, MUST FOLLOW CPT GUIDELINES FOR COMPONENTS
99203	NEW PATIENT OFFICE OR OTHER OUTPATIENT VISIT, TYPICALLY 30 MINUTES	X		TO BE USED FOR A NEW PATIENT ALSO, MUST FOLLOW CPT GUIDELINES FOR COMPONENTS
99204	NEW PATIENT OFFICE OR OTHER OUTPATIENT VISIT, TYPICALLY 45 MINUTES	X		TO BE USED FOR A NEW PATIENT ALSO, MUST FOLLOW CPT GUIDELINES FOR COMPONENTS

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99205	NEW PATIENT OFFICE OR OTHER OUTPATIENT VISIT, TYPICALLY 60 MINUTES	X		TO BE USED FOR A NEW PATIENT ALSO, MUST FOLLOW CPT GUIDELINES FOR COMPONENTS
99211	ESTABLISHED PATIENT OFFICE OR OTHER OUTPATIENT VISIT, TYPICALLY 5 MINUTES	X		TO BE USED FOR AN ESTABLISHED PATIENT. MAY BE USED AS SUPPLY VISIT BY HEALTH DEPARTMENT
99212	ESTABLISHED PATIENT OFFICE OR OTHER OUTPATIENT VISIT, TYPICALLY 10 MINUTES	X		TO BE USED FOR ESTABLISHED PATIENT
99213	ESTABLISHED PATIENT OFFICE OR OTHER OUTPATIENT VISIT, TYPICALLY 15 MINUTES	X		TO BE USED FOR ESTABLISHED PATIENT
99214	ESTABLISHED PATIENT OFFICE OR OTHER OUTPATIENT, VISIT TYPICALLY 25 MINUTES	X		TO BE USED FOR ESTABLISHED PATIENT
99215	ESTABLISHED PATIENT OFFICE OR OTHER OUTPATIENT, VISIT TYPICALLY 40 MINUTES	X		TO BE USED FOR ESTABLISHED PATIENT
99238	HOSPITAL DISCHARGE DAY MANAGEMENT, 30 MINUTES OR LESS	X		TO BE USED FOR ESTABLISHED PATIENT
99239	HOSPITAL DISCHARGE DAY MANAGEMENT, MORE THAN 30 MINUTES	X		TO BE USED FOR ESTABLISHED PATIENT
99241	PATIENT OFFICE CONSULTATION, TYPICALLY 15 MINUTES	X		MAY BE USED WHEN A PROVIDER REFERS A RECIPIENT TO ANOTHER PROVIDER FOR A STERILIZATION PROCEDURE ONLY. MUST FOLLOW CPT GUIDELINES
99242	PATIENT OFFICE CONSULTATION, TYPICALLY 30 MINUTES	X		MAY BE USED WHEN A PROVIDER REFERS A RECIPIENT TO ANOTHER PROVIDER FOR A STERILIZATION PROCEDURE ONLY. MUST FOLLOW CPT GUIDELINES

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99243	PATIENT OFFICE CONSULTATION, TYPICALLY 40 MINUTES	X		MAY BE USED WHEN A PROVIDER REFERS A RECIPIENT TO ANOTHER PROVIDER FOR A STERILIZATION PROCEDURE ONLY. MUST FOLLOW CPT GUIDELINES
99244	PATIENT OFFICE CONSULTATION, TYPICALLY 60 MINUTES	X		TO BE USED FOR AN ESTABLISHED PATIENT. MAY BE USED AS SUPPLY VISIT BY HEALTH DEPARTMENT
99245	PATIENT OFFICE CONSULTATION, TYPICALLY 80 MINUTES	X		MAY BE USED WHEN A PROVIDER REFERS A RECIPIENT TO ANOTHER PROVIDER FOR A STERILIZATION PROCEDURE ONLY. MUST FOLLOW CPT GUIDELINES
99401	PREVENTIVE MEDICINE COUNSELING, APPROXIMATELY 15 MINUTES	X		CANNOT BE USED ON THE SAME DAY AS AN OFFICE/CLINIC VISIT
99402	PREVENTIVE MEDICINE COUNSELING, APPROXIMATELY 30 MINUTES	X		CANNOT BE USED ON THE SAME DAY AS AN OFFICE/CLINIC VISIT
A4261	CERVICAL CAP FOR CONTRACEPTIVE USE	X		
A4266	DIAPHRAGM FOR CONTRACEPTIVE USE	X		
A4267	CONTRACEPTIVE SUPPLY, CONDOM MALE	X		
A4268	CONTRACEPTIVE SUPPLY, CONDOM FEMALE	X		
A4269	CONTRACEPTIVE SUPPLY, SPERMICIDE	X		
A4550	MAJOR SURGICAL TRAY (INCLUDES ANESTHESIA INJECTION)	X		
G0105	SCREENING COLONOSCOPY		X	
G0438	ANNUAL WELLNESS VISIT W/PREV PLAN, INITIAL	X		

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PROCEDURE CODES FOR FAMILY PLANNING

FAMILY PLANNING CPT / HCPCS SERVICES

CPT/ HCPCS CODE	DESCRIPTION	REQUIRES FP	FAMILY PLANNING CODES THAT ARE NOT TO BE CODED WITH FP MODIFIER	COMMENTS
G0439	ANNUAL WELLNESS VISIT W/PREVENTIVE CARE SUBSEQUENT VISIT (ESTABLISHED PATIENT)	X		
J0558	INJECTION, PENICILLIN G BENZATHINE AND PENICILLIN G PROCAINE 100,000 UNITS	X		
J0567	INJECTION, PENICILLIN G BENZATHINE, 100,000 UNITS	X		
J0696	INJECTION, CEFTRIXONE SODIUM, PER 250 MG			
J1050	INJECTION MEDROXYPROGESTERONE ACETATE (DEPO-PROVERA)	X		
J1056	INJECTION MEDROXYPROGESTERONE ACETATE/ESTRADIOL CYPINATE 25 MIG/GMG (LUNELLE)	X		
J1950	INJECTION, LEUPROLIDE ACETATE, PER 3.75 MG	X		
J7297	LEVONORGESTREL-RELEASE IU CONTRACEPTIVE 52 MG (LILETTA)	X		
J7298	LEVONORGESTREL RELEASE IU CONTRACEPTIVE 52 MG (MIRENA)	X		
J7300	INTRAUTERINE COPPER CONTRACEPTIVE	X		
J7301	SKYLA INJ, 13.5 MG	X		
J7303	CONTRACEPTIVE HORMONE W/VAGINAL RING	X		
J7304	CONTRACEPTIVE SUPPLY HORMONE PATCH	X		
J7306	LEVONORGESTREL (CONTRACEPTIVE) IMPLANT SYSTEM, INCLUDING IMPLANTS AND SUPPLIES	X		
J7307	ETONOGESTREL (CONTRACEPTIVE) IMPLANT SYSTEM, INCLUDING IMPLANT AND SUPPLIES (NEW CODE FOR IMPLANON)	X		
Q0111	WET MOUNT	X		

SECTION 4 PROCEDURE CODES

PROCEDURE CODES FOR FAMILY PLANNING

FAMILY PLANNING CPT / HCPCS SERVICES

CPT/ HCPCS CODE	DESCRIPTION	REQUIRES FP	FAMILY PLANNING CODES THAT ARE NOT TO BE CODED WITH FP MODIFIER	COMMENTS
Q9984	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM (KYLEENA®), 19.5 MG	X		
S0316	DISEASE MANAGEMENT FOLLOW UP REASSESSMENT		X	
S0320	PH CALL/RN- DISEASE MEM/MONITR; MON		X	
S3645	HIV-1 ANTIBODY TESTING OF ORAL MUCOSAL TRANSUDATE	X		
S4981	INSERTION OF LEVONORGESTREL RELEASING INTRAUTERINE SYSTEM	X		
S4993	CONTRACEPTIVE PILLS FOR BIRTH CONTROL	X		
S9445	PATIENT EDUCATION, INDIVIDUAL, NOT OTHERWISE CLASSIFIED, NON PHYSICIAN PROVIDER	X		CODE ONLY ALLOWED FOR MEDICAID ADOLESCENT PREGANCY SERVICES (MAPPS)
S9446	PATIENT EDUCATION, GROUP, NOT OTHERWISE CLASSIFIED, NON PHYSICIAN PROVIDER	X		CODE ONLY ALLOWED FOR MEDICAID ADOLESCENT PREGANCY SERVICES (MAPPS)
T1015	CLIMIN VISIT ENCOUNTER; ALL INCLUSIVE	X		CODE ONLY ALLOWED FOR FQHC/RHC PROVIDERS. ONLY ONE ENCOUNTER SERVICE PER DAY IS PERMITTED
T1023	SCREENING TO DETERMINE THE APPROPRIATENESS OF CONSIDERATION OF AN INDIVIDUAL FOR PARTICIPATION IN A SPECIFIED PROGRAM, PROJECT OR TREATMENT PROTOCOL	X		CODE ONLY ALLOWED FOR MEDICAID ADOLESCENT PREGANCY SERVICES (MAPPS)

SECTION 4 PROCEDURE CODES

PROCEDURE CODES FOR FAMILY PLANNING

FAMILY PLANNING
APPROVED SEXUALLY
TRANSMITTED INFECTION
(STI) DRUG LIST

DRUG NAME	DOSAGE
ACYCLOVIR	200 MG
ACYCLOVIR	400 MG
AZITHROMYCIN	1 GM
AZITHROMYCIN	2 GM
BENZATHINE PENICILLIN G	2.4 MILLION UNITS
BUTOCONAZOLE 2% CREAM	5 G INTRAVAGINALLY
CEFTRIAXONE	2 GM
CEFTRIAXONE	125 MG
CEFIXIME	400 MG
CIPROFLOXIN	500 MG
CLOTRIMAZOLE 1% CREAM	5 G INTRAVAGINALLY
CLOTRIMAZOLE	100 MG VAGINAL TABLET
DOXYCYCLINE	100 MG
ERYTHROMYCIN BASE	500 MG
ERYTHROMYCIN/ETHYLSUCCINATE	800 MG
FAMCIOCLOVIR	250 MG
FLUCONAZOLE	150 MG
LEVOFLOXACIN	250 MG
LEVOFLOXACIN	500 MG
METRONIDAZOLE	2 G
METRONIDAZOLE	500 MG
OFLOXACIN	300 MG
OFLOXACIN	400 MG
TETRACYCLINE	500 MG
TINIDAZOLE	2 G
VALACYCLOVIR	1 G

SECTION 4 PROCEDURE CODES

PROCEDURE CODES FOR FAMILY PLANNING

FAMILY PLANNING ICD-10-CM APPROVED STI DIAGNOSIS CODES

For dates of service on or after **October 1, 2015**, use the following ICD-10-CM Approved STI diagnosis codes.

STI DIAGNOSIS	ICD-10-CM CODE
SYPHILIS	
PRIMARY GENITAL SYPHILIS	A51.0
PRIMARY ANAL SYPHILIS	A51.1
PRIMARY SYPHILIS OF OTHER SITES	A51.2
EARLY SYPHILIS, LATENT	A51.5
EARLY SYPHILIS, UNSPECIFIED	A51.9
SYMPTOMATIC LATE SYPHILIS OF OTHER RESPIRATORY ORGANS	A52.73
OTHER GENITOURINARY SYMPTOMATIC LATE SYPHILIS	A52.76
OTHER SYMPTOMATIC LATE SYPHILIS	A52.79
CHLAMYDIA	
CHLAMYDIAL INFECTION OF LOWER GENITOURINARY TRACT, UNSP	A56.00
CHLAMYDIAL CYSTITIS AND URETHRITIS	A56.01
CHLAMYDIAL VULVOVAGINITIS	A56.02
OTHER CHLAMYDIAL INFECTION OF LOWER GENITOURINARY TRACT	A56.09
OTHER CHLAMYDIAL DISEASES	A74.89
NONSPECIFIC URETHRITIS	N34.1
GONORRHEA	
GONOCOCCAL INFECTION OF LOWER GENITOURINARY TRACT, UNSP	A54.00
GONOCOCCAL CYSTITIS AND URETHRITIS, UNSPECIFIED	A54.01
GONOCOCCAL VULVOVAGINITIS, UNSPECIFIED	A54.02
GONOCOCCAL CERVICITIS, UNSPECIFIED	A54.03
OTHER GONOCOCCAL INFECTION OF LOWER GENITOURINARY TRACT	A54.09
GONOCOCCAL INFECTION OF LOWER GENITOURINARY TRACT WITH PERIURETHRAL AND ACCESSORY GLAND ABSCESS	A54.1
GONOCOCCAL INFECTION OF KIDNEY AND URETER	A54.21
GONOCOCCAL FEMALE PELVIC INFLAMMATORY	A54.24

SECTION 4 PROCEDURE CODES

PROCEDURE CODES FOR FAMILY PLANNING

STI DIAGNOSIS	ICD-10-CM CODE
DISEASE	
OTHER GONOCOCCAL GENITOURINARY INFECTIONS	A54.29
GONOCOCCAL PHARYNGITIS	A54.5
GONOCOCCAL INFECTION OF ANUS AND RECTUM	A54.6
HERPES	
HERPESVIRAL INFECTION OF UROGENITAL SYSTEM, UNSPECIFIED	A60.00
HERPESVIRAL VULVOVAGINITIS	A60.04
HERPESVIRAL INFECTION OF OTHER UROGENITAL TRACT	A60.09
ANOGENITAL HERPESVIRAL INFECTION, UNSPECIFIED	A60.9
CANDIDIASIS	
CANDIDIASIS OF VULVA AND VAGINA	B37.3
CANDIDAL CYSTITIS AND URETHRITIS	B37.41
CANDIDAL BALANITIS	B37.42
OTHER UROGENITAL CANDIDIASIS	B37.49
TRICHOMONIASIS	
UROGENITAL TRICHOMONIASIS, UNSPECIFIED	A59.00
TRICHOMONAL VULVOVAGINITIS	A59.01
TRICHOMONAL CYSTITIS AND URETHRITIS	A59.03
OTHER UROGENITAL TRICHOMONIASIS	A59.09
TRICHOMONIASIS OF OTHER SITES	A59.8
TRICHOMONIASIS, UNSPECIFIED	A59.9

One course of STI (antibiotic treatment) from approved list for each organism identified above is allowed per calendar year under the Family Planning Program. These STIs must be diagnosed during an initial or annual family planning visit.

The provider must write the diagnosis code on the patient's prescription in order for the pharmacy to fill it.

SECTION 4 PROCEDURE CODES

PROCEDURE CODES FOR ANESTHESIA

The following tables include the CPT and basic units for anesthesia.

PROCEDURE CODE	BASIC UNITS
00100	5
00102	6
00103	5
00104	4
00120	5
00124	4
00126	4
00140	5
00142	4
00144	6
00145	6
00147	4
00148	4
00160	5
00162	7
00164	4
00170	5
00172	6
00174	6
00176	7
00190	5
00192	7
00210	11
00211	10
00212	5
00214	9
00215	9
00216	15
00218	13
00220	10
00222	6
00300	5
00320	6
00322	3

PROCEDURE CODE	BASIC UNITS
00326	7
00350	10
00352	5
00400	3
00402	5
00404	5
00406	13
00410	4
00450	5
00454	3
00470	6
00472	10
00474	13
00500	15
00520	6
00522	4
00524	4
00528	8
00529	11
00530	4
00532	4
00534	7
00537	7
00539	18
00540	12
00541	15
00542	15
00546	15
00548	17
00550	10
00560	15
00561	25
00562	20
00563	25

PROCEDURE CODE	BASIC UNITS
00566	25
00567	25
00580	20
00600	10
00604	13
00620	10
00625	13
00626	15
00630	8
00632	7
00635	4
00640	3
00670	13
00700	4
00702	4
00730	5
00731	5
00732	5
00750	4
00752	6
00754	7
00756	7
00770	15
00790	7
00792	13
00794	8
00796	30
00797	11
00800	4
00802	5
00811	5
00812	5
00813	5
00820	5

PROCEDURE CODE	BASIC UNITS
00830	4
00832	6
00834	5
00836	6
00840	6
00842	4
00844	7
00846	8
00848	8
00851	6
00860	6
00862	7
00864	8
00865	7
00866	10
00868	10
00870	5
00872	7
00873	5
00880	15
00882	10
00902	5
00904	7
00906	4
00908	6
00910	3
00912	5
00914	5
00916	5
00918	5
00920	3
00922	6
00924	4
00926	4
00928	6
00930	4
00932	4
00934	6
00936	8
00938	4
00940	3
00942	4
00944	6
00948	4
00950	5
00952	4

PROCEDURE CODE	BASIC UNITS
01112	5
01120	6
01130	3
01140	15
01150	10
01160	4
01170	8
01173	12
01200	4
01202	4
01210	6
01212	10
01214	8
01215	10
01220	4
01230	6
01232	5
01234	8
01250	4
01260	3
01270	8
01272	4
01274	6
01320	4
01340	4
01360	5
01380	3
01382	3
01390	3
01392	4
01400	4
01402	7
01404	5
01420	3
01430	3
01432	6
01440	8
01442	8
01444	8
01462	3
01464	3
01470	3
01472	5
01474	5
01480	3
01482	4

PROCEDURE CODE	BASIC UNITS
01484	4
01486	7
01490	3
01500	8
01502	6
01520	3
01522	5
01610	5
01620	4
01622	4
01630	5
01634	9
01636	15
01638	10
01650	6
01652	10
01654	8
01656	10
01670	4
01680	3
01710	3
01712	5
01714	5
01716	5
01730	3
01732	3
01740	4
01742	5
01744	5
01756	6
01758	5
01760	7
01770	6
01772	6
01780	3
01782	4
01810	3
01820	3
01829	3
01830	3
01832	6
01840	6
01842	6
01844	6
01850	3
01852	4

SECTION 4 PROCEDURE CODES

PROCEDURE CODES FOR ANESTHESIA

PROCEDURE CODE	BASIC UNITS
01860	3
01916	5
01920	7
01922	7
01924	5
01925	7
01926	8
01930	5
01931	7

PROCEDURE CODE	BASIC UNITS
01932	6
01933	7
01935	5
01936	5
01951	3
01952	5
01953	1
01960	5
01961	7

PROCEDURE CODE	BASIC UNITS
01962	8
01963	8
01965	4
01966	4
01968	2
01969	5
01991	3
01992	5

SECTION 4 PROCEDURE CODES

PROCEDURE CODES FOR ANESTHESIA

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SECTION 4 PROCEDURE CODES

PROCEDURE CODES FOR VISION

The following tables include the CPT, description of procedure code, and if manual pricing is required.

PROCEDURE CODE	DESCRIPTION OF PROCEDURE CODE	MANUAL PRICING REQUIRED
92225	OPTHALMOSCOPY EXT W/RETINAL DRAWING INIT	NO
92226	OPHTHALMOSCOPY SUBSEQUENT	NO
92230	FLUORESCEIN ANGIOSCOPY W/INTERPRET/REPOR	NO
92235	FLUORESCEIN ANGIOGRAPHY (INCLUDES MULTIFRAME IMAGING) WITH INTERPRETATION AND REPORT, UNILATERAL OR BILATERAL	NO
92240	INDOCYANINE-GREEN ANGIOGRAPHY (INCLUDES MULTIFRAME IMAGING) WITH INTERPRETATION AND REPORT, UNILATERAL OR BILATERAL	NO
92260	OPHTHALMODYNAMOMETRY	NO
92270	ELECTRO OCULOGRAPHY	NO
92273	FULL FIELD RECORDING OF RETINAL ELECTRICAL RESPONSES TO EXTERNAL STIMULI WITH INTERPRETATION AND REPORT	NO
92274	MULTIFOCAL RECORDING OF RETINAL ELECTRICAL RESPONSES TO EXTERNAL STIMULI WITH INTERPRETATION AND REPORT	NO
92285	EXT OCULAR PHOTO W/I&R RPT DOCU OF MED	NO
92286	SPEC ANTERIOR SEG PHOTOG W/INTERP & REPO	NO
92287	SPECIAL ANTER SEG PHOTO MED DIAG FLU ANG	NO
92310	PRESC OPTICAL/PHYSICAL CHARAC FITTING CO	NO
92311	RX CORNEAL LENS APHAKIA ONE EYE	NO
92312	RX CORNEAL LENS APHAKIA BOTH EYES	NO
92313	PRESCRIPTION & FITTING CORNEOSCLERAL LEN	NO
92326	REPLACEMENT CONTACT LENS	NO
92340	FITTING OF SPECTACLES EXC FOR APHAKIA MO	NO
92341	FITTING OF SPECTACLES EXC FOR APHAKIA MO	NO
92342	FIT SPECTACLES EXC FOR APHAKIA MULTIFOCA	NO
92353	FIT SPECTACLES PROST FOR APHAKIA MULTIFO	NO
92370	REP AND REFIT SPECT; EXCEPT FOR APHAKIA	NO
95999	UNLISTED NEUROLOGICAL PROCEDURE	MANUAL PRICING REQUIRED
96110	DEVELOP TESTING LIMITED W/INTERP & REPOR	NO
96112	DEVELOPMENTAL TEST ADMINISTRATION BY QUALIFIED HEALTH CARE PROFESSIONAL WITH INTERPRETATION AND REPORT, FIRST 60 MINUTES	NO

SECTION 4 PROCEDURE CODES

PROCEDURE CODES FOR VISION

PROCEDURE CODE	DESCRIPTION OF PROCEDURE CODE	MANUAL PRICING REQUIRED
96113	DEVELOPMENTAL TEST ADMINISTRATION BY QUALIFIED HEALTH CARE PROFESSIONAL WITH INTERPRETATION AND REPORT, ADDITIONAL 30 MINUTES	NO
96116	NEUROBEHAVIORAL STATUS EXAMINATION BY QUALIFIED HEALTH CARE PROFESSIONAL WITH INTERPRETATION AND REPORT, FIRST 60 MINUTES	NO
V2020	FRAME COMPLETE	NO
V2100	SPHERE, SINGLE, PLANO, TO +-4D,PER LENS	NO
V2101	SPHERE, SINGLE, +-4D,AND OVER,PER LENS	NO
V2102	SINGLE VISION SPHERE 7.12-20.00	NO
V2103	SPH-CYL, SINGLE,TO +-4D,ANY CYL,PER LENS	NO
V2104	SPHEROCYL,SNGL,PLANO+ OR-4.00D,OVER 6	NO
V2105	SPHERECYLINDER 4.00D/4.25-6D	NO
V2106	SPHERECYLINDER 4.00D/6.00D	NO
V2107	SPH-CYL,SINGLE,+-4D,&OVER,ANY CYL,PER LE	NO
V2108	SPHERECYLINDER 4.25D/2.12-14D	NO
V2109	SPHERECYLINDER 4.25D/4.25-6D	NO
V2111	SPHERE CYLINDER 7.25G/.25-2.25	NO
V2112	SPHERES/CYLINDERS 7.25 TO 12.00 G/2.25 T	NO
V2114	SPHERES/CYLINDERS 12.25 TO 20.00 G 0 12.	NO
V2200	SPHERE,BIFOCAL,PLANO TO +-4D,PER LENS	NO
V2201	SPHERE,BIFOCAL,+-4D & OVER,PER LENS	NO
V2202	BIFOCAL SPHERES/CYLINDERS 4.25 TO 6.00/7	NO
V2203	SPH-CYL,BIFOCAL,TO +-4D,ANY CYL,PER LENS	NO
V2204	BIFOCAL PLANO CYLINDER 2.12 TO 4.00 G/	NO
V2205	SPHEROCYL,BIFOC,PLANO +OR-4.D TO 6.D	NO
V2207	SPH-CYL,BIFOCAL,+-4-D,&OVER,ANY CYL,PER	NO
V2208	BIFOCAL SPHERES/CYLINDERS 4.25 TO 7.00G/	NO
V2211	SPHERES/CYLINDERS 7.25 TO 12.00G/.25 TO	NO
V2219	BIFOCAL SEG WITH OVER 28MM	NO
V2221	LENTICULAR LENS, PER LENS, BIFOCAL	NO
V2299	SPECIALTY BIFOCAL BY REPORT	MANUAL PRICING REQUIRED
V2500	CONTACT, PMMA,SPHERICAL,PER LENS	NO
V2501	CONTACT,PMMA,IORIC/PRISM BALLAST PER LEN	NO
V2510	CONTACT GAS PERMEABLE,SPHERICAL,PER LENS	NO
V2511	CONTACT,GAS PERM,TORIC,PRISM BALL,PER LE	NO
V2520	CONTACT,HYDROPHILIC,SPHERICAL,PER LENS	NO
V2599	CONTACT,NOT OTHER CLASSIFIED,PER LENS	MANUAL PRICING REQUIRED

SECTION 4 PROCEDURE CODES

PROCEDURE CODES FOR VISION

PROCEDURE CODE	DESCRIPTION OF PROCEDURE CODE	MANUAL PRICING REQUIRED
V2600	HAND HELD LOW VISION AIDS	MANUAL PRICING REQUIRED
V2610	SINGLE LENS SPECTACLE MOUNT	MANUAL PRICING REQUIRED
V2615	TELESCOP/OTHR COMPOUND LENS	MANUAL PRICING REQUIRED
V2630	ANTERIOR CHAMBER INTRAOCULAR LENS(OUTPT)	NO
V2632	POSTERIOR CHAMBER INTRAOCULAR LENS(OUTPT	NO
V2715	PRISM,PER LENS	NO
V2730	DOUBLE CONCAVE SINGLE VISION	NO
V2744	TINT,PHOTOCHROMATIC, PER LENS	NO
V2755	U-V LENS, PER LENS	NO
V2784	LENS,POLYCARB OR EQUAL,ANY INDEX,PR LENS	NO
V2797	VISION SUPPLY, ACCESSERY/SVC OTHER CODE	MANUAL PRICING REQUIRED
V2799	NOT OTHERWISE CLASSIFIED(VISION)	MANUAL PRICING REQUIRED

SECTION 4 PROCEDURE CODES

PROCEDURE CODES FOR VISION

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SECTION 4 PROCEDURE CODES

PROCEDURE CODES FOR ABORTIONS

PROCEDURE CODES FOR ANTEPARTUM VISITS

For dates of service on or after **October 1, 2015**, ICD-10-CM codes for antepartum visits are located on the SCDHHS website on the Physicians Services Provider Manual webpage.

DIAGNOSIS CODES FOR THERAPEUTIC ABORTIONS

For dates of service on or after **October 1, 2015**, please use the following ICD-10-CM codes for therapeutic abortions.

ICD-10 CODES	DESCRIPTION
O04.5	GENITAL TRACT AND PELVIC INFECTION FOLLOWING (INDUCED) TERMINATION OF PREGNANCY
O04.6	DELAYED OR EXCESSIVE HEMORRHAGE FOLLOWING (INDUCED) TERMINATION OF PREGNANCY
O04.7	EMBOLISM FOLLOWING (INDUCED) TERMINATION OF PREGNANCY
O04.80	(INDUCED) TERMINATION OF PREGNANCY WITH UNSPECIFIED COMPLICATIONS
O04.81	SHOCK FOLLOWING (INDUCED) TERMINATION OF PREGNANCY
O04.82	RENAL FAILURE FOLLOWING (INDUCED) TERMINATION OF PREGNANCY
O04.83	METABOLIC DISORDER FOLLOWING (INDUCED) TERMINATION OF PREGNANCY
O04.84	DAMAGE TO PELVIC ORGANS FOLLOWING (INDUCED) TERMINATION OF PREGNANCY
O04.85	OTHER VENOUS COMPLICATIONS FOLLOWING (INDUCED) TERMINATION OF PREGNANCY
O04.86	CARDIAC ARREST FOLLOWING (INDUCED) TERMINATION OF PREGNANCY
O04.87	SEPSIS FOLLOWING (INDUCED) TERMINATION OF PREGNANCY
O04.88	URINARY TRACT INFECTION FOLLOWING (INDUCED) TERMINATION OF PREGNANCY
O04.89	(INDUCED) TERMINATION OF PREGNANCY WITH OTHER COMPLICATIONS
Z33.2	ENCOUNTER FOR ELECTIVE TERMINATION OF PREGNANCY

SECTION 4 PROCEDURE CODES

PROCEDURE CODES FOR ABORTIONS

DIAGNOSIS CODES FOR SPONTANEOUS, INEVITABLE, AND MISSED ABORTIONS

For dates of service on or after **October 1, 2015**, please use the following ICD-10-CM codes for spontaneous, inevitable, and missed abortions.

ICD-10 CODES	DESCRIPTION
O01.0	CLASSICAL HYDATIDIFORM MOLE
O01.1	INCOMPLETE AND PARTIAL HYDATIDIFORM MOLE
O01.9	HYDATIDIFORM MOLE, UNSPECIFIED
O02.0	BLIGHTED OVUM AND NONHYDATIDIFORM MOLE
O02.1	MISSED ABORTION
O02.81	INAPPROPRIATE CHANGE IN QUANTITATIVE HUMAN CHORIONIC GONADOTROPIN (HCG) IN EARLY PREGNANCY
O02.89	OTHER ABNORMAL PRODUCTS OF CONCEPTION
O02.9	ABNORMAL PRODUCT OF CONCEPTION, UNSPECIFIED
O03.0	GENITAL TRACT AND PELVIC INFECTION FOLLOWING INCOMPLETE SPONTANEOUS ABORTION
O03.1	DELAYED OR EXCESSIVE HEMORRHAGE FOLLOWING INCOMPLETE SPONTANEOUS ABORTION
O03.2	EMBOLISM FOLLOWING INCOMPLETE SPONTANEOUS ABORTION
O03.30	UNSPECIFIED COMPLICATION FOLLOWING INCOMPLETE SPONTANEOUS ABORTION
O03.31	SHOCK FOLLOWING INCOMPLETE SPONTANEOUS ABORTION
O03.32	RENAL FAILURE FOLLOWING INCOMPLETE SPONTANEOUS ABORTION
O03.33	METABOLIC DISORDER FOLLOWING INCOMPLETE SPONTANEOUS ABORTION
O03.34	DAMAGE TO PELVIC ORGANS FOLLOWING INCOMPLETE SPONTANEOUS ABORTION
O03.35	OTHER VENOUS COMPLICATIONS FOLLOWING INCOMPLETE SPONTANEOUS ABORTION
O03.36	CARDIAC ARREST FOLLOWING INCOMPLETE SPONTANEOUS ABORTION
O03.37	SEPSIS FOLLOWING INCOMPLETE SPONTANEOUS ABORTION
O03.38	URINARY TRACT INFECTION FOLLOWING INCOMPLETE SPONTANEOUS ABORTION
O03.39	INCOMPLETE SPONTANEOUS ABORTION WITH OTHER COMPLICATIONS
O03.4	INCOMPLETE SPONTANEOUS ABORTION WITHOUT COMPLICATION
O03.5	GENITAL TRACT AND PELVIC INFECTION FOLLOWING COMPLETE OR UNSPECIFIED SPONTANEOUS ABORTION
O03.6	DELAYED OR EXCESSIVE HEMORRHAGE FOLLOWING COMPLETE OR UNSPECIFIED SPONTANEOUS ABORTION

SECTION 4 PROCEDURE CODES

PROCEDURE CODES FOR ABORTIONS

ICD-10 CODES	DESCRIPTION
O03.7	EMBOLISM FOLLOWING COMPLETE OR UNSPECIFIED SPONTANEOUS ABORTION
O03.80	UNSPECIFIED COMPLICATION FOLLOWING COMPLETE OR UNSPECIFIED SPONTANEOUS ABORTION
O03.81	SHOCK FOLLOWING COMPLETE OR UNSPECIFIED SPONTANEOUS ABORTION
O03.82	RENAL FAILURE FOLLOWING COMPLETE OR UNSPECIFIED SPONTANEOUS ABORTION
O03.83	METABOLIC DISORDER FOLLOWING COMPLETE OR UNSPECIFIED SPONTANEOUS ABORTION
O03.84	DAMAGE TO PELVIC ORGANS FOLLOWING COMPLETE OR UNSPECIFIED SPONTANEOUS ABORTION
O03.85	OTHER VENOUS COMPLICATIONS FOLLOWING COMPLETE OR UNSPECIFIED SPONTANEOUS ABORTION
O03.86	CARDIAC ARREST FOLLOWING COMPLETE OR UNSPECIFIED SPONTANEOUS ABORTION
O03.87	SEPSIS FOLLOWING COMPLETE OR UNSPECIFIED SPONTANEOUS ABORTION
O03.88	URINARY TRACT INFECTION FOLLOWING COMPLETE OR UNSPECIFIED SPONTANEOUS ABORTION
O03.89	COMPLETE OR UNSPECIFIED SPONTANEOUS ABORTION WITH OTHER COMPLICATIONS
O03.9	COMPLETE OR UNSPECIFIED SPONTANEOUS ABORTION WITHOUT COMPLICATION

DIAGNOSIS CODES THAT DO NOT REQUIRE DOCUMENTATION

For dates of service on or after **October 1, 2015**, the following abortion diagnosis codes do not require documentation.

ICD-10 CODE	DESCRIPTION
O01.0	CLASSICAL HYDATIDIFORM MOLE
O01.1	INCOMPLETE AND PARTIAL HYDATIDIFORM MOLE
O01.9	HYDATIDIFORM MOLE, UNSPECIFIED
O02.0	BLIGHTED OVUM AND NONHYDATIDIFORM MOLE
O02.81	INAPPROPRIATE CHANGE IN QUANTITATIVE HUMAN CHORIONIC GONADOTROPIN (HCG) IN EARLY PREGNANCY
O02.89	OTHER ABNORMAL PRODUCTS OF CONCEPTION
O02.9	ABNORMAL PRODUCT OF CONCEPTION, UNSPECIFIED
O02.1	MISSED ABORTION
O36.5190	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, UNSPECIFIED TRIMESTER, NOT APPLICABLE OR UNSPECIFIED
O36.5191	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL

SECTION 4 PROCEDURE CODES

PROCEDURE CODES FOR ABORTIONS

ICD-10 CODE	DESCRIPTION
	INSUFFICIENCY, UNSPECIFIED TRIMESTER, FETUS 1
O36.5192	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, UNSPECIFIED TRIMESTER, FETUS 2
O36.5193	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, UNSPECIFIED TRIMESTER, FETUS 3
O36.5194	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, UNSPECIFIED TRIMESTER, FETUS 4
O36.5195	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, UNSPECIFIED TRIMESTER, FETUS 5
O36.5199	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, UNSPECIFIED TRIMESTER, OTHER FETUS
O36.5990	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, UNSPECIFIED TRIMESTER, NOT APPLICABLE OR UNSPECIFIED
O36.5991	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, UNSPECIFIED TRIMESTER, FETUS 1
O36.5992	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, UNSPECIFIED TRIMESTER, FETUS 2
O36.5993	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, UNSPECIFIED TRIMESTER, FETUS 3
O36.5994	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, UNSPECIFIED TRIMESTER, FETUS 4
O36.5995	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, UNSPECIFIED TRIMESTER, FETUS 5
O36.5999	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, UNSPECIFIED TRIMESTER, OTHER FETUS
O36.5110	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, FIRST TRIMESTER, NOT APPLICABLE OR UNSPECIFIED
O36.5111	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, FIRST TRIMESTER, FETUS 1
O36.5112	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, FIRST TRIMESTER, FETUS 2
O36.5113	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, FIRST TRIMESTER, FETUS 3
O36.5114	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, FIRST TRIMESTER, FETUS 4
O36.5115	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, FIRST TRIMESTER, FETUS 5
O36.5119	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, FIRST TRIMESTER, OTHER FETUS
O36.5120	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, SECOND TRIMESTER, NOT APPLICABLE OR UNSPECIFIED
O36.5121	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, SECOND TRIMESTER, FETUS 1
O36.5122	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL

SECTION 4 PROCEDURE CODES

PROCEDURE CODES FOR ABORTIONS

ICD-10 CODE	DESCRIPTION
	INSUFFICIENCY, SECOND TRIMESTER, FETUS 2
O36.5123	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, SECOND TRIMESTER, FETUS 3
O36.5124	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, SECOND TRIMESTER, FETUS 4
O36.5125	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, SECOND TRIMESTER, FETUS 5
O36.5129	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, SECOND TRIMESTER, OTHER FETUS
O36.5130	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, THIRD TRIMESTER, NOT APPLICABLE OR UNSPECIFIED
O36.5131	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, THIRD TRIMESTER, FETUS 1
O36.5132	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, THIRD TRIMESTER, FETUS 2
O36.5133	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, THIRD TRIMESTER, FETUS 3
O36.5134	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, THIRD TRIMESTER, FETUS 4
O36.5135	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, THIRD TRIMESTER, FETUS 5
O36.5139	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, THIRD TRIMESTER, OTHER FETUS
O36.5910	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, FIRST TRIMESTER, NOT APPLICABLE OR UNSPECIFIED
O36.5911	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, FIRST TRIMESTER, FETUS 1
O36.5912	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, FIRST TRIMESTER, FETUS 2
O36.5913	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, FIRST TRIMESTER, FETUS 3
O36.5914	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, FIRST TRIMESTER, FETUS 4
O36.5915	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, FIRST TRIMESTER, FETUS 5
O36.5919	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, FIRST TRIMESTER, OTHER FETUS
O36.5920	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, SECOND TRIMESTER, NOT APPLICABLE OR UNSPECIFIED
O36.5921	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, SECOND TRIMESTER, FETUS 1
O36.5922	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, SECOND TRIMESTER, FETUS 2
O36.5923	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, SECOND TRIMESTER, FETUS 3
O36.5924	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL

SECTION 4 PROCEDURE CODES

PROCEDURE CODES FOR ABORTIONS

ICD-10 CODE	DESCRIPTION
	GROWTH, SECOND TRIMESTER, FETUS 4
O36.5925	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, SECOND TRIMESTER, FETUS 5
O36.5929	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, SECOND TRIMESTER, OTHER FETUS
O36.5930	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, THIRD TRIMESTER, NOT APPLICABLE OR UNSPECIFIED
O36.5931	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, THIRD TRIMESTER, FETUS 1
O36.5932	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, THIRD TRIMESTER, FETUS 2
O36.5933	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, THIRD TRIMESTER, FETUS 3
O36.5934	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, THIRD TRIMESTER, FETUS 4
O36.5935	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, THIRD TRIMESTER, FETUS 5
O36.5939	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, THIRD TRIMESTER, OTHER FETUS
O42.10	PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE, UNSPECIFIED WEEKS OF GESTATION
O42.111	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE, FIRST TRIMESTER
O42.112	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE, SECOND TRIMESTER
O42.113	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE, THIRD TRIMESTER
O42.119	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE, UNSPECIFIED TRIMESTER
O42.12	FULL-TERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE

SECTION 4 PROCEDURE CODES

NUTRITIONAL COUNSELING CODES

ADULT NUTRITIONAL COUNSELING DIAGNOSIS AND HCPCS CODES

Adult Nutritional Counseling ICD-10-CM Diagnosis Codes

October 2018 Update

For dates of service on or after **October 1, 2018**, please use the following ICD-10-CM diagnosis codes for the Adult Nutritional Counseling program. For dates of service prior to October 1, 2018, refer to the October 2017 Update included in this section.

ICD-10-CODE	DESCRIPTION
Z68.1	BODY MASS INDEX (BMI) 19.9 OR LESS, ADULT
Z68.20	BODY MASS INDEX (BMI) 20.0-20.9, ADULT
Z68.21	BODY MASS INDEX (BMI) 21.0-21.9, ADULT
Z68.22	BODY MASS INDEX (BMI) 22.0-22.9, ADULT
Z68.23	BODY MASS INDEX (BMI) 23.0-23.9, ADULT
Z68.24	BODY MASS INDEX (BMI) 24.0-24.9, ADULT
Z68.25	BODY MASS INDEX (BMI) 25.0-25.9, ADULT
Z68.26	BODY MASS INDEX (BMI) 26.0-26.9, ADULT
Z68.27	BODY MASS INDEX (BMI) 27.0-27.9, ADULT
Z68.28	BODY MASS INDEX (BMI) 28.0-28.9, ADULT
Z68.29	BODY MASS INDEX (BMI) 29.0-29.9, ADULT
Z68.30	BODY MASS INDEX (BMI) 30.0-30.9, ADULT
Z68.31	BODY MASS INDEX (BMI) 31.0-31.9, ADULT
Z68.32	BODY MASS INDEX (BMI) 32.0-32.9, ADULT
Z68.33	BODY MASS INDEX (BMI) 33.0-33.9, ADULT
Z68.34	BODY MASS INDEX (BMI) 34.0-34.9, ADULT
Z68.35	BODY MASS INDEX (BMI) 35.0-35.9, ADULT
Z68.36	BODY MASS INDEX (BMI) 36.0-36.9, ADULT
Z68.37	BODY MASS INDEX (BMI) 37.0-37.9, ADULT

SECTION 4 PROCEDURE CODES

NUTRITIONAL COUNSELING CODES

ICD-10-CODE	DESCRIPTION
Z68.38	BODY MASS INDEX (BMI) 38.0-38.9, ADULT
Z68.39	BODY MASS INDEX (BMI) 39.0-39.9, ADULT
Z68.41	BODY MASS INDEX (BMI) 40.0-44.9, ADULT
Z68.42	BODY MASS INDEX (BMI) 45.0-49.9, ADULT
Z68.43	BODY MASS INDEX (BMI) 50-59.9, ADULT
Z68.44	BODY MASS INDEX (BMI) 60.0-69.9, ADULT
Z68.45	BODY MASS INDEX (BMI) 70 OR GREATER, ADULT
Z68.51	BMI PEDIATRIC, LESS THAN 5TH PERCENTILE FOR AGE
Z68.52	BMI PEDIATRIC, 5TH PERCENTILE TO LESS THAN 85% FOR AGE
Z68.53	BMI PEDIATRIC, 85% TO LESS THAN 95TH PERCENTILE FOR AGE
Z68.54	BMI PEDIATRIC, GREATER THAN OR EQUAL TO 95% FOR AGE

October 2017 Update

For dates of service on or after **October 1, 2017** and prior to October 1, 2018, please use the following ICD-10-CM diagnosis codes for the Adult Nutritional Counseling program. For dates of service prior to October 1**,** 2017, refer to the October 2015 Update included in this section.

ICD-10-CODE	DESCRIPTION
Z68.1	BODY MASS INDEX (BMI) 19.9 OR LESS, ADULT
Z68.20	BODY MASS INDEX (BMI) 20.0-20.9, ADULT
Z68.21	BODY MASS INDEX (BMI) 21.0-21.9, ADULT
Z68.22	BODY MASS INDEX (BMI) 22.0-22.9, ADULT
Z68.23	BODY MASS INDEX (BMI) 23.0-23.9, ADULT
Z68.24	BODY MASS INDEX (BMI) 24.0-24.9, ADULT
Z68.25	BODY MASS INDEX (BMI) 25.0-25.9, ADULT
Z68.26	BODY MASS INDEX (BMI) 26.0-26.9, ADULT
Z68.27	BODY MASS INDEX (BMI) 27.0-27.9, ADULT
Z68.28	BODY MASS INDEX (BMI) 28.0-28.9, ADULT
Z68.29	BODY MASS INDEX (BMI) 29.0-29.9, ADULT
Z68.30	BODY MASS INDEX (BMI) 30.0-30.9, ADULT
Z68.31	BODY MASS INDEX (BMI) 31.0-31.9, ADULT
Z68.32	BODY MASS INDEX (BMI) 32.0-32.9, ADULT
Z68.33	BODY MASS INDEX (BMI) 33.0-33.9, ADULT
Z68.34	BODY MASS INDEX (BMI) 34.0-34.9, ADULT
Z68.35	BODY MASS INDEX (BMI) 35.0-35.9, ADULT
Z68.36	BODY MASS INDEX (BMI) 36.0-36.9, ADULT
Z68.37	BODY MASS INDEX (BMI) 37.0-37.9, ADULT

SECTION 4 PROCEDURE CODES

NUTRITIONAL COUNSELING CODES

ICD-10-CODE	DESCRIPTION
Z68.38	BODY MASS INDEX (BMI) 38.0-38.9, ADULT
Z68.39	BODY MASS INDEX (BMI) 39.0-39.9, ADULT
Z68.41	BODY MASS INDEX (BMI) 40.0-44.9, ADULT
Z68.42	BODY MASS INDEX (BMI) 45.0-49.9, ADULT
Z68.43	BODY MASS INDEX (BMI) 50-59.9 , ADULT
Z68.44	BODY MASS INDEX (BMI) 60.0-69.9, ADULT
Z68.45	BODY MASS INDEX (BMI) 70 OR GREATER, ADULT
Z68.51	BMI PEDIATRIC, LESS THAN 5TH PERCENTILE FOR AGE
Z68.52	BMI PEDIATRIC, 5TH PERCENTILE TO LESS THAN 85% FOR AGE
Z68.53	BMI PEDIATRIC, 85% TO LESS THAN 95TH PERCENTILE FOR AGE
Z68.54	BMI PEDIATRIC, GREATER THAN OR EQUAL TO 95% FOR AGE

October 2015 Update

For dates of service on or after **October 1, 2015** and prior to October 1, 2017, please use the following ICD-10-CM diagnosis codes for the Adult Nutritional Counseling program.

ICD-10 CODE	DESCRIPTION
Z68.1	BODY MASS INDEX (BMI) 19 OR LESS, ADULT
Z68.20	BODY MASS INDEX (BMI) 20.0-20.9, ADULT
Z68.21	BODY MASS INDEX (BMI) 21.0-21.9, ADULT
Z68.22	BODY MASS INDEX (BMI) 22.0-22.9, ADULT
Z68.23	BODY MASS INDEX (BMI) 23.0-23.9, ADULT
Z68.24	BODY MASS INDEX (BMI) 24.0-24.9, ADULT
Z68.25	BODY MASS INDEX (BMI) 25.0-25.9, ADULT
Z68.26	BODY MASS INDEX (BMI) 26.0-26.9, ADULT
Z68.27	BODY MASS INDEX (BMI) 27.0-27.9, ADULT
Z68.28	BODY MASS INDEX (BMI) 28.0-28.9, ADULT
Z68.29	BODY MASS INDEX (BMI) 29.0-29.9, ADULT
Z68.30	BODY MASS INDEX (BMI) 30.0-30.9, ADULT
Z68.31	BODY MASS INDEX (BMI) 31.0-31.9, ADULT
Z68.32	BODY MASS INDEX (BMI) 32.0-32.9, ADULT
Z68.33	BODY MASS INDEX (BMI) 33.0-33.9, ADULT
Z68.34	BODY MASS INDEX (BMI) 34.0-34.9, ADULT
Z68.35	BODY MASS INDEX (BMI) 35.0-35.9, ADULT
Z68.36	BODY MASS INDEX (BMI) 36.0-36.9, ADULT
Z68.37	BODY MASS INDEX (BMI) 37.0-37.9, ADULT
Z68.38	BODY MASS INDEX (BMI) 38.0-38.9, ADULT
Z68.39	BODY MASS INDEX (BMI) 39.0-39.9, ADULT

SECTION 4 PROCEDURE CODES

NUTRITIONAL COUNSELING CODES

ICD-10 CODE	DESCRIPTION
Z68.41	BODY MASS INDEX (BMI) 40.0-44.9, ADULT
Z68.42	BODY MASS INDEX (BMI) 45.0-49.9, ADULT
Z68.43	BODY MASS INDEX (BMI) 50-59.9 , ADULT
Z68.44	BODY MASS INDEX (BMI) 60.0-69.9, ADULT
Z68.45	BODY MASS INDEX (BMI) 70 OR GREATER, ADULT
Z68.51	BMI PEDIATRIC, LESS THAN 5TH PERCENTILE FOR AGE
Z68.52	BMI PEDIATRIC, 5TH PERCENTILE TO LESS THAN 85% FOR AGE
Z68.53	BMI PEDIATRIC, 85% TO LESS THAN 95TH PERCENTILE FOR AGE
Z68.54	BMI PEDIATRIC, GREATER THAN OR EQUAL TO 95% FOR AGE

Adult Nutritional Counseling HCPCS Codes

Please use the following HCPCS codes for the Adult Nutritional Counseling program.

HCPCS CODES	MODIFIER	DESCRIPTION	MAXIMUM UNITS PER CALENDAR YEAR
G0447 (RHC AND ALL FFS PROVIDERS)	SC	SCREENING TO DETERMINE THE APPROPRIATENESS OF CONSIDERATION OF AN INDIVIDUAL FOR PARTICIPATION IN A SPECIFIED PROGRAM, PROJECT OR TREATMENT PROTOCOL, PER ENCOUNTER	1 **INITIAL VISIT ONLY:** MAY BILL WITH AN E&M VISIT. IF BILLING WITH AN E&M VISIT, THE PROVIDER **MUST** APPEND THE 25 MODIFIER TO THE E&M CODE.
G0447 (RHC AND ALL FFS PROVIDERS)		FACE-TO-FACE BEHAVIORAL COUNSELING FOR OBESITY (15 MIN. SESSION)	TOTAL OF 5 SUBSEQUENT VISITS FOR EITHER GROUP OR INDIVIDUAL BEHAVIORAL COUNSELING
G0447 (RHC AND ALL FFS PROVIDERS)	HB	GROUP FACE-TO-FACE BEHAVIORAL COUNSELING	TOTAL OF 5 SUBSEQUENT VISITS FOR EITHER GROUP OR INDIVIDUAL BEHAVIORAL COUNSELING
S9470 (RHC AND ALL FFS DIETITIANS)		NUTRITIONAL COUNSELING, DIETITIAN VISIT (30 MIN. SESSION) INITIAL VISIT ONLY	1 INITIAL VISIT WITHIN 12 MONTHS
S9452 (RHC AND ALL FFS DIETITIANS)		NUTRITION CLASSES, NON-PHYSICIAN PROVIDER, PER SESSION (30 MIN. SESSION)	TOTAL OF 5 SUBSEQUENT VISITS FOR EITHER GROUP OR INDIVIDUAL NUTRITIONAL COUNSELING

SECTION 4 PROCEDURE CODES

NUTRITIONAL COUNSELING CODES

HCPCS CODES	MODIFIER	DESCRIPTION	MAXIMUM UNITS PER CALENDAR YEAR
S9452 (RHC AND ALL FFS DIETITIANS)	HB	GROUP NUTRITION CLASSES, NON-PHYSICIAN	TOTAL OF 5 SUBSEQUENT VISITS FOR EITHER GROUP OR INDIVIDUAL NUTRITIONAL COUNSELING
T1015 **(FQHC ONLY)**	SC	ENCOUNTER (INITIAL OBESITY VISIT, SUBSEQUENT OBESITY VISIT, NUTRITIONAL COUNSELING, NUTRITIONAL CLASSES)	TOTAL OF 1 INITIAL PROVIDER ENCOUNTER AND 5 SUBSEQUENT ENCOUNTERS
T1015 **(FQHC ONLY)**	HB FOR GROUP (NO MODIFIER FOR INDIVIDUALS)	ENCOUNTER (SUBSEQUENT OBESITY VISIT, NUTRITIONAL COUNSELING, NUTRITIONAL CLASSES)	TOTAL OF 5 PROVIDER ENCOUNTERS/NUTRITIONAL COUNSELING VISITS

CHILDREN'S NUTRITIONAL COUNSELING DIAGNOSIS AND HCPCS CODES

Children's Nutritional Counseling ICD-10-CM Diagnosis Code

For dates of service on or after **October 1, 2015**, please use the following ICD-10-CM diagnosis codes for the Children's Nutritional Counseling program.

ICD-10 CODE	DESCRIPTION
Z71.3	DIETARY COUNSELING AND SURVEILLANCE

Children's Nutritional Counseling HCPCS Codes

Please use the following HCPCS codes for the Children's Nutritional Counseling program.

CPT/HCPCS CODES	MODIFIER	DESCRIPTION	FREQUENCY LIMITATIONS
99201-99215		INITIAL VISIT PROVIDER MUST BILL THE APPROPRIATE LEVEL OF EVALUATION AND MANAGEMENT SERVICES.	
99201-99215		PROVIDER MUST BILL THE APPROPRIATE LEVEL OF EVALUATION AND MANAGEMENT SERVICES.	

SECTION 4 PROCEDURE CODES

NUTRITIONAL COUNSELING CODES

CPT/HCPCS CODES	MODIFIER	DESCRIPTION	FREQUENCY LIMITATIONS
97802 (DIETITIANS ONLY)		MEDICAL NUTRITION THERAPY, ASSESSMENT AND INTERVENTION, EACH 15 MINUTES	TOTAL OF 2 INITIAL UNITS FOR NUTRITIONAL COUNSELING
97803 (DIETITIANS ONLY)		MEDICAL NUTRITION THERAPY RE-ASSESSMENT AND INTERVENTION, EACH 15 MINUTES	TOTAL OF 2 UNITS PER DAY AND 10 UNITS PER YEAR
97803 (DIETITIANS ONLY)	HB	MEDICAL NUTRITION THERAPY RE-ASSESSMENT AND INTERVENTION, EACH 15 MINUTES (SEE NOTES BELOW)	TOTAL OF 2 UNITS PER DAY AND 10 UNITS PER YEAR
T1015 (FQHC ONLY)		CLINIC VISIT/ENCOUNTER ALL INCLUSIVE THIS CODE IS FOR BOTH THE PROVIDER AND DIETICIAN MEETING THE FQHC HRSA REQUIREMENT.	TOTAL OF 6 ENCOUNTERS PER YEAR

SECTION 4 PROCEDURE CODES

WRAP PAYMENT METHODOLOGY

FQHC WRAP PAYMENT METHODOLOGY

WRAP PAYMENT METHODOLOGY EFFECTIVE JULY 1, 2018	
FQHC	
Allowed CPT Codes (1)	**Exclusions from FQHC Encounter Rate (3)**
Billable as a Medical Encounter:	59025 (TC Modifier)
T1015	70000 - 79999 (TC Modifier)
99201-99205	70000 Series - 70% removed for Tech component (4)
99212-99215	90378
99241-99245	90630
99381-99385	90656
99391-99395	90657
Add. Codes for Bi-Annual Exams (Adults):	90658
99386	90620, 90621, 90670
99387	90662
99396	90672
99397	90673
Podiatry:	90685-90688
Standard E&M codes - see above	90707, 90710, 90715, 90716
Ophthalmalogy:	90732
92002	92250/TC
92004	92340
92012	93005
92014	93017
Chiropractic:	93041
98940-98942	93225
In-Home Services	93325
99341-99345	93880
99347-99350	93970
Domiciliary or Rest Home Services:	99050
99324-99328	99051
99334-99337	99217 - 99999 *
Skilled Nursing Facility Services:	A4264
99304-99310	J1050
99315-99316	J1950
99318	J7296
Family Planning Service (separate visit):	J7297
99401-99402	J7298
Postpartum Care:	J7300
59430	J7301
Health Risk Assessment (Foster Care):	J7307
96160, 96161	80305
MNT/Nutritional Counseling/Obesity Initiative:	80307
97802-97803	G0480
	Q2035 - Q2039
Billable as a Behavioral Health Encounter: (2)	Q3014
90791, 90792	
90832-90834, 90836-90838	
90839	
90847, 96101	
T1015/HE	* - Any code in this range unless included in the "Allowed CPT Code" column.
FOOTNOTES	
(1) Allowed CPT Codes are those services considered as an eligible FQHC encounter service.	
service. They are includable in the WRAP "count".	
(2) Behavioral Health Services codes that are considered as an eligible FQHC encounter.	
A behavioral health code can be provided and billed on the same date of service as a medical	
service. Both services/encounters will be included in the WRAP settlement.	
(3) Excludable procedure codes billed under MCO arrangements are not includable in the WRAP payment	
calculations and thus are carved out and reimbursed separately outside of the FQHC encounter rate. For	
any procedure code billed outside of those identified under sections (1), (2), and (3), payment of these codes	
are included in the FQHC encounter service rate and thus should not be separately reimbursed.	
(4) The professional component of the 70000 series procedure codes are included in the FQHC encounter	
service rate and thus should not be separately reimbursed.	
5) Current policy allows dietitian services as incident to a physician or mid-level service. That is, the beneficiary is seen	
by the provider (physician or mid-level) and dietitian on the same day, one encounter can be billed for the services	
received that day. Dietitian services cannot be billed independently from the services of the physician or mid-level.	
6) Group services should never be billed using the encounter rate. A billable encounter is a face-to-face, one-on-one service	
with a physician or mid-level practitioner.	
7) Procedure codes will be reviewed annually to determine if updates are required in either billable encounter codes or	
excludable services.	

Division of Ancillary Reimbursements 9/18/2018

SECTION 4 PROCEDURE CODES

WRAP PAYMENT METHODOLOGY

RHC WRAP PAYMENT METHODOLOGY

RHC WRAP PAYMENT METHODOLOGY EFFECTIVE JANUARY 1, 2018	
RHC	
Allowed CPT Codes (1)	**Exclusions from RHC Encounter Rate (3)**
Billable as a Medical Encounter:	11976,11981
T1015	58300,58301
99201-99205	59025 (TC Modifier)
99212-99215	70000 - 79999 (TC Modifier)
99241-99245	70000 Series - 70% removed for Tech component (4)
99381-99385	80000-89999
99391-99395	90378
Add. Codes for Bi-Annual Exams (Adults):	90630
99386	90656
99387	90657
99396	90658
99397	90670
Podiatry:	90620, 90621
Standard E&M codes - see above	90662
Ophthalmology:	90672
92002	90673
92004	90685-90688
92012	90707, 90710, 90715, 90716
92014	90732
Chiropractic:	93005
98940-98942	93017
In-Home Services	93041
99341-99345	93225
99347-99350	93325
Domiciliary or Rest Home Services:	93880
99324-99328	93970
99334-99337	97802, 97803
Skilled Nursing Facility Services:	99050
99304-99310	99051
99315-99316	99188
99318	99217 - 99999 *
Family Planning Service (separate visit):	A4264
99401-99402	G0447
Postpartum Care:	H0002
59430	H0004
Health Risk Assessment (Foster Care):	J1050
96160, 96161	J1950
Billable as a Behavioral Health Encounter: (2)	J7296
90791, 90792	J7297
90832-90834, 90836-90838	J7298
90839	J7300
90847, 96101	J7301
T1015/HE	J7307
	Q2035 - Q2039
	Q3014
	S4989
	S9452
	S9470
	* - Any code in this range unless included in the "Allowed CPT Code" column.
FOOTNOTES	
(1) Allowed CPT Codes are those services considered as an eligible RHC encounter	
service. They are includable in the WRAP "count".	
(2) Behavioral Health Services codes that are considered as an eligible RHC encounter.	
A behavioral health code can be provided and billed on the same date of service as a medical	
service. Both services/encounters will be included in the WRAP settlement.	
(3) Excludable procedure codes billed under MCO arrangements are not includable in the WRAP payment	
calculations and thus are carved out and reimbursed separately outside of the RHC encounter rate. For	
any procedure code billed outside of those identified under sections (1), (2), and (3), payment of these codes	
are included in the RHC encounter service rate and thus should not be separately reimbursed.	
(4) The professional component of the 70000 series procedure codes are included in the RHC encounter	
service rate and thus should not be separately reimbursed.	
(5) Group services should never be billed using the encounter rate. A billable encounter is a face-to-face, one-on-one service	
with a physician or mid-level practitioner. Note: RHCs are allowed to separately bill obesity services, some of which are group.	
The group rates are the same as individual rates.	
(6) Procedure codes will be reviewed annually to determine if updates are required in either billable encounter codes or	
excludable services.	

SECTION 5

ADMINISTRATIVE SERVICES

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GENERAL INFORMATION

ADMINISTRATION

The South Carolina Department of Health and Human Services (SCDHHS) administers the South Carolina Healthy Connections Medicaid Program. This section outlines the available resources for Medicaid providers.

CORRESPONDENCE AND INQUIRIES

All correspondence to South Carolina Healthy Connections Medicaid should be directed to the SCDHHS Provider Service Center (PSC) at 1-888-289-0709. In addition, providers may submit an online inquiry at https://www.scdhhs.gov/contact-us. Inquiries concerning specific claims should also be directed to the PSC, but only after all claims filing requirements have been met. **Allow 45 days from the submission date before requesting the status of the claim.**

BENEFICIARY ELIGIBILITY

Questions concerning beneficiary eligibility or identification numbers should be directed to the SCDHHS county office in the beneficiary's county of residence. Beneficiaries who have questions regarding specific coverage issues should be referred to the appropriate staff of their county SCDHHS office for assistance. The contact information for county offices is located on the SCDHHS website at https://www.scdhhs.gov/site-page/where-go-help.

Eligibility Status

To verify eligibility status, please use the South Carolina Medicaid Web-based Claims Submission Tool (Web Tool), which is available 24 hours a day/7 days a week. For information on the Web Tool, you may contact the PSC at 1-888-289-0709.

SECTION 5 ADMINISTRATIVE SERVICES

GENERAL INFORMATION

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SECTION 5 ADMINISTRATIVE SERVICES

PROCUREMENT OF FORMS

The South Carolina Department of Health and Human Services will not supply the CMS-1500 claim form to providers. Providers should purchase the form in its approved format from the private vendor of their choice. Examples of vendors who supply the form are listed below. This list should not be viewed as an endorsement of these vendors by SCDHHS.

REPRODUCIBLE NEGATIVES

Government Printing Office
(800) 512-1800

TFP Data Systems
(800) 482-9367 ext. 1770
1500form@tfpdata.com

SOFTWARE

Attn: Orders Department
American Medical Association
PO Box 930876
Atlanta, GA 31193-0876
(800) 621-8335
Fax: (312) 464-5600
https://commerce.ama-assn.org/store/

HARD COPY CLAIM FORMS

Government Printing Office
Superintendent of Documents
PO Box 979050
St. Louis, MO 63197-9000
(866) 512-1800 Toll Free
Fax: (202) 512-2104
https://bookstore.gpo.gov/

PRIVATE VENDORS

RR Donnelley
1210 Key Road
Columbia, SC 29201
(803) 576-1304
Fax: (803) 252-7748

SECTION 5 ADMINISTRATIVE SERVICES

PROCUREMENT OF FORMS

PRIVATE VENDORS (CONT'D.)

Physicians' Record Company
3000 S. Ridgeland Ave.
Berwyn, IL 60402-0724
(800) 323-9268 (toll free)
Fax: (708) 749-0171
orders@physiciansrecord.com

Standard Register Company
600 Albany Street
Dayton, OH 45417
(937) 221-1078
(800) 867-8465
Fax: (800) 473-3211

SCDHHS FORMS

Providers may order SCDHHS forms via email at forms@scdhhs.gov. Copies of forms, including program-specific forms, are also available in the Forms section of this manual.

WEB ADDRESS

Providers should visit the Provider Information page on the SCDHHS Web site at https://www.scdhhs.gov/provider for the most current version of this manual.

To order a paper version of this manual, please contact the SCDHHS Provider Service Center (PSC) at 1-888-289-0709. From the Main Menu, select the Provider Enrollment and Education option. Charges for printed manuals are based on actual costs of printing and mailing.

SECTION 6

BIRTH OUTCOMES INITIATIVE

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BIRTH OUTCOMES INITIATIVE (BOI)

South Carolina Birth Outcomes Initiative (BOI) is an effort by the South Carolina Department of Health and Human Services (SCDHHS) and its partners to improve the health of newborns in the Medicaid program. Launched in July 2011, the Birth Outcomes Initiative is focused on achieving five key goals:

1. Ending elective inductions for non-medically indicated deliveries prior to 39 weeks. This should also help us address reducing the number of cesarean-sections as well as NICU admissions.
2. Reducing the average length of stay in neonatal intensive care units and pediatric intensive care units.
3. Reducing health disparities among newborns.
4. Making 17P, a compound that helps prevent pre-term births, available to all at-risk pregnant women with no “hassle factor.”
5. Implementing a universal screening and referral tool for physicians. This tool will screen pregnant women for tobacco use, substance abuse, depression, and domestic violence.

Key partners in the Birth Outcomes Initiative include: the SC Hospital Association, the SC Department of Health and Environmental Control, the SC Department of Drug and Other Alcohol Abuse Services, the SC Department of Mental Health, the SC Office of Research and Statistics, the University of South Carolina’s Institute on Families in Society, and the SC March of Dimes.

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BIRTH OUTCOME INITIATIVE (BOI)

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SECTION 6 BIRTH OUTCOMES INITIATIVE

COVERAGE FOR CENTERING PREGNANCY GROUP PRENATAL CARE

As part of the Birth Outcome Initiative, Centering Pregnancy group prenatal services are a covered benefit for pregnant women. Centering Pregnancy is a model of prenatal care provided in a group setting that gives patients more time with their provider and encourages interaction with other women due to deliver a baby at the same time. Through this service, participants meet to discuss maternal and infant health as a group while receiving clinical supervision and support. To qualify for the benefit, a Medicaid member must be a female between the ages of 12 and 55 years of age.

BILLING AND REIMBURSEMENT

The Centering Healthcare Institute certifies providers offering Centering Pregnancy programs. To qualify for reimbursement for Centering Pregnancy group clinical visits, a provider must be a site approved by the Centering Healthcare Institute or be under the Centering grant contract through DHHS in preparation for formal site approval, and the provider must provide group prenatal care utilizing the Centering Pregnancy model.

Group clinical visits must last at least an hour and a half, with a minimum of two clients and a maximum of twenty clients. Following the recommended Centering Pregnancy model, up to 10 group clinical visits prior to delivery may be covered. Providers must use educational materials from the Centering Pregnancy curriculum, and these must be incorporated into the educational portion of the group clinical visit.

Providers must submit a claim for a group clinical visit for the management of pregnancy using procedure code 99078 and modifier TH. The claim must include a pregnancy diagnosis code (ICD-10 series Z34- for normal pregnancy, and ICD-10 series O09- for high-risk).

For claims with procedure code 99078 with modifier TH to be considered for reimbursement, they must be submitted for the same date of service as claims by the same provider for an established patient visit (E/M procedure codes 99211, 99212, 99213, 99214, or 99215) with modifier TH.

The Centering Healthcare Institute lists sites in South Carolina currently approved to provide Centering Pregnancy services on its webpage:
https://centeringhealthcare.secure.force.com/WebPortal/ListOfCenteringSites?stateName=SC

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BIRTH OUTCOME INITIATIVE (BOI)

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SECTION 6 BIRTH OUTCOMES INITIATIVE

ACOG DELIVERY GUIDELINES

The following conditions are generally accepted as exceptions to the guideline recommendation for planned delivery or induction no earlier than 39 weeks. Delivery < 39 weeks for these conditions may represent a benefit for the mother, the fetus or both. This list is not meant to be exclusive and each category may require a separate guideline to outline evidence-based practices regarding timing or delivery.

- Pre-eclampsia, mild or severe
- Uncontrollable chronic hypertension or gestational hypertension
- Poorly controlled diabetes mellitus
- Intra-uterine growth restriction (IUGR)
- Non-reassuring fetal status
- Oligohydramnios
- Fetal Gastroschisis
- Other congenital anomalies requiring early delivery (*i.e.*, Vein of Galen malformation)
- Fetal iso-immunization
- Allo-immune thrombocytopenia (NAIT)
- Placenta previa / accreta / percreta
- Vasa previa
- Preterm premature rupture of the membranes (PPROM)
- Premature rupture of the membranes (PROM)
- Placental abruption
- Severe maternal hemorrhage
- Chorioamnionitis
- Worsening maternal medical condition (renal failure, respiratory distress syndrome, acidosis, etc.)
- Maternal death (peri-mortem delivery)
- HIV
- Maternal malignancy
- Prior classical cesarean delivery (prior incisions into the muscular uterus)
- Prior myomectomy, uterine rupture or significant scarring
- Multiple gestation
- Cholestasis of pregnancy
- Herpes gestationis
- Impetigo herpetiformis

1. Spong C, Mercer B, D'Alton M, Kilpatrick S, Blackwell S, Saade G Timing of Indicated Late-Preterm and Early-Term Birth Obstetrics/Gynecology 118(2) Aug 2011 323-333
2. Adapted from the Society for Maternal-Fetal Medicine and the American Congress of Obstetricians and Gynecologists.

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ACOG DELIVERY GUIDELINES

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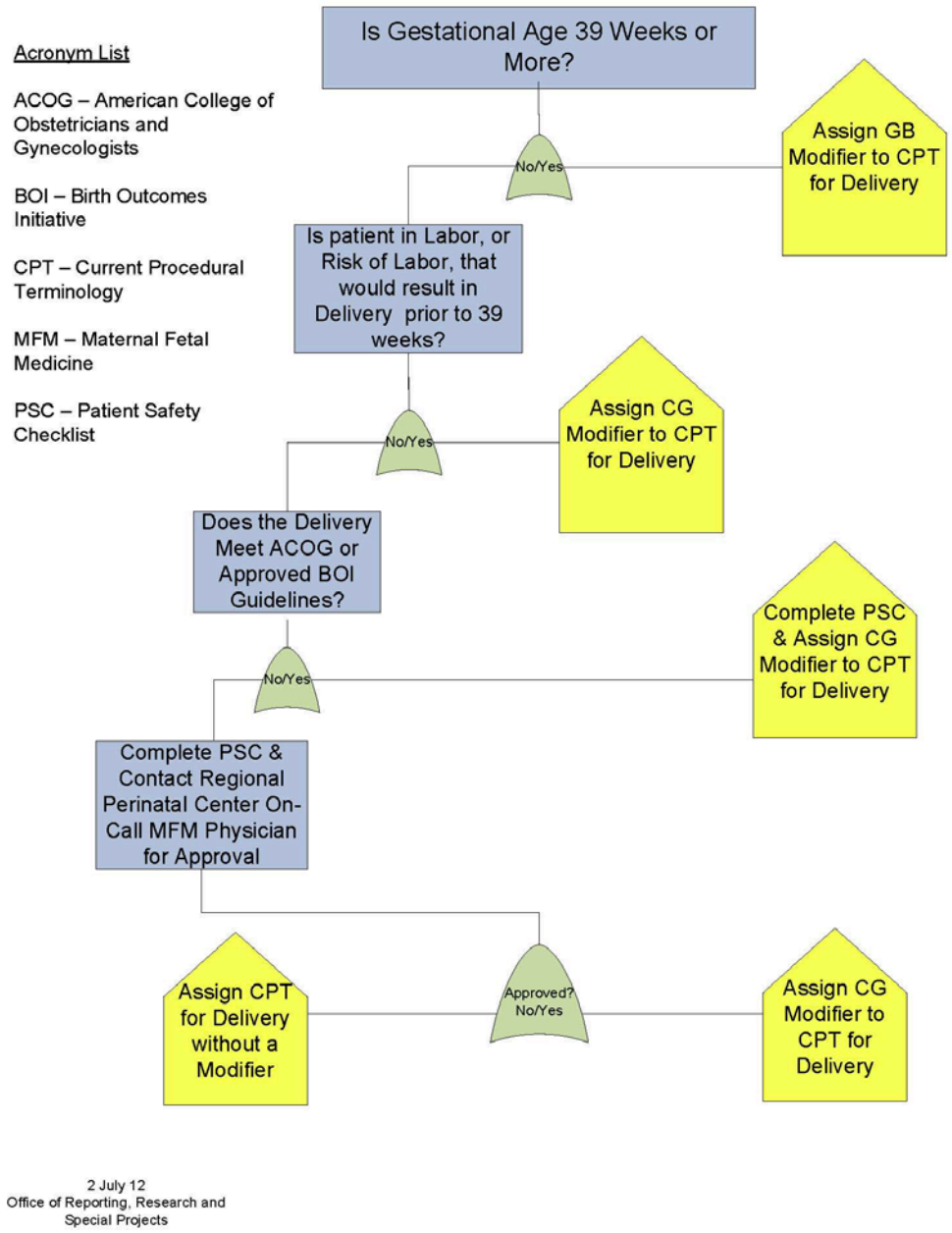
SECTION 6 BIRTH OUTCOMES INITIATIVE

FLOW OF MEDICAID MODIFIER ASSIGNMENT FOR DELIVERIES



SECTION 6 BIRTH OUTCOMES INITIATIVE

FLOW OF MEDICAID MODIFIER ASSIGNMENT FOR DELIVERIES

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SECTION 6 BIRTH OUTCOMES INITIATIVE

BOI APPROVED DELIVERY GUIDELINES

ICD-9-CM DIAGNOSIS CODES

ICD-9-CM diagnosis codes for dates of service on or before **September 30, 2015** are located on the SCDHHS website on the Physicians Services Provider Manual webpage.

ICD-10-CM DIAGNOSIS CODES

October 2018 Update

For dates of service on or after October 1, 2018, please use the following ICD-10-CM and PCS codes. For dates of service prior to October 1, 2018, refer to the October 2016 Update included in this section.

Excluded populations: For dates of service on or after October 1, 2018, the following ICD-10-CM principal diagnosis codes or ICD-10-CM other diagnosis codes for conditions possibly justifying elective delivery priorto 39 weeks gestation are excluded.

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
10900ZC	DRAINAGE OF AMNIOTIC FLUID, THERAPEUTIC FROM PRODUCTS OF CONCEPTION, OPEN APPROACH	DRAINAGE OF AMNIOTIC FL, THERAP FROM POC, OPEN APPROACH
10903ZC	DRAINAGE OF AMNIOTIC FLUID, THERAPEUTIC FROM PRODUCTS OF CONCEPTION, PERCUTANEOUS APPROACH	DRAINAGE OF AMNIOTIC FL, THERAP FROM POC, PERC APPROACH
10904ZC	DRAINAGE OF AMNIOTIC FLUID, THERAPEUTIC FROM PRODUCTS OF CONCEPTION, PERCUTANEOUS ENDOSCOPIC APPROACH	DRAINAGE OF AMNIOTIC FL, THERAP FROM POC, PERC ENDO APPROACH
10907ZC	DRAINAGE OF AMNIOTIC FLUID, THERAPEUTIC FROM PRODUCTS OF CONCEPTION, VIA NATURAL OR ARTIFICIAL OPENING	DRAINAGE OF AMNIOTIC FL, THERAPEUTIC FROM POC, VIA NATURAL OR ARTIFICIAL OPENING
10908ZC	DRAINAGE OF AMNIOTIC FLUID, THERAPEUTIC FROM PRODUCTS OF CONCEPTION, VIA NATURAL OR ARTIFICIAL OPENING ENDOSCOPIC	DRAINAGE OF AMNIOTIC FL, THERAPEUTIC FROM POC, VIA NATURAL OR ARTIFICIAL OPENING ENDOSCOPIC
0U7C7ZZ	DILATION OF CERVIX, VIA NATURAL OR ARTIFICIAL OPENING	DILATION OF CERVIX, VIA NATURAL OR ARTIFICIAL OPENING
10D00Z0	EXTRACTION OF PRODUCTS OF CONCEPTION, HIGH, OPEN APPROACH	EXTRACTION OF PRODUCTS OF CONCEPTION, HIGH, OPEN APPROACH
10D00Z1	EXTRACTION OF PRODUCTS OF CONCEPTION, LOW, OPEN APPROACH	EXTRACTION OF PRODUCTS OF CONCEPTION, LOW, OPEN APPROACH

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
10D00Z2	EXTRACTION OF PRODUCTS OF CONCEPTION, EXTRAPERITONEAL, OPEN APPROACH	EXTRACTION OF POC, EXTRAPERITONEAL, OPEN APPROACH
3E030VJ	INTRODUCTION OF OTHER HORMONE INTO PERIPHERAL VEIN, OPEN APPROACH	INTRODUCTION OF OTH HORMONE INTO PERIPH VEIN, OPEN APPROACH
3E033VJ	INTRODUCTION OF OTHER HORMONE INTO PERIPHERAL VEIN, PERCUTANEOUS APPROACH	INTRODUCTION OF OTH HORMONE INTO PERIPH VEIN, PERCUTANEOUS APPROACH
3E040VJ	INTRODUCTION OF OTHER HORMONE INTO CENTRAL VEIN, OPEN APPROACH	INTRODUCTION OF OTH HORMONE INTO CENTRAL VEIN, OPEN APPROACH
3E043VJ	INTRODUCTION OF OTHER HORMONE INTO CENTRAL VEIN, PERCUTANEOUS APPROACH	INTRODUCTION OF OTH HORMONE INTO CENTRAL VEIN, PERC APPROACH
3E050VJ	INTRODUCTION OF OTHER HORMONE INTO PERIPHERAL ARTERY, OPEN APPROACH	INTRODUCTION OF OTH HORMONE INTO PERIPH ARTERY, OPEN APPROACH
3E053VJ	INTRODUCTION OF OTHER HORMONE INTO PERIPHERAL ARTERY, PERCUTANEOUS APPROACH	INTRODUCTION OF OTHER HORMONE INTO PERIPH ART, PERC APPROACH
3E060VJ	INTRODUCTION OF OTHER HORMONE INTO CENTRAL ARTERY, OPEN APPROACH	INTRODUCTION OF OTH HORMONE INTO CENTRAL ART, OPEN APPROACH
3E063VJ	INTRODUCTION OF OTHER HORMONE INTO CENTRAL ARTERY, PERCUT APPROACH	INTRODUCTION OF OTH HORMONE INTO CENTRAL ART, PERC APPROACH
3E0DXGC	INTRODUCTION OF OTHER THERAPEUTIC SUBSTANCE INTO MOUTH AND PHARYNX, EXTERNAL APPROACH	INTRODUCE OTH THERAP SUBST IN MOUTH/PHAR, EXTERN
B20	HUMAN IMMUNODEFICIENCY VIRUS [HIV] DISEASE	HUMAN IMMUNODEFICIENCY VIRUS [HIV] DISEASE
O09.291	SUPERVISION OF PREGNANCY WITH OTHER POOR REPRODUCTIVE OR OBSTETRIC HISTORY, FIRST TRIMESTER	SUPRVSN OF PREG W POOR REPRODCTV OR OBSTET HX, FIRST TRI
O09.292	SUPERVISION OF PREGNANCY WITH OTHER POOR REPRODUCTIVE OR OBSTETRIC HISTORY, SECOND TRIMESTER	SUPRVSN OF PREG W POOR REPRODCTV OR OBSTET HX, SECOND TRI
O09.293	SUPERVISION OF PREGNANCY WITH OTHER POOR REPRODUCTIVE OR OBSTETRIC HISTORY, THIRD TRIMESTER	SUPRVSN OF PREG W POOR REPRODCTV OR OBSTET HX, THIRD TRI
O09.299	SUPERVISION OF PREGNANCY WITH OTHER POOR REPRODUCTIVE OR OBSTETRIC HISTORY, UNSPECIFIED TRIMESTER	SUPRVSN OF PREG W POOR REPRODCTV OR OBSTET HISTORY, UNSP TRI
O10.011	PRE-EXISTING ESSENTIAL HYPERTENSION COMPLICATING PREGNANCY, FIRST TRIMESTER	PRE-EXISTING ESSENTIAL HTN COMP PREGNANCY, FIRST TRIMESTER
O10.012	PRE-EXISTING ESSENTIAL HYPERTENSION	PRE-EXISTING ESSENTIAL HTN COMP

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
	COMPLICATING PREGNANCY, SECOND TRIMESTER	PREGNANCY, SECOND TRIMESTER
O10.013	PRE-EXISTING ESSENTIAL HYPERTENSION COMPLICATING PREGNANCY, THIRD TRIMESTER	PRE-EXISTING ESSENTIAL HTN COMP PREGNANCY, THIRD TRIMESTER
O10.019	PRE-EXISTING ESSENTIAL HYPERTENSION COMPLICATING PREGNANCY, UNSPECIFIED TRIMESTER	PRE-EXISTING ESSENTIAL HTN COMP PREGNANCY, UNSP TRIMESTER
O10.02	PRE-EXISTING ESSENTIAL HYPERTENSION COMPLICATING CHILDBIRTH	PRE-EXISTING ESSENTIAL HYPERTENSION COMPLICATING CHILDBIRTH
O10.03	PRE-EXISTING ESSENTIAL HYPERTENSION COMPLICATING THE PUERPERIUM	PRE-EXISTING ESSENTIAL HYPERTENSION COMP THE PUERPERIUM
O10.111	PRE-EXISTING HYPERTENSIVE HEART DISEASE COMPLICATING PREGNANCY, FIRST TRIMESTER	PRE-EXIST HYP HEART DISEASE COMP PREGNANCY, FIRST TRIMESTER
O10.112	PRE-EXISTING HYPERTENSIVE HEART DISEASE COMPLICATING PREGNANCY, SECOND TRIMESTER	PRE-EXIST HYP HEART DISEASE COMP PREGNANCY, SECOND TRIMESTER
O10.113	PRE-EXISTING HYPERTENSIVE HEART DISEASE COMPLICATING PREGNANCY, THIRD TRIMESTER	PRE-EXIST HYP HEART DISEASE COMP PREGNANCY, THIRD TRIMESTER
O10.119	PRE-EXISTING HYPERTENSIVE HEART DISEASE COMPLICATING PREGNANCY, UNSPECIFIED TRIMESTER	PRE-EXIST HYP HEART DISEASE COMP PREGNANCY, UNSP TRIMESTER
O10.12	PRE-EXISTING HYPERTENSIVE HEART DISEASE COMPLICATING CHILDBIRTH	PRE-EXISTING HYPERTENSIVE HEART DISEASE COMP CHILDBIRTH
O10.13	PRE-EXISTING HYPERTENSIVE HEART DISEASE COMPLICATING THE PUERPERIUM	PRE-EXISTING HYPERTENSIVE HEART DISEASE COMP THE PUERPERIUM
O10.211	PRE-EXISTING HYPERTENSIVE CHRONIC KIDNEY DISEASE COMPLICATING PREGNANCY, FIRST TRIMESTER	PRE-EXIST HYP CHRONIC KIDNEY DISEASE COMP PREG, FIRST TRI
O10.212	PRE-EXISTING HYPERTENSIVE CHRONIC KIDNEY DISEASE COMPLICATING PREGNANCY, SECOND TRIMESTER	PRE-EXIST HYP CHRONIC KIDNEY DISEASE COMP PREG, SECOND TRI
O10.213	PRE-EXISTING HYPERTENSIVE CHRONIC KIDNEY DISEASE COMPLICATING PREGNANCY, THIRD TRIMESTER	PRE-EXIST HYP CHRONIC KIDNEY DISEASE COMP PREG, THIRD TRI
O10.219	PRE-EXISTING HYPERTENSIVE CHRONIC KIDNEY DISEASE COMPLICATING PREGNANCY, UNSPECIFIED TRIMESTER	PRE-EXIST HYP CHRONIC KIDNEY DISEASE COMP PREG, UNSP TRI
O10.22	PRE-EXISTING HYPERTENSIVE CHRONIC KIDNEY DISEASE COMPLICATING CHILDBIRTH	PRE-EXISTING HYP CHRONIC KIDNEY DISEASE COMP CHILDBIRTH
O10.23	PRE-EXISTING HYPERTENSIVE CHRONIC KIDNEY DISEASE COMPLICATING THE	PRE-EXISTING HYP CHRONIC KIDNEY DISEASE COMP THE PUERPERIUM

SECTION 6 BIRTH OUTCOMES INITIATIVE

BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
	PUERPERIUM	
O10.311	PRE-EXISTING HYPERTENSIVE HEART AND CHRONIC KIDNEY DISEASE COMPLICATING PREGNANCY, FIRST TRIMESTER	PRE-EXIST HYP HEART AND CHR KIDNEY DIS COMP PREG, FIRST TRI
O10.312	PRE-EXISTING HYPERTENSIVE HEART AND CHRONIC KIDNEY DISEASE COMPLICATING PREGNANCY, SECOND TRIMESTER	PRE-EXIST HYP HEART AND CHR KIDNEY DIS COMP PREG, SECOND TRI
O10.313	PRE-EXISTING HYPERTENSIVE HEART AND CHRONIC KIDNEY DISEASE COMPLICATING PREGNANCY, THIRD TRIMESTER	PRE-EXIST HYP HEART AND CHR KIDNEY DIS COMP PREG, THIRD TRI
O10.319	PRE-EXISTING HYPERTENSIVE HEART AND CHRONIC KIDNEY DISEASE COMPLICATING PREGNANCY, UNSPECIFIED TRIMESTER	PRE-EXIST HYP HEART AND CHR KIDNEY DIS COMP PREG, UNSP TRI
O10.32	PRE-EXISTING HYPERTENSIVE HEART AND CHRONIC KIDNEY DISEASE COMPLICATING CHILDBIRTH	PRE-EXIST HYP HEART AND CHRONIC KIDNEY DISEASE COMP CHLDBRTH
O10.33	PRE-EXISTING HYPERTENSIVE HEART AND CHRONIC KIDNEY DISEASE COMPLICATING THE PUERPERIUM	PRE-EXIST HYP HEART AND CHR KIDNEY DISEASE COMP THE PUERP
O10.411	PRE-EXISTING SECONDARY HYPERTENSION COMPLICATING PREGNANCY, FIRST TRIMESTER	PRE-EXISTING SECONDARY HTN COMP PREGNANCY, FIRST TRIMESTER
O10.412	PRE-EXISTING SECONDARY HYPERTENSION COMPLICATING PREGNANCY, SECOND TRIMESTER	PRE-EXISTING SECONDARY HTN COMP PREGNANCY, SECOND TRIMESTER
O10.413	PRE-EXISTING SECONDARY HYPERTENSION COMPLICATING PREGNANCY, THIRD TRIMESTER	PRE-EXISTING SECONDARY HTN COMP PREGNANCY, THIRD TRIMESTER
O10.419	PRE-EXISTING SECONDARY HYPERTENSION COMPLICATING PREGNANCY, UNSPECIFIED TRIMESTER	PRE-EXISTING SECONDARY HTN COMP PREGNANCY, UNSP TRIMESTER
O10.42	PRE-EXISTING SECONDARY HYPERTENSION COMPLICATING CHILDBIRTH	PRE-EXISTING SECONDARY HYPERTENSION COMPLICATING CHILDBIRTH
O10.43	PRE-EXISTING SECONDARY HYPERTENSION COMPLICATING THE PUERPERIUM	PRE-EXISTING SECONDARY HYPERTENSION COMP THE PUERPERIUM
O10.911	UNSPECIFIED PRE-EXISTING HYPERTENSION COMPLICATING PREGNANCY, FIRST TRIMESTER	UNSP PRE-EXISTING HTN COMP PREGNANCY, FIRST TRIMESTER
O10.912	UNSPECIFIED PRE-EXISTING HYPERTENSION COMPLICATING PREGNANCY, SECOND TRIMESTER	UNSP PRE-EXISTING HTN COMP PREGNANCY, SECOND TRIMESTER
O10.913	UNSPECIFIED PRE-EXISTING HYPERTENSION COMPLICATING PREGNANCY, THIRD TRIMESTER	UNSP PRE-EXISTING HTN COMP PREGNANCY, THIRD TRIMESTER
O10.919	UNSPECIFIED PRE-EXISTING HYPERTENSION	UNSP PRE-EXISTING HTN COMP

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
	COMPLICATING PREGNANCY, UNSPECIFIED TRIMESTER	PREGNANCY, UNSP TRIMESTER
O10.92	UNSPECIFIED PRE-EXISTING HYPERTENSION COMPLICATING CHILDBIRTH	UNSP PRE-EXISTING HYPERTENSION COMPLICATING CHILDBIRTH
O10.93	UNSPECIFIED PRE-EXISTING HYPERTENSION COMPLICATING THE PUERPERIUM	UNSP PRE-EXISTING HYPERTENSION COMPLICATING THE PUERPERIUM
O11.1	PRE-EXISTING HYPERTENSION WITH PRE-ECLAMPSIA, FIRST TRIMESTER	PRE-EXISTING HYPERTENSION W PRE-ECLAMPSIA, FIRST TRIMESTER
O11.2	PRE-EXISTING HYPERTENSION WITH PRE-ECLAMPSIA, SECOND TRIMESTER	PRE-EXISTING HYPERTENSION W PRE-ECLAMPSIA, SECOND TRIMESTER
O11.3	PRE-EXISTING HYPERTENSION WITH PRE-ECLAMPSIA, THIRD TRIMESTER	PRE-EXISTING HYPERTENSION W PRE-ECLAMPSIA, THIRD TRIMESTER
O11.4	PRE-EXISTING HYPERTENSION WITH PREECLAMPSIA, COMPLICATING CHILDBIRTH	PRE-EXISTING HTN WITH PREECLAMPSIA, COMP CHILDBIRTH
O11.5	PRE-EXISTING HYPERTENSION WITH PREECLAMPSIA, COMPLICATING THE PUERPERIUM	PRE-EXISTING HTN WITH PREECLAMPSIA, COMP THE PUERPERIUM
O11.9	PRE-EXISTING HYPERTENSION WITH PRE-ECLAMPSIA, UNSPECIFIED TRIMESTER	PRE-EXISTING HYPERTENSION WITH PRE-ECLAMPSIA, UNSP TRIMESTER
O12.10	GESTATIONAL PROTEINURIA, UNSPECIFIED TRIMESTER	GESTATIONAL PROTEINURIA, UNSPECIFIED TRIMESTER
O12.11	GESTATIONAL PROTEINURIA, FIRST TRIMESTER	GESTATIONAL PROTEINURIA, FIRST TRIMESTER
O12.12	GESTATIONAL PROTEINURIA, SECOND TRIMESTER	GESTATIONAL PROTEINURIA, SECOND TRIMESTER
O12.13	GESTATIONAL PROTEINURIA, THIRD TRIMESTER	GESTATIONAL PROTEINURIA, THIRD TRIMESTER
O12.14	GESTATIONAL PROTEINURIA, COMPLICATING CHILDBIRTH	GESTATIONAL PROTEINURIA, COMPLICATING CHILDBIRTH
O12.15	GESTATIONAL PROTEINURIA, COMPLICATING THE PUERPERIUM	GESTATIONAL PROTEINURIA, COMPLICATING THE PUERPERIUM
O12.20	GESTATIONAL EDEMA WITH PROTEINURIA, UNSPECIFIED TRIMESTER	GESTATIONAL EDEMA WITH PROTEINURIA, UNSPECIFIED TRIMESTER
O12.21	GESTATIONAL EDEMA WITH PROTEINURIA, FIRST TRIMESTER	GESTATIONAL EDEMA WITH PROTEINURIA, FIRST TRIMESTER
O12.22	GESTATIONAL EDEMA WITH PROTEINURIA, SECOND TRIMESTER	GESTATIONAL EDEMA WITH PROTEINURIA, SECOND TRIMESTER
O12.23	GESTATIONAL EDEMA WITH PROTEINURIA, THIRD TRIMESTER	GESTATIONAL EDEMA WITH PROTEINURIA, THIRD TRIMESTER
O12.24	GESTATIONAL EDEMA WITH PROTEINURIA, COMPLICATING CHILDBIRTH	GESTATIONAL EDEMA WITH PROTEINURIA, COMPLICATING CHILDBIRTH

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ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O12.25	GESTATIONAL EDEMA WITH PROTEINURIA, COMPLICATING THE PUERPERIUM	GESTATIONAL EDEMA WITH PROTEINURIA, COMP THE PUERPERIUM
O13.1	GESTATIONAL [PREGNANCY-INDUCED] HYPERTENSION WITHOUT SIGNIFICANT PROTEINURIA, FIRST TRIMESTER	GESTATIONAL HTN W/O SIGNIFICANT PROTEINURIA, FIRST TRIMESTER
O13.2	GESTATIONAL [PREGNANCY-INDUCED] HYPERTENSION WITHOUT SIGNIFICANT PROTEINURIA, SECOND TRIMESTER	GESTATNL HTN W/O SIGNIFICANT PROTEINURIA, SECOND TRIMESTER
O13.3	GESTATIONAL [PREGNANCY-INDUCED] HYPERTENSION WITHOUT SIGNIFICANT PROTEINURIA, THIRD TRIMESTER	GESTATIONAL HTN W/O SIGNIFICANT PROTEINURIA, THIRD TRIMESTER
O13.4	GESTATIONAL [PREGNANCY-INDUCED] HYPERTENSION WITHOUT SIGNIFICANT PROTEINURIA, COMPLICATING CHILDBIRTH	GESTATNL HTN WITHOUT SIGNIFICANT PROTEIN, COMP CHILDBIRTH
O13.5	GESTATIONAL [PREGNANCY-INDUCED] HYPERTENSION WITHOUT SIGNIFICANT PROTEINURIA, COMPLICATING THE PUERPERIUM	GESTATNL HTN WITHOUT SIGNIFICANT PROTEIN, COMP THE PUERP
O13.9	GESTATIONAL [PREGNANCY-INDUCED] HYPERTENSION WITHOUT SIGNIFICANT PROTEINURIA, UNSPECIFIED TRIMESTER	GESTATIONAL HTN W/O SIGNIFICANT PROTEINURIA, UNSP TRIMESTER
O14.00	MILD TO MODERATE PRE-ECLAMPSIA, UNSPECIFIED TRIMESTER	MILD TO MODERATE PRE-ECLAMPSIA, UNSPECIFIED TRIMESTER
O14.02	MILD TO MODERATE PRE-ECLAMPSIA, SECOND TRIMESTER	MILD TO MODERATE PRE-ECLAMPSIA, SECOND TRIMESTER
O14.03	MILD TO MODERATE PRE-ECLAMPSIA, THIRD TRIMESTER	MILD TO MODERATE PRE-ECLAMPSIA, THIRD TRIMESTER
O14.04	MILD TO MODERATE PRE-ECLAMPSIA, COMPLICATING CHILDBIRTH	MILD TO MODERATE PREECLAMPSIA, COMPLICATING CHILDBIRTH
O14.05	MILD TO MODERATE PRE-ECLAMPSIA, COMPLICATING THE PUERPERIUM	MILD TO MODERATE PREECLAMPSIA, COMPLICATING THE PUERPERIUM
O14.10	SEVERE PRE-ECLAMPSIA, UNSPECIFIED TRIMESTER	SEVERE PRE-ECLAMPSIA, UNSPECIFIED TRIMESTER
O14.12	SEVERE PRE-ECLAMPSIA, SECOND TRIMESTER	SEVERE PRE-ECLAMPSIA, SECOND TRIMESTER
O14.13	SEVERE PRE-ECLAMPSIA, THIRD TRIMESTER	SEVERE PRE-ECLAMPSIA, THIRD TRIMESTER
O14.14	SEVERE PRE-ECLAMPSIA COMPLICATING CHILDBIRTH	SEVERE PRE-ECLAMPSIA COMPLICATING CHILDBIRTH
O14.15	SEVERE PRE-ECLAMPSIA, COMPLICATING THE PUERPERIUM	SEVERE PRE-ECLAMPSIA, COMPLICATING THE PUERPERIUM
O14.20	HELLP SYNDROME (HELLP), UNSPECIFIED	HELLP SYNDROME (HELLP),

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ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
	TRIMESTER	UNSPECIFIED TRIMESTER
O14.22	HELLP SYNDROME (HELLP), SECOND TRIMESTER	HELLP SYNDROME (HELLP), SECOND TRIMESTER
O14.23	HELLP SYNDROME (HELLP), THIRD TRIMESTER	HELLP SYNDROME (HELLP), THIRD TRIMESTER
O14.24	HELLP SYNDROME, COMPLICATING CHILDBIRTH	HELLP SYNDROME, COMPLICATING CHILDBIRTH
O14.25	HELLP SYNDROME, COMPLICATING THE PUERPERIUM	HELLP SYNDROME, COMPLICATING THE PUERPERIUM
O14.90	UNSPECIFIED PRE-ECLAMPSIA, UNSPECIFIED TRIMESTER	UNSPECIFIED PRE-ECLAMPSIA, UNSPECIFIED TRIMESTER
O14.92	UNSPECIFIED PRE-ECLAMPSIA, SECOND TRIMESTER	UNSPECIFIED PRE-ECLAMPSIA, SECOND TRIMESTER
O14.93	UNSPECIFIED PRE-ECLAMPSIA, THIRD TRIMESTER	UNSPECIFIED PRE-ECLAMPSIA, THIRD TRIMESTER
O14.94	UNSPECIFIED PRE-ECLAMPSIA, COMPLICATING CHILDBIRTH	UNSPECIFIED PRE-ECLAMPSIA, COMPLICATING CHILDBIRTH
O14.95	UNSPECIFIED PRE-ECLAMPSIA, COMPLICATING THE PUERPERIUM	UNSPECIFIED PRE-ECLAMPSIA, COMPLICATING THE PUERPERIUM
O15.00	ECLAMPSIA IN PREGNANCY, UNSPECIFIED TRIMESTER	ECLAMPSIA IN PREGNANCY, UNSPECIFIED TRIMESTER
O15.02	ECLAMPSIA IN PREGNANCY, SECOND TRIMESTER	ECLAMPSIA IN PREGNANCY, SECOND TRIMESTER
O15.03	ECLAMPSIA IN PREGNANCY, THIRD TRIMESTER	ECLAMPSIA IN PREGNANCY, THIRD TRIMESTER
O15.1	ECLAMPSIA IN LABOR	ECLAMPSIA IN LABOR
O15.2	ECLAMPSIA IN THE PUERPERIUM	ECLAMPSIA IN THE PUERPERIUM
O15.9	ECLAMPSIA, UNSPECIFIED AS TO TIME PERIOD	ECLAMPSIA, UNSPECIFIED AS TO TIME PERIOD
O16.1	UNSPECIFIED MATERNAL HYPERTENSION, FIRST TRIMESTER	UNSPECIFIED MATERNAL HYPERTENSION, FIRST TRIMESTER
O16.2	UNSPECIFIED MATERNAL HYPERTENSION, SECOND TRIMESTER	UNSPECIFIED MATERNAL HYPERTENSION, SECOND TRIMESTER
O16.3	UNSPECIFIED MATERNAL HYPERTENSION, THIRD TRIMESTER	UNSPECIFIED MATERNAL HYPERTENSION, THIRD TRIMESTER
O16.4	UNSPECIFIED MATERNAL HYPERTENSION, COMPLICATING CHILDBIRTH	UNSPECIFIED MATERNAL HYPERTENSION, COMPLICATING CHILDBIRTH
O16.5	UNSPECIFIED MATERNAL HYPERTENSION, COMPLICATING THE PUERPERIUM	UNSPECIFIED MATERNAL HYPERTENSION, COMP THE PUERPERIUM
O16.9	UNSPECIFIED MATERNAL HYPERTENSION, UNSPECIFIED TRIMESTER	UNSPECIFIED MATERNAL HYPERTENSION, UNSPECIFIED

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
		TRIMESTER
O24.410	GESTATIONAL DIABETES MELLITUS IN PREGNANCY, DIET CONTROLLED	GESTATIONAL DIABETES MELLITUS IN PREGNANCY, DIET CONTROLLED
O24.414	GESTATIONAL DIABETES MELLITUS IN PREGNANCY, INSULIN CONTROLLED	GESTATIONAL DIABETES IN PREGNANCY, INSULIN CONTROLLED
O24.415	GESTATIONAL DIABETES MELLITUS IN PREGNANCY, CONTROLLED BY ORAL HYPOGLYCEMIC DRUGS	GESTATNL DIABETES IN PREG, CTRL BY ORAL HYPOGLYCEMIC DRUGS
O24.419	GESTATIONAL DIABETES MELLITUS IN PREGNANCY, UNSPECIFIED CONTROL	GESTATIONAL DIABETES MELLITUS IN PREGNANCY, UNSP CONTROL
O24.420	GESTATIONAL DIABETES MELLITUS IN CHILDBIRTH, DIET CONTROLLED	GESTATIONAL DIABETES MELLITUS IN CHILDBIRTH, DIET CONTROLLED
O24.424	GESTATIONAL DIABETES MELLITUS IN CHILDBIRTH, INSULIN CONTROLLED	GESTATIONAL DIABETES IN CHILDBIRTH, INSULIN CONTROLLED
O24.425	GESTATIONAL DIABETES MELLITUS IN CHILDBIRTH, CONTROLLED BY ORAL HYPOGLYCEMIC DRUGS	GESTATNL DIAB IN CHLDBRTH, CTRL BY ORAL HYPOGLYCEMIC DRUGS
O24.429	GESTATIONAL DIABETES MELLITUS IN CHILDBIRTH, UNSPECIFIED CONTROL	GESTATIONAL DIABETES MELLITUS IN CHILDBIRTH, UNSP CONTROL
O24.430	GESTATIONAL DIABETES MELLITUS IN THE PUERPERIUM, DIET CONTROLLED	GESTATIONAL DIABETES IN THE PUERPERIUM, DIET CONTROLLED
O24.434	GESTATIONAL DIABETES MELLITUS IN THE PUERPERIUM, INSULIN CONTROLLED	GESTATIONAL DIABETES IN THE PUERPERIUM, INSULIN CONTROLLED
O24.435	GESTATIONAL DIABETES MELLITUS IN PUERPERIUM, CONTROLLED BY ORAL HYPOGLYCEMIC DRUGS	GESTATNL DIABETES IN PUERP, CTRL BY ORAL HYPOGLYCEMIC DRUGS
O24.439	GESTATIONAL DIABETES MELLITUS IN THE PUERPERIUM, UNSPECIFIED CONTROL	GESTATIONAL DIABETES IN THE PUERPERIUM, UNSP CONTROL
O24.811	OTHER PRE-EXISTING DIABETES MELLITUS IN PREGNANCY, FIRST TRIMESTER	OTH PRE-EXISTING DIABETES IN PREGNANCY, FIRST TRIMESTER
O24.812	OTHER PRE-EXISTING DIABETES MELLITUS IN PREGNANCY, SECOND TRIMESTER	OTH PRE-EXISTING DIABETES IN PREGNANCY, SECOND TRIMESTER
O24.813	OTHER PRE-EXISTING DIABETES MELLITUS IN PREGNANCY, THIRD TRIMESTER	OTH PRE-EXISTING DIABETES IN PREGNANCY, THIRD TRIMESTER
O24.819	OTHER PRE-EXISTING DIABETES MELLITUS IN PREGNANCY, UNSPECIFIED TRIMESTER	OTH PRE-EXISTING DIABETES IN PREGNANCY, UNSP TRIMESTER
O24.82	OTHER PRE-EXISTING DIABETES MELLITUS IN CHILDBIRTH	OTHER PRE-EXISTING DIABETES MELLITUS IN CHILDBIRTH
O24.83	OTHER PRE-EXISTING DIABETES MELLITUS IN THE PUERPERIUM	OTHER PRE-EXISTING DIABETES MELLITUS IN THE PUERPERIUM
O24.911	UNSPECIFIED DIABETES MELLITUS IN PREGNANCY, FIRST TRIMESTER	UNSPECIFIED DIABETES MELLITUS IN PREGNANCY, FIRST TRIMESTER
O24.912	UNSPECIFIED DIABETES MELLITUS IN PREGNANCY, SECOND TRIMESTER	UNSPECIFIED DIABETES MELLITUS IN PREGNANCY, SECOND TRIMESTER

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O24.913	UNSPECIFIED DIABETES MELLITUS IN PREGNANCY, THIRD TRIMESTER	UNSPECIFIED DIABETES MELLITUS IN PREGNANCY, THIRD TRIMESTER
O24.919	UNSPECIFIED DIABETES MELLITUS IN PREGNANCY, UNSPECIFIED TRIMESTER	UNSP DIABETES MELLITUS IN PREGNANCY, UNSPECIFIED TRIMESTER
O24.92	UNSPECIFIED DIABETES MELLITUS IN CHILDBIRTH	UNSPECIFIED DIABETES MELLITUS IN CHILDBIRTH
O24.93	UNSPECIFIED DIABETES MELLITUS IN THE PUERPERIUM	UNSPECIFIED DIABETES MELLITUS IN THE PUERPERIUM
O26.611	LIVER AND BILIARY TRACT DISORDERS IN PREGNANCY, FIRST TRIMESTER	LIVER AND BILIARY TRACT DISORD IN PREGNANCY, FIRST TRIMESTER
O26.612	LIVER AND BILIARY TRACT DISORDERS IN PREGNANCY, SECOND TRIMESTER	LIVER AND BILIARY TRACT DISORD IN PREG, SECOND TRIMESTER
O26.613	LIVER AND BILIARY TRACT DISORDERS IN PREGNANCY, THIRD TRIMESTER	LIVER AND BILIARY TRACT DISORD IN PREGNANCY, THIRD TRIMESTER
O26.619	LIVER AND BILIARY TRACT DISORDERS IN PREGNANCY, UNSPECIFIED TRIMESTER	LIVER AND BILIARY TRACT DISORD IN PREGNANCY, UNSP TRIMESTER
O26.62	LIVER AND BILIARY TRACT DISORDERS IN CHILDBIRTH	LIVER AND BILIARY TRACT DISORDERS IN CHILDBIRTH
O26.63	LIVER AND BILIARY TRACT DISORDERS IN THE PUERPERIUM	LIVER AND BILIARY TRACT DISORDERS IN THE PUERPERIUM
O26.831	PREGNANCY RELATED RENAL DISEASE, FIRST TRIMESTER	PREGNANCY RELATED RENAL DISEASE, FIRST TRIMESTER
O26.832	PREGNANCY RELATED RENAL DISEASE, SECOND TRIMESTER	PREGNANCY RELATED RENAL DISEASE, SECOND TRIMESTER
O26.833	PREGNANCY RELATED RENAL DISEASE, THIRD TRIMESTER	PREGNANCY RELATED RENAL DISEASE, THIRD TRIMESTER
O26.839	PREGNANCY RELATED RENAL DISEASE, UNSPECIFIED TRIMESTER	PREGNANCY RELATED RENAL DISEASE, UNSPECIFIED TRIMESTER
O30.001	TWIN PREGNANCY, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, FIRST TRIMESTER	TWIN PREG, UNSP NUM PLCNTA & AMNIO SACS, FIRST TRIMESTER
O30.002	TWIN PREGNANCY, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, SECOND TRIMESTER	TWIN PREG, UNSP NUM PLCNTA & AMNIO SACS, SECOND TRIMESTER
O30.003	TWIN PREGNANCY, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, THIRD TRIMESTER	TWIN PREG, UNSP NUM PLCNTA & AMNIO SACS, THIRD TRIMESTER
O30.009	TWIN PREGNANCY, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, UNSPECIFIED TRIMESTER	TWIN PREGNANCY, UNSP NUM PLCNTA & AMNIO SACS, UNSP TRIMESTER
O30.011	TWIN PREGNANCY, MONOCHORIONIC/MONOAMNIOTIC, FIRST TRIMESTER	TWIN PREGNANCY, MONOCHORIONIC/MONOAMNIOTIC, FIRST TRIMESTER
O30.012	TWIN PREGNANCY,	TWIN PREGNANCY,

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ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
	MONOCHORIONIC/MONOAMNIOTIC, SECOND TRIMESTER	MONOCHORIONIC/MONOAMNIOTIC, SECOND TRIMESTER
O30.013	TWIN PREGNANCY, MONOCHORIONIC/MONOAMNIOTIC, THIRD TRIMESTER	TWIN PREGNANCY, MONOCHORIONIC/MONOAMNIOTIC, THIRD TRIMESTER
O30.019	TWIN PREGNANCY, MONOCHORIONIC/MONOAMNIOTIC, UNSPECIFIED TRIMESTER	TWIN PREGNANCY, MONOCHORIONIC/MONOAMNIOTIC, UNSP TRIMESTER
O30.021	CONJOINED TWIN PREGNANCY, FIRST TRIMESTER	CONJOINED TWIN PREGNANCY, FIRST TRIMESTER
O30.022	CONJOINED TWIN PREGNANCY, SECOND TRIMESTER	CONJOINED TWIN PREGNANCY, SECOND TRIMESTER
O30.023	CONJOINED TWIN PREGNANCY, THIRD TRIMESTER	CONJOINED TWIN PREGNANCY, THIRD TRIMESTER
O30.029	CONJOINED TWIN PREGNANCY, UNSPECIFIED TRIMESTER	CONJOINED TWIN PREGNANCY, UNSPECIFIED TRIMESTER
O30.031	TWIN PREGNANCY, MONOCHORIONIC/DIAMNIOTIC, FIRST TRIMESTER	TWIN PREGNANCY, MONOCHORIONIC/DIAMNIOTIC, FIRST TRIMESTER
O30.032	TWIN PREGNANCY, MONOCHORIONIC/DIAMNIOTIC, SECOND TRIMESTER	TWIN PREGNANCY, MONOCHORIONIC/DIAMNIOTIC, SECOND TRIMESTER
O30.033	TWIN PREGNANCY, MONOCHORIONIC/DIAMNIOTIC, THIRD TRIMESTER	TWIN PREGNANCY, MONOCHORIONIC/DIAMNIOTIC, THIRD TRIMESTER
O30.039	TWIN PREGNANCY, MONOCHORIONIC/DIAMNIOTIC, UNSPECIFIED TRIMESTER	TWIN PREGNANCY, MONOCHORIONIC/DIAMNIOTIC, UNSP TRIMESTER
O30.041	TWIN PREGNANCY, DICHORIONIC/DIAMNIOTIC, FIRST TRIMESTER	TWIN PREGNANCY, DICHORIONIC/DIAMNIOTIC, FIRST TRIMESTER
O30.042	TWIN PREGNANCY, DICHORIONIC/DIAMNIOTIC, SECOND TRIMESTER	TWIN PREGNANCY, DICHORIONIC/DIAMNIOTIC, SECOND TRIMESTER
O30.043	TWIN PREGNANCY, DICHORIONIC/DIAMNIOTIC, THIRD TRIMESTER	TWIN PREGNANCY, DICHORIONIC/DIAMNIOTIC, THIRD TRIMESTER
O30.049	TWIN PREGNANCY, DICHORIONIC/DIAMNIOTIC, UNSPECIFIED TRIMESTER	TWIN PREGNANCY, DICHORIONIC/DIAMNIOTIC, UNSP TRIMESTER
O30.091	TWIN PREGNANCY, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, FIRST TRIMESTER	TWIN PREG, UNABLE TO DTRM NUM PLCNTA & AMNIO SACS, FIRST TRI
O30.092	TWIN PREGNANCY, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, SECOND TRIMESTER	TWIN PREG, UNABLE TO DTRM NUM PLCNTA & AMNIO SACS, 2ND TRI

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O30.093	TWIN PREGNANCY, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, THIRD TRIMESTER	TWIN PREG, UNABLE TO DTRM NUM PLCNTA & AMNIO SACS, THIRD TRI
O30.099	TWIN PREGNANCY, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, UNSPECIFIED TRIMESTER	TWIN PREG, UNABLE TO DTRM NUM PLCNTA & AMNIO SACS, UNSP TRI
O30.101	TRIPLET PREGNANCY, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, FIRST TRIMESTER	TRIPLET PREG, UNSP NUM PLCNTA & AMNIO SACS, FIRST TRIMESTER
O30.102	TRIPLET PREGNANCY, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, SECOND TRIMESTER	TRIPLET PREG, UNSP NUM PLCNTA & AMNIO SACS, SECOND TRIMESTER
O30.103	TRIPLET PREGNANCY, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, THIRD TRIMESTER	TRIPLET PREG, UNSP NUM PLCNTA & AMNIO SACS, THIRD TRIMESTER
O30.109	TRIPLET PREGNANCY, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, UNSPECIFIED TRIMESTER	TRIPLET PREG, UNSP NUM PLCNTA & AMNIO SACS, UNSP TRIMESTER
O30.111	TRIPLET PREGNANCY WITH TWO OR MORE MONOCHORIONIC FETUSES, FIRST TRIMESTER	TRIPLET PREG W TWO OR MORE MONOCHORIONIC FETUSES, FIRST TRI
O30.112	TRIPLET PREGNANCY WITH TWO OR MORE MONOCHORIONIC FETUSES, SECOND TRIMESTER	TRIPLET PREG W TWO OR MORE MONOCHORIONIC FETUSES, SECOND TRI
O30.113	TRIPLET PREGNANCY WITH TWO OR MORE MONOCHORIONIC FETUSES, THIRD TRIMESTER	TRIPLET PREG W TWO OR MORE MONOCHORIONIC FETUSES, THIRD TRI
O30.119	TRIPLET PREGNANCY WITH TWO OR MORE MONOCHORIONIC FETUSES, UNSPECIFIED TRIMESTER	TRIPLET PREG W TWO OR MORE MONOCHORIONIC FETUSES, UNSP TRI
O30.121	TRIPLET PREGNANCY WITH TWO OR MORE MONOAMNIOTIC FETUSES, FIRST TRIMESTER	TRIPLET PREG W TWO OR MORE MONOAMNIO FETUSES, FIRST TRI
O30.122	TRIPLET PREGNANCY WITH TWO OR MORE MONOAMNIOTIC FETUSES, SECOND TRIMESTER	TRIPLET PREG W TWO OR MORE MONOAMNIO FETUSES, SECOND TRI
O30.123	TRIPLET PREGNANCY WITH TWO OR MORE MONOAMNIOTIC FETUSES, THIRD TRIMESTER	TRIPLET PREG W TWO OR MORE MONOAMNIO FETUSES, THIRD TRI
O30.129	TRIPLET PREGNANCY WITH TWO OR MORE MONOAMNIOTIC FETUSES, UNSPECIFIED TRIMESTER	TRIPLET PREG W TWO OR MORE MONOAMNIO FETUSES, UNSP TRIMESTER
O30.131	TRIPLET PREGNANCY, TRICHORIONIC/TRIAMNIOTIC, FIRST TRIMESTER	TRIPLET PREGNANCY, TRICHORIONIC/TRIAMNIOTIC, FIRST TRIMESTER
O30.132	TRIPLET PREGNANCY, TRICHORIONIC/TRIAMNIOTIC, SECOND TRIMESTER	TRIPLET PREG, TRICHORIONIC/TRIAMNIOTIC, SECOND TRIMESTER
O30.133	TRIPLET PREGNANCY,	TRIPLET PREGNANCY,

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ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
	TRICHORIONIC/TRIAMNIOTIC, THIRD TRIMESTER	TRICHORIONIC/TRIAMNIOTIC, THIRD TRIMESTER
O30.139	TRIPLET PREGNANCY, TRICHORIONIC/TRIAMNIOTIC, UNSPECIFIED TRIMESTER	TRIPLET PREGNANCY, TRICHORIONIC/TRIAMNIOTIC, UNSP TRIMESTER
O30.191	TRIPLET PREGNANCY, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, FIRST TRIMESTER	TRP PREG, UNABLE TO DTRM NUM PLCNTA & AMNIO SACS, FIRST TRI
O30.192	TRIPLET PREGNANCY, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, SECOND TRIMESTER	TRP PREG, UNABLE TO DTRM NUM PLCNTA & AMNIO SACS, SECOND TRI
O30.193	TRIPLET PREGNANCY, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, THIRD TRIMESTER	TRP PREG, UNABLE TO DTRM NUM PLCNTA & AMNIO SACS, THIRD TRI
O30.199	TRIPLET PREGNANCY, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, UNSPECIFIED TRIMESTER	TRP PREG, UNABLE TO DTRM NUM PLCNTA & AMNIO SACS, UNSP TRI
O30.201	QUADRUPLET PREGNANCY, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, FIRST TRIMESTER	QUAD PREG, UNSP NUM PLCNTA & AMNIO SACS, FIRST TRIMESTER
O30.202	QUADRUPLET PREGNANCY, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, SECOND TRIMESTER	QUAD PREG, UNSP NUM PLCNTA & AMNIO SACS, SECOND TRIMESTER
O30.203	QUADRUPLET PREGNANCY, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, THIRD TRIMESTER	QUAD PREG, UNSP NUM PLCNTA & AMNIO SACS, THIRD TRIMESTER
O30.209	QUADRUPLET PREGNANCY, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, UNSPECIFIED TRIMESTER	QUAD PREGNANCY, UNSP NUM PLCNTA & AMNIO SACS, UNSP TRIMESTER
O30.211	QUADRUPLET PREGNANCY WITH TWO OR MORE MONOCHORIONIC FETUSES, FIRST TRIMESTER	QUAD PREG W TWO OR MORE MONOCHORIONIC FETUSES, FIRST TRI
O30.212	QUADRUPLET PREGNANCY WITH TWO OR MORE MONOCHORIONIC FETUSES, SECOND TRIMESTER	QUAD PREG W TWO OR MORE MONOCHORIONIC FETUSES, SECOND TRI
O30.213	QUADRUPLET PREGNANCY WITH TWO OR MORE MONOCHORIONIC FETUSES, THIRD TRIMESTER	QUAD PREG W TWO OR MORE MONOCHORIONIC FETUSES, THIRD TRI
O30.219	QUADRUPLET PREGNANCY WITH TWO OR MORE MONOCHORIONIC FETUSES, UNSPECIFIED TRIMESTER	QUAD PREG W TWO OR MORE MONOCHORIONIC FETUSES, UNSP TRI
O30.221	QUADRUPLET PREGNANCY WITH TWO OR MORE MONOAMNIOTIC FETUSES, FIRST TRIMESTER	QUAD PREG W TWO OR MORE MONOAMNIO FETUSES, FIRST TRIMESTER

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O30.222	QUADRUPLET PREGNANCY WITH TWO OR MORE MONOAMNIOTIC FETUSES, SECOND TRIMESTER	QUAD PREG W TWO OR MORE MONOAMNIO FETUSES, SECOND TRIMESTER
O30.223	QUADRUPLET PREGNANCY WITH TWO OR MORE MONOAMNIOTIC FETUSES, THIRD TRIMESTER	QUAD PREG W TWO OR MORE MONOAMNIO FETUSES, THIRD TRIMESTER
O30.229	QUADRUPLET PREGNANCY WITH TWO OR MORE MONOAMNIOTIC FETUSES, UNSPECIFIED TRIMESTER	QUAD PREG W TWO OR MORE MONOAMNIO FETUSES, UNSP TRIMESTER
O30.231	QUADRUPLET PREGNANCY, QUADRACHORIONIC/QUADRA-AMNIOTIC, FIRST TRIMESTER	QUAD PREG, QUADRACHORIONIC/QUADRA-AMNIOTIC, FIRST TRIMESTER
O30.232	QUADRUPLET PREGNANCY, QUADRACHORIONIC/QUADRA-AMNIOTIC, SECOND TRIMESTER	QUAD PREG, QUADRACHORIONIC/QUADRA-AMNIOTIC, SECOND TRIMESTER
O30.233	QUADRUPLET PREGNANCY, QUADRACHORIONIC/QUADRA-AMNIOTIC, THIRD TRIMESTER	QUAD PREG, QUADRACHORIONIC/QUADRA-AMNIOTIC, THIRD TRIMESTER
O30.239	QUADRUPLET PREGNANCY, QUADRACHORIONIC/QUADRA-AMNIOTIC, UNSPECIFIED TRIMESTER	QUAD PREG, QUADRACHORIONIC/QUADRA-AMNIOTIC, UNSP TRIMESTER
O30.291	QUADRUPLET PREGNANCY, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, FIRST TRIMESTER	QUAD PREG, UNABLE TO DTRM NUM PLCNTA & AMNIO SACS, FIRST TRI
O30.292	QUADRUPLET PREGNANCY, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, SECOND TRIMESTER	QUAD PREG, UNABLE TO DTRM NUM PLCNTA & AMNIO SACS, 2ND TRI
O30.293	QUADRUPLET PREGNANCY, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, THIRD TRIMESTER	QUAD PREG, UNABLE TO DTRM NUM PLCNTA & AMNIO SACS, THIRD TRI
O30.299	QUADRUPLET PREGNANCY, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, UNSPECIFIED TRIMESTER	QUAD PREG, UNABLE TO DTRM NUM PLCNTA & AMNIO SACS, UNSP TRI
O30.801	OTHER SPECIFIED MULTIPLE GESTATION, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, FIRST TRIMESTER	OTH MULTIPLE GEST, UNSP NUM PLCNTA & AMNIO SACS, FIRST TRI
O30.802	OTHER SPECIFIED MULTIPLE GESTATION, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, SECOND TRIMESTER	OTH MULTIPLE GEST, UNSP NUM PLCNTA & AMNIO SACS, SECOND TRI
O30.803	OTHER SPECIFIED MULTIPLE GESTATION, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, THIRD TRIMESTER	OTH MULTIPLE GEST, UNSP NUM PLCNTA & AMNIO SACS, THIRD TRI

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O30.809	OTHER SPECIFIED MULTIPLE GESTATION, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, UNSPECIFIED TRIMESTER	OTH MULTIPLE GEST, UNSP NUM PLCNTA & AMNIO SACS, UNSP TRI
O30.811	OTHER SPECIFIED MULTIPLE GESTATION WITH TWO OR MORE MONOCHORIONIC FETUSES, FIRST TRIMESTER	OTH MULT GEST W TWO OR MORE MONOCHORIONIC FETUSES, FIRST TRI
O30.812	OTHER SPECIFIED MULTIPLE GESTATION WITH TWO OR MORE MONOCHORIONIC FETUSES, SECOND TRIMESTER	OTH MULT GEST W TWO OR MORE MONOCHORIONIC FETUSES, 2ND TRI
O30.813	OTHER SPECIFIED MULTIPLE GESTATION WITH TWO OR MORE MONOCHORIONIC FETUSES, THIRD TRIMESTER	OTH MULT GEST W TWO OR MORE MONOCHORIONIC FETUSES, THIRD TRI
O30.819	OTHER SPECIFIED MULTIPLE GESTATION WITH TWO OR MORE MONOCHORIONIC FETUSES, UNSPECIFIED TRIMESTER	OTH MULT GEST W TWO OR MORE MONOCHORIONIC FETUSES, UNSP TRI
O30.821	OTHER SPECIFIED MULTIPLE GESTATION WITH TWO OR MORE MONOAMNIOTIC FETUSES, FIRST TRIMESTER	OTH MULTIPLE GEST W TWO OR MORE MONOAMNIO FETUSES, FIRST TRI
O30.822	OTHER SPECIFIED MULTIPLE GESTATION WITH TWO OR MORE MONOAMNIOTIC FETUSES, SECOND TRIMESTER	OTH MULT GEST W TWO OR MORE MONOAMNIO FETUSES, SECOND TRI
O30.823	OTHER SPECIFIED MULTIPLE GESTATION WITH TWO OR MORE MONOAMNIOTIC FETUSES, THIRD TRIMESTER	OTH MULTIPLE GEST W TWO OR MORE MONOAMNIO FETUSES, THIRD TRI
O30.829	OTHER SPECIFIED MULTIPLE GESTATION WITH TWO OR MORE MONOAMNIOTIC FETUSES, UNSPECIFIED TRIMESTER	OTH MULTIPLE GEST W TWO OR MORE MONOAMNIO FETUSES, UNSP TRI
O30.831	OTHER SPECIFIED MULTIPLE GESTATION, NUMBER OF CHORIONS AND AMNIONS ARE BOTH EQUAL TO THE NUMBER OF FETUSES, FIRST TRIMESTER	OTH MULT GEST, NUM CHORIONS & AMNIONS = NUM FTSES, 1ST TRI
O30.832	OTHER SPECIFIED MULTIPLE GESTATION, NUMBER OF CHORIONS AND AMNIONS ARE BOTH EQUAL TO THE NUMBER OF FETUSES, SECOND TRIMESTER	OTH MULT GEST, NUM CHORIONS & AMNIONS = NUM FTSES, 2ND TRI
O30.833	OTHER SPECIFIED MULTIPLE GESTATION, NUMBER OF CHORIONS AND AMNIONS ARE BOTH EQUAL TO THE NUMBER OF FETUSES, THIRD TRIMESTER	OTH MULT GEST, NUM CHORIONS & AMNIONS = NUM FTSES, 3RD TRI
O30.839	OTHER SPECIFIED MULTIPLE GESTATION, NUMBER OF CHORIONS AND AMNIONS ARE BOTH EQUAL TO THE NUMBER OF FETUSES, UNSPECIFIED TRIMESTER	OTH MULT GEST, NUM CHORIONS & AMNIONS = NUM FTSES, UNSP TRI
O30.891	OTHER SPECIFIED MULTIPLE GESTATION, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, FIRST TRIMESTER	OTH MULT GEST, UNAB TO DTRM NUM PLCNTA & AMNIO SACS, 1ST TRI

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O30.892	OTHER SPECIFIED MULTIPLE GESTATION, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, SECOND TRIMESTER	OTH MULT GEST, UNAB TO DTRM NUM PLCNTA & AMNIO SACS, 2ND TRI
O30.893	OTHER SPECIFIED MULTIPLE GESTATION, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, THIRD TRIMESTER	OTH MULT GEST, UNAB TO DTRM NUM PLCNTA & AMNIO SACS, 3RD TRI
O30.899	OTHER SPECIFIED MULTIPLE GESTATION, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, UNSPECIFIED TRIMESTER	OTH MULT GEST,UNAB TO DTRM NUM PLCNTA & AMNIO SACS, UNSP TRI
O30.90	MULTIPLE GESTATION, UNSPECIFIED, UNSPECIFIED TRIMESTER	MULTIPLE GESTATION, UNSPECIFIED, UNSPECIFIED TRIMESTER
O30.91	MULTIPLE GESTATION, UNSPECIFIED, FIRST TRIMESTER	MULTIPLE GESTATION, UNSPECIFIED, FIRST TRIMESTER
O30.92	MULTIPLE GESTATION, UNSPECIFIED, SECOND TRIMESTER	MULTIPLE GESTATION, UNSPECIFIED, SECOND TRIMESTER
O30.93	MULTIPLE GESTATION, UNSPECIFIED, THIRD TRIMESTER	MULTIPLE GESTATION, UNSPECIFIED, THIRD TRIMESTER
O31.10X0	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, UNSP TRI, UNSP
O31.10X1	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 1	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, UNSP TRI, FTS1
O31.10X2	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 2	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, UNSP TRI, FTS2
O31.10X3	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 3	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, UNSP TRI, FTS3
O31.10X4	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 4	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, UNSP TRI, FTS4
O31.10X5	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 5	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, UNSP TRI, FTS5
O31.10X9	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, OTHER FETUS	CONT PREG AFT SPON ABORT OF ONE FETUS OR MORE, UNSP TRI, OTH
O31.11X0	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, FIRST TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, FIRST TRI, UNSP

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O31.11X1	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 1	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, FIRST TRI, FTS1
O31.11X2	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 2	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, FIRST TRI, FTS2
O31.11X3	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 3	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, FIRST TRI, FTS3
O31.11X4	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 4	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, FIRST TRI, FTS4
O31.11X5	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 5	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, FIRST TRI, FTS5
O31.11X9	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, FIRST TRIMESTER, OTHER FETUS	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, FIRST TRI, OTH
O31.12X0	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, SECOND TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	CONT PREG AFT SPON ABORT OF ONE FETUS OR MORE, 2ND TRI, UNSP
O31.12X1	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 1	CONT PREG AFT SPON ABORT OF ONE FETUS OR MORE, 2ND TRI, FTS1
O31.12X2	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 2	CONT PREG AFT SPON ABORT OF ONE FETUS OR MORE, 2ND TRI, FTS2
O31.12X3	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 3	CONT PREG AFT SPON ABORT OF ONE FETUS OR MORE, 2ND TRI, FTS3
O31.12X4	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 4	CONT PREG AFT SPON ABORT OF ONE FETUS OR MORE, 2ND TRI, FTS4
O31.12X5	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 5	CONT PREG AFT SPON ABORT OF ONE FETUS OR MORE, 2ND TRI, FTS5
O31.12X9	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, SECOND TRIMESTER, OTHER FETUS	CONT PREG AFT SPON ABORT OF ONE FETUS OR MORE, 2ND TRI, OTH
O31.13X0	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, THIRD TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, THIRD TRI, UNSP
O31.13X1	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 1	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, THIRD TRI, FTS1

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O31.13X2	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 2	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, THIRD TRI, FTS2
O31.13X3	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 3	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, THIRD TRI, FTS3
O31.13X4	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 4	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, THIRD TRI, FTS4
O31.13X5	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 5	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, THIRD TRI, FTS5
O31.13X9	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, THIRD TRIMESTER, OTHER FETUS	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, THIRD TRI, OTH
O31.20X0	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, UNSP TRI, UNSP
O31.20X1	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 1	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, UNSP TRI, FTS1
O31.20X2	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 2	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, UNSP TRI, FTS2
O31.20X3	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 3	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, UNSP TRI, FTS3
O31.20X4	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 4	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, UNSP TRI, FTS4
O31.20X5	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 5	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, UNSP TRI, FTS5
O31.20X9	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, OTHER FETUS	CONT PREG AFT UTERIN DTH OF ONE FETUS OR MORE, UNSP TRI, OTH
O31.21X0	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, FIRST TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, FIRST TRI, UNSP
O31.21X1	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 1	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, FIRST TRI, FTS1
O31.21X2	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 2	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, FIRST TRI, FTS2

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O31.21X3	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 3	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, FIRST TRI, FTS3
O31.21X4	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 4	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, FIRST TRI, FTS4
O31.21X5	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 5	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, FIRST TRI, FTS5
O31.21X9	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, FIRST TRIMESTER, OTHER FETUS	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, FIRST TRI, OTH
O31.22X0	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, SECOND TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	CONT PREG AFT UTERIN DTH OF ONE FETUS OR MORE, 2ND TRI, UNSP
O31.22X1	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 1	CONT PREG AFT UTERIN DTH OF ONE FETUS OR MORE, 2ND TRI, FTS1
O31.22X2	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 2	CONT PREG AFT UTERIN DTH OF ONE FETUS OR MORE, 2ND TRI, FTS2
O31.22X3	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 3	CONT PREG AFT UTERIN DTH OF ONE FETUS OR MORE, 2ND TRI, FTS3
O31.22X4	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 4	CONT PREG AFT UTERIN DTH OF ONE FETUS OR MORE, 2ND TRI, FTS4
O31.22X5	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 5	CONT PREG AFT UTERIN DTH OF ONE FETUS OR MORE, 2ND TRI, FTS5
O31.22X9	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, SECOND TRIMESTER, OTHER FETUS	CONT PREG AFT UTERIN DTH OF ONE FETUS OR MORE, 2ND TRI, OTH
O31.23X0	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, THIRD TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, THIRD TRI, UNSP
O31.23X1	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 1	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, THIRD TRI, FTS1
O31.23X2	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 2	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, THIRD TRI, FTS2
O31.23X3	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 3	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, THIRD TRI, FTS3

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ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O31.23X4	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 4	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, THIRD TRI, FTS4
O31.23X5	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 5	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, THIRD TRI, FTS5
O31.23X9	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, THIRD TRIMESTER, OTHER FETUS	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, THIRD TRI, OTH
O31.30X0	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,UNSP TRI,UNSP
O31.30X1	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 1	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,UNSP TRI,FTS1
O31.30X2	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 2	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,UNSP TRI,FTS2
O31.30X3	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 3	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,UNSP TRI,FTS3
O31.30X4	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 4	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,UNSP TRI,FTS4
O31.30X5	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 5	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,UNSP TRI,FTS5
O31.30X9	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, OTHER FETUS	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,UNSP TRI, OTH
O31.31X0	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, FIRST TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,1ST TRI, UNSP
O31.31X1	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 1	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,1ST TRI, FTS1
O31.31X2	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 2	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,1ST TRI, FTS2
O31.31X3	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 3	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,1ST TRI, FTS3
O31.31X4	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 4	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,1ST TRI, FTS4

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ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O31.31X5	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 5	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,1ST TRI, FTS5
O31.31X9	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, FIRST TRIMESTER, OTHER FETUS	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE, 1ST TRI, OTH
O31.32X0	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, SECOND TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,2ND TRI, UNSP
O31.32X1	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 1	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,2ND TRI, FTS1
O31.32X2	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 2	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,2ND TRI, FTS2
O31.32X3	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 3	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,2ND TRI, FTS3
O31.32X4	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 4	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,2ND TRI, FTS4
O31.32X5	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 5	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,2ND TRI, FTS5
O31.32X9	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, SECOND TRIMESTER, OTHER FETUS	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE, 2ND TRI, OTH
O31.33X0	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, THIRD TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,3RD TRI, UNSP
O31.33X1	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 1	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,3RD TRI, FTS1
O31.33X2	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 2	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,3RD TRI, FTS2
O31.33X3	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 3	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,3RD TRI, FTS3
O31.33X4	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 4	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,3RD TRI, FTS4
O31.33X5	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 5	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,3RD TRI, FTS5

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O31.33X9	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, THIRD TRIMESTER, OTHER FETUS	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE, 3RD TRI, OTH
O31.8X10	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, FIRST TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	OTH COMP SPECIFIC TO MULTIPLE GEST, FIRST TRIMESTER, UNSP
O31.8X11	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, FIRST TRIMESTER, FETUS 1	OTH COMP SPECIFIC TO MULTIPLE GEST, FIRST TRIMESTER, FETUS 1
O31.8X12	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, FIRST TRIMESTER, FETUS 2	OTH COMP SPECIFIC TO MULTIPLE GEST, FIRST TRIMESTER, FETUS 2
O31.8X13	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, FIRST TRIMESTER, FETUS 3	OTH COMP SPECIFIC TO MULTIPLE GEST, FIRST TRIMESTER, FETUS 3
O31.8X14	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, FIRST TRIMESTER, FETUS 4	OTH COMP SPECIFIC TO MULTIPLE GEST, FIRST TRIMESTER, FETUS 4
O31.8X15	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, FIRST TRIMESTER, FETUS 5	OTH COMP SPECIFIC TO MULTIPLE GEST, FIRST TRIMESTER, FETUS 5
O31.8X19	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, FIRST TRIMESTER, OTHER FETUS	OTH COMP SPECIFIC TO MULTIPLE GEST, FIRST TRIMESTER, OTH
O31.8X20	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, SECOND TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	OTH COMP SPECIFIC TO MULTIPLE GEST, SECOND TRIMESTER, UNSP
O31.8X21	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, SECOND TRIMESTER, FETUS 1	OTH COMP SPECIFIC TO MULTIPLE GEST, SECOND TRI, FETUS 1
O31.8X22	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, SECOND TRIMESTER, FETUS 2	OTH COMP SPECIFIC TO MULTIPLE GEST, SECOND TRI, FETUS 2
O31.8X23	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, SECOND TRIMESTER, FETUS 3	OTH COMP SPECIFIC TO MULTIPLE GEST, SECOND TRI, FETUS 3
O31.8X24	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, SECOND TRIMESTER, FETUS 4	OTH COMP SPECIFIC TO MULTIPLE GEST, SECOND TRI, FETUS 4
O31.8X25	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, SECOND TRIMESTER, FETUS 5	OTH COMP SPECIFIC TO MULTIPLE GEST, SECOND TRI, FETUS 5
O31.8X29	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, SECOND TRIMESTER, OTHER FETUS	OTH COMP SPECIFIC TO MULTIPLE GEST, SECOND TRIMESTER, OTH
O31.8X30	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, THIRD TRIMESTER, NOT	OTH COMP SPECIFIC TO MULTIPLE GEST, THIRD TRIMESTER, UNSP

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
	APPLICABLE OR UNSPECIFIED	
O31.8X31	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, THIRD TRIMESTER, FETUS 1	OTH COMP SPECIFIC TO MULTIPLE GEST, THIRD TRIMESTER, FETUS 1
O31.8X32	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, THIRD TRIMESTER, FETUS 2	OTH COMP SPECIFIC TO MULTIPLE GEST, THIRD TRIMESTER, FETUS 2
O31.8X33	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, THIRD TRIMESTER, FETUS 3	OTH COMP SPECIFIC TO MULTIPLE GEST, THIRD TRIMESTER, FETUS 3
O31.8X34	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, THIRD TRIMESTER, FETUS 4	OTH COMP SPECIFIC TO MULTIPLE GEST, THIRD TRIMESTER, FETUS 4
O31.8X35	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, THIRD TRIMESTER, FETUS 5	OTH COMP SPECIFIC TO MULTIPLE GEST, THIRD TRIMESTER, FETUS 5
O31.8X39	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, THIRD TRIMESTER, OTHER FETUS	OTH COMP SPECIFIC TO MULTIPLE GEST, THIRD TRIMESTER, OTH
O32.0XX0	MATERNAL CARE FOR UNSTABLE LIE, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR UNSTABLE LIE, NOT APPLICABLE OR UNSP
O32.0XX1	MATERNAL CARE FOR UNSTABLE LIE, FETUS 1	MATERNAL CARE FOR UNSTABLE LIE, FETUS 1
O32.0XX2	MATERNAL CARE FOR UNSTABLE LIE, FETUS 2	MATERNAL CARE FOR UNSTABLE LIE, FETUS 2
O32.0XX3	MATERNAL CARE FOR UNSTABLE LIE, FETUS 3	MATERNAL CARE FOR UNSTABLE LIE, FETUS 3
O32.0XX4	MATERNAL CARE FOR UNSTABLE LIE, FETUS 4	MATERNAL CARE FOR UNSTABLE LIE, FETUS 4
O32.0XX5	MATERNAL CARE FOR UNSTABLE LIE, FETUS 5	MATERNAL CARE FOR UNSTABLE LIE, FETUS 5
O32.0XX9	MATERNAL CARE FOR UNSTABLE LIE, OTHER FETUS	MATERNAL CARE FOR UNSTABLE LIE, OTHER FETUS
O32.8XX0	MATERNAL CARE FOR OTHER MALPRESENTATION OF FETUS, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR OTH MALPRESENTATION OF FETUS, UNSP
O32.8XX1	MATERNAL CARE FOR OTHER MALPRESENTATION OF FETUS, FETUS 1	MATERNAL CARE FOR OTHER MALPRESENTATION OF FETUS, FETUS 1
O32.8XX2	MATERNAL CARE FOR OTHER MALPRESENTATION OF FETUS, FETUS 2	MATERNAL CARE FOR OTHER MALPRESENTATION OF FETUS, FETUS 2
O32.8XX3	MATERNAL CARE FOR OTHER MALPRESENTATION OF FETUS, FETUS 3	MATERNAL CARE FOR OTHER MALPRESENTATION OF FETUS, FETUS 3

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O32.8XX4	MATERNAL CARE FOR OTHER MALPRESENTATION OF FETUS, FETUS 4	MATERNAL CARE FOR OTHER MALPRESENTATION OF FETUS, FETUS 4
O32.8XX5	MATERNAL CARE FOR OTHER MALPRESENTATION OF FETUS, FETUS 5	MATERNAL CARE FOR OTHER MALPRESENTATION OF FETUS, FETUS 5
O32.8XX9	MATERNAL CARE FOR OTHER MALPRESENTATION OF FETUS, OTHER FETUS	MATERNAL CARE FOR OTH MALPRESENTATION OF FETUS, OTHER FETUS
O32.9XX0	MATERNAL CARE FOR MALPRESENTATION OF FETUS, UNSPECIFIED, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR MALPRESENTATION OF FETUS, UNSP, UNSP
O32.9XX1	MATERNAL CARE FOR MALPRESENTATION OF FETUS, UNSPECIFIED, FETUS 1	MATERNAL CARE FOR MALPRESENTATION OF FETUS, UNSP, FETUS 1
O32.9XX2	MATERNAL CARE FOR MALPRESENTATION OF FETUS, UNSPECIFIED, FETUS 2	MATERNAL CARE FOR MALPRESENTATION OF FETUS, UNSP, FETUS 2
O32.9XX3	MATERNAL CARE FOR MALPRESENTATION OF FETUS, UNSPECIFIED, FETUS 3	MATERNAL CARE FOR MALPRESENTATION OF FETUS, UNSP, FETUS 3
O32.9XX4	MATERNAL CARE FOR MALPRESENTATION OF FETUS, UNSPECIFIED, FETUS 4	MATERNAL CARE FOR MALPRESENTATION OF FETUS, UNSP, FETUS 4
O32.9XX5	MATERNAL CARE FOR MALPRESENTATION OF FETUS, UNSPECIFIED, FETUS 5	MATERNAL CARE FOR MALPRESENTATION OF FETUS, UNSP, FETUS 5
O32.9XX9	MATERNAL CARE FOR MALPRESENTATION OF FETUS, UNSPECIFIED, OTHER FETUS	MATERNAL CARE FOR MALPRESENTATION OF FETUS, UNSP, OTH FETUS
O35.0XX0	MATERNAL CARE FOR (SUSPECTED) CENTRAL NERVOUS SYSTEM MALFORMATION IN FETUS, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR (SUSPECTED) CNSL MALFORM IN FETUS, UNSP
O35.0XX1	MATERNAL CARE FOR (SUSPECTED) CENTRAL NERVOUS SYSTEM MALFORMATION IN FETUS, FETUS 1	MATERNAL CARE FOR (SUSPECTED) CNSL MALFORM IN FETUS, FETUS 1
O35.0XX2	MATERNAL CARE FOR (SUSPECTED) CENTRAL NERVOUS SYSTEM MALFORMATION IN FETUS, FETUS 2	MATERNAL CARE FOR (SUSPECTED) CNSL MALFORM IN FETUS, FETUS 2
O35.0XX3	MATERNAL CARE FOR (SUSPECTED) CENTRAL NERVOUS SYSTEM MALFORMATION IN FETUS, FETUS 3	MATERNAL CARE FOR (SUSPECTED) CNSL MALFORM IN FETUS, FETUS 3
O35.0XX4	MATERNAL CARE FOR (SUSPECTED) CENTRAL NERVOUS SYSTEM MALFORMATION IN FETUS, FETUS 4	MATERNAL CARE FOR (SUSPECTED) CNSL MALFORM IN FETUS, FETUS 4
O35.0XX5	MATERNAL CARE FOR (SUSPECTED) CENTRAL NERVOUS SYSTEM MALFORMATION IN FETUS,	MATERNAL CARE FOR (SUSPECTED) CNSL MALFORM IN FETUS, FETUS 5

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
	FETUS 5	
O35.0XX9	MATERNAL CARE FOR (SUSPECTED) CENTRAL NERVOUS SYSTEM MALFORMATION IN FETUS, OTHER FETUS	MATERNAL CARE FOR (SUSPECTED) CNSL MALFORM IN FETUS, OTH
O35.1XX0	MATERNAL CARE FOR (SUSPECTED) CHROMOSOMAL ABNORMALITY IN FETUS, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR CHROMOSOMAL ABNORMALITY IN FETUS, UNSP
O35.1XX1	MATERNAL CARE FOR (SUSPECTED) CHROMOSOMAL ABNORMALITY IN FETUS, FETUS 1	MATERNAL CARE FOR CHROMOSOMAL ABNORMALITY IN FETUS, FETUS 1
O35.1XX2	MATERNAL CARE FOR (SUSPECTED) CHROMOSOMAL ABNORMALITY IN FETUS, FETUS 2	MATERNAL CARE FOR CHROMOSOMAL ABNORMALITY IN FETUS, FETUS 2
O35.1XX3	MATERNAL CARE FOR (SUSPECTED) CHROMOSOMAL ABNORMALITY IN FETUS, FETUS 3	MATERNAL CARE FOR CHROMOSOMAL ABNORMALITY IN FETUS, FETUS 3
O35.1XX4	MATERNAL CARE FOR (SUSPECTED) CHROMOSOMAL ABNORMALITY IN FETUS, FETUS 4	MATERNAL CARE FOR CHROMOSOMAL ABNORMALITY IN FETUS, FETUS 4
O35.1XX5	MATERNAL CARE FOR (SUSPECTED) CHROMOSOMAL ABNORMALITY IN FETUS, FETUS 5	MATERNAL CARE FOR CHROMOSOMAL ABNORMALITY IN FETUS, FETUS 5
O35.1XX9	MATERNAL CARE FOR (SUSPECTED) CHROMOSOMAL ABNORMALITY IN FETUS, OTHER FETUS	MATERNAL CARE FOR CHROMOSOMAL ABNORMALITY IN FETUS, OTH
O35.3XX0	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS FROM VIRAL DISEASE IN MOTHER, NOT APPLICABLE OR UNSPECIFIED	MATERN CARE FOR DAMAG TO FTS FROM VIRAL DIS IN MOTHER, UNSP
O35.3XX1	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS FROM VIRAL DISEASE IN MOTHER, FETUS 1	MATERN CARE FOR DAMAG TO FTS FROM VIRAL DIS IN MOTHER, FTS1
O35.3XX2	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS FROM VIRAL DISEASE IN MOTHER, FETUS 2	MATERN CARE FOR DAMAG TO FTS FROM VIRAL DIS IN MOTHER, FTS2
O35.3XX3	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS FROM VIRAL DISEASE IN MOTHER, FETUS 3	MATERN CARE FOR DAMAG TO FTS FROM VIRAL DIS IN MOTHER, FTS3
O35.3XX4	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS FROM VIRAL DISEASE IN MOTHER, FETUS 4	MATERN CARE FOR DAMAG TO FTS FROM VIRAL DIS IN MOTHER, FTS4
O35.3XX5	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS FROM VIRAL DISEASE IN MOTHER, FETUS 5	MATERN CARE FOR DAMAG TO FTS FROM VIRAL DIS IN MOTHER, FTS5
O35.3XX9	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS FROM VIRAL DISEASE IN MOTHER, OTHER FETUS	MATERN CARE FOR DAMAG TO FETUS FROM VIRAL DIS IN MOTHER, OTH
O35.4XX0	MATERNAL CARE FOR (SUSPECTED) DAMAGE	MATERNAL CARE FOR DAMAGE TO

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ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
	TO FETUS FROM ALCOHOL, NOT APPLICABLE OR UNSPECIFIED	FETUS FROM ALCOHOL, UNSP
O35.4XX1	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS FROM ALCOHOL, FETUS 1	MATERNAL CARE FOR DAMAGE TO FETUS FROM ALCOHOL, FETUS 1
O35.4XX2	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS FROM ALCOHOL, FETUS 2	MATERNAL CARE FOR DAMAGE TO FETUS FROM ALCOHOL, FETUS 2
O35.4XX3	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS FROM ALCOHOL, FETUS 3	MATERNAL CARE FOR DAMAGE TO FETUS FROM ALCOHOL, FETUS 3
O35.4XX4	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS FROM ALCOHOL, FETUS 4	MATERNAL CARE FOR DAMAGE TO FETUS FROM ALCOHOL, FETUS 4
O35.4XX5	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS FROM ALCOHOL, FETUS 5	MATERNAL CARE FOR DAMAGE TO FETUS FROM ALCOHOL, FETUS 5
O35.4XX9	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS FROM ALCOHOL, OTHER FETUS	MATERNAL CARE FOR DAMAGE TO FETUS FROM ALCOHOL, OTH
O35.5XX0	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY DRUGS, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY DRUGS, UNSP
O35.5XX1	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY DRUGS, FETUS 1	MATERNAL CARE FOR DAMAGE TO FETUS BY DRUGS, FETUS 1
O35.5XX2	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY DRUGS, FETUS 2	MATERNAL CARE FOR DAMAGE TO FETUS BY DRUGS, FETUS 2
O35.5XX3	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY DRUGS, FETUS 3	MATERNAL CARE FOR DAMAGE TO FETUS BY DRUGS, FETUS 3
O35.5XX4	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY DRUGS, FETUS 4	MATERNAL CARE FOR DAMAGE TO FETUS BY DRUGS, FETUS 4
O35.5XX5	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY DRUGS, FETUS 5	MATERNAL CARE FOR DAMAGE TO FETUS BY DRUGS, FETUS 5
O35.5XX9	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY DRUGS, OTHER FETUS	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY DRUGS, OTH
O35.6XX0	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY RADIATION, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR DAMAGE TO FETUS BY RADIATION, UNSP
O35.6XX1	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY RADIATION, FETUS 1	MATERNAL CARE FOR DAMAGE TO FETUS BY RADIATION, FETUS 1
O35.6XX2	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY RADIATION, FETUS 2	MATERNAL CARE FOR DAMAGE TO FETUS BY RADIATION, FETUS 2
O35.6XX3	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY RADIATION, FETUS 3	MATERNAL CARE FOR DAMAGE TO FETUS BY RADIATION, FETUS 3
O35.6XX4	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY RADIATION, FETUS 4	MATERNAL CARE FOR DAMAGE TO FETUS BY RADIATION, FETUS 4
O35.6XX5	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY RADIATION, FETUS 5	MATERNAL CARE FOR DAMAGE TO FETUS BY RADIATION, FETUS 5
O35.6XX9	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY RADIATION, OTHER FETUS	MATERNAL CARE FOR DAMAGE TO FETUS BY RADIATION, OTH

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O36.0110	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, FIRST TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR ANTI-D ANTIBODIES, FIRST TRIMESTER, UNSP
O36.0111	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, FIRST TRIMESTER, FETUS 1	MATERNAL CARE FOR ANTI-D ANTIBODIES, FIRST TRI, FETUS 1
O36.0112	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, FIRST TRIMESTER, FETUS 2	MATERNAL CARE FOR ANTI-D ANTIBODIES, FIRST TRI, FETUS 2
O36.0113	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, FIRST TRIMESTER, FETUS 3	MATERNAL CARE FOR ANTI-D ANTIBODIES, FIRST TRI, FETUS 3
O36.0114	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, FIRST TRIMESTER, FETUS 4	MATERNAL CARE FOR ANTI-D ANTIBODIES, FIRST TRI, FETUS 4
O36.0115	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, FIRST TRIMESTER, FETUS 5	MATERNAL CARE FOR ANTI-D ANTIBODIES, FIRST TRI, FETUS 5
O36.0119	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, FIRST TRIMESTER, OTHER FETUS	MATERNAL CARE FOR ANTI-D ANTIBODIES, FIRST TRIMESTER, OTH
O36.0120	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, SECOND TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR ANTI-D ANTIBODIES, SECOND TRIMESTER, UNSP
O36.0121	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, SECOND TRIMESTER, FETUS 1	MATERNAL CARE FOR ANTI-D ANTIBODIES, SECOND TRI, FETUS 1
O36.0122	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, SECOND TRIMESTER, FETUS 2	MATERNAL CARE FOR ANTI-D ANTIBODIES, SECOND TRI, FETUS 2
O36.0123	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, SECOND TRIMESTER, FETUS 3	MATERNAL CARE FOR ANTI-D ANTIBODIES, SECOND TRI, FETUS 3
O36.0124	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, SECOND TRIMESTER, FETUS 4	MATERNAL CARE FOR ANTI-D ANTIBODIES, SECOND TRI, FETUS 4
O36.0125	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, SECOND TRIMESTER, FETUS 5	MATERNAL CARE FOR ANTI-D ANTIBODIES, SECOND TRI, FETUS 5
O36.0129	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, SECOND TRIMESTER, OTHER FETUS	MATERNAL CARE FOR ANTI-D ANTIBODIES, SECOND TRIMESTER, OTH
O36.0130	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, THIRD TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR ANTI-D ANTIBODIES, THIRD TRIMESTER, UNSP
O36.0131	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, THIRD TRIMESTER, FETUS 1	MATERNAL CARE FOR ANTI-D ANTIBODIES, THIRD TRI, FETUS 1
O36.0132	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, THIRD TRIMESTER, FETUS 2	MATERNAL CARE FOR ANTI-D ANTIBODIES, THIRD TRI, FETUS 2
O36.0133	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, THIRD TRIMESTER, FETUS 3	MATERNAL CARE FOR ANTI-D ANTIBODIES, THIRD TRI, FETUS 3
O36.0134	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, THIRD TRIMESTER, FETUS 4	MATERNAL CARE FOR ANTI-D ANTIBODIES, THIRD TRI, FETUS 4
O36.0135	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, THIRD TRIMESTER, FETUS 5	MATERNAL CARE FOR ANTI-D ANTIBODIES, THIRD TRI, FETUS 5

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O36.0139	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, THIRD TRIMESTER, OTHER FETUS	MATERNAL CARE FOR ANTI-D ANTIBODIES, THIRD TRIMESTER, OTH
O36.0190	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, UNSPECIFIED TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR ANTI-D ANTIBODIES, UNSP TRIMESTER, UNSP
O36.0191	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, UNSPECIFIED TRIMESTER, FETUS 1	MATERNAL CARE FOR ANTI-D ANTIBODIES, UNSP TRIMESTER, FETUS 1
O36.0192	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, UNSPECIFIED TRIMESTER, FETUS 2	MATERNAL CARE FOR ANTI-D ANTIBODIES, UNSP TRIMESTER, FETUS 2
O36.0193	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, UNSPECIFIED TRIMESTER, FETUS 3	MATERNAL CARE FOR ANTI-D ANTIBODIES, UNSP TRIMESTER, FETUS 3
O36.0194	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, UNSPECIFIED TRIMESTER, FETUS 4	MATERNAL CARE FOR ANTI-D ANTIBODIES, UNSP TRIMESTER, FETUS 4
O36.0195	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, UNSPECIFIED TRIMESTER, FETUS 5	MATERNAL CARE FOR ANTI-D ANTIBODIES, UNSP TRIMESTER, FETUS 5
O36.0199	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, UNSPECIFIED TRIMESTER, OTHER FETUS	MATERNAL CARE FOR ANTI-D ANTIBODIES, UNSP TRIMESTER, OTH
O36.0910	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, FIRST TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, FIRST TRIMESTER, UNSP
O36.0911	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, FIRST TRIMESTER, FETUS 1	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, FIRST TRI, FETUS 1
O36.0912	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, FIRST TRIMESTER, FETUS 2	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, FIRST TRI, FETUS 2
O36.0913	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, FIRST TRIMESTER, FETUS 3	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, FIRST TRI, FETUS 3
O36.0914	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, FIRST TRIMESTER, FETUS 4	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, FIRST TRI, FETUS 4
O36.0915	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, FIRST TRIMESTER, FETUS 5	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, FIRST TRI, FETUS 5
O36.0919	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, FIRST TRIMESTER, OTHER FETUS	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, FIRST TRIMESTER, OTH
O36.0920	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, SECOND TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, SECOND TRI, UNSP
O36.0921	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, SECOND TRIMESTER, FETUS 1	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, SECOND TRI, FETUS 1
O36.0922	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, SECOND TRIMESTER,	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, SECOND TRI, FETUS 2

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
	FETUS 2	
O36.0923	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, SECOND TRIMESTER, FETUS 3	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, SECOND TRI, FETUS 3
O36.0924	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, SECOND TRIMESTER, FETUS 4	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, SECOND TRI, FETUS 4
O36.0925	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, SECOND TRIMESTER, FETUS 5	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, SECOND TRI, FETUS 5
O36.0929	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, SECOND TRIMESTER, OTHER FETUS	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, SECOND TRIMESTER, OTH
O36.0930	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, THIRD TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, THIRD TRIMESTER, UNSP
O36.0931	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, THIRD TRIMESTER, FETUS 1	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, THIRD TRI, FETUS 1
O36.0932	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, THIRD TRIMESTER, FETUS 2	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, THIRD TRI, FETUS 2
O36.0933	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, THIRD TRIMESTER, FETUS 3	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, THIRD TRI, FETUS 3
O36.0934	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, THIRD TRIMESTER, FETUS 4	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, THIRD TRI, FETUS 4
O36.0935	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, THIRD TRIMESTER, FETUS 5	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, THIRD TRI, FETUS 5
O36.0939	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, THIRD TRIMESTER, OTHER FETUS	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, THIRD TRIMESTER, OTH
O36.0990	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, UNSPECIFIED TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, UNSP TRIMESTER, UNSP
O36.0991	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, UNSPECIFIED TRIMESTER, FETUS 1	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, UNSP TRI, FETUS 1
O36.0992	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, UNSPECIFIED TRIMESTER, FETUS 2	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, UNSP TRI, FETUS 2
O36.0993	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, UNSPECIFIED TRIMESTER, FETUS 3	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, UNSP TRI, FETUS 3
O36.0994	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, UNSPECIFIED TRIMESTER, FETUS 4	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, UNSP TRI, FETUS 4
O36.0995	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, UNSPECIFIED TRIMESTER,	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, UNSP TRI, FETUS 5

SECTION 6 BIRTH OUTCOMES INITIATIVE

BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
	FETUS 5	
O36.0999	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, UNSPECIFIED TRIMESTER, OTHER FETUS	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, UNSP TRIMESTER, OTH
O36.1110	MATERNAL CARE FOR ANTI-A SENSITIZATION, FIRST TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR ANTI-A SENSITIZATION, FIRST TRI, UNSP
O36.1111	MATERNAL CARE FOR ANTI-A SENSITIZATION, FIRST TRIMESTER, FETUS 1	MATERNAL CARE FOR ANTI-A SENSITIZATION, FIRST TRI, FETUS 1
O36.1112	MATERNAL CARE FOR ANTI-A SENSITIZATION, FIRST TRIMESTER, FETUS 2	MATERNAL CARE FOR ANTI-A SENSITIZATION, FIRST TRI, FETUS 2
O36.1113	MATERNAL CARE FOR ANTI-A SENSITIZATION, FIRST TRIMESTER, FETUS 3	MATERNAL CARE FOR ANTI-A SENSITIZATION, FIRST TRI, FETUS 3
O36.1114	MATERNAL CARE FOR ANTI-A SENSITIZATION, FIRST TRIMESTER, FETUS 4	MATERNAL CARE FOR ANTI-A SENSITIZATION, FIRST TRI, FETUS 4
O36.1115	MATERNAL CARE FOR ANTI-A SENSITIZATION, FIRST TRIMESTER, FETUS 5	MATERNAL CARE FOR ANTI-A SENSITIZATION, FIRST TRI, FETUS 5
O36.1119	MATERNAL CARE FOR ANTI-A SENSITIZATION, FIRST TRIMESTER, OTHER FETUS	MATERNAL CARE FOR ANTI-A SENSITIZATION, FIRST TRIMESTER, OTH
O36.1120	MATERNAL CARE FOR ANTI-A SENSITIZATION, SECOND TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR ANTI-A SENSITIZATION, SECOND TRI, UNSP
O36.1121	MATERNAL CARE FOR ANTI-A SENSITIZATION, SECOND TRIMESTER, FETUS 1	MATERNAL CARE FOR ANTI-A SENSITIZATION, SECOND TRI, FETUS 1
O36.1122	MATERNAL CARE FOR ANTI-A SENSITIZATION, SECOND TRIMESTER, FETUS 2	MATERNAL CARE FOR ANTI-A SENSITIZATION, SECOND TRI, FETUS 2
O36.1123	MATERNAL CARE FOR ANTI-A SENSITIZATION, SECOND TRIMESTER, FETUS 3	MATERNAL CARE FOR ANTI-A SENSITIZATION, SECOND TRI, FETUS 3
O36.1124	MATERNAL CARE FOR ANTI-A SENSITIZATION, SECOND TRIMESTER, FETUS 4	MATERNAL CARE FOR ANTI-A SENSITIZATION, SECOND TRI, FETUS 4
O36.1125	MATERNAL CARE FOR ANTI-A SENSITIZATION, SECOND TRIMESTER, FETUS 5	MATERNAL CARE FOR ANTI-A SENSITIZATION, SECOND TRI, FETUS 5
O36.1129	MATERNAL CARE FOR ANTI-A SENSITIZATION, SECOND TRIMESTER, OTHER FETUS	MATERNAL CARE FOR ANTI-A SENSITIZATION, SECOND TRI, OTH
O36.1130	MATERNAL CARE FOR ANTI-A SENSITIZATION, THIRD TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR ANTI-A SENSITIZATION, THIRD TRI, UNSP
O36.1131	MATERNAL CARE FOR ANTI-A SENSITIZATION, THIRD TRIMESTER, FETUS 1	MATERNAL CARE FOR ANTI-A SENSITIZATION, THIRD TRI, FETUS 1

SECTION 6 BIRTH OUTCOMES INITIATIVE

BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O36.1132	MATERNAL CARE FOR ANTI-A SENSITIZATION, THIRD TRIMESTER, FETUS 2	MATERNAL CARE FOR ANTI-A SENSITIZATION, THIRD TRI, FETUS 2
O36.1133	MATERNAL CARE FOR ANTI-A SENSITIZATION, THIRD TRIMESTER, FETUS 3	MATERNAL CARE FOR ANTI-A SENSITIZATION, THIRD TRI, FETUS 3
O36.1134	MATERNAL CARE FOR ANTI-A SENSITIZATION, THIRD TRIMESTER, FETUS 4	MATERNAL CARE FOR ANTI-A SENSITIZATION, THIRD TRI, FETUS 4
O36.1135	MATERNAL CARE FOR ANTI-A SENSITIZATION, THIRD TRIMESTER, FETUS 5	MATERNAL CARE FOR ANTI-A SENSITIZATION, THIRD TRI, FETUS 5
O36.1139	MATERNAL CARE FOR ANTI-A SENSITIZATION, THIRD TRIMESTER, OTHER FETUS	MATERNAL CARE FOR ANTI-A SENSITIZATION, THIRD TRIMESTER, OTH
O36.1190	MATERNAL CARE FOR ANTI-A SENSITIZATION, UNSPECIFIED TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR ANTI-A SENSITIZATION, UNSP TRIMESTER, UNSP
O36.1191	MATERNAL CARE FOR ANTI-A SENSITIZATION, UNSPECIFIED TRIMESTER, FETUS 1	MATERNAL CARE FOR ANTI-A SENSITIZATION, UNSP TRI, FETUS 1
O36.1192	MATERNAL CARE FOR ANTI-A SENSITIZATION, UNSPECIFIED TRIMESTER, FETUS 2	MATERNAL CARE FOR ANTI-A SENSITIZATION, UNSP TRI, FETUS 2
O36.1193	MATERNAL CARE FOR ANTI-A SENSITIZATION, UNSPECIFIED TRIMESTER, FETUS 3	MATERNAL CARE FOR ANTI-A SENSITIZATION, UNSP TRI, FETUS 3
O36.1194	MATERNAL CARE FOR ANTI-A SENSITIZATION, UNSPECIFIED TRIMESTER, FETUS 4	MATERNAL CARE FOR ANTI-A SENSITIZATION, UNSP TRI, FETUS 4
O36.1195	MATERNAL CARE FOR ANTI-A SENSITIZATION, UNSPECIFIED TRIMESTER, FETUS 5	MATERNAL CARE FOR ANTI-A SENSITIZATION, UNSP TRI, FETUS 5
O36.1199	MATERNAL CARE FOR ANTI-A SENSITIZATION, UNSPECIFIED TRIMESTER, OTHER FETUS	MATERNAL CARE FOR ANTI-A SENSITIZATION, UNSP TRIMESTER, OTH
O36.1910	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, FIRST TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR OTH ISOIMMUNIZATION, FIRST TRIMESTER, UNSP
O36.1911	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, FIRST TRIMESTER, FETUS 1	MATERNAL CARE FOR OTH ISOIMMUN, FIRST TRIMESTER, FETUS 1
O36.1912	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, FIRST TRIMESTER, FETUS 2	MATERNAL CARE FOR OTH ISOIMMUN, FIRST TRIMESTER, FETUS 2
O36.1913	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, FIRST TRIMESTER, FETUS 3	MATERNAL CARE FOR OTH ISOIMMUN, FIRST TRIMESTER, FETUS 3
O36.1914	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, FIRST TRIMESTER, FETUS 4	MATERNAL CARE FOR OTH ISOIMMUN, FIRST TRIMESTER, FETUS 4
O36.1915	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, FIRST TRIMESTER, FETUS 5	MATERNAL CARE FOR OTH ISOIMMUN, FIRST TRIMESTER, FETUS 5

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O36.1919	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, FIRST TRIMESTER, OTHER FETUS	MATERNAL CARE FOR OTH ISOIMMUNIZATION, FIRST TRIMESTER, OTH
O36.1920	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, SECOND TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR OTH ISOIMMUN, SECOND TRIMESTER, UNSP
O36.1921	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, SECOND TRIMESTER, FETUS 1	MATERNAL CARE FOR OTH ISOIMMUN, SECOND TRIMESTER, FETUS 1
O36.1922	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, SECOND TRIMESTER, FETUS 2	MATERNAL CARE FOR OTH ISOIMMUN, SECOND TRIMESTER, FETUS 2
O36.1923	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, SECOND TRIMESTER, FETUS 3	MATERNAL CARE FOR OTH ISOIMMUN, SECOND TRIMESTER, FETUS 3
O36.1924	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, SECOND TRIMESTER, FETUS 4	MATERNAL CARE FOR OTH ISOIMMUN, SECOND TRIMESTER, FETUS 4
O36.1925	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, SECOND TRIMESTER, FETUS 5	MATERNAL CARE FOR OTH ISOIMMUN, SECOND TRIMESTER, FETUS 5
O36.1929	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, SECOND TRIMESTER, OTHER FETUS	MATERNAL CARE FOR OTH ISOIMMUNIZATION, SECOND TRIMESTER, OTH
O36.1930	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, THIRD TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR OTH ISOIMMUNIZATION, THIRD TRIMESTER, UNSP
O36.1931	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, THIRD TRIMESTER, FETUS 1	MATERNAL CARE FOR OTH ISOIMMUN, THIRD TRIMESTER, FETUS 1
O36.1932	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, THIRD TRIMESTER, FETUS 2	MATERNAL CARE FOR OTH ISOIMMUN, THIRD TRIMESTER, FETUS 2
O36.1933	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, THIRD TRIMESTER, FETUS 3	MATERNAL CARE FOR OTH ISOIMMUN, THIRD TRIMESTER, FETUS 3
O36.1934	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, THIRD TRIMESTER, FETUS 4	MATERNAL CARE FOR OTH ISOIMMUN, THIRD TRIMESTER, FETUS 4
O36.1935	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, THIRD TRIMESTER, FETUS 5	MATERNAL CARE FOR OTH ISOIMMUN, THIRD TRIMESTER, FETUS 5
O36.1939	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, THIRD TRIMESTER, OTHER FETUS	MATERNAL CARE FOR OTH ISOIMMUNIZATION, THIRD TRIMESTER, OTH
O36.1990	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, UNSPECIFIED TRIMESTER,	MATERNAL CARE FOR OTH ISOIMMUNIZATION, UNSP

SECTION 6 BIRTH OUTCOMES INITIATIVE

BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
	NOT APPLICABLE OR UNSPECIFIED	TRIMESTER, UNSP
O36.1991	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, UNSPECIFIED TRIMESTER, FETUS 1	MATERNAL CARE FOR OTH ISOIMMUN, UNSP TRIMESTER, FETUS 1
O36.1992	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, UNSPECIFIED TRIMESTER, FETUS 2	MATERNAL CARE FOR OTH ISOIMMUN, UNSP TRIMESTER, FETUS 2
O36.1993	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, UNSPECIFIED TRIMESTER, FETUS 3	MATERNAL CARE FOR OTH ISOIMMUN, UNSP TRIMESTER, FETUS 3
O36.1994	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, UNSPECIFIED TRIMESTER, FETUS 4	MATERNAL CARE FOR OTH ISOIMMUN, UNSP TRIMESTER, FETUS 4
O36.1995	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, UNSPECIFIED TRIMESTER, FETUS 5	MATERNAL CARE FOR OTH ISOIMMUN, UNSP TRIMESTER, FETUS 5
O36.1999	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, UNSPECIFIED TRIMESTER, OTHER FETUS	MATERNAL CARE FOR OTH ISOIMMUNIZATION, UNSP TRIMESTER, OTH
O36.4XX0	MATERNAL CARE FOR INTRAUTERINE DEATH, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR INTRAUTERINE DEATH, NOT APPLICABLE OR UNSP
O36.4XX1	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 1	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 1
O36.4XX2	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 2	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 2
O36.4XX3	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 3	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 3
O36.4XX4	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 4	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 4
O36.4XX5	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 5	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 5
O36.4XX9	MATERNAL CARE FOR INTRAUTERINE DEATH, OTHER FETUS	MATERNAL CARE FOR INTRAUTERINE DEATH, OTHER FETUS
O36.5110	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, FIRST TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, 1ST TRI, UNSP
O36.5111	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, FIRST TRIMESTER, FETUS 1	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, 1ST TRI, FTS1
O36.5112	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, FIRST TRIMESTER, FETUS 2	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, 1ST TRI, FTS2
O36.5113	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, FIRST TRIMESTER, FETUS 3	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, 1ST TRI, FTS3

SECTION 6 BIRTH OUTCOMES INITIATIVE

BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O36.5114	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, FIRST TRIMESTER, FETUS 4	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, 1ST TRI, FTS4
O36.5115	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, FIRST TRIMESTER, FETUS 5	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, 1ST TRI, FTS5
O36.5119	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, FIRST TRIMESTER, OTHER FETUS	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, FIRST TRI, OTH
O36.5120	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, SECOND TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, 2ND TRI, UNSP
O36.5121	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, SECOND TRIMESTER, FETUS 1	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, 2ND TRI, FTS1
O36.5122	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, SECOND TRIMESTER, FETUS 2	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, 2ND TRI, FTS2
O36.5123	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, SECOND TRIMESTER, FETUS 3	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, 2ND TRI, FTS3
O36.5124	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, SECOND TRIMESTER, FETUS 4	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, 2ND TRI, FTS4
O36.5125	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, SECOND TRIMESTER, FETUS 5	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, 2ND TRI, FTS5
O36.5129	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, SECOND TRIMESTER, OTHER FETUS	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, 2ND TRI, OTH
O36.5130	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, THIRD TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERN CARE FOR OR SUSP PLACNTL INSUFF, THIRD TRI, UNSP
O36.5131	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, THIRD TRIMESTER, FETUS 1	MATERN CARE FOR OR SUSP PLACNTL INSUFF, THIRD TRI, FTS1
O36.5132	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, THIRD TRIMESTER, FETUS 2	MATERN CARE FOR OR SUSP PLACNTL INSUFF, THIRD TRI, FTS2
O36.5133	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, THIRD TRIMESTER, FETUS 3	MATERN CARE FOR OR SUSP PLACNTL INSUFF, THIRD TRI, FTS3
O36.5134	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, THIRD TRIMESTER, FETUS 4	MATERN CARE FOR OR SUSP PLACNTL INSUFF, THIRD TRI, FTS4
O36.5135	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, THIRD	MATERN CARE FOR OR SUSP PLACNTL INSUFF, THIRD TRI, FTS5

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
	TRIMESTER, FETUS 5	
O36.5139	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, THIRD TRIMESTER, OTHER FETUS	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, THIRD TRI, OTH
O36.5190	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, UNSPECIFIED TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, UNSP TRI, UNSP
O36.5191	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, UNSPECIFIED TRIMESTER, FETUS 1	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, UNSP TRI, FTS1
O36.5192	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, UNSPECIFIED TRIMESTER, FETUS 2	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, UNSP TRI, FTS2
O36.5193	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, UNSPECIFIED TRIMESTER, FETUS 3	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, UNSP TRI, FTS3
O36.5194	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, UNSPECIFIED TRIMESTER, FETUS 4	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, UNSP TRI, FTS4
O36.5195	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, UNSPECIFIED TRIMESTER, FETUS 5	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, UNSP TRI, FTS5
O36.5199	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, UNSPECIFIED TRIMESTER, OTHER FETUS	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, UNSP TRI, OTH
O36.5910	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, FIRST TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, 1ST TRI, UNSP
O36.5911	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, FIRST TRIMESTER, FETUS 1	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, 1ST TRI, FTS1
O36.5912	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, FIRST TRIMESTER, FETUS 2	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, 1ST TRI, FTS2
O36.5913	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, FIRST TRIMESTER, FETUS 3	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, 1ST TRI, FTS3
O36.5914	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, FIRST TRIMESTER, FETUS 4	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, 1ST TRI, FTS4
O36.5915	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, FIRST TRIMESTER, FETUS 5	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, 1ST TRI, FTS5
O36.5919	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, FIRST TRIMESTER, OTHER FETUS	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, 1ST TRI, OTH
O36.5920	MATERNAL CARE FOR OTHER KNOWN OR	MATERN CARE FOR OTH OR SUSP

SECTION 6 BIRTH OUTCOMES INITIATIVE

BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
	SUSPECTED POOR FETAL GROWTH, SECOND TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	POOR FETL GRTH, 2ND TRI, UNSP
O36.5921	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, SECOND TRIMESTER, FETUS 1	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, 2ND TRI, FTS1
O36.5922	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, SECOND TRIMESTER, FETUS 2	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, 2ND TRI, FTS2
O36.5923	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, SECOND TRIMESTER, FETUS 3	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, 2ND TRI, FTS3
O36.5924	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, SECOND TRIMESTER, FETUS 4	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, 2ND TRI, FTS4
O36.5925	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, SECOND TRIMESTER, FETUS 5	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, 2ND TRI, FTS5
O36.5929	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, SECOND TRIMESTER, OTHER FETUS	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, 2ND TRI, OTH
O36.5930	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, THIRD TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, THIRD TRI, UNSP
O36.5931	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, THIRD TRIMESTER, FETUS 1	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, THIRD TRI, FTS1
O36.5932	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, THIRD TRIMESTER, FETUS 2	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, THIRD TRI, FTS2
O36.5933	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, THIRD TRIMESTER, FETUS 3	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, THIRD TRI, FTS3
O36.5934	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, THIRD TRIMESTER, FETUS 4	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, THIRD TRI, FTS4
O36.5935	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, THIRD TRIMESTER, FETUS 5	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, THIRD TRI, FTS5
O36.5939	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, THIRD TRIMESTER, OTHER FETUS	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, THIRD TRI, OTH
O36.5990	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, UNSPECIFIED TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, UNSP TRI, UNSP
O36.5991	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH,	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, UNSP TRI, FTS1

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ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
	UNSPECIFIED TRIMESTER, FETUS 1	
O36.5992	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, UNSPECIFIED TRIMESTER, FETUS 2	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, UNSP TRI, FTS2
O36.5993	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, UNSPECIFIED TRIMESTER, FETUS 3	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, UNSP TRI, FTS3
O36.5994	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, UNSPECIFIED TRIMESTER, FETUS 4	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, UNSP TRI, FTS4
O36.5995	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, UNSPECIFIED TRIMESTER, FETUS 5	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, UNSP TRI, FTS5
O36.5999	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, UNSPECIFIED TRIMESTER, OTHER FETUS	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, UNSP TRI, OTH
O40.1XX0	POLYHYDRAMNIOS, FIRST TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	POLYHYDRAMNIOS, FIRST TRIMESTER, NOT APPLICABLE OR UNSP
O40.1XX1	POLYHYDRAMNIOS, FIRST TRIMESTER, FETUS 1	POLYHYDRAMNIOS, FIRST TRIMESTER, FETUS 1
O40.1XX2	POLYHYDRAMNIOS, FIRST TRIMESTER, FETUS 2	POLYHYDRAMNIOS, FIRST TRIMESTER, FETUS 2
O40.1XX3	POLYHYDRAMNIOS, FIRST TRIMESTER, FETUS 3	POLYHYDRAMNIOS, FIRST TRIMESTER, FETUS 3
O40.1XX4	POLYHYDRAMNIOS, FIRST TRIMESTER, FETUS 4	POLYHYDRAMNIOS, FIRST TRIMESTER, FETUS 4
O40.1XX5	POLYHYDRAMNIOS, FIRST TRIMESTER, FETUS 5	POLYHYDRAMNIOS, FIRST TRIMESTER, FETUS 5
O40.1XX9	POLYHYDRAMNIOS, FIRST TRIMESTER, OTHER FETUS	POLYHYDRAMNIOS, FIRST TRIMESTER, OTHER FETUS
O40.2XX0	POLYHYDRAMNIOS, SECOND TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	POLYHYDRAMNIOS, SECOND TRIMESTER, NOT APPLICABLE OR UNSP
O40.2XX1	POLYHYDRAMNIOS, SECOND TRIMESTER, FETUS 1	POLYHYDRAMNIOS, SECOND TRIMESTER, FETUS 1
O40.2XX2	POLYHYDRAMNIOS, SECOND TRIMESTER, FETUS 2	POLYHYDRAMNIOS, SECOND TRIMESTER, FETUS 2
O40.2XX3	POLYHYDRAMNIOS, SECOND TRIMESTER, FETUS 3	POLYHYDRAMNIOS, SECOND TRIMESTER, FETUS 3
O40.2XX4	POLYHYDRAMNIOS, SECOND TRIMESTER, FETUS 4	POLYHYDRAMNIOS, SECOND TRIMESTER, FETUS 4
O40.2XX5	POLYHYDRAMNIOS, SECOND TRIMESTER, FETUS 5	POLYHYDRAMNIOS, SECOND TRIMESTER, FETUS 5
O40.2XX9	POLYHYDRAMNIOS, SECOND TRIMESTER,	POLYHYDRAMNIOS, SECOND

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ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
	OTHER FETUS	TRIMESTER, OTHER FETUS
O40.3XX0	POLYHYDRAMNIOS, THIRD TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	POLYHYDRAMNIOS, THIRD TRIMESTER, NOT APPLICABLE OR UNSP
O40.3XX1	POLYHYDRAMNIOS, THIRD TRIMESTER, FETUS 1	POLYHYDRAMNIOS, THIRD TRIMESTER, FETUS 1
O40.3XX2	POLYHYDRAMNIOS, THIRD TRIMESTER, FETUS 2	POLYHYDRAMNIOS, THIRD TRIMESTER, FETUS 2
O40.3XX3	POLYHYDRAMNIOS, THIRD TRIMESTER, FETUS 3	POLYHYDRAMNIOS, THIRD TRIMESTER, FETUS 3
O40.3XX4	POLYHYDRAMNIOS, THIRD TRIMESTER, FETUS 4	POLYHYDRAMNIOS, THIRD TRIMESTER, FETUS 4
O40.3XX5	POLYHYDRAMNIOS, THIRD TRIMESTER, FETUS 5	POLYHYDRAMNIOS, THIRD TRIMESTER, FETUS 5
O40.3XX9	POLYHYDRAMNIOS, THIRD TRIMESTER, OTHER FETUS	POLYHYDRAMNIOS, THIRD TRIMESTER, OTHER FETUS
O40.9XX0	POLYHYDRAMNIOS, UNSPECIFIED TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	POLYHYDRAMNIOS, UNSP TRIMESTER, NOT APPLICABLE OR UNSP
O40.9XX1	POLYHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 1	POLYHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 1
O40.9XX2	POLYHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 2	POLYHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 2
O40.9XX3	POLYHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 3	POLYHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 3
O40.9XX4	POLYHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 4	POLYHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 4
O40.9XX5	POLYHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 5	POLYHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 5
O40.9XX9	POLYHYDRAMNIOS, UNSPECIFIED TRIMESTER, OTHER FETUS	POLYHYDRAMNIOS, UNSPECIFIED TRIMESTER, OTHER FETUS
O41.00X0	OLIGOHYDRAMNIOS, UNSPECIFIED TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	OLIGOHYDRAMNIOS, UNSP TRIMESTER, NOT APPLICABLE OR UNSP
O41.00X1	OLIGOHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 1	OLIGOHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 1
O41.00X2	OLIGOHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 2	OLIGOHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 2
O41.00X3	OLIGOHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 3	OLIGOHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 3
O41.00X4	OLIGOHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 4	OLIGOHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 4
O41.00X5	OLIGOHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 5	OLIGOHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 5

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ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O41.00X9	OLIGOHYDRAMNIOS, UNSPECIFIED TRIMESTER, OTHER FETUS	OLIGOHYDRAMNIOS, UNSPECIFIED TRIMESTER, OTHER FETUS
O41.01X0	OLIGOHYDRAMNIOS, FIRST TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	OLIGOHYDRAMNIOS, FIRST TRIMESTER, NOT APPLICABLE OR UNSP
O41.01X1	OLIGOHYDRAMNIOS, FIRST TRIMESTER, FETUS 1	OLIGOHYDRAMNIOS, FIRST TRIMESTER, FETUS 1
O41.01X2	OLIGOHYDRAMNIOS, FIRST TRIMESTER, FETUS 2	OLIGOHYDRAMNIOS, FIRST TRIMESTER, FETUS 2
O41.01X3	OLIGOHYDRAMNIOS, FIRST TRIMESTER, FETUS 3	OLIGOHYDRAMNIOS, FIRST TRIMESTER, FETUS 3
O41.01X4	OLIGOHYDRAMNIOS, FIRST TRIMESTER, FETUS 4	OLIGOHYDRAMNIOS, FIRST TRIMESTER, FETUS 4
O41.01X5	OLIGOHYDRAMNIOS, FIRST TRIMESTER, FETUS 5	OLIGOHYDRAMNIOS, FIRST TRIMESTER, FETUS 5
O41.01X9	OLIGOHYDRAMNIOS, FIRST TRIMESTER, OTHER FETUS	OLIGOHYDRAMNIOS, FIRST TRIMESTER, OTHER FETUS
O41.02X0	OLIGOHYDRAMNIOS, SECOND TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	OLIGOHYDRAMNIOS, SECOND TRIMESTER, NOT APPLICABLE OR UNSP
O41.02X1	OLIGOHYDRAMNIOS, SECOND TRIMESTER, FETUS 1	OLIGOHYDRAMNIOS, SECOND TRIMESTER, FETUS 1
O41.02X2	OLIGOHYDRAMNIOS, SECOND TRIMESTER, FETUS 2	OLIGOHYDRAMNIOS, SECOND TRIMESTER, FETUS 2
O41.02X3	OLIGOHYDRAMNIOS, SECOND TRIMESTER, FETUS 3	OLIGOHYDRAMNIOS, SECOND TRIMESTER, FETUS 3
O41.02X4	OLIGOHYDRAMNIOS, SECOND TRIMESTER, FETUS 4	OLIGOHYDRAMNIOS, SECOND TRIMESTER, FETUS 4
O41.02X5	OLIGOHYDRAMNIOS, SECOND TRIMESTER, FETUS 5	OLIGOHYDRAMNIOS, SECOND TRIMESTER, FETUS 5
O41.02X9	OLIGOHYDRAMNIOS, SECOND TRIMESTER, OTHER FETUS	OLIGOHYDRAMNIOS, SECOND TRIMESTER, OTHER FETUS
O41.03X0	OLIGOHYDRAMNIOS, THIRD TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	OLIGOHYDRAMNIOS, THIRD TRIMESTER, NOT APPLICABLE OR UNSP
O41.03X1	OLIGOHYDRAMNIOS, THIRD TRIMESTER, FETUS 1	OLIGOHYDRAMNIOS, THIRD TRIMESTER, FETUS 1
O41.03X2	OLIGOHYDRAMNIOS, THIRD TRIMESTER, FETUS 2	OLIGOHYDRAMNIOS, THIRD TRIMESTER, FETUS 2
O41.03X3	OLIGOHYDRAMNIOS, THIRD TRIMESTER, FETUS 3	OLIGOHYDRAMNIOS, THIRD TRIMESTER, FETUS 3
O41.03X4	OLIGOHYDRAMNIOS, THIRD TRIMESTER, FETUS 4	OLIGOHYDRAMNIOS, THIRD TRIMESTER, FETUS 4
O41.03X5	OLIGOHYDRAMNIOS, THIRD TRIMESTER, FETUS	OLIGOHYDRAMNIOS, THIRD

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ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
	5	TRIMESTER, FETUS 5
O41.03X9	OLIGOHYDRAMNIOS, THIRD TRIMESTER, OTHER FETUS	OLIGOHYDRAMNIOS, THIRD TRIMESTER, OTHER FETUS
O42.00	PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR WITHIN 24 HOURS OF RUPTURE, UNSPECIFIED WEEKS OF GESTATION	PREM ROM, ONSET LABOR W/N 24 HR OF RUPT, UNSP WEEKS OF GEST
O42.011	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR WITHIN 24 HOURS OF RUPTURE, FIRST TRIMESTER	PRETRM PREM ROM, ONSET LABOR W/N 24 HOURS OF RUPT, FIRST TRI
O42.012	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR WITHIN 24 HOURS OF RUPTURE, SECOND TRIMESTER	PRETRM PREM ROM, ONSET LABOR W/N 24 HOURS OF RUPT, 2ND TRI
O42.013	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR WITHIN 24 HOURS OF RUPTURE, THIRD TRIMESTER	PRETRM PREM ROM, ONSET LABOR W/N 24 HOURS OF RUPT, THIRD TRI
O42.019	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR WITHIN 24 HOURS OF RUPTURE, UNSPECIFIED TRIMESTER	PRETRM PREM ROM, ONSET LABOR W/N 24 HOURS OF RUPT, UNSP TRI
O42.02	FULL-TERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR WITHIN 24 HOURS OF RUPTURE	FULL-TERM PREM ROM, ONSET LABOR WITHIN 24 HOURS OF RUPTURE
O42.10	PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE, UNSPECIFIED WEEKS OF GESTATION	PREM ROM, ONSET LABOR > 24 HR FOL RUPT, UNSP WEEKS OF GEST
O42.111	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE, FIRST TRIMESTER	PRETRM PREM ROM, ONSET LABOR > 24 HOURS FOL RUPT, FIRST TRI
O42.112	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE, SECOND TRIMESTER	PRETRM PREM ROM, ONSET LABOR > 24 HOURS FOL RUPT, SECOND TRI
O42.113	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE, THIRD TRIMESTER	PRETRM PREM ROM, ONSET LABOR > 24 HOURS FOL RUPT, THIRD TRI
O42.119	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE, UNSPECIFIED TRIMESTER	PRETRM PREM ROM, ONSET LABOR > 24 HOURS FOL RUPT, UNSP TRI
O42.12	FULL-TERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE	FULL-TERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE
O42.90	PREMATURE RUPTURE OF MEMBRANES,	PREM ROM, UNSP AS TO LENGTH OF

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ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
	UNSPECIFIED AS TO LENGTH OF TIME BETWEEN RUPTURE AND ONSET OF LABOR, UNSPECIFIED WEEKS OF GESTATION	TIME, BETW RUPT & ONST LABR, UNSP WEEKS OF GEST
O42.911	PRETERM PREMATURE RUPTURE OF MEMBRANES, UNSPECIFIED AS TO LENGTH OF TIME BETWEEN RUPTURE AND ONSET OF LABOR, FIRST TRIMESTER	PRETRM PREM ROM, UNSP TIME BETW RUPT AND ONSET LABR, 1ST TRI
O42.912	PRETERM PREMATURE RUPTURE OF MEMBRANES, UNSPECIFIED AS TO LENGTH OF TIME BETWEEN RUPTURE AND ONSET OF LABOR, SECOND TRIMESTER	PRETRM PREM ROM, UNSP TIME BETW RUPT AND ONSET LABR, 2ND TRI
O42.913	PRETERM PREMATURE RUPTURE OF MEMBRANES, UNSPECIFIED AS TO LENGTH OF TIME BETWEEN RUPTURE AND ONSET OF LABOR, THIRD TRIMESTER	PRETRM PREM ROM, UNSP TIME BETW RUPT AND ONST LABR, 3RD TRI
O42.919	PRETERM PREMATURE RUPTURE OF MEMBRANES, UNSPECIFIED AS TO LENGTH OF TIME BETWEEN RUPTURE AND ONSET OF LABOR, UNSPECIFIED TRIMESTER	PRETRM PREM ROM, UNSP TIME BETW RUPT AND ONST LABR, UNSP TRI
O42.92	FULL-TERM PREMATURE RUPTURE OF MEMBRANES, UNSPECIFIED AS TO LENGTH OF TIME BETWEEN RUPTURE AND ONSET OF LABOR	FULL-TERM PREM ROM, UNSP TIME BETW RUPTURE AND ONSET LABOR
O43.011	FETOMATERNAL PLACENTAL TRANSFUSION SYNDROME, FIRST TRIMESTER	FETOMATERNAL PLACENTAL TRANSFUSION SYNDROME, FIRST TRIMESTER
O43.012	FETOMATERNAL PLACENTAL TRANSFUSION SYNDROME, SECOND TRIMESTER	FETOMATERNAL PLACENTAL TRANSFUSE SYNDROME, SECOND TRIMESTER
O43.013	FETOMATERNAL PLACENTAL TRANSFUSION SYNDROME, THIRD TRIMESTER	FETOMATERNAL PLACENTAL TRANSFUSION SYNDROME, THIRD TRIMESTER
O43.019	FETOMATERNAL PLACENTAL TRANSFUSION SYNDROME, UNSPECIFIED TRIMESTER	FETOMATERNAL PLACENTAL TRANSFUSION SYNDROME, UNSP TRIMESTER
O44.00	PLACENTA PREVIA SPECIFIED AS WITHOUT HEMORRHAGE, UNSPECIFIED TRIMESTER	PLACENTA PREVIA SPECIFIED AS W/O HEMORRHAGE, UNSP TRIMESTER
O44.01	PLACENTA PREVIA SPECIFIED AS WITHOUT HEMORRHAGE, FIRST TRIMESTER	PLACENTA PREVIA SPECIFIED AS W/O HEMORRHAGE, FIRST TRIMESTER
O44.02	PLACENTA PREVIA SPECIFIED AS WITHOUT HEMORRHAGE, SECOND TRIMESTER	PLACENTA PREVIA SPECIFIED AS W/O HEMOR, SECOND TRIMESTER
O44.03	PLACENTA PREVIA SPECIFIED AS WITHOUT HEMORRHAGE, THIRD TRIMESTER	PLACENTA PREVIA SPECIFIED AS W/O HEMORRHAGE, THIRD TRIMESTER
O44.10	PLACENTA PREVIA WITH HEMORRHAGE, UNSPECIFIED TRIMESTER	PLACENTA PREVIA WITH HEMORRHAGE, UNSPECIFIED

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ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
		TRIMESTER
O44.11	PLACENTA PREVIA WITH HEMORRHAGE, FIRST TRIMESTER	PLACENTA PREVIA WITH HEMORRHAGE, FIRST TRIMESTER
O44.12	PLACENTA PREVIA WITH HEMORRHAGE, SECOND TRIMESTER	PLACENTA PREVIA WITH HEMORRHAGE, SECOND TRIMESTER
O44.13	PLACENTA PREVIA WITH HEMORRHAGE, THIRD TRIMESTER	PLACENTA PREVIA WITH HEMORRHAGE, THIRD TRIMESTER
O44.20	PARTIAL PLACENTA PREVIA NOS OR WITHOUT HEMORRHAGE, UNSPECIFIED TRIMESTER	PARTIAL PLACENTA PREVIA NOS OR WITHOUT HEMOR, UNSP TRIMESTER
O44.21	PARTIAL PLACENTA PREVIA NOS OR WITHOUT HEMORRHAGE, FIRST TRIMESTER	PARTIAL PLACENTA PREVIA NOS OR WITHOUT HEMOR, FIRST TRI
O44.22	PARTIAL PLACENTA PREVIA NOS OR WITHOUT HEMORRHAGE, SECOND TRIMESTER	PARTIAL PLACENTA PREVIA NOS OR WITHOUT HEMOR, SECOND TRI
O44.23	PARTIAL PLACENTA PREVIA NOS OR WITHOUT HEMORRHAGE, THIRD TRIMESTER	PARTIAL PLACENTA PREVIA NOS OR WITHOUT HEMOR, THIRD TRI
O44.30	PARTIAL PLACENTA PREVIA WITH HEMORRHAGE, UNSPECIFIED TRIMESTER	PARTIAL PLACENTA PREVIA WITH HEMORRHAGE, UNSP TRIMESTER
O44.31	PARTIAL PLACENTA PREVIA WITH HEMORRHAGE, FIRST TRIMESTER	PARTIAL PLACENTA PREVIA WITH HEMORRHAGE, FIRST TRIMESTER
O44.32	PARTIAL PLACENTA PREVIA WITH HEMORRHAGE, SECOND TRIMESTER	PARTIAL PLACENTA PREVIA WITH HEMORRHAGE, SECOND TRIMESTER
O44.33	PARTIAL PLACENTA PREVIA WITH HEMORRHAGE, THIRD TRIMESTER	PARTIAL PLACENTA PREVIA WITH HEMORRHAGE, THIRD TRIMESTER
O45.001	PREMATURE SEPARATION OF PLACENTA WITH COAGULATION DEFECT, UNSPECIFIED, FIRST TRIMESTER	PREM SEPARTN OF PLACENTA W COAG DEFECT, UNSP, FIRST TRI
O45.002	PREMATURE SEPARATION OF PLACENTA WITH COAGULATION DEFECT, UNSPECIFIED, SECOND TRIMESTER	PREM SEPARTN OF PLACENTA W COAG DEFECT, UNSP, SECOND TRI
O45.003	PREMATURE SEPARATION OF PLACENTA WITH COAGULATION DEFECT, UNSPECIFIED, THIRD TRIMESTER	PREM SEPARTN OF PLACENTA W COAG DEFECT, UNSP, THIRD TRI
O45.009	PREMATURE SEPARATION OF PLACENTA WITH COAGULATION DEFECT, UNSPECIFIED, UNSPECIFIED TRIMESTER	PREM SEPARTN OF PLACENTA W COAG DEFECT, UNSP, UNSP TRIMESTER
O45.011	PREMATURE SEPARATION OF PLACENTA WITH AFIBRINOGENEMIA, FIRST TRIMESTER	PREM SEPARTN OF PLACENTA W AFIBRINOGENEMIA, FIRST TRIMESTER
O45.012	PREMATURE SEPARATION OF PLACENTA WITH AFIBRINOGENEMIA, SECOND TRIMESTER	PREM SEPARTN OF PLACENTA W AFIBRINOGENEMIA, SECOND TRIMESTER
O45.013	PREMATURE SEPARATION OF PLACENTA WITH AFIBRINOGENEMIA, THIRD TRIMESTER	PREM SEPARTN OF PLACENTA W AFIBRINOGENEMIA, THIRD TRIMESTER
O45.019	PREMATURE SEPARATION OF PLACENTA WITH	PREM SEPARTN OF PLACENTA W

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ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
	AFIBRINOGENEMIA, UNSPECIFIED TRIMESTER	AFIBRINOGENEMIA, UNSP TRIMESTER
O45.021	PREMATURE SEPARATION OF PLACENTA WITH DISSEMINATED INTRAVASCULAR COAGULATION, FIRST TRIMESTER	PREM SEPARTN OF PLACENTA W DISSEM INTRAVASC COAG, FIRST TRI
O45.022	PREMATURE SEPARATION OF PLACENTA WITH DISSEMINATED INTRAVASCULAR COAGULATION, SECOND TRIMESTER	PREM SEPARTN OF PLACENTA W DISSEM INTRAVASC COAG, SECOND TRI
O45.023	PREMATURE SEPARATION OF PLACENTA WITH DISSEMINATED INTRAVASCULAR COAGULATION, THIRD TRIMESTER	PREM SEPARTN OF PLACENTA W DISSEM INTRAVASC COAG, THIRD TRI
O45.029	PREMATURE SEPARATION OF PLACENTA WITH DISSEMINATED INTRAVASCULAR COAGULATION, UNSPECIFIED TRIMESTER	PREM SEPARTN OF PLACENTA W DISSEM INTRAVASC COAG, UNSP TRI
O45.091	PREMATURE SEPARATION OF PLACENTA WITH OTHER COAGULATION DEFECT, FIRST TRIMESTER	PREM SEPARTN OF PLACENTA W OTH COAG DEFECT, FIRST TRIMESTER
O45.092	PREMATURE SEPARATION OF PLACENTA WITH OTHER COAGULATION DEFECT, SECOND TRIMESTER	PREM SEPARTN OF PLACENTA W OTH COAG DEFECT, SECOND TRIMESTER
O45.093	PREMATURE SEPARATION OF PLACENTA WITH OTHER COAGULATION DEFECT, THIRD TRIMESTER	PREM SEPARTN OF PLACENTA W OTH COAG DEFECT, THIRD TRIMESTER
O45.099	PREMATURE SEPARATION OF PLACENTA WITH OTHER COAGULATION DEFECT, UNSPECIFIED TRIMESTER	PREM SEPARTN OF PLACENTA W OTH COAG DEFECT, UNSP TRIMESTER
O45.8X1	OTHER PREMATURE SEPARATION OF PLACENTA, FIRST TRIMESTER	OTHER PREMATURE SEPARATION OF PLACENTA, FIRST TRIMESTER
O45.8X2	OTHER PREMATURE SEPARATION OF PLACENTA, SECOND TRIMESTER	OTHER PREMATURE SEPARATION OF PLACENTA, SECOND TRIMESTER
O45.8X3	OTHER PREMATURE SEPARATION OF PLACENTA, THIRD TRIMESTER	OTHER PREMATURE SEPARATION OF PLACENTA, THIRD TRIMESTER
O45.8X9	OTHER PREMATURE SEPARATION OF PLACENTA, UNSPECIFIED TRIMESTER	OTHER PREMATURE SEPARATION OF PLACENTA, UNSP TRIMESTER
O45.90	PREMATURE SEPARATION OF PLACENTA, UNSPECIFIED, UNSPECIFIED TRIMESTER	PREMATURE SEPARATION OF PLACENTA, UNSP, UNSP TRIMESTER
O45.91	PREMATURE SEPARATION OF PLACENTA, UNSPECIFIED, FIRST TRIMESTER	PREMATURE SEPARATION OF PLACENTA, UNSP, FIRST TRIMESTER
O45.92	PREMATURE SEPARATION OF PLACENTA, UNSPECIFIED, SECOND TRIMESTER	PREMATURE SEPARATION OF PLACENTA, UNSP, SECOND TRIMESTER
O45.93	PREMATURE SEPARATION OF PLACENTA, UNSPECIFIED, THIRD TRIMESTER	PREMATURE SEPARATION OF PLACENTA, UNSP, THIRD TRIMESTER
O46.001	ANTEPARTUM HEMORRHAGE WITH COAGULATION DEFECT, UNSPECIFIED, FIRST TRIMESTER	ANTEPARTUM HEMORRHAGE W COAG DEFECT, UNSP, FIRST TRIMESTER

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ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O46.002	ANTEPARTUM HEMORRHAGE WITH COAGULATION DEFECT, UNSPECIFIED, SECOND TRIMESTER	ANTEPARTUM HEMORRHAGE W COAG DEFECT, UNSP, SECOND TRIMESTER
O46.003	ANTEPARTUM HEMORRHAGE WITH COAGULATION DEFECT, UNSPECIFIED, THIRD TRIMESTER	ANTEPARTUM HEMORRHAGE W COAG DEFECT, UNSP, THIRD TRIMESTER
O46.009	ANTEPARTUM HEMORRHAGE WITH COAGULATION DEFECT, UNSPECIFIED, UNSPECIFIED TRIMESTER	ANTEPARTUM HEMORRHAGE W COAG DEFECT, UNSP, UNSP TRIMESTER
O46.011	ANTEPARTUM HEMORRHAGE WITH AFIBRINOGENEMIA, FIRST TRIMESTER	ANTEPARTUM HEMORRHAGE WITH AFIBRINOGENEMIA, FIRST TRIMESTER
O46.012	ANTEPARTUM HEMORRHAGE WITH AFIBRINOGENEMIA, SECOND TRIMESTER	ANTEPARTUM HEMORRHAGE WITH AFIBRINOGENEMIA, SECOND TRIMESTER
O46.013	ANTEPARTUM HEMORRHAGE WITH AFIBRINOGENEMIA, THIRD TRIMESTER	ANTEPARTUM HEMORRHAGE WITH AFIBRINOGENEMIA, THIRD TRIMESTER
O46.019	ANTEPARTUM HEMORRHAGE WITH AFIBRINOGENEMIA, UNSPECIFIED TRIMESTER	ANTEPARTUM HEMORRHAGE WITH AFIBRINOGENEMIA, UNSP TRIMESTER
O46.021	ANTEPARTUM HEMORRHAGE WITH DISSEMINATED INTRAVASCULAR COAGULATION, FIRST TRIMESTER	ANTEPART HEMORRHAGE W DISSEM INTRAVASC COAG, FIRST TRIMESTER
O46.022	ANTEPARTUM HEMORRHAGE WITH DISSEMINATED INTRAVASCULAR COAGULATION, SECOND TRIMESTER	ANTEPART HEMOR W DISSEM INTRAVASC COAG, SECOND TRIMESTER
O46.023	ANTEPARTUM HEMORRHAGE WITH DISSEMINATED INTRAVASCULAR COAGULATION, THIRD TRIMESTER	ANTEPART HEMORRHAGE W DISSEM INTRAVASC COAG, THIRD TRIMESTER
O46.029	ANTEPARTUM HEMORRHAGE WITH DISSEMINATED INTRAVASCULAR COAGULATION, UNSPECIFIED TRIMESTER	ANTEPART HEMORRHAGE W DISSEM INTRAVASC COAG, UNSP TRIMESTER
O46.091	ANTEPARTUM HEMORRHAGE WITH OTHER COAGULATION DEFECT, FIRST TRIMESTER	ANTEPARTUM HEMORRHAGE W OTH COAG DEFECT, FIRST TRIMESTER
O46.092	ANTEPARTUM HEMORRHAGE WITH OTHER COAGULATION DEFECT, SECOND TRIMESTER	ANTEPARTUM HEMORRHAGE W OTH COAG DEFECT, SECOND TRIMESTER
O46.093	ANTEPARTUM HEMORRHAGE WITH OTHER COAGULATION DEFECT, THIRD TRIMESTER	ANTEPARTUM HEMORRHAGE W OTH COAG DEFECT, THIRD TRIMESTER
O46.099	ANTEPARTUM HEMORRHAGE WITH OTHER COAGULATION DEFECT, UNSPECIFIED TRIMESTER	ANTEPARTUM HEMORRHAGE W OTH COAG DEFECT, UNSP TRIMESTER
O46.8X1	OTHER ANTEPARTUM HEMORRHAGE, FIRST TRIMESTER	OTHER ANTEPARTUM HEMORRHAGE, FIRST TRIMESTER
O46.8X2	OTHER ANTEPARTUM HEMORRHAGE, SECOND TRIMESTER	OTHER ANTEPARTUM HEMORRHAGE, SECOND TRIMESTER

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O46.8X3	OTHER ANTEPARTUM HEMORRHAGE, THIRD TRIMESTER	OTHER ANTEPARTUM HEMORRHAGE, THIRD TRIMESTER
O46.8X9	OTHER ANTEPARTUM HEMORRHAGE, UNSPECIFIED TRIMESTER	OTHER ANTEPARTUM HEMORRHAGE, UNSPECIFIED TRIMESTER
O46.90	ANTEPARTUM HEMORRHAGE, UNSPECIFIED, UNSPECIFIED TRIMESTER	ANTEPARTUM HEMORRHAGE, UNSPECIFIED, UNSPECIFIED TRIMESTER
O46.91	ANTEPARTUM HEMORRHAGE, UNSPECIFIED, FIRST TRIMESTER	ANTEPARTUM HEMORRHAGE, UNSPECIFIED, FIRST TRIMESTER
O46.92	ANTEPARTUM HEMORRHAGE, UNSPECIFIED, SECOND TRIMESTER	ANTEPARTUM HEMORRHAGE, UNSPECIFIED, SECOND TRIMESTER
O46.93	ANTEPARTUM HEMORRHAGE, UNSPECIFIED, THIRD TRIMESTER	ANTEPARTUM HEMORRHAGE, UNSPECIFIED, THIRD TRIMESTER
O48.0	POST-TERM PREGNANCY	POST-TERM PREGNANCY
O48.1	PROLONGED PREGNANCY	PROLONGED PREGNANCY
O66.6	OBSTRUCTED LABOR DUE TO OTHER MULTIPLE FETUSES	OBSTRUCTED LABOR DUE TO OTHER MULTIPLE FETUSES
O67.0	INTRAPARTUM HEMORRHAGE WITH COAGULATION DEFECT	INTRAPARTUM HEMORRHAGE WITH COAGULATION DEFECT
O67.8	OTHER INTRAPARTUM HEMORRHAGE	OTHER INTRAPARTUM HEMORRHAGE
O67.9	INTRAPARTUM HEMORRHAGE, UNSPECIFIED	INTRAPARTUM HEMORRHAGE, UNSPECIFIED
O68	LABOR AND DELIVERY COMPLICATED BY ABNORMALITY OF FETAL ACID-BASE BALANCE	LABOR AND DELIVERY COMP BY ABNLT OF FETAL ACID-BASE BALANCE
O69.0XX0	LABOR AND DELIVERY COMPLICATED BY PROLAPSE OF CORD, NOT APPLICABLE OR UNSPECIFIED	LABOR AND DELIVERY COMPLICATED BY PROLAPSE OF CORD, UNSP
O69.0XX1	LABOR AND DELIVERY COMPLICATED BY PROLAPSE OF CORD, FETUS 1	LABOR AND DELIVERY COMPLICATED BY PROLAPSE OF CORD, FETUS 1
O69.0XX2	LABOR AND DELIVERY COMPLICATED BY PROLAPSE OF CORD, FETUS 2	LABOR AND DELIVERY COMPLICATED BY PROLAPSE OF CORD, FETUS 2
O69.0XX3	LABOR AND DELIVERY COMPLICATED BY PROLAPSE OF CORD, FETUS 3	LABOR AND DELIVERY COMPLICATED BY PROLAPSE OF CORD, FETUS 3
O69.0XX4	LABOR AND DELIVERY COMPLICATED BY PROLAPSE OF CORD, FETUS 4	LABOR AND DELIVERY COMPLICATED BY PROLAPSE OF CORD, FETUS 4
O69.0XX5	LABOR AND DELIVERY COMPLICATED BY PROLAPSE OF CORD, FETUS 5	LABOR AND DELIVERY COMPLICATED BY PROLAPSE OF CORD, FETUS 5
O69.0XX9	LABOR AND DELIVERY COMPLICATED BY PROLAPSE OF CORD, OTHER FETUS	LABOR AND DELIVERY COMPLICATED BY PROLAPSE OF CORD, OTH
O69.1XX0	LABOR AND DELIVERY COMPLICATED BY CORD AROUND NECK, WITH COMPRESSION, NOT APPLICABLE OR UNSPECIFIED	LABOR AND DELIVERY COMP BY CORD AROUND NECK, W COMPRSN, UNSP
O69.1XX1	LABOR AND DELIVERY COMPLICATED BY CORD	LABOR AND DEL COMP BY CORD

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
	AROUND NECK, WITH COMPRESSION, FETUS 1	AROUND NECK, W COMPRSN, FETUS 1
O69.1XX2	LABOR AND DELIVERY COMPLICATED BY CORD AROUND NECK, WITH COMPRESSION, FETUS 2	LABOR AND DEL COMP BY CORD AROUND NECK, W COMPRSN, FETUS 2
O69.1XX3	LABOR AND DELIVERY COMPLICATED BY CORD AROUND NECK, WITH COMPRESSION, FETUS 3	LABOR AND DEL COMP BY CORD AROUND NECK, W COMPRSN, FETUS 3
O69.1XX4	LABOR AND DELIVERY COMPLICATED BY CORD AROUND NECK, WITH COMPRESSION, FETUS 4	LABOR AND DEL COMP BY CORD AROUND NECK, W COMPRSN, FETUS 4
O69.1XX5	LABOR AND DELIVERY COMPLICATED BY CORD AROUND NECK, WITH COMPRESSION, FETUS 5	LABOR AND DEL COMP BY CORD AROUND NECK, W COMPRSN, FETUS 5
O69.1XX9	LABOR AND DELIVERY COMPLICATED BY CORD AROUND NECK, WITH COMPRESSION, OTHER FETUS	LABOR AND DELIVERY COMP BY CORD AROUND NECK, W COMPRSN, OTH
O69.2XX0	LABOR AND DELIVERY COMPLICATED BY OTHER CORD ENTANGLEMENT, WITH COMPRESSION, NOT APPLICABLE OR UNSPECIFIED	LABOR AND DEL COMP BY OTH CORD ENTANGLE, W COMPRSN, UNSP
O69.2XX1	LABOR AND DELIVERY COMPLICATED BY OTHER CORD ENTANGLEMENT, WITH COMPRESSION, FETUS 1	LABOR AND DEL COMP BY OTH CORD ENTANGLE, W COMPRSN, FETUS 1
O69.2XX2	LABOR AND DELIVERY COMPLICATED BY OTHER CORD ENTANGLEMENT, WITH COMPRESSION, FETUS 2	LABOR AND DEL COMP BY OTH CORD ENTANGLE, W COMPRSN, FETUS 2
O69.2XX3	LABOR AND DELIVERY COMPLICATED BY OTHER CORD ENTANGLEMENT, WITH COMPRESSION, FETUS 3	LABOR AND DEL COMP BY OTH CORD ENTANGLE, W COMPRSN, FETUS 3
O69.2XX4	LABOR AND DELIVERY COMPLICATED BY OTHER CORD ENTANGLEMENT, WITH COMPRESSION, FETUS 4	LABOR AND DEL COMP BY OTH CORD ENTANGLE, W COMPRSN, FETUS 4
O69.2XX5	LABOR AND DELIVERY COMPLICATED BY OTHER CORD ENTANGLEMENT, WITH COMPRESSION, FETUS 5	LABOR AND DEL COMP BY OTH CORD ENTANGLE, W COMPRSN, FETUS 5
O69.2XX9	LABOR AND DELIVERY COMPLICATED BY OTHER CORD ENTANGLEMENT, WITH COMPRESSION, OTHER FETUS	LABOR AND DELIVERY COMP BY OTH CORD ENTANGLE, W COMPRSN, OTH
O69.3XX0	LABOR AND DELIVERY COMPLICATED BY SHORT CORD, NOT APPLICABLE OR UNSPECIFIED	LABOR AND DELIVERY COMPLICATED BY SHORT CORD, UNSP
O69.3XX1	LABOR AND DELIVERY COMPLICATED BY SHORT CORD, FETUS 1	LABOR AND DELIVERY COMPLICATED BY SHORT CORD, FETUS 1
O69.3XX2	LABOR AND DELIVERY COMPLICATED BY SHORT CORD, FETUS 2	LABOR AND DELIVERY COMPLICATED BY SHORT CORD, FETUS 2
O69.3XX3	LABOR AND DELIVERY COMPLICATED BY	LABOR AND DELIVERY COMPLICATED

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
	SHORT CORD, FETUS 3	BY SHORT CORD, FETUS 3
O69.3XX4	LABOR AND DELIVERY COMPLICATED BY SHORT CORD, FETUS 4	LABOR AND DELIVERY COMPLICATED BY SHORT CORD, FETUS 4
O69.3XX5	LABOR AND DELIVERY COMPLICATED BY SHORT CORD, FETUS 5	LABOR AND DELIVERY COMPLICATED BY SHORT CORD, FETUS 5
O69.3XX9	LABOR AND DELIVERY COMPLICATED BY SHORT CORD, OTHER FETUS	LABOR AND DELIVERY COMPLICATED BY SHORT CORD, OTHER FETUS
O69.81X0	LABOR AND DELIVERY COMPLICATED BY CORD AROUND NECK, WITHOUT COMPRESSION, NOT APPLICABLE OR UNSPECIFIED	LABOR AND DEL COMP BY CORD AROUND NECK, W/O COMPRSN, UNSP
O69.81X1	LABOR AND DELIVERY COMPLICATED BY CORD AROUND NECK, WITHOUT COMPRESSION, FETUS 1	LABOR AND DEL COMP BY CORD AROUND NECK, W/O COMPRSN, FETUS 1
O69.81X2	LABOR AND DELIVERY COMPLICATED BY CORD AROUND NECK, WITHOUT COMPRESSION, FETUS 2	LABOR AND DEL COMP BY CORD AROUND NECK, W/O COMPRSN, FETUS 2
O69.81X3	LABOR AND DELIVERY COMPLICATED BY CORD AROUND NECK, WITHOUT COMPRESSION, FETUS 3	LABOR AND DEL COMP BY CORD AROUND NECK, W/O COMPRSN, FETUS 3
O69.81X4	LABOR AND DELIVERY COMPLICATED BY CORD AROUND NECK, WITHOUT COMPRESSION, FETUS 4	LABOR AND DEL COMP BY CORD AROUND NECK, W/O COMPRSN, FETUS 4
O69.81X5	LABOR AND DELIVERY COMPLICATED BY CORD AROUND NECK, WITHOUT COMPRESSION, FETUS 5	LABOR AND DEL COMP BY CORD AROUND NECK, W/O COMPRSN, FETUS 5
O69.81X9	LABOR AND DELIVERY COMPLICATED BY CORD AROUND NECK, WITHOUT COMPRESSION, OTHER FETUS	LABOR AND DEL COMP BY CORD AROUND NECK, W/O COMPRSN, OTH
O69.82X0	LABOR AND DELIVERY COMPLICATED BY OTHER CORD ENTANGLEMENT, WITHOUT COMPRESSION, NOT APPLICABLE OR UNSPECIFIED	LABOR AND DEL COMP BY OTH CORD ENTANGLE, W/O COMPRSN, UNSP
O69.82X1	LABOR AND DELIVERY COMPLICATED BY OTHER CORD ENTANGLEMENT, WITHOUT COMPRESSION, FETUS 1	LABOR AND DEL COMP BY OTH CORD ENTANGLE, W/O COMPRSN, FTS1
O69.82X2	LABOR AND DELIVERY COMPLICATED BY OTHER CORD ENTANGLEMENT, WITHOUT COMPRESSION, FETUS 2	LABOR AND DEL COMP BY OTH CORD ENTANGLE, W/O COMPRSN, FTS2
O69.82X3	LABOR AND DELIVERY COMPLICATED BY OTHER CORD ENTANGLEMENT, WITHOUT COMPRESSION, FETUS 3	LABOR AND DEL COMP BY OTH CORD ENTANGLE, W/O COMPRSN, FTS3
O69.82X4	LABOR AND DELIVERY COMPLICATED BY OTHER CORD ENTANGLEMENT, WITHOUT COMPRESSION, FETUS 4	LABOR AND DEL COMP BY OTH CORD ENTANGLE, W/O COMPRSN, FTS4
O69.82X5	LABOR AND DELIVERY COMPLICATED BY OTHER CORD ENTANGLEMENT, WITHOUT COMPRESSION, FETUS 5	LABOR AND DEL COMP BY OTH CORD ENTANGLE, W/O COMPRSN, FTS5

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O69.82X9	LABOR AND DELIVERY COMPLICATED BY OTHER CORD ENTANGLEMENT, WITHOUT COMPRESSION, OTHER FETUS	LABOR AND DEL COMP BY OTH CORD ENTANGLE, W/O COMPRSN, OTH
O69.89X0	LABOR AND DELIVERY COMPLICATED BY OTHER CORD COMPLICATIONS, NOT APPLICABLE OR UNSPECIFIED	LABOR AND DELIVERY COMPLICATED BY OTH CORD COMP, UNSP
O69.89X1	LABOR AND DELIVERY COMPLICATED BY OTHER CORD COMPLICATIONS, FETUS 1	LABOR AND DELIVERY COMPLICATED BY OTH CORD COMP, FETUS 1
O69.89X2	LABOR AND DELIVERY COMPLICATED BY OTHER CORD COMPLICATIONS, FETUS 2	LABOR AND DELIVERY COMPLICATED BY OTH CORD COMP, FETUS 2
O69.89X3	LABOR AND DELIVERY COMPLICATED BY OTHER CORD COMPLICATIONS, FETUS 3	LABOR AND DELIVERY COMPLICATED BY OTH CORD COMP, FETUS 3
O69.89X4	LABOR AND DELIVERY COMPLICATED BY OTHER CORD COMPLICATIONS, FETUS 4	LABOR AND DELIVERY COMPLICATED BY OTH CORD COMP, FETUS 4
O69.89X5	LABOR AND DELIVERY COMPLICATED BY OTHER CORD COMPLICATIONS, FETUS 5	LABOR AND DELIVERY COMPLICATED BY OTH CORD COMP, FETUS 5
O69.89X9	LABOR AND DELIVERY COMPLICATED BY OTHER CORD COMPLICATIONS, OTHER FETUS	LABOR AND DELIVERY COMPLICATED BY OTH CORD COMP, OTH
O69.9XX0	LABOR AND DELIVERY COMPLICATED BY CORD COMPLICATION, UNSPECIFIED, NOT APPLICABLE OR UNSPECIFIED	LABOR AND DELIVERY COMPLICATED BY CORD COMP, UNSP, UNSP
O69.9XX1	LABOR AND DELIVERY COMPLICATED BY CORD COMPLICATION, UNSPECIFIED, FETUS 1	LABOR AND DELIVERY COMPLICATED BY CORD COMP, UNSP, FETUS 1
O69.9XX2	LABOR AND DELIVERY COMPLICATED BY CORD COMPLICATION, UNSPECIFIED, FETUS 2	LABOR AND DELIVERY COMPLICATED BY CORD COMP, UNSP, FETUS 2
O69.9XX3	LABOR AND DELIVERY COMPLICATED BY CORD COMPLICATION, UNSPECIFIED, FETUS 3	LABOR AND DELIVERY COMPLICATED BY CORD COMP, UNSP, FETUS 3
O69.9XX4	LABOR AND DELIVERY COMPLICATED BY CORD COMPLICATION, UNSPECIFIED, FETUS 4	LABOR AND DELIVERY COMPLICATED BY CORD COMP, UNSP, FETUS 4
O69.9XX5	LABOR AND DELIVERY COMPLICATED BY CORD COMPLICATION, UNSPECIFIED, FETUS 5	LABOR AND DELIVERY COMPLICATED BY CORD COMP, UNSP, FETUS 5
O69.9XX9	LABOR AND DELIVERY COMPLICATED BY CORD COMPLICATION, UNSPECIFIED, OTHER FETUS	LABOR AND DELIVERY COMPLICATED BY CORD COMP, UNSP, OTH
O76	ABNORMALITY IN FETAL HEART RATE AND RHYTHM COMPLICATING LABOR AND DELIVERY	ABNLT IN FETAL HEART RATE AND RHYTHM COMP LABOR AND DELIVERY
O77.0	LABOR AND DELIVERY COMPLICATED BY MECONIUM IN AMNIOTIC FLUID	LABOR AND DELIVERY COMPLICATED BY MECONIUM IN AMNIOTIC FLUID
O77.1	FETAL STRESS IN LABOR OR DELIVERY DUE TO DRUG ADMINISTRATION	FETAL STRESS IN LABOR OR DELIVERY DUE TO DRUG ADMINISTRATION
O77.8	LABOR AND DELIVERY COMPLICATED BY OTHER EVIDENCE OF FETAL STRESS	LABOR AND DELIVERY COMP BY OTH EVIDENCE OF FETAL STRESS
O77.9	LABOR AND DELIVERY COMPLICATED BY FETAL STRESS, UNSPECIFIED	LABOR AND DELIVERY COMPLICATED BY FETAL STRESS, UNSPECIFIED

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O99.111	OTHER DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS AND CERTAIN DISORDERS INVOLVING THE IMMUNE MECHANISM COMPLICATING PREGNANCY, FIRST TRIMESTER	OTH DIS OF BLD/BLD-FORM ORG/IMMUN MECHNSM COMP PREG, 1ST TRI
O99.112	OTHER DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS AND CERTAIN DISORDERS INVOLVING THE IMMUNE MECHANISM COMPLICATING PREGNANCY, SECOND TRIMESTER	OTH DIS OF BLD/BLD-FORM ORG/IMMUN MECHNSM COMP PREG, 2ND TRI
O99.113	OTHER DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS AND CERTAIN DISORDERS INVOLVING THE IMMUNE MECHANISM COMPLICATING PREGNANCY, THIRD TRIMESTER	OTH DIS OF BLD/BLD-FORM ORG/IMMUN MECHNSM COMP PREG, 3RD TRI
O99.119	OTHER DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS AND CERTAIN DISORDERS INVOLVING THE IMMUNE MECHANISM COMPLICATING PREGNANCY, UNSPECIFIED TRIMESTER	OTH DIS OF BLD/BLD-FORM ORG/IMMUN MECHNSM COMP PREG,UNSP TRI
O99.12	OTHER DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS AND CERTAIN DISORDERS INVOLVING THE IMMUNE MECHANISM COMPLICATING CHILDBIRTH	OTH DIS OF THE BLD/BLD-FORM ORG/IMMUN MECHNSM COMP CHLDBRTH
O99.13	OTHER DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS AND CERTAIN DISORDERS INVOLVING THE IMMUNE MECHANISM COMPLICATING THE PUERPERIUM	OTH DIS OF THE BLD/BLD-FORM ORG/IMMUN MECHNSM COMP THE PUERP
O99.411	DISEASES OF THE CIRCULATORY SYSTEM COMPLICATING PREGNANCY, FIRST TRIMESTER	DISEASES OF THE CIRC SYS COMP PREGNANCY, FIRST TRIMESTER
O99.412	DISEASES OF THE CIRCULATORY SYSTEM COMPLICATING PREGNANCY, SECOND TRIMESTER	DISEASES OF THE CIRC SYS COMP PREGNANCY, SECOND TRIMESTER
O99.413	DISEASES OF THE CIRCULATORY SYSTEM COMPLICATING PREGNANCY, THIRD TRIMESTER	DISEASES OF THE CIRC SYS COMP PREGNANCY, THIRD TRIMESTER
O99.419	DISEASES OF THE CIRCULATORY SYSTEM COMPLICATING PREGNANCY, UNSPECIFIED TRIMESTER	DISEASES OF THE CIRC SYS COMP PREGNANCY, UNSP TRIMESTER
O99.42	DISEASES OF THE CIRCULATORY SYSTEM COMPLICATING CHILDBIRTH	DISEASES OF THE CIRCULATORY SYSTEM COMPLICATING CHILDBIRTH
O99.43	DISEASES OF THE CIRCULATORY SYSTEM COMPLICATING THE PUERPERIUM	DISEASES OF THE CIRC SYS COMPLICATING THE PUERPERIUM
O99.810	ABNORMAL GLUCOSE COMPLICATING PREGNANCY	ABNORMAL GLUCOSE COMPLICATING PREGNANCY
O99.814	ABNORMAL GLUCOSE COMPLICATING CHILDBIRTH	ABNORMAL GLUCOSE COMPLICATING CHILDBIRTH

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ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O99.815	ABNORMAL GLUCOSE COMPLICATING THE PUERPERIUM	ABNORMAL GLUCOSE COMPLICATING THE PUERPERIUM
O99.89	OTHER SPECIFIED DISEASES AND CONDITIONS COMPLICATING PREGNANCY, CHILDBIRTH AND THE PUERPERIUM	OTHER SPECIFIED DISEASES AND CONDITIONS COMPLICATING PREGNANCY, CHILDBIRTH AND THE PUERPERIUM
Z21	ASYMPTOMATIC HUMAN IMMUNODEFICIENCY VIRUS [HIV] INFECTION STATUS	ASYMPTOMATIC HUMAN IMMUNODEFICIENCY VIRUS INFECTION STATUS
Z37.1	SINGLE STILLBIRTH	SINGLE STILLBIRTH
Z37.3	TWINS, ONE LIVEBORN AND ONE STILLBORN	TWINS, ONE LIVEBORN AND ONE STILLBORN
Z37.4	TWINS, BOTH STILLBORN	TWINS, BOTH STILLBORN
Z37.60	MULTIPLE BIRTHS, UNSPECIFIED, SOME LIVEBORN	MULTIPLE BIRTHS, UNSPECIFIED, SOME LIVEBORN
Z37.61	TRIPLETS, SOME LIVEBORN	TRIPLETS, SOME LIVEBORN
Z37.62	QUADRUPLETS, SOME LIVEBORN	QUADRUPLETS, SOME LIVEBORN
Z37.63	QUINTUPLETS, SOME LIVEBORN	QUINTUPLETS, SOME LIVEBORN
Z37.64	SEXTUPLETS, SOME LIVEBORN	SEXTUPLETS, SOME LIVEBORN
Z37.69	OTHER MULTIPLE BIRTHS, SOME LIVEBORN	OTHER MULTIPLE BIRTHS, SOME LIVEBORN
Z37.7	OTHER MULTIPLE BIRTHS, ALL STILLBORN	OTHER MULTIPLE BIRTHS, ALL STILLBORN

October 2016 Update

For dates of service on or after **October 1, 2016** and prior to October 1, 2017, please use the following ICD-10-CM diagnosis codes. For dates of service prior to October 1, 2016, refer to the October 2015 Update included in this section.

Excluded populations: For dates of service on or after October 1, 2015, the following ICD-10-CM principal diagnosis codes or ICD-10-CM other diagnosis codes for conditions possibly justifying elective delivery prior to 39 weeks gestation are excluded.

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
10900ZC	DRAINAGE OF AMNIOTIC FLUID, THERAPEUTIC FROM PRODUCTS OF CONCEPTION, OPEN APPROACH	DRAINAGE OF AMNIOTIC FL, THERAP FROM POC, OPEN APPROACH
10903ZC	DRAINAGE OF AMNIOTIC FLUID, THERAPEUTIC FROM PRODUCTS OF CONCEPTION, PERCUTANEOUS APPROACH	DRAINAGE OF AMNIOTIC FL, THERAP FROM POC, PERC APPROACH

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
10904ZC	DRAINAGE OF AMNIOTIC FLUID, THERAPEUTIC FROM PRODUCTS OF CONCEPTION, PERCUTANEOUS ENDOSCOPIC APPROACH	DRAINAGE OF AMNIOTIC FL, THERAP FROM POC, PERC ENDO APPROACH
10907ZC	DRAINAGE OF AMNIOTIC FLUID, THERAPEUTIC FROM PRODUCTS OF CONCEPTION, VIA NATURAL OR ARTIFICIAL OPENING	DRAINAGE OF AMNIOTIC FL, THERAPEUTIC FROM POC, VIA NATURAL OR ARTIFICIAL OPENING
10908ZC	DRAINAGE OF AMNIOTIC FLUID, THERAPEUTIC FROM PRODUCTS OF CONCEPTION, VIA NATURAL OR ARTIFICIAL OPENING ENDOSCOPIC	DRAINAGE OF AMNIOTIC FL, THERAPEUTIC FROM POC, VIA NATURAL OR ARTIFICIAL OPENING ENDOSCOPIC
0U7C7ZZ	DILATION OF CERVIX, VIA NATURAL OR ARTIFICIAL OPENING	DILATION OF CERVIX, VIA NATURAL OR ARTIFICIAL OPENING
10D00Z0	EXTRACTION OF PRODUCTS OF CONCEPTION, CLASSICAL, OPEN APPROACH	EXTRACTION OF POC, CLASSICAL, OPEN APPROACH
10D00Z1	EXTRACTION OF PRODUCTS OF CONCEPTION, LOW CERVICAL, OPEN APPROACH	EXTRACTION OF POC, CLASSICAL, OPEN APPROACH
10D00Z2	EXTRACTION OF PRODUCTS OF CONCEPTION, EXTRAPERITONEAL, OPEN APPROACH	EXTRACTION OF POC, EXTRAPERITONEAL, OPEN APPROACH
3E030VJ	INTRODUCTION OF OTHER HORMONE INTO PERIPHERAL VEIN, OPEN APPROACH	INTRODUCTION OF OTH HORMONE INTO PERIPH VEIN, OPEN APPROACH
3E033VJ	INTRODUCTION OF OTHER HORMONE INTO PERIPHERAL VEIN, PERCUTANEOUS APPROACH	INTRODUCTION OF OTH HORMONE INTO PERIPH VEIN, PERCUTANEOUS APPROACH
3E040VJ	INTRODUCTION OF OTHER HORMONE INTO CENTRAL VEIN, OPEN APPROACH	INTRODUCTION OF OTH HORMONE INTO CENTRAL VEIN, OPEN APPROACH
3E043VJ	INTRODUCTION OF OTHER HORMONE INTO CENTRAL VEIN, PERCUTANEOUS APPROACH	INTRODUCTION OF OTH HORMONE INTO CENTRAL VEIN, PERC APPROACH
3E050VJ	INTRODUCTION OF OTHER HORMONE INTO PERIPHERAL ARTERY, OPEN APPROACH	INTRODUCTION OF OTH HORMONE INTO PERIPH ARTERY, OPEN APPROACH
3E053VJ	INTRODUCTION OF OTHER HORMONE INTO PERIPHERAL ARTERY, PERCUTANEOUS APPROACH	INTRODUCTION OF OTHER HORMONE INTO PERIPH ART, PERC APPROACH
3E060VJ	INTRODUCTION OF OTHER HORMONE INTO CENTRAL ARTERY, OPEN APPROACH	INTRODUCTION OF OTH HORMONE INTO CENTRAL ART, OPEN APPROACH
3E063VJ	INTRODUCTION OF OTHER HORMONE INTO CENTRAL ARTERY, PERCUT APPROACH	INTRODUCTION OF OTH HORMONE INTO CENTRAL ART, PERC APPROACH
3E0DXGC	INTRODUCTION OF OTHER THERAPEUTIC SUBSTANCE INTO MOUTH AND PHARYNX, EXTERNAL APPROACH	INTRODUCE OTH THERAP SUBST IN MOUTH/PHAR, EXTERN

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
B20	HUMAN IMMUNODEFICIENCY VIRUS [HIV] DISEASE	HUMAN IMMUNODEFICIENCY VIRUS [HIV] DISEASE
O09.291	SUPERVISION OF PREGNANCY WITH OTHER POOR REPRODUCTIVE OR OBSTETRIC HISTORY, FIRST TRIMESTER	SUPRVSN OF PREG W POOR REPRODCTV OR OBSTET HX, FIRST TRI
O09.292	SUPERVISION OF PREGNANCY WITH OTHER POOR REPRODUCTIVE OR OBSTETRIC HISTORY, SECOND TRIMESTER	SUPRVSN OF PREG W POOR REPRODCTV OR OBSTET HX, SECOND TRI
O09.293	SUPERVISION OF PREGNANCY WITH OTHER POOR REPRODUCTIVE OR OBSTETRIC HISTORY, THIRD TRIMESTER	SUPRVSN OF PREG W POOR REPRODCTV OR OBSTET HX, THIRD TRI
O09.299	SUPERVISION OF PREGNANCY WITH OTHER POOR REPRODUCTIVE OR OBSTETRIC HISTORY, UNSPECIFIED TRIMESTER	SUPRVSN OF PREG W POOR REPRODCTV OR OBSTET HISTORY, UNSP TRI
O10.011	PRE-EXISTING ESSENTIAL HYPERTENSION COMPLICATING PREGNANCY, FIRST TRIMESTER	PRE-EXISTING ESSENTIAL HTN COMP PREGNANCY, FIRST TRIMESTER
O10.012	PRE-EXISTING ESSENTIAL HYPERTENSION COMPLICATING PREGNANCY, SECOND TRIMESTER	PRE-EXISTING ESSENTIAL HTN COMP PREGNANCY, SECOND TRIMESTER
O10.013	PRE-EXISTING ESSENTIAL HYPERTENSION COMPLICATING PREGNANCY, THIRD TRIMESTER	PRE-EXISTING ESSENTIAL HTN COMP PREGNANCY, THIRD TRIMESTER
O10.019	PRE-EXISTING ESSENTIAL HYPERTENSION COMPLICATING PREGNANCY, UNSPECIFIED TRIMESTER	PRE-EXISTING ESSENTIAL HTN COMP PREGNANCY, UNSP TRIMESTER
O10.02	PRE-EXISTING ESSENTIAL HYPERTENSION COMPLICATING CHILDBIRTH	PRE-EXISTING ESSENTIAL HYPERTENSION COMPLICATING CHILDBIRTH
O10.03	PRE-EXISTING ESSENTIAL HYPERTENSION COMPLICATING THE PUERPERIUM	PRE-EXISTING ESSENTIAL HYPERTENSION COMP THE PUERPERIUM
O10.111	PRE-EXISTING HYPERTENSIVE HEART DISEASE COMPLICATING PREGNANCY, FIRST TRIMESTER	PRE-EXIST HYP HEART DISEASE COMP PREGNANCY, FIRST TRIMESTER
O10.112	PRE-EXISTING HYPERTENSIVE HEART DISEASE COMPLICATING PREGNANCY, SECOND TRIMESTER	PRE-EXIST HYP HEART DISEASE COMP PREGNANCY, SECOND TRIMESTER
O10.113	PRE-EXISTING HYPERTENSIVE HEART DISEASE COMPLICATING PREGNANCY, THIRD TRIMESTER	PRE-EXIST HYP HEART DISEASE COMP PREGNANCY, THIRD TRIMESTER
O10.119	PRE-EXISTING HYPERTENSIVE HEART DISEASE COMPLICATING PREGNANCY, UNSPECIFIED TRIMESTER	PRE-EXIST HYP HEART DISEASE COMP PREGNANCY, UNSP TRIMESTER
O10.12	PRE-EXISTING HYPERTENSIVE HEART DISEASE COMPLICATING CHILDBIRTH	PRE-EXISTING HYPERTENSIVE HEART DISEASE COMP CHILDBIRTH

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O10.13	PRE-EXISTING HYPERTENSIVE HEART DISEASE COMPLICATING THE PUERPERIUM	PRE-EXISTING HYPERTENSIVE HEART DISEASE COMP THE PUERPERIUM
O10.211	PRE-EXISTING HYPERTENSIVE CHRONIC KIDNEY DISEASE COMPLICATING PREGNANCY, FIRST TRIMESTER	PRE-EXIST HYP CHRONIC KIDNEY DISEASE COMP PREG, FIRST TRI
O10.212	PRE-EXISTING HYPERTENSIVE CHRONIC KIDNEY DISEASE COMPLICATING PREGNANCY, SECOND TRIMESTER	PRE-EXIST HYP CHRONIC KIDNEY DISEASE COMP PREG, SECOND TRI
O10.213	PRE-EXISTING HYPERTENSIVE CHRONIC KIDNEY DISEASE COMPLICATING PREGNANCY, THIRD TRIMESTER	PRE-EXIST HYP CHRONIC KIDNEY DISEASE COMP PREG, THIRD TRI
O10.219	PRE-EXISTING HYPERTENSIVE CHRONIC KIDNEY DISEASE COMPLICATING PREGNANCY, UNSPECIFIED TRIMESTER	PRE-EXIST HYP CHRONIC KIDNEY DISEASE COMP PREG, UNSP TRI
O10.22	PRE-EXISTING HYPERTENSIVE CHRONIC KIDNEY DISEASE COMPLICATING CHILDBIRTH	PRE-EXISTING HYP CHRONIC KIDNEY DISEASE COMP CHILDBIRTH
O10.23	PRE-EXISTING HYPERTENSIVE CHRONIC KIDNEY DISEASE COMPLICATING THE PUERPERIUM	PRE-EXISTING HYP CHRONIC KIDNEY DISEASE COMP THE PUERPERIUM
O10.311	PRE-EXISTING HYPERTENSIVE HEART AND CHRONIC KIDNEY DISEASE COMPLICATING PREGNANCY, FIRST TRIMESTER	PRE-EXIST HYP HEART AND CHR KIDNEY DIS COMP PREG, FIRST TRI
O10.312	PRE-EXISTING HYPERTENSIVE HEART AND CHRONIC KIDNEY DISEASE COMPLICATING PREGNANCY, SECOND TRIMESTER	PRE-EXIST HYP HEART AND CHR KIDNEY DIS COMP PREG, SECOND TRI
O10.313	PRE-EXISTING HYPERTENSIVE HEART AND CHRONIC KIDNEY DISEASE COMPLICATING PREGNANCY, THIRD TRIMESTER	PRE-EXIST HYP HEART AND CHR KIDNEY DIS COMP PREG, THIRD TRI
O10.319	PRE-EXISTING HYPERTENSIVE HEART AND CHRONIC KIDNEY DISEASE COMPLICATING PREGNANCY, UNSPECIFIED TRIMESTER	PRE-EXIST HYP HEART AND CHR KIDNEY DIS COMP PREG, UNSP TRI
O10.32	PRE-EXISTING HYPERTENSIVE HEART AND CHRONIC KIDNEY DISEASE COMPLICATING CHILDBIRTH	PRE-EXIST HYP HEART AND CHRONIC KIDNEY DISEASE COMP CHLDBRTH
O10.33	PRE-EXISTING HYPERTENSIVE HEART AND CHRONIC KIDNEY DISEASE COMPLICATING THE PUERPERIUM	PRE-EXIST HYP HEART AND CHR KIDNEY DISEASE COMP THE PUERP
O10.411	PRE-EXISTING SECONDARY HYPERTENSION COMPLICATING PREGNANCY, FIRST TRIMESTER	PRE-EXISTING SECONDARY HTN COMP PREGNANCY, FIRST TRIMESTER
O10.412	PRE-EXISTING SECONDARY HYPERTENSION COMPLICATING PREGNANCY, SECOND TRIMESTER	PRE-EXISTING SECONDARY HTN COMP PREGNANCY, SECOND TRIMESTER
O10.413	PRE-EXISTING SECONDARY HYPERTENSION COMPLICATING PREGNANCY, THIRD	PRE-EXISTING SECONDARY HTN COMP PREGNANCY, THIRD

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
	TRIMESTER	TRIMESTER
O10.419	PRE-EXISTING SECONDARY HYPERTENSION COMPLICATING PREGNANCY, UNSPECIFIED TRIMESTER	PRE-EXISTING SECONDARY HTN COMP PREGNANCY, UNSP TRIMESTER
O10.42	PRE-EXISTING SECONDARY HYPERTENSION COMPLICATING CHILDBIRTH	PRE-EXISTING SECONDARY HYPERTENSION COMPLICATING CHILDBIRTH
O10.43	PRE-EXISTING SECONDARY HYPERTENSION COMPLICATING THE PUERPERIUM	PRE-EXISTING SECONDARY HYPERTENSION COMP THE PUERPERIUM
O10.911	UNSPECIFIED PRE-EXISTING HYPERTENSION COMPLICATING PREGNANCY, FIRST TRIMESTER	UNSP PRE-EXISTING HTN COMP PREGNANCY, FIRST TRIMESTER
O10.912	UNSPECIFIED PRE-EXISTING HYPERTENSION COMPLICATING PREGNANCY, SECOND TRIMESTER	UNSP PRE-EXISTING HTN COMP PREGNANCY, SECOND TRIMESTER
O10.913	UNSPECIFIED PRE-EXISTING HYPERTENSION COMPLICATING PREGNANCY, THIRD TRIMESTER	UNSP PRE-EXISTING HTN COMP PREGNANCY, THIRD TRIMESTER
O10.919	UNSPECIFIED PRE-EXISTING HYPERTENSION COMPLICATING PREGNANCY, UNSPECIFIED TRIMESTER	UNSP PRE-EXISTING HTN COMP PREGNANCY, UNSP TRIMESTER
O10.92	UNSPECIFIED PRE-EXISTING HYPERTENSION COMPLICATING CHILDBIRTH	UNSP PRE-EXISTING HYPERTENSION COMPLICATING CHILDBIRTH
O10.93	UNSPECIFIED PRE-EXISTING HYPERTENSION COMPLICATING THE PUERPERIUM	UNSP PRE-EXISTING HYPERTENSION COMPLICATING THE PUERPERIUM
O11.1	PRE-EXISTING HYPERTENSION WITH PRE-ECLAMPSIA, FIRST TRIMESTER	PRE-EXISTING HYPERTENSION W PRE-ECLAMPSIA, FIRST TRIMESTER
O11.2	PRE-EXISTING HYPERTENSION WITH PRE-ECLAMPSIA, SECOND TRIMESTER	PRE-EXISTING HYPERTENSION W PRE-ECLAMPSIA, SECOND TRIMESTER
O11.3	PRE-EXISTING HYPERTENSION WITH PRE-ECLAMPSIA, THIRD TRIMESTER	PRE-EXISTING HYPERTENSION W PRE-ECLAMPSIA, THIRD TRIMESTER
O11.4	PRE-EXISTING HYPERTENSION WITH PRE-ECLAMPSIA, COMPLICATING CHILDBIRTH	PRE-EXISTING HTN WITH PRE-ECLAMPSIA, COMP CHILDBIRTH
O11.5	PRE-EXISTING HYPERTENSION WITH PRE-ECLAMPSIA, COMPLICATING THE PUERPERIUM	PRE-EXISTING HTN WITH PRE-ECLAMPSIA, COMP THE PUERPERIUM
O11.9	PRE-EXISTING HYPERTENSION WITH PRE-ECLAMPSIA, UNSPECIFIED TRIMESTER	PRE-EXISTING HYPERTENSION WITH PRE-ECLAMPSIA, UNSP TRIMESTER
O12.10	GESTATIONAL PROTEINURIA, UNSPECIFIED TRIMESTER	GESTATIONAL PROTEINURIA, UNSPECIFIED TRIMESTER
O12.11	GESTATIONAL PROTEINURIA, FIRST TRIMESTER	GESTATIONAL PROTEINURIA, FIRST TRIMESTER

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O12.12	GESTATIONAL PROTEINURIA, SECOND TRIMESTER	GESTATIONAL PROTEINURIA, SECOND TRIMESTER
O12.13	GESTATIONAL PROTEINURIA, THIRD TRIMESTER	GESTATIONAL PROTEINURIA, THIRD TRIMESTER
O12.14	GESTATIONAL PROTEINURIA, COMPLICATING CHILDBIRTH	GESTATIONAL PROTEINURIA, COMPLICATING CHILDBIRTH
O12.15	GESTATIONAL PROTEINURIA, COMPLICATING THE PUERPERIUM	GESTATIONAL PROTEINURIA, COMPLICATING THE PUERPERIUM
O12.20	GESTATIONAL EDEMA WITH PROTEINURIA, UNSPECIFIED TRIMESTER	GESTATIONAL EDEMA WITH PROTEINURIA, UNSPECIFIED TRIMESTER
O12.21	GESTATIONAL EDEMA WITH PROTEINURIA, FIRST TRIMESTER	GESTATIONAL EDEMA WITH PROTEINURIA, FIRST TRIMESTER
O12.22	GESTATIONAL EDEMA WITH PROTEINURIA, SECOND TRIMESTER	GESTATIONAL EDEMA WITH PROTEINURIA, SECOND TRIMESTER
O12.23	GESTATIONAL EDEMA WITH PROTEINURIA, THIRD TRIMESTER	GESTATIONAL EDEMA WITH PROTEINURIA, THIRD TRIMESTER
O12.24	GESTATIONAL EDEMA WITH PROTEINURIA, COMPLICATING CHILDBIRTH	GESTATIONAL EDEMA WITH PROTEINURIA, COMPLICATING CHILDBIRTH
O12.25	GESTATIONAL EDEMA WITH PROTEINURIA, COMPLICATING THE PUERPERIUM	GESTATIONAL EDEMA WITH PROTEINURIA, COMP THE PUERPERIUM
O13.1	GESTATIONAL [PREGNANCY-INDUCED] HYPERTENSION WITHOUT SIGNIFICANT PROTEINURIA, FIRST TRIMESTER	GESTATIONAL HTN W/O SIGNIFICANT PROTEINURIA, FIRST TRIMESTER
O13.2	GESTATIONAL [PREGNANCY-INDUCED] HYPERTENSION WITHOUT SIGNIFICANT PROTEINURIA, SECOND TRIMESTER	GESTATNL HTN W/O SIGNIFICANT PROTEINURIA, SECOND TRIMESTER
O13.3	GESTATIONAL [PREGNANCY-INDUCED] HYPERTENSION WITHOUT SIGNIFICANT PROTEINURIA, THIRD TRIMESTER	GESTATIONAL HTN W/O SIGNIFICANT PROTEINURIA, THIRD TRIMESTER
O13.4	GESTATIONAL [PREGNANCY-INDUCED] HYPERTENSION WITHOUT SIGNIFICANT PROTEINURIA, COMPLICATING CHILDBIRTH	GESTATNL HTN WITHOUT SIGNIFICANT PROTEIN, COMP CHILDBIRTH
O13.5	GESTATIONAL [PREGNANCY-INDUCED] HYPERTENSION WITHOUT SIGNIFICANT PROTEINURIA, COMPLICATING THE PUERPERIUM	GESTATNL HTN WITHOUT SIGNIFICANT PROTEIN, COMP THE PUERP
O13.9	GESTATIONAL [PREGNANCY-INDUCED] HYPERTENSION WITHOUT SIGNIFICANT PROTEINURIA, UNSPECIFIED TRIMESTER	GESTATIONAL HTN W/O SIGNIFICANT PROTEINURIA, UNSP TRIMESTER
O14.00	MILD TO MODERATE PRE-ECLAMPSIA, UNSPECIFIED TRIMESTER	MILD TO MODERATE PRE-ECLAMPSIA, UNSPECIFIED TRIMESTER

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O14.02	MILD TO MODERATE PRE-ECLAMPSIA, SECOND TRIMESTER	MILD TO MODERATE PRE-ECLAMPSIA, SECOND TRIMESTER
O14.03	MILD TO MODERATE PRE-ECLAMPSIA, THIRD TRIMESTER	MILD TO MODERATE PRE-ECLAMPSIA, THIRD TRIMESTER
O14.04	MILD TO MODERATE PRE-ECLAMPSIA, COMPLICATING CHILDBIRTH	MILD TO MODERATE PRE-ECLAMPSIA, COMPLICATING CHILDBIRTH
O14.05	MILD TO MODERATE PRE-ECLAMPSIA, COMPLICATING THE PUERPERIUM	MILD TO MODERATE PRE-ECLAMPSIA, COMPLICATING THE PUERPERIUM
O14.10	SEVERE PRE-ECLAMPSIA, UNSPECIFIED TRIMESTER	SEVERE PRE-ECLAMPSIA, UNSPECIFIED TRIMESTER
O14.12	SEVERE PRE-ECLAMPSIA, SECOND TRIMESTER	SEVERE PRE-ECLAMPSIA, SECOND TRIMESTER
O14.13	SEVERE PRE-ECLAMPSIA, THIRD TRIMESTER	SEVERE PRE-ECLAMPSIA, THIRD TRIMESTER
O14.14	SEVERE PRE-ECLAMPSIA COMPLICATING CHILDBIRTH	SEVERE PRE-ECLAMPSIA COMPLICATING CHILDBIRTH
O14.15	SEVERE PRE-ECLAMPSIA, COMPLICATING THE PUERPERIUM	SEVERE PRE-ECLAMPSIA, COMPLICATING THE PUERPERIUM
O14.20	HELLP SYNDROME (HELLP), UNSPECIFIED TRIMESTER	HELLP SYNDROME (HELLP), UNSPECIFIED TRIMESTER
O14.22	HELLP SYNDROME (HELLP), SECOND TRIMESTER	HELLP SYNDROME (HELLP), SECOND TRIMESTER
O14.23	HELLP SYNDROME (HELLP), THIRD TRIMESTER	HELLP SYNDROME (HELLP), THIRD TRIMESTER
O14.24	HELLP SYNDROME, COMPLICATING CHILDBIRTH	HELLP SYNDROME, COMPLICATING CHILDBIRTH
O14.25	HELLP SYNDROME, COMPLICATING THE PUERPERIUM	HELLP SYNDROME, COMPLICATING THE PUERPERIUM
O14.90	UNSPECIFIED PRE-ECLAMPSIA, UNSPECIFIED TRIMESTER	UNSPECIFIED PRE-ECLAMPSIA, UNSPECIFIED TRIMESTER
O14.92	UNSPECIFIED PRE-ECLAMPSIA, SECOND TRIMESTER	UNSPECIFIED PRE-ECLAMPSIA, SECOND TRIMESTER
O14.93	UNSPECIFIED PRE-ECLAMPSIA, THIRD TRIMESTER	UNSPECIFIED PRE-ECLAMPSIA, THIRD TRIMESTER
O14.94	UNSPECIFIED PRE-ECLAMPSIA, COMPLICATING CHILDBIRTH	UNSPECIFIED PRE-ECLAMPSIA, COMPLICATING CHILDBIRTH
O14.95	UNSPECIFIED PRE-ECLAMPSIA, COMPLICATING THE PUERPERIUM	UNSPECIFIED PRE-ECLAMPSIA, COMPLICATING THE PUERPERIUM
O15.00	ECLAMPSIA COMPLICATING PREGNANCY, UNSPECIFIED TRIMESTER	ECLAMPSIA COMPLICATING PREGNANCY, UNSPECIFIED TRIMESTER

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O15.02	ECLAMPSIA COMPLICATING PREGNANCY, SECOND TRIMESTER	ECLAMPSIA COMPLICATING PREGNANCY, SECOND TRIMESTER
O15.03	ECLAMPSIA COMPLICATING PREGNANCY, THIRD TRIMESTER	ECLAMPSIA COMPLICATING PREGNANCY, THIRD TRIMESTER
O15.1	ECLAMPSIA COMPLICATING LABOR	ECLAMPSIA COMPLICATING LABOR
O15.2	ECLAMPSIA COMPLICATING THE PUERPERIUM	ECLAMPSIA COMPLICATING THE PUERPERIUM
O15.9	ECLAMPSIA, UNSPECIFIED AS TO TIME PERIOD	ECLAMPSIA, UNSPECIFIED AS TO TIME PERIOD
O16.1	UNSPECIFIED MATERNAL HYPERTENSION, FIRST TRIMESTER	UNSPECIFIED MATERNAL HYPERTENSION, FIRST TRIMESTER
O16.2	UNSPECIFIED MATERNAL HYPERTENSION, SECOND TRIMESTER	UNSPECIFIED MATERNAL HYPERTENSION, SECOND TRIMESTER
O16.3	UNSPECIFIED MATERNAL HYPERTENSION, THIRD TRIMESTER	UNSPECIFIED MATERNAL HYPERTENSION, THIRD TRIMESTER
O16.4	UNSPECIFIED MATERNAL HYPERTENSION, COMPLICATING CHILDBIRTH	UNSPECIFIED MATERNAL HYPERTENSION, COMPLICATING CHILDBIRTH
O16.5	UNSPECIFIED MATERNAL HYPERTENSION, COMPLICATING THE PUERPERIUM	UNSPECIFIED MATERNAL HYPERTENSION, COMP THE PUERPERIUM
O16.9	UNSPECIFIED MATERNAL HYPERTENSION, UNSPECIFIED TRIMESTER	UNSPECIFIED MATERNAL HYPERTENSION, UNSPECIFIED TRIMESTER
O24.410	GESTATIONAL DIABETES MELLITUS IN PREGNANCY, DIET CONTROLLED	GESTATIONAL DIABETES MELLITUS IN PREGNANCY, DIET CONTROLLED
O24.414	GESTATIONAL DIABETES MELLITUS IN PREGNANCY, INSULIN CONTROLLED	GESTATIONAL DIABETES IN PREGNANCY, INSULIN CONTROLLED
O24.415	GESTATIONAL DIABETES MELLITUS IN PREGNANCY, CONTROLLED BY ORAL HYPOGLYCEMIC DRUGS	GESTATNL DIABETES IN PREG, CTRL BY ORAL HYPOGLYCEMIC DRUGS
O24.419	GESTATIONAL DIABETES MELLITUS IN PREGNANCY, UNSPECIFIED CONTROL	GESTATIONAL DIABETES MELLITUS IN PREGNANCY, UNSP CONTROL
O24.420	GESTATIONAL DIABETES MELLITUS IN CHILDBIRTH, DIET CONTROLLED	GESTATIONAL DIABETES MELLITUS IN CHILDBIRTH, DIET CONTROLLED
O24.424	GESTATIONAL DIABETES MELLITUS IN CHILDBIRTH, INSULIN CONTROLLED	GESTATIONAL DIABETES IN CHILDBIRTH, INSULIN CONTROLLED
O24.425	GESTATIONAL DIABETES MELLITUS IN CHILDBIRTH, CONTROLLED BY ORAL HYPOGLYCEMIC DRUGS	GESTATNL DIAB IN CHLDBRTH, CTRL BY ORAL HYPOGLYCEMIC DRUGS
O24.429	GESTATIONAL DIABETES MELLITUS IN CHILDBIRTH, UNSPECIFIED CONTROL	GESTATIONAL DIABETES MELLITUS IN CHILDBIRTH, UNSP CONTROL

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O24.430	GESTATIONAL DIABETES MELLITUS IN THE PUERPERIUM, DIET CONTROLLED	GESTATIONAL DIABETES IN THE PUERPERIUM, DIET CONTROLLED
O24.434	GESTATIONAL DIABETES MELLITUS IN THE PUERPERIUM, INSULIN CONTROLLED	GESTATIONAL DIABETES IN THE PUERPERIUM, INSULIN CONTROLLED
O24.435	GESTATIONAL DIABETES MELLITUS IN PUERPERIUM, CONTROLLED BY ORAL HYPOGLYCEMIC DRUGS	GESTATNL DIABETES IN PUERP, CTRL BY ORAL HYPOGLYCEMIC DRUGS
O24.439	GESTATIONAL DIABETES MELLITUS IN THE PUERPERIUM, UNSPECIFIED CONTROL	GESTATIONAL DIABETES IN THE PUERPERIUM, UNSP CONTROL
O24.811	OTHER PRE-EXISTING DIABETES MELLITUS IN PREGNANCY, FIRST TRIMESTER	OTH PRE-EXISTING DIABETES IN PREGNANCY, FIRST TRIMESTER
O24.812	OTHER PRE-EXISTING DIABETES MELLITUS IN PREGNANCY, SECOND TRIMESTER	OTH PRE-EXISTING DIABETES IN PREGNANCY, SECOND TRIMESTER
O24.813	OTHER PRE-EXISTING DIABETES MELLITUS IN PREGNANCY, THIRD TRIMESTER	OTH PRE-EXISTING DIABETES IN PREGNANCY, THIRD TRIMESTER
O24.819	OTHER PRE-EXISTING DIABETES MELLITUS IN PREGNANCY, UNSPECIFIED TRIMESTER	OTH PRE-EXISTING DIABETES IN PREGNANCY, UNSP TRIMESTER
O24.82	OTHER PRE-EXISTING DIABETES MELLITUS IN CHILDBIRTH	OTHER PRE-EXISTING DIABETES MELLITUS IN CHILDBIRTH
O24.83	OTHER PRE-EXISTING DIABETES MELLITUS IN THE PUERPERIUM	OTHER PRE-EXISTING DIABETES MELLITUS IN THE PUERPERIUM
O24.911	UNSPECIFIED DIABETES MELLITUS IN PREGNANCY, FIRST TRIMESTER	UNSPECIFIED DIABETES MELLITUS IN PREGNANCY, FIRST TRIMESTER
O24.912	UNSPECIFIED DIABETES MELLITUS IN PREGNANCY, SECOND TRIMESTER	UNSPECIFIED DIABETES MELLITUS IN PREGNANCY, SECOND TRIMESTER
O24.913	UNSPECIFIED DIABETES MELLITUS IN PREGNANCY, THIRD TRIMESTER	UNSPECIFIED DIABETES MELLITUS IN PREGNANCY, THIRD TRIMESTER
O24.919	UNSPECIFIED DIABETES MELLITUS IN PREGNANCY, UNSPECIFIED TRIMESTER	UNSP DIABETES MELLITUS IN PREGNANCY, UNSPECIFIED TRIMESTER
O24.92	UNSPECIFIED DIABETES MELLITUS IN CHILDBIRTH	UNSPECIFIED DIABETES MELLITUS IN CHILDBIRTH
O24.93	UNSPECIFIED DIABETES MELLITUS IN THE PUERPERIUM	UNSPECIFIED DIABETES MELLITUS IN THE PUERPERIUM
O26.611	LIVER AND BILIARY TRACT DISORDERS IN PREGNANCY, FIRST TRIMESTER	LIVER AND BILIARY TRACT DISORD IN PREGNANCY, FIRST TRIMESTER
O26.612	LIVER AND BILIARY TRACT DISORDERS IN PREGNANCY, SECOND TRIMESTER	LIVER AND BILIARY TRACT DISORD IN PREG, SECOND TRIMESTER
O26.613	LIVER AND BILIARY TRACT DISORDERS IN PREGNANCY, THIRD TRIMESTER	LIVER AND BILIARY TRACT DISORD IN PREGNANCY, THIRD TRIMESTER
O26.619	LIVER AND BILIARY TRACT DISORDERS IN PREGNANCY, UNSPECIFIED TRIMESTER	LIVER AND BILIARY TRACT DISORD IN PREGNANCY, UNSP TRIMESTER

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O26.62	LIVER AND BILIARY TRACT DISORDERS IN CHILDBIRTH	LIVER AND BILIARY TRACT DISORDERS IN CHILDBIRTH
O26.63	LIVER AND BILIARY TRACT DISORDERS IN THE PUERPERIUM	LIVER AND BILIARY TRACT DISORDERS IN THE PUERPERIUM
O26.831	PREGNANCY RELATED RENAL DISEASE, FIRST TRIMESTER	PREGNANCY RELATED RENAL DISEASE, FIRST TRIMESTER
O26.832	PREGNANCY RELATED RENAL DISEASE, SECOND TRIMESTER	PREGNANCY RELATED RENAL DISEASE, SECOND TRIMESTER
O26.833	PREGNANCY RELATED RENAL DISEASE, THIRD TRIMESTER	PREGNANCY RELATED RENAL DISEASE, THIRD TRIMESTER
O26.839	PREGNANCY RELATED RENAL DISEASE, UNSPECIFIED TRIMESTER	PREGNANCY RELATED RENAL DISEASE, UNSPECIFIED TRIMESTER
O30.001	TWIN PREGNANCY, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, FIRST TRIMESTER	TWIN PREG, UNSP NUM PLCNTA & AMNIO SACS, FIRST TRIMESTER
O30.002	TWIN PREGNANCY, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, SECOND TRIMESTER	TWIN PREG, UNSP NUM PLCNTA & AMNIO SACS, SECOND TRIMESTER
O30.003	TWIN PREGNANCY, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, THIRD TRIMESTER	TWIN PREG, UNSP NUM PLCNTA & AMNIO SACS, THIRD TRIMESTER
O30.009	TWIN PREGNANCY, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, UNSPECIFIED TRIMESTER	TWIN PREGNANCY, UNSP NUM PLCNTA & AMNIO SACS, UNSP TRIMESTER
O30.011	TWIN PREGNANCY, MONOCHORIONIC/MONOAMNIOTIC, FIRST TRIMESTER	TWIN PREGNANCY, MONOCHORIONIC/MONOAMNIOTIC, FIRST TRIMESTER
O30.012	TWIN PREGNANCY, MONOCHORIONIC/MONOAMNIOTIC, SECOND TRIMESTER	TWIN PREGNANCY, MONOCHORIONIC/MONOAMNIOTIC, SECOND TRIMESTER
O30.013	TWIN PREGNANCY, MONOCHORIONIC/MONOAMNIOTIC, THIRD TRIMESTER	TWIN PREGNANCY, MONOCHORIONIC/MONOAMNIOTIC, THIRD TRIMESTER
O30.019	TWIN PREGNANCY, MONOCHORIONIC/MONOAMNIOTIC, UNSPECIFIED TRIMESTER	TWIN PREGNANCY, MONOCHORIONIC/MONOAMNIOTIC, UNSP TRIMESTER
O30.021	CONJOINED TWIN PREGNANCY, FIRST TRIMESTER	CONJOINED TWIN PREGNANCY, FIRST TRIMESTER
O30.022	CONJOINED TWIN PREGNANCY, SECOND TRIMESTER	CONJOINED TWIN PREGNANCY, SECOND TRIMESTER
O30.023	CONJOINED TWIN PREGNANCY, THIRD TRIMESTER	CONJOINED TWIN PREGNANCY, THIRD TRIMESTER
O30.029	CONJOINED TWIN PREGNANCY, UNSPECIFIED TRIMESTER	CONJOINED TWIN PREGNANCY, UNSPECIFIED TRIMESTER

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O30.031	TWIN PREGNANCY, MONOCHORIONIC/DIAMNIOTIC, FIRST TRIMESTER	TWIN PREGNANCY, MONOCHORIONIC/DIAMNIOTIC, FIRST TRIMESTER
O30.032	TWIN PREGNANCY, MONOCHORIONIC/DIAMNIOTIC, SECOND TRIMESTER	TWIN PREGNANCY, MONOCHORIONIC/DIAMNIOTIC, SECOND TRIMESTER
O30.033	TWIN PREGNANCY, MONOCHORIONIC/DIAMNIOTIC, THIRD TRIMESTER	TWIN PREGNANCY, MONOCHORIONIC/DIAMNIOTIC, THIRD TRIMESTER
O30.039	TWIN PREGNANCY, MONOCHORIONIC/DIAMNIOTIC, UNSPECIFIED TRIMESTER	TWIN PREGNANCY, MONOCHORIONIC/DIAMNIOTIC, UNSP TRIMESTER
O30.041	TWIN PREGNANCY, DICHORIONIC/DIAMNIOTIC, FIRST TRIMESTER	TWIN PREGNANCY, DICHORIONIC/DIAMNIOTIC, FIRST TRIMESTER
O30.042	TWIN PREGNANCY, DICHORIONIC/DIAMNIOTIC, SECOND TRIMESTER	TWIN PREGNANCY, DICHORIONIC/DIAMNIOTIC, SECOND TRIMESTER
O30.043	TWIN PREGNANCY, DICHORIONIC/DIAMNIOTIC, THIRD TRIMESTER	TWIN PREGNANCY, DICHORIONIC/DIAMNIOTIC, THIRD TRIMESTER
O30.049	TWIN PREGNANCY, DICHORIONIC/DIAMNIOTIC, UNSPECIFIED TRIMESTER	TWIN PREGNANCY, DICHORIONIC/DIAMNIOTIC, UNSP TRIMESTER
O30.091	TWIN PREGNANCY, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, FIRST TRIMESTER	TWIN PREG, UNABLE TO DTRM NUM PLCNTA & AMNIO SACS, FIRST TRI
O30.092	TWIN PREGNANCY, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, SECOND TRIMESTER	TWIN PREG, UNABLE TO DTRM NUM PLCNTA & AMNIO SACS, 2ND TRI
O30.093	TWIN PREGNANCY, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, THIRD TRIMESTER	TWIN PREG, UNABLE TO DTRM NUM PLCNTA & AMNIO SACS, THIRD TRI
O30.099	TWIN PREGNANCY, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, UNSPECIFIED TRIMESTER	TWIN PREG, UNABLE TO DTRM NUM PLCNTA & AMNIO SACS, UNSP TRI
O30.101	TRIPLET PREGNANCY, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, FIRST TRIMESTER	TRIPLET PREG, UNSP NUM PLCNTA & AMNIO SACS, FIRST TRIMESTER
O30.102	TRIPLET PREGNANCY, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, SECOND TRIMESTER	TRIPLET PREG, UNSP NUM PLCNTA & AMNIO SACS, SECOND TRIMESTER
O30.103	TRIPLET PREGNANCY, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, THIRD TRIMESTER	TRIPLET PREG, UNSP NUM PLCNTA & AMNIO SACS, THIRD TRIMESTER
O30.109	TRIPLET PREGNANCY, UNSPECIFIED NUMBER	TRIPLET PREG, UNSP NUM PLCNTA &

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ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
	OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, UNSPECIFIED TRIMESTER	AMNIO SACS, UNSP TRIMESTER
O30.111	TRIPLET PREGNANCY WITH TWO OR MORE MONOCHORIONIC FETUSES, FIRST TRIMESTER	TRIPLET PREG W TWO OR MORE MONOCHORIONIC FETUSES, FIRST TRI
O30.112	TRIPLET PREGNANCY WITH TWO OR MORE MONOCHORIONIC FETUSES, SECOND TRIMESTER	TRIPLET PREG W TWO OR MORE MONOCHORIONIC FETUSES, SECOND TRI
O30.113	TRIPLET PREGNANCY WITH TWO OR MORE MONOCHORIONIC FETUSES, THIRD TRIMESTER	TRIPLET PREG W TWO OR MORE MONOCHORIONIC FETUSES, THIRD TRI
O30.119	TRIPLET PREGNANCY WITH TWO OR MORE MONOCHORIONIC FETUSES, UNSPECIFIED TRIMESTER	TRIPLET PREG W TWO OR MORE MONOCHORIONIC FETUSES, UNSP TRI
O30.121	TRIPLET PREGNANCY WITH TWO OR MORE MONOAMNIOTIC FETUSES, FIRST TRIMESTER	TRIPLET PREG W TWO OR MORE MONOAMNIO FETUSES, FIRST TRI
O30.122	TRIPLET PREGNANCY WITH TWO OR MORE MONOAMNIOTIC FETUSES, SECOND TRIMESTER	TRIPLET PREG W TWO OR MORE MONOAMNIO FETUSES, SECOND TRI
O30.123	TRIPLET PREGNANCY WITH TWO OR MORE MONOAMNIOTIC FETUSES, THIRD TRIMESTER	TRIPLET PREG W TWO OR MORE MONOAMNIO FETUSES, THIRD TRI
O30.129	TRIPLET PREGNANCY WITH TWO OR MORE MONOAMNIOTIC FETUSES, UNSPECIFIED TRIMESTER	TRIPLET PREG W TWO OR MORE MONOAMNIO FETUSES, UNSP TRIMESTER
O30.191	TRIPLET PREGNANCY, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, FIRST TRIMESTER	TRP PREG, UNABLE TO DTRM NUM PLCNTA & AMNIO SACS, FIRST TRI
O30.192	TRIPLET PREGNANCY, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, SECOND TRIMESTER	TRP PREG, UNABLE TO DTRM NUM PLCNTA & AMNIO SACS, SECOND TRI
O30.193	TRIPLET PREGNANCY, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, THIRD TRIMESTER	TRP PREG, UNABLE TO DTRM NUM PLCNTA & AMNIO SACS, THIRD TRI
O30.199	TRIPLET PREGNANCY, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, UNSPECIFIED TRIMESTER	TRP PREG, UNABLE TO DTRM NUM PLCNTA & AMNIO SACS, UNSP TRI
O30.201	QUADRUPLET PREGNANCY, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, FIRST TRIMESTER	QUAD PREG, UNSP NUM PLCNTA & AMNIO SACS, FIRST TRIMESTER
O30.202	QUADRUPLET PREGNANCY, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, SECOND TRIMESTER	QUAD PREG, UNSP NUM PLCNTA & AMNIO SACS, SECOND TRIMESTER
O30.203	QUADRUPLET PREGNANCY, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, THIRD	QUAD PREG, UNSP NUM PLCNTA & AMNIO SACS, THIRD TRIMESTER

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ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
	TRIMESTER	
O30.209	QUADRUPLET PREGNANCY, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, UNSPECIFIED TRIMESTER	QUAD PREGNANCY, UNSP NUM PLCNTA & AMNIO SACS, UNSP TRIMESTER
O30.211	QUADRUPLET PREGNANCY WITH TWO OR MORE MONOCHORIONIC FETUSES, FIRST TRIMESTER	QUAD PREG W TWO OR MORE MONOCHORIONIC FETUSES, FIRST TRI
O30.212	QUADRUPLET PREGNANCY WITH TWO OR MORE MONOCHORIONIC FETUSES, SECOND TRIMESTER	QUAD PREG W TWO OR MORE MONOCHORIONIC FETUSES, SECOND TRI
O30.213	QUADRUPLET PREGNANCY WITH TWO OR MORE MONOCHORIONIC FETUSES, THIRD TRIMESTER	QUAD PREG W TWO OR MORE MONOCHORIONIC FETUSES, THIRD TRI
O30.219	QUADRUPLET PREGNANCY WITH TWO OR MORE MONOCHORIONIC FETUSES, UNSPECIFIED TRIMESTER	QUAD PREG W TWO OR MORE MONOCHORIONIC FETUSES, UNSP TRI
O30.221	QUADRUPLET PREGNANCY WITH TWO OR MORE MONOAMNIOTIC FETUSES, FIRST TRIMESTER	QUAD PREG W TWO OR MORE MONOAMNIO FETUSES, FIRST TRIMESTER
O30.222	QUADRUPLET PREGNANCY WITH TWO OR MORE MONOAMNIOTIC FETUSES, SECOND TRIMESTER	QUAD PREG W TWO OR MORE MONOAMNIO FETUSES, SECOND TRIMESTER
O30.223	QUADRUPLET PREGNANCY WITH TWO OR MORE MONOAMNIOTIC FETUSES, THIRD TRIMESTER	QUAD PREG W TWO OR MORE MONOAMNIO FETUSES, THIRD TRIMESTER
O30.229	QUADRUPLET PREGNANCY WITH TWO OR MORE MONOAMNIOTIC FETUSES, UNSPECIFIED TRIMESTER	QUAD PREG W TWO OR MORE MONOAMNIO FETUSES, UNSP TRIMESTER
O30.291	QUADRUPLET PREGNANCY, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, FIRST TRIMESTER	QUAD PREG, UNABLE TO DTRM NUM PLCNTA & AMNIO SACS, FIRST TRI
O30.292	QUADRUPLET PREGNANCY, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, SECOND TRIMESTER	QUAD PREG, UNABLE TO DTRM NUM PLCNTA & AMNIO SACS, 2ND TRI
O30.293	QUADRUPLET PREGNANCY, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, THIRD TRIMESTER	QUAD PREG, UNABLE TO DTRM NUM PLCNTA & AMNIO SACS, THIRD TRI
O30.299	QUADRUPLET PREGNANCY, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, UNSPECIFIED TRIMESTER	QUAD PREG, UNABLE TO DTRM NUM PLCNTA & AMNIO SACS, UNSP TRI
O30.801	OTHER SPECIFIED MULTIPLE GESTATION, UNSPECIFIED NUMBER OF PLACENTA AND	OTH MULTIPLE GEST, UNSP NUM PLCNTA & AMNIO SACS, FIRST TRI

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ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
	UNSPECIFIED NUMBER OF AMNIOTIC SACS, FIRST TRIMESTER	
O30.802	OTHER SPECIFIED MULTIPLE GESTATION, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, SECOND TRIMESTER	OTH MULTIPLE GEST, UNSP NUM PLCNTA & AMNIO SACS, SECOND TRI
O30.803	OTHER SPECIFIED MULTIPLE GESTATION, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, THIRD TRIMESTER	OTH MULTIPLE GEST, UNSP NUM PLCNTA & AMNIO SACS, THIRD TRI
O30.809	OTHER SPECIFIED MULTIPLE GESTATION, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, UNSPECIFIED TRIMESTER	OTH MULTIPLE GEST, UNSP NUM PLCNTA & AMNIO SACS, UNSP TRI
O30.811	OTHER SPECIFIED MULTIPLE GESTATION WITH TWO OR MORE MONOCHORIONIC FETUSES, FIRST TRIMESTER	OTH MULT GEST W TWO OR MORE MONOCHORIONIC FETUSES, FIRST TRI
O30.812	OTHER SPECIFIED MULTIPLE GESTATION WITH TWO OR MORE MONOCHORIONIC FETUSES, SECOND TRIMESTER	OTH MULT GEST W TWO OR MORE MONOCHORIONIC FETUSES, 2ND TRI
O30.813	OTHER SPECIFIED MULTIPLE GESTATION WITH TWO OR MORE MONOCHORIONIC FETUSES, THIRD TRIMESTER	OTH MULT GEST W TWO OR MORE MONOCHORIONIC FETUSES, THIRD TRI
O30.819	OTHER SPECIFIED MULTIPLE GESTATION WITH TWO OR MORE MONOCHORIONIC FETUSES, UNSPECIFIED TRIMESTER	OTH MULT GEST W TWO OR MORE MONOCHORIONIC FETUSES, UNSP TRI
O30.821	OTHER SPECIFIED MULTIPLE GESTATION WITH TWO OR MORE MONOAMNIOTIC FETUSES, FIRST TRIMESTER	OTH MULTIPLE GEST W TWO OR MORE MONOAMNIO FETUSES, FIRST TRI
O30.822	OTHER SPECIFIED MULTIPLE GESTATION WITH TWO OR MORE MONOAMNIOTIC FETUSES, SECOND TRIMESTER	OTH MULT GEST W TWO OR MORE MONOAMNIO FETUSES, SECOND TRI
O30.823	OTHER SPECIFIED MULTIPLE GESTATION WITH TWO OR MORE MONOAMNIOTIC FETUSES, THIRD TRIMESTER	OTH MULTIPLE GEST W TWO OR MORE MONOAMNIO FETUSES, THIRD TRI
O30.829	OTHER SPECIFIED MULTIPLE GESTATION WITH TWO OR MORE MONOAMNIOTIC FETUSES, UNSPECIFIED TRIMESTER	OTH MULTIPLE GEST W TWO OR MORE MONOAMNIO FETUSES, UNSP TRI
O30.891	OTHER SPECIFIED MULTIPLE GESTATION, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, FIRST TRIMESTER	OTH MULT GEST, UNAB TO DTRM NUM PLCNTA & AMNIO SACS, 1ST TRI
O30.892	OTHER SPECIFIED MULTIPLE GESTATION, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, SECOND TRIMESTER	OTH MULT GEST, UNAB TO DTRM NUM PLCNTA & AMNIO SACS, 2ND TRI

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ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O30.893	OTHER SPECIFIED MULTIPLE GESTATION, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, THIRD TRIMESTER	OTH MULT GEST, UNAB TO DTRM NUM PLCNTA & AMNIO SACS, 3RD TRI
O30.899	OTHER SPECIFIED MULTIPLE GESTATION, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, UNSPECIFIED TRIMESTER	OTH MULT GEST,UNAB TO DTRM NUM PLCNTA & AMNIO SACS, UNSP TRI
O30.90	MULTIPLE GESTATION, UNSPECIFIED, UNSPECIFIED TRIMESTER	MULTIPLE GESTATION, UNSPECIFIED, UNSPECIFIED TRIMESTER
O30.91	MULTIPLE GESTATION, UNSPECIFIED, FIRST TRIMESTER	MULTIPLE GESTATION, UNSPECIFIED, FIRST TRIMESTER
O30.92	MULTIPLE GESTATION, UNSPECIFIED, SECOND TRIMESTER	MULTIPLE GESTATION, UNSPECIFIED, SECOND TRIMESTER
O30.93	MULTIPLE GESTATION, UNSPECIFIED, THIRD TRIMESTER	MULTIPLE GESTATION, UNSPECIFIED, THIRD TRIMESTER
O31.10X0	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, UNSP TRI, UNSP
O31.10X1	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 1	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, UNSP TRI, FTS1
O31.10X2	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 2	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, UNSP TRI, FTS2
O31.10X3	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 3	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, UNSP TRI, FTS3
O31.10X4	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 4	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, UNSP TRI, FTS4
O31.10X5	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 5	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, UNSP TRI, FTS5
O31.10X9	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, OTHER FETUS	CONT PREG AFT SPON ABORT OF ONE FETUS OR MORE, UNSP TRI, OTH
O31.11X0	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, FIRST TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, FIRST TRI, UNSP
O31.11X1	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 1	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, FIRST TRI, FTS1

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ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O31.11X2	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 2	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, FIRST TRI, FTS2
O31.11X3	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 3	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, FIRST TRI, FTS3
O31.11X4	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 4	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, FIRST TRI, FTS4
O31.11X5	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 5	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, FIRST TRI, FTS5
O31.11X9	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, FIRST TRIMESTER, OTHER FETUS	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, FIRST TRI, OTH
O31.12X0	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, SECOND TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	CONT PREG AFT SPON ABORT OF ONE FETUS OR MORE, 2ND TRI, UNSP
O31.12X1	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 1	CONT PREG AFT SPON ABORT OF ONE FETUS OR MORE, 2ND TRI, FTS1
O31.12X2	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 2	CONT PREG AFT SPON ABORT OF ONE FETUS OR MORE, 2ND TRI, FTS2
O31.12X3	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 3	CONT PREG AFT SPON ABORT OF ONE FETUS OR MORE, 2ND TRI, FTS3
O31.12X4	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 4	CONT PREG AFT SPON ABORT OF ONE FETUS OR MORE, 2ND TRI, FTS4
O31.12X5	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 5	CONT PREG AFT SPON ABORT OF ONE FETUS OR MORE, 2ND TRI, FTS5
O31.12X9	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, SECOND TRIMESTER, OTHER FETUS	CONT PREG AFT SPON ABORT OF ONE FETUS OR MORE, 2ND TRI, OTH
O31.13X0	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, THIRD TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, THIRD TRI, UNSP
O31.13X1	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 1	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, THIRD TRI, FTS1
O31.13X2	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 2	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, THIRD TRI, FTS2

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ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O31.13X3	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 3	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, THIRD TRI, FTS3
O31.13X4	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 4	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, THIRD TRI, FTS4
O31.13X5	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 5	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, THIRD TRI, FTS5
O31.13X9	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, THIRD TRIMESTER, OTHER FETUS	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, THIRD TRI, OTH
O31.20X0	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, UNSP TRI, UNSP
O31.20X1	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 1	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, UNSP TRI, FTS1
O31.20X2	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 2	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, UNSP TRI, FTS2
O31.20X3	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 3	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, UNSP TRI, FTS3
O31.20X4	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 4	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, UNSP TRI, FTS4
O31.20X5	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 5	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, UNSP TRI, FTS5
O31.20X9	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, OTHER FETUS	CONT PREG AFT UTERIN DTH OF ONE FETUS OR MORE, UNSP TRI, OTH
O31.21X0	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, FIRST TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, FIRST TRI, UNSP
O31.21X1	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 1	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, FIRST TRI, FTS1
O31.21X2	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 2	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, FIRST TRI, FTS2
O31.21X3	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, FIRST TRI, FTS3

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ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
	MORE, FIRST TRIMESTER, FETUS 3	
O31.21X4	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 4	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, FIRST TRI, FTS4
O31.21X5	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 5	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, FIRST TRI, FTS5
O31.21X9	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, FIRST TRIMESTER, OTHER FETUS	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, FIRST TRI, OTH
O31.22X0	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, SECOND TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	CONT PREG AFT UTERIN DTH OF ONE FETUS OR MORE, 2ND TRI, UNSP
O31.22X1	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 1	CONT PREG AFT UTERIN DTH OF ONE FETUS OR MORE, 2ND TRI, FTS1
O31.22X2	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 2	CONT PREG AFT UTERIN DTH OF ONE FETUS OR MORE, 2ND TRI, FTS2
O31.22X3	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 3	CONT PREG AFT UTERIN DTH OF ONE FETUS OR MORE, 2ND TRI, FTS3
O31.22X4	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 4	CONT PREG AFT UTERIN DTH OF ONE FETUS OR MORE, 2ND TRI, FTS4
O31.22X5	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 5	CONT PREG AFT UTERIN DTH OF ONE FETUS OR MORE, 2ND TRI, FTS5
O31.22X9	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, SECOND TRIMESTER, OTHER FETUS	CONT PREG AFT UTERIN DTH OF ONE FETUS OR MORE, 2ND TRI, OTH
O31.23X0	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, THIRD TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, THIRD TRI, UNSP
O31.23X1	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 1	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, THIRD TRI, FTS1
O31.23X2	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 2	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, THIRD TRI, FTS2
O31.23X3	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 3	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, THIRD TRI, FTS3

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ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O31.23X4	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 4	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, THIRD TRI, FTS4
O31.23X5	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 5	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, THIRD TRI, FTS5
O31.23X9	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, THIRD TRIMESTER, OTHER FETUS	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, THIRD TRI, OTH
O31.30X0	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,UNSP TRI,UNSP
O31.30X1	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 1	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,UNSP TRI,FTS1
O31.30X2	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 2	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,UNSP TRI,FTS2
O31.30X3	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 3	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,UNSP TRI,FTS3
O31.30X4	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 4	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,UNSP TRI,FTS4
O31.30X5	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 5	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,UNSP TRI,FTS5
O31.30X9	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, OTHER FETUS	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,UNSP TRI, OTH
O31.31X0	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, FIRST TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,1ST TRI, UNSP
O31.31X1	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 1	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,1ST TRI, FTS1
O31.31X2	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 2	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,1ST TRI, FTS2
O31.31X3	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 3	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,1ST TRI, FTS3
O31.31X4	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 4	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,1ST TRI, FTS4

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ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O31.31X5	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 5	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,1ST TRI, FTS5
O31.31X9	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, FIRST TRIMESTER, OTHER FETUS	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE, 1ST TRI, OTH
O31.32X0	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, SECOND TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,2ND TRI, UNSP
O31.32X1	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 1	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,2ND TRI, FTS1
O31.32X2	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 2	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,2ND TRI, FTS2
O31.32X3	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 3	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,2ND TRI, FTS3
O31.32X4	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 4	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,2ND TRI, FTS4
O31.32X5	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 5	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,2ND TRI, FTS5
O31.32X9	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, SECOND TRIMESTER, OTHER FETUS	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE, 2ND TRI, OTH
O31.33X0	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, THIRD TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,3RD TRI, UNSP
O31.33X1	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 1	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,3RD TRI, FTS1
O31.33X2	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 2	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,3RD TRI, FTS2
O31.33X3	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 3	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,3RD TRI, FTS3
O31.33X4	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 4	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,3RD TRI, FTS4
O31.33X5	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 5	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,3RD TRI, FTS5

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ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O31.33X9	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, THIRD TRIMESTER, OTHER FETUS	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE, 3RD TRI, OTH
O31.8X10	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, FIRST TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	OTH COMP SPECIFIC TO MULTIPLE GEST, FIRST TRIMESTER, UNSP
O31.8X11	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, FIRST TRIMESTER, FETUS 1	OTH COMP SPECIFIC TO MULTIPLE GEST, FIRST TRIMESTER, FETUS 1
O31.8X12	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, FIRST TRIMESTER, FETUS 2	OTH COMP SPECIFIC TO MULTIPLE GEST, FIRST TRIMESTER, FETUS 2
O31.8X13	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, FIRST TRIMESTER, FETUS 3	OTH COMP SPECIFIC TO MULTIPLE GEST, FIRST TRIMESTER, FETUS 3
O31.8X14	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, FIRST TRIMESTER, FETUS 4	OTH COMP SPECIFIC TO MULTIPLE GEST, FIRST TRIMESTER, FETUS 4
O31.8X15	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, FIRST TRIMESTER, FETUS 5	OTH COMP SPECIFIC TO MULTIPLE GEST, FIRST TRIMESTER, FETUS 5
O31.8X19	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, FIRST TRIMESTER, OTHER FETUS	OTH COMP SPECIFIC TO MULTIPLE GEST, FIRST TRIMESTER, OTH
O31.8X20	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, SECOND TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	OTH COMP SPECIFIC TO MULTIPLE GEST, SECOND TRIMESTER, UNSP
O31.8X21	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, SECOND TRIMESTER, FETUS 1	OTH COMP SPECIFIC TO MULTIPLE GEST, SECOND TRI, FETUS 1
O31.8X22	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, SECOND TRIMESTER, FETUS 2	OTH COMP SPECIFIC TO MULTIPLE GEST, SECOND TRI, FETUS 2
O31.8X23	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, SECOND TRIMESTER, FETUS 3	OTH COMP SPECIFIC TO MULTIPLE GEST, SECOND TRI, FETUS 3
O31.8X24	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, SECOND TRIMESTER, FETUS 4	OTH COMP SPECIFIC TO MULTIPLE GEST, SECOND TRI, FETUS 4
O31.8X25	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, SECOND TRIMESTER, FETUS 5	OTH COMP SPECIFIC TO MULTIPLE GEST, SECOND TRI, FETUS 5
O31.8X29	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, SECOND TRIMESTER, OTHER FETUS	OTH COMP SPECIFIC TO MULTIPLE GEST, SECOND TRIMESTER, OTH
O31.8X30	OTHER COMPLICATIONS SPECIFIC TO	OTH COMP SPECIFIC TO MULTIPLE

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ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
	MULTIPLE GESTATION, THIRD TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	GEST, THIRD TRIMESTER, UNSP
O31.8X31	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, THIRD TRIMESTER, FETUS 1	OTH COMP SPECIFIC TO MULTIPLE GEST, THIRD TRIMESTER, FETUS 1
O31.8X32	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, THIRD TRIMESTER, FETUS 2	OTH COMP SPECIFIC TO MULTIPLE GEST, THIRD TRIMESTER, FETUS 2
O31.8X33	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, THIRD TRIMESTER, FETUS 3	OTH COMP SPECIFIC TO MULTIPLE GEST, THIRD TRIMESTER, FETUS 3
O31.8X34	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, THIRD TRIMESTER, FETUS 4	OTH COMP SPECIFIC TO MULTIPLE GEST, THIRD TRIMESTER, FETUS 4
O31.8X35	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, THIRD TRIMESTER, FETUS 5	OTH COMP SPECIFIC TO MULTIPLE GEST, THIRD TRIMESTER, FETUS 5
O31.8X39	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, THIRD TRIMESTER, OTHER FETUS	OTH COMP SPECIFIC TO MULTIPLE GEST, THIRD TRIMESTER, OTH
O32.0XX0	MATERNAL CARE FOR UNSTABLE LIE, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR UNSTABLE LIE, NOT APPLICABLE OR UNSP
O32.0XX1	MATERNAL CARE FOR UNSTABLE LIE, FETUS 1	MATERNAL CARE FOR UNSTABLE LIE, FETUS 1
O32.0XX2	MATERNAL CARE FOR UNSTABLE LIE, FETUS 2	MATERNAL CARE FOR UNSTABLE LIE, FETUS 2
O32.0XX3	MATERNAL CARE FOR UNSTABLE LIE, FETUS 3	MATERNAL CARE FOR UNSTABLE LIE, FETUS 3
O32.0XX4	MATERNAL CARE FOR UNSTABLE LIE, FETUS 4	MATERNAL CARE FOR UNSTABLE LIE, FETUS 4
O32.0XX5	MATERNAL CARE FOR UNSTABLE LIE, FETUS 5	MATERNAL CARE FOR UNSTABLE LIE, FETUS 5
O32.0XX9	MATERNAL CARE FOR UNSTABLE LIE, OTHER FETUS	MATERNAL CARE FOR UNSTABLE LIE, OTHER FETUS
O32.8XX0	MATERNAL CARE FOR OTHER MALPRESENTATION OF FETUS, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR OTH MALPRESENTATION OF FETUS, UNSP
O32.8XX1	MATERNAL CARE FOR OTHER MALPRESENTATION OF FETUS, FETUS 1	MATERNAL CARE FOR OTHER MALPRESENTATION OF FETUS, FETUS 1
O32.8XX2	MATERNAL CARE FOR OTHER MALPRESENTATION OF FETUS, FETUS 2	MATERNAL CARE FOR OTHER MALPRESENTATION OF FETUS, FETUS 2
O32.8XX3	MATERNAL CARE FOR OTHER MALPRESENTATION OF FETUS, FETUS 3	MATERNAL CARE FOR OTHER MALPRESENTATION OF FETUS,

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ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
		FETUS 3
O32.8XX4	MATERNAL CARE FOR OTHER MALPRESENTATION OF FETUS, FETUS 4	MATERNAL CARE FOR OTHER MALPRESENTATION OF FETUS, FETUS 4
O32.8XX5	MATERNAL CARE FOR OTHER MALPRESENTATION OF FETUS, FETUS 5	MATERNAL CARE FOR OTHER MALPRESENTATION OF FETUS, FETUS 5
O32.8XX9	MATERNAL CARE FOR OTHER MALPRESENTATION OF FETUS, OTHER FETUS	MATERNAL CARE FOR OTH MALPRESENTATION OF FETUS, OTHER FETUS
O32.9XX0	MATERNAL CARE FOR MALPRESENTATION OF FETUS, UNSPECIFIED, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR MALPRESENTATION OF FETUS, UNSP, UNSP
O32.9XX1	MATERNAL CARE FOR MALPRESENTATION OF FETUS, UNSPECIFIED, FETUS 1	MATERNAL CARE FOR MALPRESENTATION OF FETUS, UNSP, FETUS 1
O32.9XX2	MATERNAL CARE FOR MALPRESENTATION OF FETUS, UNSPECIFIED, FETUS 2	MATERNAL CARE FOR MALPRESENTATION OF FETUS, UNSP, FETUS 2
O32.9XX3	MATERNAL CARE FOR MALPRESENTATION OF FETUS, UNSPECIFIED, FETUS 3	MATERNAL CARE FOR MALPRESENTATION OF FETUS, UNSP, FETUS 3
O32.9XX4	MATERNAL CARE FOR MALPRESENTATION OF FETUS, UNSPECIFIED, FETUS 4	MATERNAL CARE FOR MALPRESENTATION OF FETUS, UNSP, FETUS 4
O32.9XX5	MATERNAL CARE FOR MALPRESENTATION OF FETUS, UNSPECIFIED, FETUS 5	MATERNAL CARE FOR MALPRESENTATION OF FETUS, UNSP, FETUS 5
O32.9XX9	MATERNAL CARE FOR MALPRESENTATION OF FETUS, UNSPECIFIED, OTHER FETUS	MATERNAL CARE FOR MALPRESENTATION OF FETUS, UNSP, OTH FETUS
O35.0XX0	MATERNAL CARE FOR (SUSPECTED) CENTRAL NERVOUS SYSTEM MALFORMATION IN FETUS, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR (SUSPECTED) CNSL MALFORM IN FETUS, UNSP
O35.0XX1	MATERNAL CARE FOR (SUSPECTED) CENTRAL NERVOUS SYSTEM MALFORMATION IN FETUS, FETUS 1	MATERNAL CARE FOR (SUSPECTED) CNSL MALFORM IN FETUS, FETUS 1
O35.0XX2	MATERNAL CARE FOR (SUSPECTED) CENTRAL NERVOUS SYSTEM MALFORMATION IN FETUS, FETUS 2	MATERNAL CARE FOR (SUSPECTED) CNSL MALFORM IN FETUS, FETUS 2
O35.0XX3	MATERNAL CARE FOR (SUSPECTED) CENTRAL NERVOUS SYSTEM MALFORMATION IN FETUS, FETUS 3	MATERNAL CARE FOR (SUSPECTED) CNSL MALFORM IN FETUS, FETUS 3
O35.0XX4	MATERNAL CARE FOR (SUSPECTED) CENTRAL NERVOUS SYSTEM MALFORMATION IN FETUS, FETUS 4	MATERNAL CARE FOR (SUSPECTED) CNSL MALFORM IN FETUS, FETUS 4

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ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O35.0XX5	MATERNAL CARE FOR (SUSPECTED) CENTRAL NERVOUS SYSTEM MALFORMATION IN FETUS, FETUS 5	MATERNAL CARE FOR (SUSPECTED) CNSL MALFORM IN FETUS, FETUS 5
O35.0XX9	MATERNAL CARE FOR (SUSPECTED) CENTRAL NERVOUS SYSTEM MALFORMATION IN FETUS, OTHER FETUS	MATERNAL CARE FOR (SUSPECTED) CNSL MALFORM IN FETUS, OTH
O35.1XX0	MATERNAL CARE FOR (SUSPECTED) CHROMOSOMAL ABNORMALITY IN FETUS, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR CHROMOSOMAL ABNORMALITY IN FETUS, UNSP
O35.1XX1	MATERNAL CARE FOR (SUSPECTED) CHROMOSOMAL ABNORMALITY IN FETUS, FETUS 1	MATERNAL CARE FOR CHROMOSOMAL ABNORMALITY IN FETUS, FETUS 1
O35.1XX2	MATERNAL CARE FOR (SUSPECTED) CHROMOSOMAL ABNORMALITY IN FETUS, FETUS 2	MATERNAL CARE FOR CHROMOSOMAL ABNORMALITY IN FETUS, FETUS 2
O35.1XX3	MATERNAL CARE FOR (SUSPECTED) CHROMOSOMAL ABNORMALITY IN FETUS, FETUS 3	MATERNAL CARE FOR CHROMOSOMAL ABNORMALITY IN FETUS, FETUS 3
O35.1XX4	MATERNAL CARE FOR (SUSPECTED) CHROMOSOMAL ABNORMALITY IN FETUS, FETUS 4	MATERNAL CARE FOR CHROMOSOMAL ABNORMALITY IN FETUS, FETUS 4
O35.1XX5	MATERNAL CARE FOR (SUSPECTED) CHROMOSOMAL ABNORMALITY IN FETUS, FETUS 5	MATERNAL CARE FOR CHROMOSOMAL ABNORMALITY IN FETUS, FETUS 5
O35.1XX9	MATERNAL CARE FOR (SUSPECTED) CHROMOSOMAL ABNORMALITY IN FETUS, OTHER FETUS	MATERNAL CARE FOR CHROMOSOMAL ABNORMALITY IN FETUS, OTH
O35.3XX0	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS FROM VIRAL DISEASE IN MOTHER, NOT APPLICABLE OR UNSPECIFIED	MATERN CARE FOR DAMAG TO FTS FROM VIRAL DIS IN MOTHER, UNSP
O35.3XX1	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS FROM VIRAL DISEASE IN MOTHER, FETUS 1	MATERN CARE FOR DAMAG TO FTS FROM VIRAL DIS IN MOTHER, FTS1
O35.3XX2	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS FROM VIRAL DISEASE IN MOTHER, FETUS 2	MATERN CARE FOR DAMAG TO FTS FROM VIRAL DIS IN MOTHER, FTS2
O35.3XX3	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS FROM VIRAL DISEASE IN MOTHER, FETUS 3	MATERN CARE FOR DAMAG TO FTS FROM VIRAL DIS IN MOTHER, FTS3
O35.3XX4	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS FROM VIRAL DISEASE IN MOTHER, FETUS 4	MATERN CARE FOR DAMAG TO FTS FROM VIRAL DIS IN MOTHER, FTS4
O35.3XX5	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS FROM VIRAL DISEASE IN MOTHER, FETUS 5	MATERN CARE FOR DAMAG TO FTS FROM VIRAL DIS IN MOTHER, FTS5
O35.3XX9	MATERNAL CARE FOR (SUSPECTED) DAMAGE	MATERN CARE FOR DAMAG TO

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ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
	TO FETUS FROM VIRAL DISEASE IN MOTHER, OTHER FETUS	FETUS FROM VIRAL DIS IN MOTHER, OTH
O35.4XX0	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS FROM ALCOHOL, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR DAMAGE TO FETUS FROM ALCOHOL, UNSP
O35.4XX1	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS FROM ALCOHOL, FETUS 1	MATERNAL CARE FOR DAMAGE TO FETUS FROM ALCOHOL, FETUS 1
O35.4XX2	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS FROM ALCOHOL, FETUS 2	MATERNAL CARE FOR DAMAGE TO FETUS FROM ALCOHOL, FETUS 2
O35.4XX3	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS FROM ALCOHOL, FETUS 3	MATERNAL CARE FOR DAMAGE TO FETUS FROM ALCOHOL, FETUS 3
O35.4XX4	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS FROM ALCOHOL, FETUS 4	MATERNAL CARE FOR DAMAGE TO FETUS FROM ALCOHOL, FETUS 4
O35.4XX5	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS FROM ALCOHOL, FETUS 5	MATERNAL CARE FOR DAMAGE TO FETUS FROM ALCOHOL, FETUS 5
O35.4XX9	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS FROM ALCOHOL, OTHER FETUS	MATERNAL CARE FOR DAMAGE TO FETUS FROM ALCOHOL, OTH
O35.5XX0	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY DRUGS, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY DRUGS, UNSP
O35.5XX1	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY DRUGS, FETUS 1	MATERNAL CARE FOR DAMAGE TO FETUS BY DRUGS, FETUS 1
O35.5XX2	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY DRUGS, FETUS 2	MATERNAL CARE FOR DAMAGE TO FETUS BY DRUGS, FETUS 2
O35.5XX3	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY DRUGS, FETUS 3	MATERNAL CARE FOR DAMAGE TO FETUS BY DRUGS, FETUS 3
O35.5XX4	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY DRUGS, FETUS 4	MATERNAL CARE FOR DAMAGE TO FETUS BY DRUGS, FETUS 4
O35.5XX5	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY DRUGS, FETUS 5	MATERNAL CARE FOR DAMAGE TO FETUS BY DRUGS, FETUS 5
O35.5XX9	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY DRUGS, OTHER FETUS	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY DRUGS, OTH
O35.6XX0	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY RADIATION, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR DAMAGE TO FETUS BY RADIATION, UNSP
O35.6XX1	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY RADIATION, FETUS 1	MATERNAL CARE FOR DAMAGE TO FETUS BY RADIATION, FETUS 1
O35.6XX2	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY RADIATION, FETUS 2	MATERNAL CARE FOR DAMAGE TO FETUS BY RADIATION, FETUS 2
O35.6XX3	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY RADIATION, FETUS 3	MATERNAL CARE FOR DAMAGE TO FETUS BY RADIATION, FETUS 3
O35.6XX4	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY RADIATION, FETUS 4	MATERNAL CARE FOR DAMAGE TO FETUS BY RADIATION, FETUS 4

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ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O35.6XX5	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY RADIATION, FETUS 5	MATERNAL CARE FOR DAMAGE TO FETUS BY RADIATION, FETUS 5
O35.6XX9	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY RADIATION, OTHER FETUS	MATERNAL CARE FOR DAMAGE TO FETUS BY RADIATION, OTH
O36.0110	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, FIRST TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR ANTI-D ANTIBODIES, FIRST TRIMESTER, UNSP
O36.0111	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, FIRST TRIMESTER, FETUS 1	MATERNAL CARE FOR ANTI-D ANTIBODIES, FIRST TRI, FETUS 1
O36.0112	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, FIRST TRIMESTER, FETUS 2	MATERNAL CARE FOR ANTI-D ANTIBODIES, FIRST TRI, FETUS 2
O36.0113	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, FIRST TRIMESTER, FETUS 3	MATERNAL CARE FOR ANTI-D ANTIBODIES, FIRST TRI, FETUS 3
O36.0114	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, FIRST TRIMESTER, FETUS 4	MATERNAL CARE FOR ANTI-D ANTIBODIES, FIRST TRI, FETUS 4
O36.0115	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, FIRST TRIMESTER, FETUS 5	MATERNAL CARE FOR ANTI-D ANTIBODIES, FIRST TRI, FETUS 5
O36.0119	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, FIRST TRIMESTER, OTHER FETUS	MATERNAL CARE FOR ANTI-D ANTIBODIES, FIRST TRIMESTER, OTH
O36.0120	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, SECOND TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR ANTI-D ANTIBODIES, SECOND TRIMESTER, UNSP
O36.0121	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, SECOND TRIMESTER, FETUS 1	MATERNAL CARE FOR ANTI-D ANTIBODIES, SECOND TRI, FETUS 1
O36.0122	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, SECOND TRIMESTER, FETUS 2	MATERNAL CARE FOR ANTI-D ANTIBODIES, SECOND TRI, FETUS 2
O36.0123	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, SECOND TRIMESTER, FETUS 3	MATERNAL CARE FOR ANTI-D ANTIBODIES, SECOND TRI, FETUS 3
O36.0124	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, SECOND TRIMESTER, FETUS 4	MATERNAL CARE FOR ANTI-D ANTIBODIES, SECOND TRI, FETUS 4
O36.0125	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, SECOND TRIMESTER, FETUS 5	MATERNAL CARE FOR ANTI-D ANTIBODIES, SECOND TRI, FETUS 5
O36.0129	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, SECOND TRIMESTER, OTHER FETUS	MATERNAL CARE FOR ANTI-D ANTIBODIES, SECOND TRIMESTER, OTH
O36.0130	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, THIRD TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR ANTI-D ANTIBODIES, THIRD TRIMESTER, UNSP
O36.0131	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, THIRD TRIMESTER, FETUS 1	MATERNAL CARE FOR ANTI-D ANTIBODIES, THIRD TRI, FETUS 1
O36.0132	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, THIRD TRIMESTER, FETUS 2	MATERNAL CARE FOR ANTI-D ANTIBODIES, THIRD TRI, FETUS 2
O36.0133	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, THIRD TRIMESTER, FETUS 3	MATERNAL CARE FOR ANTI-D ANTIBODIES, THIRD TRI, FETUS 3

SECTION 6 BIRTH OUTCOMES INITIATIVE

BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O36.0134	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, THIRD TRIMESTER, FETUS 4	MATERNAL CARE FOR ANTI-D ANTIBODIES, THIRD TRI, FETUS 4
O36.0135	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, THIRD TRIMESTER, FETUS 5	MATERNAL CARE FOR ANTI-D ANTIBODIES, THIRD TRI, FETUS 5
O36.0139	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, THIRD TRIMESTER, OTHER FETUS	MATERNAL CARE FOR ANTI-D ANTIBODIES, THIRD TRIMESTER, OTH
O36.0190	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, UNSPECIFIED TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR ANTI-D ANTIBODIES, UNSP TRIMESTER, UNSP
O36.0191	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, UNSPECIFIED TRIMESTER, FETUS 1	MATERNAL CARE FOR ANTI-D ANTIBODIES, UNSP TRIMESTER, FETUS 1
O36.0192	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, UNSPECIFIED TRIMESTER, FETUS 2	MATERNAL CARE FOR ANTI-D ANTIBODIES, UNSP TRIMESTER, FETUS 2
O36.0193	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, UNSPECIFIED TRIMESTER, FETUS 3	MATERNAL CARE FOR ANTI-D ANTIBODIES, UNSP TRIMESTER, FETUS 3
O36.0194	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, UNSPECIFIED TRIMESTER, FETUS 4	MATERNAL CARE FOR ANTI-D ANTIBODIES, UNSP TRIMESTER, FETUS 4
O36.0195	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, UNSPECIFIED TRIMESTER, FETUS 5	MATERNAL CARE FOR ANTI-D ANTIBODIES, UNSP TRIMESTER, FETUS 5
O36.0199	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, UNSPECIFIED TRIMESTER, OTHER FETUS	MATERNAL CARE FOR ANTI-D ANTIBODIES, UNSP TRIMESTER, OTH
O36.0910	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, FIRST TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, FIRST TRIMESTER, UNSP
O36.0911	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, FIRST TRIMESTER, FETUS 1	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, FIRST TRI, FETUS 1
O36.0912	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, FIRST TRIMESTER, FETUS 2	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, FIRST TRI, FETUS 2
O36.0913	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, FIRST TRIMESTER, FETUS 3	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, FIRST TRI, FETUS 3
O36.0914	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, FIRST TRIMESTER, FETUS 4	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, FIRST TRI, FETUS 4
O36.0915	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, FIRST TRIMESTER, FETUS 5	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, FIRST TRI, FETUS 5
O36.0919	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, FIRST TRIMESTER, OTHER FETUS	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, FIRST TRIMESTER, OTH
O36.0920	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, SECOND TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, SECOND TRI, UNSP

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O36.0921	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, SECOND TRIMESTER, FETUS 1	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, SECOND TRI, FETUS 1
O36.0922	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, SECOND TRIMESTER, FETUS 2	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, SECOND TRI, FETUS 2
O36.0923	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, SECOND TRIMESTER, FETUS 3	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, SECOND TRI, FETUS 3
O36.0924	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, SECOND TRIMESTER, FETUS 4	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, SECOND TRI, FETUS 4
O36.0925	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, SECOND TRIMESTER, FETUS 5	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, SECOND TRI, FETUS 5
O36.0929	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, SECOND TRIMESTER, OTHER FETUS	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, SECOND TRIMESTER, OTH
O36.0930	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, THIRD TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, THIRD TRIMESTER, UNSP
O36.0931	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, THIRD TRIMESTER, FETUS 1	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, THIRD TRI, FETUS 1
O36.0932	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, THIRD TRIMESTER, FETUS 2	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, THIRD TRI, FETUS 2
O36.0933	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, THIRD TRIMESTER, FETUS 3	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, THIRD TRI, FETUS 3
O36.0934	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, THIRD TRIMESTER, FETUS 4	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, THIRD TRI, FETUS 4
O36.0935	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, THIRD TRIMESTER, FETUS 5	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, THIRD TRI, FETUS 5
O36.0939	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, THIRD TRIMESTER, OTHER FETUS	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, THIRD TRIMESTER, OTH
O36.0990	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, UNSPECIFIED TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, UNSP TRIMESTER, UNSP
O36.0991	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, UNSPECIFIED TRIMESTER, FETUS 1	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, UNSP TRI, FETUS 1
O36.0992	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, UNSPECIFIED TRIMESTER, FETUS 2	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, UNSP TRI, FETUS 2
O36.0993	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, UNSPECIFIED TRIMESTER, FETUS 3	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, UNSP TRI, FETUS 3

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O36.0994	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, UNSPECIFIED TRIMESTER, FETUS 4	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, UNSP TRI, FETUS 4
O36.0995	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, UNSPECIFIED TRIMESTER, FETUS 5	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, UNSP TRI, FETUS 5
O36.0999	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, UNSPECIFIED TRIMESTER, OTHER FETUS	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, UNSP TRIMESTER, OTH
O36.1110	MATERNAL CARE FOR ANTI-A SENSITIZATION, FIRST TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR ANTI-A SENSITIZATION, FIRST TRI, UNSP
O36.1111	MATERNAL CARE FOR ANTI-A SENSITIZATION, FIRST TRIMESTER, FETUS 1	MATERNAL CARE FOR ANTI-A SENSITIZATION, FIRST TRI, FETUS 1
O36.1112	MATERNAL CARE FOR ANTI-A SENSITIZATION, FIRST TRIMESTER, FETUS 2	MATERNAL CARE FOR ANTI-A SENSITIZATION, FIRST TRI, FETUS 2
O36.1113	MATERNAL CARE FOR ANTI-A SENSITIZATION, FIRST TRIMESTER, FETUS 3	MATERNAL CARE FOR ANTI-A SENSITIZATION, FIRST TRI, FETUS 3
O36.1114	MATERNAL CARE FOR ANTI-A SENSITIZATION, FIRST TRIMESTER, FETUS 4	MATERNAL CARE FOR ANTI-A SENSITIZATION, FIRST TRI, FETUS 4
O36.1115	MATERNAL CARE FOR ANTI-A SENSITIZATION, FIRST TRIMESTER, FETUS 5	MATERNAL CARE FOR ANTI-A SENSITIZATION, FIRST TRI, FETUS 5
O36.1119	MATERNAL CARE FOR ANTI-A SENSITIZATION, FIRST TRIMESTER, OTHER FETUS	MATERNAL CARE FOR ANTI-A SENSITIZATION, FIRST TRIMESTER, OTH
O36.1120	MATERNAL CARE FOR ANTI-A SENSITIZATION, SECOND TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR ANTI-A SENSITIZATION, SECOND TRI, UNSP
O36.1121	MATERNAL CARE FOR ANTI-A SENSITIZATION, SECOND TRIMESTER, FETUS 1	MATERNAL CARE FOR ANTI-A SENSITIZATION, SECOND TRI, FETUS 1
O36.1122	MATERNAL CARE FOR ANTI-A SENSITIZATION, SECOND TRIMESTER, FETUS 2	MATERNAL CARE FOR ANTI-A SENSITIZATION, SECOND TRI, FETUS 2
O36.1123	MATERNAL CARE FOR ANTI-A SENSITIZATION, SECOND TRIMESTER, FETUS 3	MATERNAL CARE FOR ANTI-A SENSITIZATION, SECOND TRI, FETUS 3
O36.1124	MATERNAL CARE FOR ANTI-A SENSITIZATION, SECOND TRIMESTER, FETUS 4	MATERNAL CARE FOR ANTI-A SENSITIZATION, SECOND TRI, FETUS 4
O36.1125	MATERNAL CARE FOR ANTI-A SENSITIZATION, SECOND TRIMESTER, FETUS 5	MATERNAL CARE FOR ANTI-A SENSITIZATION, SECOND TRI, FETUS 5
O36.1129	MATERNAL CARE FOR ANTI-A SENSITIZATION, SECOND TRIMESTER, OTHER FETUS	MATERNAL CARE FOR ANTI-A SENSITIZATION, SECOND TRI, OTH

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O36.1130	MATERNAL CARE FOR ANTI-A SENSITIZATION, THIRD TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR ANTI-A SENSITIZATION, THIRD TRI, UNSP
O36.1131	MATERNAL CARE FOR ANTI-A SENSITIZATION, THIRD TRIMESTER, FETUS 1	MATERNAL CARE FOR ANTI-A SENSITIZATION, THIRD TRI, FETUS 1
O36.1132	MATERNAL CARE FOR ANTI-A SENSITIZATION, THIRD TRIMESTER, FETUS 2	MATERNAL CARE FOR ANTI-A SENSITIZATION, THIRD TRI, FETUS 2
O36.1133	MATERNAL CARE FOR ANTI-A SENSITIZATION, THIRD TRIMESTER, FETUS 3	MATERNAL CARE FOR ANTI-A SENSITIZATION, THIRD TRI, FETUS 3
O36.1134	MATERNAL CARE FOR ANTI-A SENSITIZATION, THIRD TRIMESTER, FETUS 4	MATERNAL CARE FOR ANTI-A SENSITIZATION, THIRD TRI, FETUS 4
O36.1135	MATERNAL CARE FOR ANTI-A SENSITIZATION, THIRD TRIMESTER, FETUS 5	MATERNAL CARE FOR ANTI-A SENSITIZATION, THIRD TRI, FETUS 5
O36.1139	MATERNAL CARE FOR ANTI-A SENSITIZATION, THIRD TRIMESTER, OTHER FETUS	MATERNAL CARE FOR ANTI-A SENSITIZATION, THIRD TRIMESTER, OTH
O36.1190	MATERNAL CARE FOR ANTI-A SENSITIZATION, UNSPECIFIED TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR ANTI-A SENSITIZATION, UNSP TRIMESTER, UNSP
O36.1191	MATERNAL CARE FOR ANTI-A SENSITIZATION, UNSPECIFIED TRIMESTER, FETUS 1	MATERNAL CARE FOR ANTI-A SENSITIZATION, UNSP TRI, FETUS 1
O36.1192	MATERNAL CARE FOR ANTI-A SENSITIZATION, UNSPECIFIED TRIMESTER, FETUS 2	MATERNAL CARE FOR ANTI-A SENSITIZATION, UNSP TRI, FETUS 2
O36.1193	MATERNAL CARE FOR ANTI-A SENSITIZATION, UNSPECIFIED TRIMESTER, FETUS 3	MATERNAL CARE FOR ANTI-A SENSITIZATION, UNSP TRI, FETUS 3
O36.1194	MATERNAL CARE FOR ANTI-A SENSITIZATION, UNSPECIFIED TRIMESTER, FETUS 4	MATERNAL CARE FOR ANTI-A SENSITIZATION, UNSP TRI, FETUS 4
O36.1195	MATERNAL CARE FOR ANTI-A SENSITIZATION, UNSPECIFIED TRIMESTER, FETUS 5	MATERNAL CARE FOR ANTI-A SENSITIZATION, UNSP TRI, FETUS 5
O36.1199	MATERNAL CARE FOR ANTI-A SENSITIZATION, UNSPECIFIED TRIMESTER, OTHER FETUS	MATERNAL CARE FOR ANTI-A SENSITIZATION, UNSP TRIMESTER, OTH
O36.1910	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, FIRST TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR OTH ISOIMMUNIZATION, FIRST TRIMESTER, UNSP
O36.1911	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, FIRST TRIMESTER, FETUS 1	MATERNAL CARE FOR OTH ISOIMMUN, FIRST TRIMESTER, FETUS 1
O36.1912	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, FIRST TRIMESTER, FETUS 2	MATERNAL CARE FOR OTH ISOIMMUN, FIRST TRIMESTER, FETUS 2
O36.1913	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, FIRST TRIMESTER, FETUS 3	MATERNAL CARE FOR OTH ISOIMMUN, FIRST TRIMESTER, FETUS 3

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O36.1914	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, FIRST TRIMESTER, FETUS 4	MATERNAL CARE FOR OTH ISOIMMUN, FIRST TRIMESTER, FETUS 4
O36.1915	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, FIRST TRIMESTER, FETUS 5	MATERNAL CARE FOR OTH ISOIMMUN, FIRST TRIMESTER, FETUS 5
O36.1919	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, FIRST TRIMESTER, OTHER FETUS	MATERNAL CARE FOR OTH ISOIMMUNIZATION, FIRST TRIMESTER, OTH
O36.1920	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, SECOND TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR OTH ISOIMMUN, SECOND TRIMESTER, UNSP
O36.1921	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, SECOND TRIMESTER, FETUS 1	MATERNAL CARE FOR OTH ISOIMMUN, SECOND TRIMESTER, FETUS 1
O36.1922	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, SECOND TRIMESTER, FETUS 2	MATERNAL CARE FOR OTH ISOIMMUN, SECOND TRIMESTER, FETUS 2
O36.1923	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, SECOND TRIMESTER, FETUS 3	MATERNAL CARE FOR OTH ISOIMMUN, SECOND TRIMESTER, FETUS 3
O36.1924	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, SECOND TRIMESTER, FETUS 4	MATERNAL CARE FOR OTH ISOIMMUN, SECOND TRIMESTER, FETUS 4
O36.1925	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, SECOND TRIMESTER, FETUS 5	MATERNAL CARE FOR OTH ISOIMMUN, SECOND TRIMESTER, FETUS 5
O36.1929	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, SECOND TRIMESTER, OTHER FETUS	MATERNAL CARE FOR OTH ISOIMMUNIZATION, SECOND TRIMESTER, OTH
O36.1930	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, THIRD TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR OTH ISOIMMUNIZATION, THIRD TRIMESTER, UNSP
O36.1931	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, THIRD TRIMESTER, FETUS 1	MATERNAL CARE FOR OTH ISOIMMUN, THIRD TRIMESTER, FETUS 1
O36.1932	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, THIRD TRIMESTER, FETUS 2	MATERNAL CARE FOR OTH ISOIMMUN, THIRD TRIMESTER, FETUS 2
O36.1933	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, THIRD TRIMESTER, FETUS 3	MATERNAL CARE FOR OTH ISOIMMUN, THIRD TRIMESTER, FETUS 3
O36.1934	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, THIRD TRIMESTER, FETUS 4	MATERNAL CARE FOR OTH ISOIMMUN, THIRD TRIMESTER, FETUS 4
O36.1935	MATERNAL CARE FOR OTHER	MATERNAL CARE FOR OTH

SECTION 6 BIRTH OUTCOMES INITIATIVE

BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
	ISOIMMUNIZATION, THIRD TRIMESTER, FETUS 5	ISOIMMUN, THIRD TRIMESTER, FETUS 5
O36.1939	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, THIRD TRIMESTER, OTHER FETUS	MATERNAL CARE FOR OTH ISOIMMUNIZATION, THIRD TRIMESTER, OTH
O36.1990	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, UNSPECIFIED TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR OTH ISOIMMUNIZATION, UNSP TRIMESTER, UNSP
O36.1991	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, UNSPECIFIED TRIMESTER, FETUS 1	MATERNAL CARE FOR OTH ISOIMMUN, UNSP TRIMESTER, FETUS 1
O36.1992	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, UNSPECIFIED TRIMESTER, FETUS 2	MATERNAL CARE FOR OTH ISOIMMUN, UNSP TRIMESTER, FETUS 2
O36.1993	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, UNSPECIFIED TRIMESTER, FETUS 3	MATERNAL CARE FOR OTH ISOIMMUN, UNSP TRIMESTER, FETUS 3
O36.1994	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, UNSPECIFIED TRIMESTER, FETUS 4	MATERNAL CARE FOR OTH ISOIMMUN, UNSP TRIMESTER, FETUS 4
O36.1995	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, UNSPECIFIED TRIMESTER, FETUS 5	MATERNAL CARE FOR OTH ISOIMMUN, UNSP TRIMESTER, FETUS 5
O36.1999	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, UNSPECIFIED TRIMESTER, OTHER FETUS	MATERNAL CARE FOR OTH ISOIMMUNIZATION, UNSP TRIMESTER, OTH
O36.4XX0	MATERNAL CARE FOR INTRAUTERINE DEATH, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR INTRAUTERINE DEATH, NOT APPLICABLE OR UNSP
O36.4XX1	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 1	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 1
O36.4XX2	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 2	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 2
O36.4XX3	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 3	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 3
O36.4XX4	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 4	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 4
O36.4XX5	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 5	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 5
O36.4XX9	MATERNAL CARE FOR INTRAUTERINE DEATH, OTHER FETUS	MATERNAL CARE FOR INTRAUTERINE DEATH, OTHER FETUS
O36.5110	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, FIRST TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, 1ST TRI, UNSP
O36.5111	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, FIRST TRIMESTER,	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, 1ST TRI, FTS1

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
	FETUS 1	
O36.5112	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, FIRST TRIMESTER, FETUS 2	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, 1ST TRI, FTS2
O36.5113	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, FIRST TRIMESTER, FETUS 3	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, 1ST TRI, FTS3
O36.5114	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, FIRST TRIMESTER, FETUS 4	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, 1ST TRI, FTS4
O36.5115	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, FIRST TRIMESTER, FETUS 5	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, 1ST TRI, FTS5
O36.5119	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, FIRST TRIMESTER, OTHER FETUS	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, FIRST TRI, OTH
O36.5120	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, SECOND TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, 2ND TRI, UNSP
O36.5121	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, SECOND TRIMESTER, FETUS 1	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, 2ND TRI, FTS1
O36.5122	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, SECOND TRIMESTER, FETUS 2	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, 2ND TRI, FTS2
O36.5123	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, SECOND TRIMESTER, FETUS 3	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, 2ND TRI, FTS3
O36.5124	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, SECOND TRIMESTER, FETUS 4	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, 2ND TRI, FTS4
O36.5125	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, SECOND TRIMESTER, FETUS 5	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, 2ND TRI, FTS5
O36.5129	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, SECOND TRIMESTER, OTHER FETUS	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, 2ND TRI, OTH
O36.5130	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, THIRD TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERN CARE FOR OR SUSP PLACNTL INSUFF, THIRD TRI, UNSP
O36.5131	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, THIRD TRIMESTER, FETUS 1	MATERN CARE FOR OR SUSP PLACNTL INSUFF, THIRD TRI, FTS1
O36.5132	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, THIRD TRIMESTER, FETUS 2	MATERN CARE FOR OR SUSP PLACNTL INSUFF, THIRD TRI, FTS2

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O36.5133	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, THIRD TRIMESTER, FETUS 3	MATERN CARE FOR OR SUSP PLACNTL INSUFF, THIRD TRI, FTS3
O36.5134	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, THIRD TRIMESTER, FETUS 4	MATERN CARE FOR OR SUSP PLACNTL INSUFF, THIRD TRI, FTS4
O36.5135	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, THIRD TRIMESTER, FETUS 5	MATERN CARE FOR OR SUSP PLACNTL INSUFF, THIRD TRI, FTS5
O36.5139	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, THIRD TRIMESTER, OTHER FETUS	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, THIRD TRI, OTH
O36.5190	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, UNSPECIFIED TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, UNSP TRI, UNSP
O36.5191	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, UNSPECIFIED TRIMESTER, FETUS 1	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, UNSP TRI, FTS1
O36.5192	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, UNSPECIFIED TRIMESTER, FETUS 2	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, UNSP TRI, FTS2
O36.5193	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, UNSPECIFIED TRIMESTER, FETUS 3	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, UNSP TRI, FTS3
O36.5194	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, UNSPECIFIED TRIMESTER, FETUS 4	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, UNSP TRI, FTS4
O36.5195	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, UNSPECIFIED TRIMESTER, FETUS 5	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, UNSP TRI, FTS5
O36.5199	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, UNSPECIFIED TRIMESTER, OTHER FETUS	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, UNSP TRI, OTH
O36.5910	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, FIRST TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, 1ST TRI, UNSP
O36.5911	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, FIRST TRIMESTER, FETUS 1	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, 1ST TRI, FTS1
O36.5912	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, FIRST TRIMESTER, FETUS 2	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, 1ST TRI, FTS2
O36.5913	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, FIRST TRIMESTER, FETUS 3	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, 1ST TRI, FTS3
O36.5914	MATERNAL CARE FOR OTHER KNOWN OR	MATERN CARE FOR OTH OR SUSP

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	SUSPECTED POOR FETAL GROWTH, FIRST TRIMESTER, FETUS 4	POOR FETL GRTH, 1ST TRI, FTS4
O36.5915	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, FIRST TRIMESTER, FETUS 5	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, 1ST TRI, FTS5
O36.5919	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, FIRST TRIMESTER, OTHER FETUS	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, 1ST TRI, OTH
O36.5920	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, SECOND TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, 2ND TRI, UNSP
O36.5921	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, SECOND TRIMESTER, FETUS 1	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, 2ND TRI, FTS1
O36.5922	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, SECOND TRIMESTER, FETUS 2	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, 2ND TRI, FTS2
O36.5923	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, SECOND TRIMESTER, FETUS 3	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, 2ND TRI, FTS3
O36.5924	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, SECOND TRIMESTER, FETUS 4	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, 2ND TRI, FTS4
O36.5925	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, SECOND TRIMESTER, FETUS 5	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, 2ND TRI, FTS5
O36.5929	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, SECOND TRIMESTER, OTHER FETUS	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, 2ND TRI, OTH
O36.5930	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, THIRD TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, THIRD TRI, UNSP
O36.5931	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, THIRD TRIMESTER, FETUS 1	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, THIRD TRI, FTS1
O36.5932	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, THIRD TRIMESTER, FETUS 2	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, THIRD TRI, FTS2
O36.5933	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, THIRD TRIMESTER, FETUS 3	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, THIRD TRI, FTS3
O36.5934	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, THIRD TRIMESTER, FETUS 4	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, THIRD TRI, FTS4
O36.5935	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, THIRD	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, THIRD TRI, FTS5

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	TRIMESTER, FETUS 5	
O36.5939	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, THIRD TRIMESTER, OTHER FETUS	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, THIRD TRI, OTH
O36.5990	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, UNSPECIFIED TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, UNSP TRI, UNSP
O36.5991	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, UNSPECIFIED TRIMESTER, FETUS 1	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, UNSP TRI, FTS1
O36.5992	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, UNSPECIFIED TRIMESTER, FETUS 2	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, UNSP TRI, FTS2
O36.5993	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, UNSPECIFIED TRIMESTER, FETUS 3	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, UNSP TRI, FTS3
O36.5994	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, UNSPECIFIED TRIMESTER, FETUS 4	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, UNSP TRI, FTS4
O36.5995	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, UNSPECIFIED TRIMESTER, FETUS 5	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, UNSP TRI, FTS5
O36.5999	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, UNSPECIFIED TRIMESTER, OTHER FETUS	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, UNSP TRI, OTH
O40.1XX0	POLYHYDRAMNIOS, FIRST TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	POLYHYDRAMNIOS, FIRST TRIMESTER, NOT APPLICABLE OR UNSP
O40.1XX1	POLYHYDRAMNIOS, FIRST TRIMESTER, FETUS 1	POLYHYDRAMNIOS, FIRST TRIMESTER, FETUS 1
O40.1XX2	POLYHYDRAMNIOS, FIRST TRIMESTER, FETUS 2	POLYHYDRAMNIOS, FIRST TRIMESTER, FETUS 2
O40.1XX3	POLYHYDRAMNIOS, FIRST TRIMESTER, FETUS 3	POLYHYDRAMNIOS, FIRST TRIMESTER, FETUS 3
O40.1XX4	POLYHYDRAMNIOS, FIRST TRIMESTER, FETUS 4	POLYHYDRAMNIOS, FIRST TRIMESTER, FETUS 4
O40.1XX5	POLYHYDRAMNIOS, FIRST TRIMESTER, FETUS 5	POLYHYDRAMNIOS, FIRST TRIMESTER, FETUS 5
O40.1XX9	POLYHYDRAMNIOS, FIRST TRIMESTER, OTHER FETUS	POLYHYDRAMNIOS, FIRST TRIMESTER, OTHER FETUS
O40.2XX0	POLYHYDRAMNIOS, SECOND TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	POLYHYDRAMNIOS, SECOND TRIMESTER, NOT APPLICABLE OR UNSP

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O40.2XX1	POLYHYDRAMNIOS, SECOND TRIMESTER, FETUS 1	POLYHYDRAMNIOS, SECOND TRIMESTER, FETUS 1
O40.2XX2	POLYHYDRAMNIOS, SECOND TRIMESTER, FETUS 2	POLYHYDRAMNIOS, SECOND TRIMESTER, FETUS 2
O40.2XX3	POLYHYDRAMNIOS, SECOND TRIMESTER, FETUS 3	POLYHYDRAMNIOS, SECOND TRIMESTER, FETUS 3
O40.2XX4	POLYHYDRAMNIOS, SECOND TRIMESTER, FETUS 4	POLYHYDRAMNIOS, SECOND TRIMESTER, FETUS 4
O40.2XX5	POLYHYDRAMNIOS, SECOND TRIMESTER, FETUS 5	POLYHYDRAMNIOS, SECOND TRIMESTER, FETUS 5
O40.2XX9	POLYHYDRAMNIOS, SECOND TRIMESTER, OTHER FETUS	POLYHYDRAMNIOS, SECOND TRIMESTER, OTHER FETUS
O40.3XX0	POLYHYDRAMNIOS, THIRD TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	POLYHYDRAMNIOS, THIRD TRIMESTER, NOT APPLICABLE OR UNSP
O40.3XX1	POLYHYDRAMNIOS, THIRD TRIMESTER, FETUS 1	POLYHYDRAMNIOS, THIRD TRIMESTER, FETUS 1
O40.3XX2	POLYHYDRAMNIOS, THIRD TRIMESTER, FETUS 2	POLYHYDRAMNIOS, THIRD TRIMESTER, FETUS 2
O40.3XX3	POLYHYDRAMNIOS, THIRD TRIMESTER, FETUS 3	POLYHYDRAMNIOS, THIRD TRIMESTER, FETUS 3
O40.3XX4	POLYHYDRAMNIOS, THIRD TRIMESTER, FETUS 4	POLYHYDRAMNIOS, THIRD TRIMESTER, FETUS 4
O40.3XX5	POLYHYDRAMNIOS, THIRD TRIMESTER, FETUS 5	POLYHYDRAMNIOS, THIRD TRIMESTER, FETUS 5
O40.3XX9	POLYHYDRAMNIOS, THIRD TRIMESTER, OTHER FETUS	POLYHYDRAMNIOS, THIRD TRIMESTER, OTHER FETUS
O40.9XX0	POLYHYDRAMNIOS, UNSPECIFIED TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	POLYHYDRAMNIOS, UNSP TRIMESTER, NOT APPLICABLE OR UNSP
O40.9XX1	POLYHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 1	POLYHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 1
O40.9XX2	POLYHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 2	POLYHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 2
O40.9XX3	POLYHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 3	POLYHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 3
O40.9XX4	POLYHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 4	POLYHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 4
O40.9XX5	POLYHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 5	POLYHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 5
O40.9XX9	POLYHYDRAMNIOS, UNSPECIFIED TRIMESTER, OTHER FETUS	POLYHYDRAMNIOS, UNSPECIFIED TRIMESTER, OTHER FETUS

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O41.00X0	OLIGOHYDRAMNIOS, UNSPECIFIED TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	OLIGOHYDRAMNIOS, UNSP TRIMESTER, NOT APPLICABLE OR UNSP
O41.00X1	OLIGOHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 1	OLIGOHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 1
O41.00X2	OLIGOHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 2	OLIGOHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 2
O41.00X3	OLIGOHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 3	OLIGOHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 3
O41.00X4	OLIGOHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 4	OLIGOHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 4
O41.00X5	OLIGOHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 5	OLIGOHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 5
O41.00X9	OLIGOHYDRAMNIOS, UNSPECIFIED TRIMESTER, OTHER FETUS	OLIGOHYDRAMNIOS, UNSPECIFIED TRIMESTER, OTHER FETUS
O41.01X0	OLIGOHYDRAMNIOS, FIRST TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	OLIGOHYDRAMNIOS, FIRST TRIMESTER, NOT APPLICABLE OR UNSP
O41.01X1	OLIGOHYDRAMNIOS, FIRST TRIMESTER, FETUS 1	OLIGOHYDRAMNIOS, FIRST TRIMESTER, FETUS 1
O41.01X2	OLIGOHYDRAMNIOS, FIRST TRIMESTER, FETUS 2	OLIGOHYDRAMNIOS, FIRST TRIMESTER, FETUS 2
O41.01X3	OLIGOHYDRAMNIOS, FIRST TRIMESTER, FETUS 3	OLIGOHYDRAMNIOS, FIRST TRIMESTER, FETUS 3
O41.01X4	OLIGOHYDRAMNIOS, FIRST TRIMESTER, FETUS 4	OLIGOHYDRAMNIOS, FIRST TRIMESTER, FETUS 4
O41.01X5	OLIGOHYDRAMNIOS, FIRST TRIMESTER, FETUS 5	OLIGOHYDRAMNIOS, FIRST TRIMESTER, FETUS 5
O41.01X9	OLIGOHYDRAMNIOS, FIRST TRIMESTER, OTHER FETUS	OLIGOHYDRAMNIOS, FIRST TRIMESTER, OTHER FETUS
O41.02X0	OLIGOHYDRAMNIOS, SECOND TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	OLIGOHYDRAMNIOS, SECOND TRIMESTER, NOT APPLICABLE OR UNSP
O41.02X1	OLIGOHYDRAMNIOS, SECOND TRIMESTER, FETUS 1	OLIGOHYDRAMNIOS, SECOND TRIMESTER, FETUS 1
O41.02X2	OLIGOHYDRAMNIOS, SECOND TRIMESTER, FETUS 2	OLIGOHYDRAMNIOS, SECOND TRIMESTER, FETUS 2
O41.02X3	OLIGOHYDRAMNIOS, SECOND TRIMESTER, FETUS 3	OLIGOHYDRAMNIOS, SECOND TRIMESTER, FETUS 3
O41.02X4	OLIGOHYDRAMNIOS, SECOND TRIMESTER, FETUS 4	OLIGOHYDRAMNIOS, SECOND TRIMESTER, FETUS 4
O41.02X5	OLIGOHYDRAMNIOS, SECOND TRIMESTER, FETUS 5	OLIGOHYDRAMNIOS, SECOND TRIMESTER, FETUS 5

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O41.02X9	OLIGOHYDRAMNIOS, SECOND TRIMESTER, OTHER FETUS	OLIGOHYDRAMNIOS, SECOND TRIMESTER, OTHER FETUS
O41.03X0	OLIGOHYDRAMNIOS, THIRD TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	OLIGOHYDRAMNIOS, THIRD TRIMESTER, NOT APPLICABLE OR UNSP
O41.03X1	OLIGOHYDRAMNIOS, THIRD TRIMESTER, FETUS 1	OLIGOHYDRAMNIOS, THIRD TRIMESTER, FETUS 1
O41.03X2	OLIGOHYDRAMNIOS, THIRD TRIMESTER, FETUS 2	OLIGOHYDRAMNIOS, THIRD TRIMESTER, FETUS 2
O41.03X3	OLIGOHYDRAMNIOS, THIRD TRIMESTER, FETUS 3	OLIGOHYDRAMNIOS, THIRD TRIMESTER, FETUS 3
O41.03X4	OLIGOHYDRAMNIOS, THIRD TRIMESTER, FETUS 4	OLIGOHYDRAMNIOS, THIRD TRIMESTER, FETUS 4
O41.03X5	OLIGOHYDRAMNIOS, THIRD TRIMESTER, FETUS 5	OLIGOHYDRAMNIOS, THIRD TRIMESTER, FETUS 5
O41.03X9	OLIGOHYDRAMNIOS, THIRD TRIMESTER, OTHER FETUS	OLIGOHYDRAMNIOS, THIRD TRIMESTER, OTHER FETUS
O42.00	PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR WITHIN 24 HOURS OF RUPTURE, UNSPECIFIED WEEKS OF GESTATION	PREM ROM, ONSET LABOR W/N 24 HR OF RUPT, UNSP WEEKS OF GEST
O42.011	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR WITHIN 24 HOURS OF RUPTURE, FIRST TRIMESTER	PRETRM PREM ROM, ONSET LABOR W/N 24 HOURS OF RUPT, FIRST TRI
O42.012	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR WITHIN 24 HOURS OF RUPTURE, SECOND TRIMESTER	PRETRM PREM ROM, ONSET LABOR W/N 24 HOURS OF RUPT, 2ND TRI
O42.013	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR WITHIN 24 HOURS OF RUPTURE, THIRD TRIMESTER	PRETRM PREM ROM, ONSET LABOR W/N 24 HOURS OF RUPT, THIRD TRI
O42.019	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR WITHIN 24 HOURS OF RUPTURE, UNSPECIFIED TRIMESTER	PRETRM PREM ROM, ONSET LABOR W/N 24 HOURS OF RUPT, UNSP TRI
O42.02	FULL-TERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR WITHIN 24 HOURS OF RUPTURE	FULL-TERM PREM ROM, ONSET LABOR WITHIN 24 HOURS OF RUPTURE
O42.10	PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE, UNSPECIFIED WEEKS OF GESTATION	PREM ROM, ONSET LABOR > 24 HR FOL RUPT, UNSP WEEKS OF GEST
O42.111	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE, FIRST TRIMESTER	PRETRM PREM ROM, ONSET LABOR > 24 HOURS FOL RUPT, FIRST TRI

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O42.112	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE, SECOND TRIMESTER	PRETRM PREM ROM, ONSET LABOR > 24 HOURS FOL RUPT, SECOND TRI
O42.113	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE, THIRD TRIMESTER	PRETRM PREM ROM, ONSET LABOR > 24 HOURS FOL RUPT, THIRD TRI
O42.119	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE, UNSPECIFIED TRIMESTER	PRETRM PREM ROM, ONSET LABOR > 24 HOURS FOL RUPT, UNSP TRI
O42.12	FULL-TERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE	FULL-TERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE
O42.90	PREMATURE RUPTURE OF MEMBRANES, UNSPECIFIED AS TO LENGTH OF TIME BETWEEN RUPTURE AND ONSET OF LABOR, UNSPECIFIED WEEKS OF GESTATION	PREM ROM, UNSP AS TO LENGTH OF TIME, BETW RUPT & ONST LABR, UNSP WEEKS OF GEST
O42.911	PRETERM PREMATURE RUPTURE OF MEMBRANES, UNSPECIFIED AS TO LENGTH OF TIME BETWEEN RUPTURE AND ONSET OF LABOR, FIRST TRIMESTER	PRETRM PREM ROM, UNSP TIME BETW RUPT AND ONSET LABR, 1ST TRI
O42.912	PRETERM PREMATURE RUPTURE OF MEMBRANES, UNSPECIFIED AS TO LENGTH OF TIME BETWEEN RUPTURE AND ONSET OF LABOR, SECOND TRIMESTER	PRETRM PREM ROM, UNSP TIME BETW RUPT AND ONSET LABR, 2ND TRI
O42.913	PRETERM PREMATURE RUPTURE OF MEMBRANES, UNSPECIFIED AS TO LENGTH OF TIME BETWEEN RUPTURE AND ONSET OF LABOR, THIRD TRIMESTER	PRETRM PREM ROM, UNSP TIME BETW RUPT AND ONST LABR, 3RD TRI
O42.919	PRETERM PREMATURE RUPTURE OF MEMBRANES, UNSPECIFIED AS TO LENGTH OF TIME BETWEEN RUPTURE AND ONSET OF LABOR, UNSPECIFIED TRIMESTER	PRETRM PREM ROM, UNSP TIME BETW RUPT AND ONST LABR, UNSP TRI
O42.92	FULL-TERM PREMATURE RUPTURE OF MEMBRANES, UNSPECIFIED AS TO LENGTH OF TIME BETWEEN RUPTURE AND ONSET OF LABOR	FULL-TERM PREM ROM, UNSP TIME BETW RUPTURE AND ONSET LABOR
O43.011	FETOMATERNAL PLACENTAL TRANSFUSION SYNDROME, FIRST TRIMESTER	FETOMATERNAL PLACENTAL TRANSFUSION SYNDROME, FIRST TRIMESTER
O43.012	FETOMATERNAL PLACENTAL TRANSFUSION SYNDROME, SECOND TRIMESTER	FETOMATERNAL PLACENTAL TRANSFUSE SYNDROME, SECOND TRIMESTER
O43.013	FETOMATERNAL PLACENTAL TRANSFUSION SYNDROME, THIRD TRIMESTER	FETOMATERNAL PLACENTAL TRANSFUSION SYNDROME, THIRD

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		TRIMESTER
O43.019	FETOMATERNAL PLACENTAL TRANSFUSION SYNDROME, UNSPECIFIED TRIMESTER	FETOMATERNAL PLACENTAL TRANSFUSION SYNDROME, UNSP TRIMESTER
O44.00	COMPLETE PLACENTA PREVIA NOS OR WITHOUT HEMORRHAGE, UNSPECIFIED TRIMESTER	COMPLETE PLACENTA PREVIA NOS OR WITHOUT HEMOR, UNSP TRI
O44.01	COMPLETE PLACENTA PREVIA NOS OR WITHOUT HEMORRHAGE, FIRST TRIMESTER	COMPLETE PLACENTA PREVIA NOS OR WITHOUT HEMOR, FIRST TRI
O44.02	COMPLETE PLACENTA PREVIA NOS OR WITHOUT HEMORRHAGE, SECOND TRIMESTER	COMPLETE PLACENTA PREVIA NOS OR WITHOUT HEMOR, SECOND TRI
O44.03	COMPLETE PLACENTA PREVIA NOS OR WITHOUT HEMORRHAGE, THIRD TRIMESTER	COMPLETE PLACENTA PREVIA NOS OR WITHOUT HEMOR, THIRD TRI
O44.10	COMPLETE PLACENTA PREVIA WITH HEMORRHAGE, UNSPECIFIED TRIMESTER	COMPLETE PLACENTA PREVIA WITH HEMORRHAGE, UNSP TRIMESTER
O44.11	COMPLETE PLACENTA PREVIA WITH HEMORRHAGE, FIRST TRIMESTER	COMPLETE PLACENTA PREVIA WITH HEMORRHAGE, FIRST TRIMESTER
O44.12	COMPLETE PLACENTA PREVIA WITH HEMORRHAGE, SECOND TRIMESTER	COMPLETE PLACENTA PREVIA WITH HEMORRHAGE, SECOND TRIMESTER
O44.13	COMPLETE PLACENTA PREVIA WITH HEMORRHAGE, THIRD TRIMESTER	COMPLETE PLACENTA PREVIA WITH HEMORRHAGE, THIRD TRIMESTER
O44.20	PARTIAL PLACENTA PREVIA NOS OR WITHOUT HEMORRHAGE, UNSPECIFIED TRIMESTER	PARTIAL PLACENTA PREVIA NOS OR WITHOUT HEMOR, UNSP TRIMESTER
O44.21	PARTIAL PLACENTA PREVIA NOS OR WITHOUT HEMORRHAGE, FIRST TRIMESTER	PARTIAL PLACENTA PREVIA NOS OR WITHOUT HEMOR, FIRST TRI
O44.22	PARTIAL PLACENTA PREVIA NOS OR WITHOUT HEMORRHAGE, SECOND TRIMESTER	PARTIAL PLACENTA PREVIA NOS OR WITHOUT HEMOR, SECOND TRI
O44.23	PARTIAL PLACENTA PREVIA NOS OR WITHOUT HEMORRHAGE, THIRD TRIMESTER	PARTIAL PLACENTA PREVIA NOS OR WITHOUT HEMOR, THIRD TRI
O44.30	PARTIAL PLACENTA PREVIA WITH HEMORRHAGE, UNSPECIFIED TRIMESTER	PARTIAL PLACENTA PREVIA WITH HEMORRHAGE, UNSP TRIMESTER
O44.31	PARTIAL PLACENTA PREVIA WITH HEMORRHAGE, FIRST TRIMESTER	PARTIAL PLACENTA PREVIA WITH HEMORRHAGE, FIRST TRIMESTER
O44.32	PARTIAL PLACENTA PREVIA WITH HEMORRHAGE, SECOND TRIMESTER	PARTIAL PLACENTA PREVIA WITH HEMORRHAGE, SECOND TRIMESTER
O44.33	PARTIAL PLACENTA PREVIA WITH HEMORRHAGE, THIRD TRIMESTER	PARTIAL PLACENTA PREVIA WITH HEMORRHAGE, THIRD TRIMESTER
O45.001	PREMATURE SEPARATION OF PLACENTA WITH COAGULATION DEFECT, UNSPECIFIED, FIRST TRIMESTER	PREM SEPARTN OF PLACENTA W COAG DEFECT, UNSP, FIRST TRI
O45.002	PREMATURE SEPARATION OF PLACENTA WITH COAGULATION DEFECT, UNSPECIFIED, SECOND TRIMESTER	PREM SEPARTN OF PLACENTA W COAG DEFECT, UNSP, SECOND TRI

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O45.003	PREMATURE SEPARATION OF PLACENTA WITH COAGULATION DEFECT, UNSPECIFIED, THIRD TRIMESTER	PREM SEPARTN OF PLACENTA W COAG DEFECT, UNSP, THIRD TRI
O45.009	PREMATURE SEPARATION OF PLACENTA WITH COAGULATION DEFECT, UNSPECIFIED, UNSPECIFIED TRIMESTER	PREM SEPARTN OF PLACENTA W COAG DEFECT, UNSP, UNSP TRIMESTER
O45.011	PREMATURE SEPARATION OF PLACENTA WITH AFIBRINOGENEMIA, FIRST TRIMESTER	PREM SEPARTN OF PLACENTA W AFIBRINOGENEMIA, FIRST TRIMESTER
O45.012	PREMATURE SEPARATION OF PLACENTA WITH AFIBRINOGENEMIA, SECOND TRIMESTER	PREM SEPARTN OF PLACENTA W AFIBRINOGENEMIA, SECOND TRIMESTER
O45.013	PREMATURE SEPARATION OF PLACENTA WITH AFIBRINOGENEMIA, THIRD TRIMESTER	PREM SEPARTN OF PLACENTA W AFIBRINOGENEMIA, THIRD TRIMESTER
O45.019	PREMATURE SEPARATION OF PLACENTA WITH AFIBRINOGENEMIA, UNSPECIFIED TRIMESTER	PREM SEPARTN OF PLACENTA W AFIBRINOGENEMIA, UNSP TRIMESTER
O45.021	PREMATURE SEPARATION OF PLACENTA WITH DISSEMINATED INTRAVASCULAR COAGULATION, FIRST TRIMESTER	PREM SEPARTN OF PLACENTA W DISSEM INTRAVASC COAG, FIRST TRI
O45.022	PREMATURE SEPARATION OF PLACENTA WITH DISSEMINATED INTRAVASCULAR COAGULATION, SECOND TRIMESTER	PREM SEPARTN OF PLACENTA W DISSEM INTRAVASC COAG, SECOND TRI
O45.023	PREMATURE SEPARATION OF PLACENTA WITH DISSEMINATED INTRAVASCULAR COAGULATION, THIRD TRIMESTER	PREM SEPARTN OF PLACENTA W DISSEM INTRAVASC COAG, THIRD TRI
O45.029	PREMATURE SEPARATION OF PLACENTA WITH DISSEMINATED INTRAVASCULAR COAGULATION, UNSPECIFIED TRIMESTER	PREM SEPARTN OF PLACENTA W DISSEM INTRAVASC COAG, UNSP TRI
O45.091	PREMATURE SEPARATION OF PLACENTA WITH OTHER COAGULATION DEFECT, FIRST TRIMESTER	PREM SEPARTN OF PLACENTA W OTH COAG DEFECT, FIRST TRIMESTER
O45.092	PREMATURE SEPARATION OF PLACENTA WITH OTHER COAGULATION DEFECT, SECOND TRIMESTER	PREM SEPARTN OF PLACENTA W OTH COAG DEFECT, SECOND TRIMESTER
O45.093	PREMATURE SEPARATION OF PLACENTA WITH OTHER COAGULATION DEFECT, THIRD TRIMESTER	PREM SEPARTN OF PLACENTA W OTH COAG DEFECT, THIRD TRIMESTER
O45.099	PREMATURE SEPARATION OF PLACENTA WITH OTHER COAGULATION DEFECT, UNSPECIFIED TRIMESTER	PREM SEPARTN OF PLACENTA W OTH COAG DEFECT, UNSP TRIMESTER
O45.8X1	OTHER PREMATURE SEPARATION OF PLACENTA, FIRST TRIMESTER	OTHER PREMATURE SEPARATION OF PLACENTA, FIRST TRIMESTER
O45.8X2	OTHER PREMATURE SEPARATION OF PLACENTA, SECOND TRIMESTER	OTHER PREMATURE SEPARATION OF PLACENTA, SECOND TRIMESTER

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O45.8X3	OTHER PREMATURE SEPARATION OF PLACENTA, THIRD TRIMESTER	OTHER PREMATURE SEPARATION OF PLACENTA, THIRD TRIMESTER
O45.8X9	OTHER PREMATURE SEPARATION OF PLACENTA, UNSPECIFIED TRIMESTER	OTHER PREMATURE SEPARATION OF PLACENTA, UNSP TRIMESTER
O45.90	PREMATURE SEPARATION OF PLACENTA, UNSPECIFIED, UNSPECIFIED TRIMESTER	PREMATURE SEPARATION OF PLACENTA, UNSP, UNSP TRIMESTER
O45.91	PREMATURE SEPARATION OF PLACENTA, UNSPECIFIED, FIRST TRIMESTER	PREMATURE SEPARATION OF PLACENTA, UNSP, FIRST TRIMESTER
O45.92	PREMATURE SEPARATION OF PLACENTA, UNSPECIFIED, SECOND TRIMESTER	PREMATURE SEPARATION OF PLACENTA, UNSP, SECOND TRIMESTER
O45.93	PREMATURE SEPARATION OF PLACENTA, UNSPECIFIED, THIRD TRIMESTER	PREMATURE SEPARATION OF PLACENTA, UNSP, THIRD TRIMESTER
O46.001	ANTEPARTUM HEMORRHAGE WITH COAGULATION DEFECT, UNSPECIFIED, FIRST TRIMESTER	ANTEPARTUM HEMORRHAGE W COAG DEFECT, UNSP, FIRST TRIMESTER
O46.002	ANTEPARTUM HEMORRHAGE WITH COAGULATION DEFECT, UNSPECIFIED, SECOND TRIMESTER	ANTEPARTUM HEMORRHAGE W COAG DEFECT, UNSP, SECOND TRIMESTER
O46.003	ANTEPARTUM HEMORRHAGE WITH COAGULATION DEFECT, UNSPECIFIED, THIRD TRIMESTER	ANTEPARTUM HEMORRHAGE W COAG DEFECT, UNSP, THIRD TRIMESTER
O46.009	ANTEPARTUM HEMORRHAGE WITH COAGULATION DEFECT, UNSPECIFIED, UNSPECIFIED TRIMESTER	ANTEPARTUM HEMORRHAGE W COAG DEFECT, UNSP, UNSP TRIMESTER
O46.011	ANTEPARTUM HEMORRHAGE WITH AFIBRINOGENEMIA, FIRST TRIMESTER	ANTEPARTUM HEMORRHAGE WITH AFIBRINOGENEMIA, FIRST TRIMESTER
O46.012	ANTEPARTUM HEMORRHAGE WITH AFIBRINOGENEMIA, SECOND TRIMESTER	ANTEPARTUM HEMORRHAGE WITH AFIBRINOGENEMIA, SECOND TRIMESTER
O46.013	ANTEPARTUM HEMORRHAGE WITH AFIBRINOGENEMIA, THIRD TRIMESTER	ANTEPARTUM HEMORRHAGE WITH AFIBRINOGENEMIA, THIRD TRIMESTER
O46.019	ANTEPARTUM HEMORRHAGE WITH AFIBRINOGENEMIA, UNSPECIFIED TRIMESTER	ANTEPARTUM HEMORRHAGE WITH AFIBRINOGENEMIA, UNSP TRIMESTER
O46.021	ANTEPARTUM HEMORRHAGE WITH DISSEMINATED INTRAVASCULAR COAGULATION, FIRST TRIMESTER	ANTEPART HEMORRHAGE W DISSEM INTRAVASC COAG, FIRST TRIMESTER
O46.022	ANTEPARTUM HEMORRHAGE WITH DISSEMINATED INTRAVASCULAR COAGULATION, SECOND TRIMESTER	ANTEPART HEMOR W DISSEM INTRAVASC COAG, SECOND TRIMESTER
O46.023	ANTEPARTUM HEMORRHAGE WITH DISSEMINATED INTRAVASCULAR COAGULATION, THIRD TRIMESTER	ANTEPART HEMORRHAGE W DISSEM INTRAVASC COAG, THIRD TRIMESTER

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O46.029	ANTEPARTUM HEMORRHAGE WITH DISSEMINATED INTRAVASCULAR COAGULATION, UNSPECIFIED TRIMESTER	ANTEPART HEMORRHAGE W DISSEM INTRAVASC COAG, UNSP TRIMESTER
O46.091	ANTEPARTUM HEMORRHAGE WITH OTHER COAGULATION DEFECT, FIRST TRIMESTER	ANTEPARTUM HEMORRHAGE W OTH COAG DEFECT, FIRST TRIMESTER
O46.092	ANTEPARTUM HEMORRHAGE WITH OTHER COAGULATION DEFECT, SECOND TRIMESTER	ANTEPARTUM HEMORRHAGE W OTH COAG DEFECT, SECOND TRIMESTER
O46.093	ANTEPARTUM HEMORRHAGE WITH OTHER COAGULATION DEFECT, THIRD TRIMESTER	ANTEPARTUM HEMORRHAGE W OTH COAG DEFECT, THIRD TRIMESTER
O46.099	ANTEPARTUM HEMORRHAGE WITH OTHER COAGULATION DEFECT, UNSPECIFIED TRIMESTER	ANTEPARTUM HEMORRHAGE W OTH COAG DEFECT, UNSP TRIMESTER
O46.8X1	OTHER ANTEPARTUM HEMORRHAGE, FIRST TRIMESTER	OTHER ANTEPARTUM HEMORRHAGE, FIRST TRIMESTER
O46.8X2	OTHER ANTEPARTUM HEMORRHAGE, SECOND TRIMESTER	OTHER ANTEPARTUM HEMORRHAGE, SECOND TRIMESTER
O46.8X3	OTHER ANTEPARTUM HEMORRHAGE, THIRD TRIMESTER	OTHER ANTEPARTUM HEMORRHAGE, THIRD TRIMESTER
O46.8X9	OTHER ANTEPARTUM HEMORRHAGE, UNSPECIFIED TRIMESTER	OTHER ANTEPARTUM HEMORRHAGE, UNSPECIFIED TRIMESTER
O46.90	ANTEPARTUM HEMORRHAGE, UNSPECIFIED, UNSPECIFIED TRIMESTER	ANTEPARTUM HEMORRHAGE, UNSPECIFIED, UNSPECIFIED TRIMESTER
O46.91	ANTEPARTUM HEMORRHAGE, UNSPECIFIED, FIRST TRIMESTER	ANTEPARTUM HEMORRHAGE, UNSPECIFIED, FIRST TRIMESTER
O46.92	ANTEPARTUM HEMORRHAGE, UNSPECIFIED, SECOND TRIMESTER	ANTEPARTUM HEMORRHAGE, UNSPECIFIED, SECOND TRIMESTER
O46.93	ANTEPARTUM HEMORRHAGE, UNSPECIFIED, THIRD TRIMESTER	ANTEPARTUM HEMORRHAGE, UNSPECIFIED, THIRD TRIMESTER
O48.0	POST-TERM PREGNANCY	POST-TERM PREGNANCY
O48.1	PROLONGED PREGNANCY	PROLONGED PREGNANCY
O66.6	OBSTRUCTED LABOR DUE TO OTHER MULTIPLE FETUSES	OBSTRUCTED LABOR DUE TO OTHER MULTIPLE FETUSES
O67.0	INTRAPARTUM HEMORRHAGE WITH COAGULATION DEFECT	INTRAPARTUM HEMORRHAGE WITH COAGULATION DEFECT
O67.8	OTHER INTRAPARTUM HEMORRHAGE	OTHER INTRAPARTUM HEMORRHAGE
O67.9	INTRAPARTUM HEMORRHAGE, UNSPECIFIED	INTRAPARTUM HEMORRHAGE, UNSPECIFIED
O68	LABOR AND DELIVERY COMPLICATED BY ABNORMALITY OF FETAL ACID-BASE BALANCE	LABOR AND DELIVERY COMP BY ABNLT OF FETAL ACID-BASE BALANCE

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O69.0XX0	LABOR AND DELIVERY COMPLICATED BY PROLAPSE OF CORD, NOT APPLICABLE OR UNSPECIFIED	LABOR AND DELIVERY COMPLICATED BY PROLAPSE OF CORD, UNSP
O69.0XX1	LABOR AND DELIVERY COMPLICATED BY PROLAPSE OF CORD, FETUS 1	LABOR AND DELIVERY COMPLICATED BY PROLAPSE OF CORD, FETUS 1
O69.0XX2	LABOR AND DELIVERY COMPLICATED BY PROLAPSE OF CORD, FETUS 2	LABOR AND DELIVERY COMPLICATED BY PROLAPSE OF CORD, FETUS 2
O69.0XX3	LABOR AND DELIVERY COMPLICATED BY PROLAPSE OF CORD, FETUS 3	LABOR AND DELIVERY COMPLICATED BY PROLAPSE OF CORD, FETUS 3
O69.0XX4	LABOR AND DELIVERY COMPLICATED BY PROLAPSE OF CORD, FETUS 4	LABOR AND DELIVERY COMPLICATED BY PROLAPSE OF CORD, FETUS 4
O69.0XX5	LABOR AND DELIVERY COMPLICATED BY PROLAPSE OF CORD, FETUS 5	LABOR AND DELIVERY COMPLICATED BY PROLAPSE OF CORD, FETUS 5
O69.0XX9	LABOR AND DELIVERY COMPLICATED BY PROLAPSE OF CORD, OTHER FETUS	LABOR AND DELIVERY COMPLICATED BY PROLAPSE OF CORD, OTH
O69.1XX0	LABOR AND DELIVERY COMPLICATED BY CORD AROUND NECK, WITH COMPRESSION, NOT APPLICABLE OR UNSPECIFIED	LABOR AND DELIVERY COMP BY CORD AROUND NECK, W COMPRSN, UNSP
O69.1XX1	LABOR AND DELIVERY COMPLICATED BY CORD AROUND NECK, WITH COMPRESSION, FETUS 1	LABOR AND DEL COMP BY CORD AROUND NECK, W COMPRSN, FETUS 1
O69.1XX2	LABOR AND DELIVERY COMPLICATED BY CORD AROUND NECK, WITH COMPRESSION, FETUS 2	LABOR AND DEL COMP BY CORD AROUND NECK, W COMPRSN, FETUS 2
O69.1XX3	LABOR AND DELIVERY COMPLICATED BY CORD AROUND NECK, WITH COMPRESSION, FETUS 3	LABOR AND DEL COMP BY CORD AROUND NECK, W COMPRSN, FETUS 3
O69.1XX4	LABOR AND DELIVERY COMPLICATED BY CORD AROUND NECK, WITH COMPRESSION, FETUS 4	LABOR AND DEL COMP BY CORD AROUND NECK, W COMPRSN, FETUS 4
O69.1XX5	LABOR AND DELIVERY COMPLICATED BY CORD AROUND NECK, WITH COMPRESSION, FETUS 5	LABOR AND DEL COMP BY CORD AROUND NECK, W COMPRSN, FETUS 5
O69.1XX9	LABOR AND DELIVERY COMPLICATED BY CORD AROUND NECK, WITH COMPRESSION, OTHER FETUS	LABOR AND DELIVERY COMP BY CORD AROUND NECK, W COMPRSN, OTH
O69.2XX0	LABOR AND DELIVERY COMPLICATED BY OTHER CORD ENTANGLEMENT, WITH COMPRESSION, NOT APPLICABLE OR UNSPECIFIED	LABOR AND DEL COMP BY OTH CORD ENTANGLE, W COMPRSN, UNSP
O69.2XX1	LABOR AND DELIVERY COMPLICATED BY OTHER CORD ENTANGLEMENT, WITH COMPRESSION, FETUS 1	LABOR AND DEL COMP BY OTH CORD ENTANGLE, W COMPRSN, FETUS 1
O69.2XX2	LABOR AND DELIVERY COMPLICATED BY OTHER CORD ENTANGLEMENT, WITH COMPRESSION, FETUS 2	LABOR AND DEL COMP BY OTH CORD ENTANGLE, W COMPRSN, FETUS 2

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O69.2XX3	LABOR AND DELIVERY COMPLICATED BY OTHER CORD ENTANGLEMENT, WITH COMPRESSION, FETUS 3	LABOR AND DEL COMP BY OTH CORD ENTANGLE, W COMPRSN, FETUS 3
O69.2XX4	LABOR AND DELIVERY COMPLICATED BY OTHER CORD ENTANGLEMENT, WITH COMPRESSION, FETUS 4	LABOR AND DEL COMP BY OTH CORD ENTANGLE, W COMPRSN, FETUS 4
O69.2XX5	LABOR AND DELIVERY COMPLICATED BY OTHER CORD ENTANGLEMENT, WITH COMPRESSION, FETUS 5	LABOR AND DEL COMP BY OTH CORD ENTANGLE, W COMPRSN, FETUS 5
O69.2XX9	LABOR AND DELIVERY COMPLICATED BY OTHER CORD ENTANGLEMENT, WITH COMPRESSION, OTHER FETUS	LABOR AND DELIVERY COMP BY OTH CORD ENTANGLE, W COMPRSN, OTH
O69.3XX0	LABOR AND DELIVERY COMPLICATED BY SHORT CORD, NOT APPLICABLE OR UNSPECIFIED	LABOR AND DELIVERY COMPLICATED BY SHORT CORD, UNSP
O69.3XX1	LABOR AND DELIVERY COMPLICATED BY SHORT CORD, FETUS 1	LABOR AND DELIVERY COMPLICATED BY SHORT CORD, FETUS 1
O69.3XX2	LABOR AND DELIVERY COMPLICATED BY SHORT CORD, FETUS 2	LABOR AND DELIVERY COMPLICATED BY SHORT CORD, FETUS 2
O69.3XX3	LABOR AND DELIVERY COMPLICATED BY SHORT CORD, FETUS 3	LABOR AND DELIVERY COMPLICATED BY SHORT CORD, FETUS 3
O69.3XX4	LABOR AND DELIVERY COMPLICATED BY SHORT CORD, FETUS 4	LABOR AND DELIVERY COMPLICATED BY SHORT CORD, FETUS 4
O69.3XX5	LABOR AND DELIVERY COMPLICATED BY SHORT CORD, FETUS 5	LABOR AND DELIVERY COMPLICATED BY SHORT CORD, FETUS 5
O69.3XX9	LABOR AND DELIVERY COMPLICATED BY SHORT CORD, OTHER FETUS	LABOR AND DELIVERY COMPLICATED BY SHORT CORD, OTHER FETUS
O69.81X0	LABOR AND DELIVERY COMPLICATED BY CORD AROUND NECK, WITHOUT COMPRESSION, NOT APPLICABLE OR UNSPECIFIED	LABOR AND DEL COMP BY CORD AROUND NECK, W/O COMPRSN, UNSP
O69.81X1	LABOR AND DELIVERY COMPLICATED BY CORD AROUND NECK, WITHOUT COMPRESSION, FETUS 1	LABOR AND DEL COMP BY CORD AROUND NECK, W/O COMPRSN, FETUS 1
O69.81X2	LABOR AND DELIVERY COMPLICATED BY CORD AROUND NECK, WITHOUT COMPRESSION, FETUS 2	LABOR AND DEL COMP BY CORD AROUND NECK, W/O COMPRSN, FETUS 2
O69.81X3	LABOR AND DELIVERY COMPLICATED BY CORD AROUND NECK, WITHOUT COMPRESSION, FETUS 3	LABOR AND DEL COMP BY CORD AROUND NECK, W/O COMPRSN, FETUS 3
O69.81X4	LABOR AND DELIVERY COMPLICATED BY CORD AROUND NECK, WITHOUT COMPRESSION, FETUS 4	LABOR AND DEL COMP BY CORD AROUND NECK, W/O COMPRSN, FETUS 4
O69.81X5	LABOR AND DELIVERY COMPLICATED BY CORD AROUND NECK, WITHOUT COMPRESSION, FETUS 5	LABOR AND DEL COMP BY CORD AROUND NECK, W/O COMPRSN, FETUS 5

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O69.81X9	LABOR AND DELIVERY COMPLICATED BY CORD AROUND NECK, WITHOUT COMPRESSION, OTHER FETUS	LABOR AND DEL COMP BY CORD AROUND NECK, W/O COMPRSN, OTH
O69.82X0	LABOR AND DELIVERY COMPLICATED BY OTHER CORD ENTANGLEMENT, WITHOUT COMPRESSION, NOT APPLICABLE OR UNSPECIFIED	LABOR AND DEL COMP BY OTH CORD ENTANGLE, W/O COMPRSN, UNSP
O69.82X1	LABOR AND DELIVERY COMPLICATED BY OTHER CORD ENTANGLEMENT, WITHOUT COMPRESSION, FETUS 1	LABOR AND DEL COMP BY OTH CORD ENTANGLE, W/O COMPRSN, FTS1
O69.82X2	LABOR AND DELIVERY COMPLICATED BY OTHER CORD ENTANGLEMENT, WITHOUT COMPRESSION, FETUS 2	LABOR AND DEL COMP BY OTH CORD ENTANGLE, W/O COMPRSN, FTS2
O69.82X3	LABOR AND DELIVERY COMPLICATED BY OTHER CORD ENTANGLEMENT, WITHOUT COMPRESSION, FETUS 3	LABOR AND DEL COMP BY OTH CORD ENTANGLE, W/O COMPRSN, FTS3
O69.82X4	LABOR AND DELIVERY COMPLICATED BY OTHER CORD ENTANGLEMENT, WITHOUT COMPRESSION, FETUS 4	LABOR AND DEL COMP BY OTH CORD ENTANGLE, W/O COMPRSN, FTS4
O69.82X5	LABOR AND DELIVERY COMPLICATED BY OTHER CORD ENTANGLEMENT, WITHOUT COMPRESSION, FETUS 5	LABOR AND DEL COMP BY OTH CORD ENTANGLE, W/O COMPRSN, FTS5
O69.82X9	LABOR AND DELIVERY COMPLICATED BY OTHER CORD ENTANGLEMENT, WITHOUT COMPRESSION, OTHER FETUS	LABOR AND DEL COMP BY OTH CORD ENTANGLE, W/O COMPRSN, OTH
O69.89X0	LABOR AND DELIVERY COMPLICATED BY OTHER CORD COMPLICATIONS, NOT APPLICABLE OR UNSPECIFIED	LABOR AND DELIVERY COMPLICATED BY OTH CORD COMP, UNSP
O69.89X1	LABOR AND DELIVERY COMPLICATED BY OTHER CORD COMPLICATIONS, FETUS 1	LABOR AND DELIVERY COMPLICATED BY OTH CORD COMP, FETUS 1
O69.89X2	LABOR AND DELIVERY COMPLICATED BY OTHER CORD COMPLICATIONS, FETUS 2	LABOR AND DELIVERY COMPLICATED BY OTH CORD COMP, FETUS 2
O69.89X3	LABOR AND DELIVERY COMPLICATED BY OTHER CORD COMPLICATIONS, FETUS 3	LABOR AND DELIVERY COMPLICATED BY OTH CORD COMP, FETUS 3
O69.89X4	LABOR AND DELIVERY COMPLICATED BY OTHER CORD COMPLICATIONS, FETUS 4	LABOR AND DELIVERY COMPLICATED BY OTH CORD COMP, FETUS 4
O69.89X5	LABOR AND DELIVERY COMPLICATED BY OTHER CORD COMPLICATIONS, FETUS 5	LABOR AND DELIVERY COMPLICATED BY OTH CORD COMP, FETUS 5
O69.89X9	LABOR AND DELIVERY COMPLICATED BY OTHER CORD COMPLICATIONS, OTHER FETUS	LABOR AND DELIVERY COMPLICATED BY OTH CORD COMP, OTH
O69.9XX0	LABOR AND DELIVERY COMPLICATED BY CORD COMPLICATION, UNSPECIFIED, NOT APPLICABLE OR UNSPECIFIED	LABOR AND DELIVERY COMPLICATED BY CORD COMP, UNSP, UNSP
O69.9XX1	LABOR AND DELIVERY COMPLICATED BY CORD COMPLICATION, UNSPECIFIED, FETUS 1	LABOR AND DELIVERY COMPLICATED BY CORD COMP, UNSP, FETUS 1

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O69.9XX2	LABOR AND DELIVERY COMPLICATED BY CORD COMPLICATION, UNSPECIFIED, FETUS 2	LABOR AND DELIVERY COMPLICATED BY CORD COMP, UNSP, FETUS 2
O69.9XX3	LABOR AND DELIVERY COMPLICATED BY CORD COMPLICATION, UNSPECIFIED, FETUS 3	LABOR AND DELIVERY COMPLICATED BY CORD COMP, UNSP, FETUS 3
O69.9XX4	LABOR AND DELIVERY COMPLICATED BY CORD COMPLICATION, UNSPECIFIED, FETUS 4	LABOR AND DELIVERY COMPLICATED BY CORD COMP, UNSP, FETUS 4
O69.9XX5	LABOR AND DELIVERY COMPLICATED BY CORD COMPLICATION, UNSPECIFIED, FETUS 5	LABOR AND DELIVERY COMPLICATED BY CORD COMP, UNSP, FETUS 5
O69.9XX9	LABOR AND DELIVERY COMPLICATED BY CORD COMPLICATION, UNSPECIFIED, OTHER FETUS	LABOR AND DELIVERY COMPLICATED BY CORD COMP, UNSP, OTH
O76	ABNORMALITY IN FETAL HEART RATE AND RHYTHM COMPLICATING LABOR AND DELIVERY	ABNLT IN FETAL HEART RATE AND RHYTHM COMP LABOR AND DELIVERY
O77.0	LABOR AND DELIVERY COMPLICATED BY MECONIUM IN AMNIOTIC FLUID	LABOR AND DELIVERY COMPLICATED BY MECONIUM IN AMNIOTIC FLUID
O77.1	FETAL STRESS IN LABOR OR DELIVERY DUE TO DRUG ADMINISTRATION	FETAL STRESS IN LABOR OR DELIVERY DUE TO DRUG ADMINISTRATION
O77.8	LABOR AND DELIVERY COMPLICATED BY OTHER EVIDENCE OF FETAL STRESS	LABOR AND DELIVERY COMP BY OTH EVIDENCE OF FETAL STRESS
O77.9	LABOR AND DELIVERY COMPLICATED BY FETAL STRESS, UNSPECIFIED	LABOR AND DELIVERY COMPLICATED BY FETAL STRESS, UNSPECIFIED
O99.111	OTHER DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS AND CERTAIN DISORDERS INVOLVING THE IMMUNE MECHANISM COMPLICATING PREGNANCY, FIRST TRIMESTER	OTH DIS OF BLD/BLD-FORM ORG/IMMUN MECHNSM COMP PREG, 1ST TRI
O99.112	OTHER DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS AND CERTAIN DISORDERS INVOLVING THE IMMUNE MECHANISM COMPLICATING PREGNANCY, SECOND TRIMESTER	OTH DIS OF BLD/BLD-FORM ORG/IMMUN MECHNSM COMP PREG, 2ND TRI
O99.113	OTHER DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS AND CERTAIN DISORDERS INVOLVING THE IMMUNE MECHANISM COMPLICATING PREGNANCY, THIRD TRIMESTER	OTH DIS OF BLD/BLD-FORM ORG/IMMUN MECHNSM COMP PREG, 3RD TRI
O99.119	OTHER DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS AND CERTAIN DISORDERS INVOLVING THE IMMUNE MECHANISM COMPLICATING PREGNANCY, UNSPECIFIED TRIMESTER	OTH DIS OF BLD/BLD-FORM ORG/IMMUN MECHNSM COMP PREG,UNSP TRI
O99.12	OTHER DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS AND CERTAIN DISORDERS INVOLVING THE IMMUNE MECHANISM COMPLICATING CHILDBIRTH	OTH DIS OF THE BLD/BLD-FORM ORG/IMMUN MECHNSM COMP CHLDBRTH

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O99.13	OTHER DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS AND CERTAIN DISORDERS INVOLVING THE IMMUNE MECHANISM COMPLICATING THE PUERPERIUM	OTH DIS OF THE BLD/BLD-FORM ORG/IMMUN MECHNSM COMP THE PUERP
O99.411	DISEASES OF THE CIRCULATORY SYSTEM COMPLICATING PREGNANCY, FIRST TRIMESTER	DISEASES OF THE CIRC SYS COMP PREGNANCY, FIRST TRIMESTER
O99.412	DISEASES OF THE CIRCULATORY SYSTEM COMPLICATING PREGNANCY, SECOND TRIMESTER	DISEASES OF THE CIRC SYS COMP PREGNANCY, SECOND TRIMESTER
O99.413	DISEASES OF THE CIRCULATORY SYSTEM COMPLICATING PREGNANCY, THIRD TRIMESTER	DISEASES OF THE CIRC SYS COMP PREGNANCY, THIRD TRIMESTER
O99.419	DISEASES OF THE CIRCULATORY SYSTEM COMPLICATING PREGNANCY, UNSPECIFIED TRIMESTER	DISEASES OF THE CIRC SYS COMP PREGNANCY, UNSP TRIMESTER
O99.42	DISEASES OF THE CIRCULATORY SYSTEM COMPLICATING CHILDBIRTH	DISEASES OF THE CIRCULATORY SYSTEM COMPLICATING CHILDBIRTH
O99.43	DISEASES OF THE CIRCULATORY SYSTEM COMPLICATING THE PUERPERIUM	DISEASES OF THE CIRC SYS COMPLICATING THE PUERPERIUM
O99.810	ABNORMAL GLUCOSE COMPLICATING PREGNANCY	ABNORMAL GLUCOSE COMPLICATING PREGNANCY
O99.814	ABNORMAL GLUCOSE COMPLICATING CHILDBIRTH	ABNORMAL GLUCOSE COMPLICATING CHILDBIRTH
O99.815	ABNORMAL GLUCOSE COMPLICATING THE PUERPERIUM	ABNORMAL GLUCOSE COMPLICATING THE PUERPERIUM
O99.89	OTHER SPECIFIED DISEASES AND CONDITIONS COMPLICATING PREGNANCY, CHILDBIRTH AND THE PUERPERIUM	OTHER SPECIFIED DISEASES AND CONDITIONS COMPLICATING PREGNANCY, CHILDBIRTH AND THE PUERPERIUM
Z21	ASYMPTOMATIC HUMAN IMMUNODEFICIENCY VIRUS [HIV] INFECTION STATUS	ASYMPTOMATIC HUMAN IMMUNODEFICIENCY VIRUS INFECTION STATUS
Z37.1	SINGLE STILLBIRTH	SINGLE STILLBIRTH
Z37.3	TWINS, ONE LIVEBORN AND ONE STILLBORN	TWINS, ONE LIVEBORN AND ONE STILLBORN
Z37.4	TWINS, BOTH STILLBORN	TWINS, BOTH STILLBORN
Z37.60	MULTIPLE BIRTHS, UNSPECIFIED, SOME LIVEBORN	MULTIPLE BIRTHS, UNSPECIFIED, SOME LIVEBORN
Z37.61	TRIPLETS, SOME LIVEBORN	TRIPLETS, SOME LIVEBORN
Z37.62	QUADRUPLETS, SOME LIVEBORN	QUADRUPLETS, SOME LIVEBORN

SECTION 6 BIRTH OUTCOMES INITIATIVE

BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
Z37.63	QUINTUPLETS, SOME LIVEBORN	QUINTUPLETS, SOME LIVEBORN
Z37.64	SEXTUPLETS, SOME LIVEBORN	SEXTUPLETS, SOME LIVEBORN
Z37.69	OTHER MULTIPLE BIRTHS, SOME LIVEBORN	OTHER MULTIPLE BIRTHS, SOME LIVEBORN
Z37.7	OTHER MULTIPLE BIRTHS, ALL STILLBORN	OTHER MULTIPLE BIRTHS, ALL STILLBORN

October 2015 Update

For dates of service on or after **October 1, 2015**, please use the following ICD-10-CM diagnosis codes. For dates of service on or after October 1, 2016, refer to the October 2016 Update included in this section.

Excluded populations: For dates of service on or after October 1, 2015, the following ICD-10-CM principal diagnosis codes or ICD-10-CM other diagnosis codes for conditions possibly justifying elective delivery prior to 39 weeks gestation are excluded.

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
10900ZC	DRAINAGE OF AMNIOTIC FLUID, THERAPEUTIC FROM PRODUCTS OF CONCEPTION, OPEN APPROACH	DRAINAGE OF AMNIOTIC FL, THERAP FROM POC, OPEN APPROACH
10903ZC	DRAINAGE OF AMNIOTIC FLUID, THERAPEUTIC FROM PRODUCTS OF CONCEPTION, PERCUTANEOUS APPROACH	DRAINAGE OF AMNIOTIC FL, THERAP FROM POC, PERC APPROACH
10904ZC	DRAINAGE OF AMNIOTIC FLUID, THERAPEUTIC FROM PRODUCTS OF CONCEPTION, PERCUTANEOUS ENDOSCOPIC APPROACH	DRAINAGE OF AMNIOTIC FL, THERAP FROM POC, PERC ENDO APPROACH
10907ZC	DRAINAGE OF AMNIOTIC FLUID, THERAPEUTIC FROM PRODUCTS OF CONCEPTION, VIA NATURAL OR ARTIFICIAL OPENING	DRAINAGE OF AMNIOTIC FL, THERAPEUTIC FROM POC, VIA NATURAL OR ARTIFICIAL OPENING
10908ZC	DRAINAGE OF AMNIOTIC FLUID, THERAPEUTIC FROM PRODUCTS OF CONCEPTION, VIA NATURAL OR ARTIFICIAL OPENING ENDOSCOPIC	DRAINAGE OF AMNIOTIC FL, THERAPEUTIC FROM POC, VIA NATURAL OR ARTIFICIAL OPENING ENDOSCOPIC
0U7C7ZZ	DILATION OF CERVIX, VIA NATURAL OR ARTIFICIAL OPENING	DILATION OF CERVIX, VIA NATURAL OR ARTIFICIAL OPENING
10D00Z0	EXTRACTION OF PRODUCTS OF CONCEPTION, CLASSICAL, OPEN APPROACH	EXTRACTION OF POC, CLASSICAL, OPEN APPROACH
10D00Z1	EXTRACTION OF PRODUCTS OF CONCEPTION, LOW CERVICAL, OPEN APPROACH	EXTRACTION OF POC, CLASSICAL, OPEN APPROACH
10D00Z2	EXTRACTION OF PRODUCTS OF CONCEPTION, EXTRAPERITONEAL, OPEN APPROACH	EXTRACTION OF POC, EXTRAPERITONEAL, OPEN

SECTION 6 BIRTH OUTCOMES INITIATIVE

BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
		APPROACH
3E030VJ	INTRODUCTION OF OTHER HORMONE INTO PERIPHERAL VEIN, OPEN APPROACH	INTRODUCTION OF OTH HORMONE INTO PERIPH VEIN, OPEN APPROACH
3E033VJ	INTRODUCTION OF OTHER HORMONE INTO PERIPHERAL VEIN, PERCUTANEOUS APPROACH	INTRODUCTION OF OTH HORMONE INTO PERIPH VEIN, PERCUTANEOUS APPROACH
3E040VJ	INTRODUCTION OF OTHER HORMONE INTO CENTRAL VEIN, OPEN APPROACH	INTRODUCTION OF OTH HORMONE INTO CENTRAL VEIN, OPEN APPROACH
3E043VJ	INTRODUCTION OF OTHER HORMONE INTO CENTRAL VEIN, PERCUTANEOUS APPROACH	INTRODUCTION OF OTH HORMONE INTO CENTRAL VEIN, PERC APPROACH
3E050VJ	INTRODUCTION OF OTHER HORMONE INTO PERIPHERAL ARTERY, OPEN APPROACH	INTRODUCTION OF OTH HORMONE INTO PERIPH ARTERY, OPEN APPROACH
3E053VJ	INTRODUCTION OF OTHER HORMONE INTO PERIPHERAL ARTERY, PERCUTANEOUS APPROACH	INTRODUCTION OF OTHER HORMONE INTO PERIPH ART, PERC APPROACH
3E060VJ	INTRODUCTION OF OTHER HORMONE INTO CENTRAL ARTERY, OPEN APPROACH	INTRODUCTION OF OTH HORMONE INTO CENTRAL ART, OPEN APPROACH
3E063VJ	INTRODUCTION OF OTHER HORMONE INTO CENTRAL ARTERY, PERCUT APPROACH	INTRODUCTION OF OTH HORMONE INTO CENTRAL ART, PERC APPROACH
3E0DXGC	INTRODUCTION OF OTHER THERAPEUTIC SUBSTANCE INTO MOUTH AND PHARYNX, EXTERNAL APPROACH	INTRODUCE OTH THERAP SUBST IN MOUTH/PHAR, EXTERN
B20	HUMAN IMMUNODEFICIENCY VIRUS [HIV] DISEASE	HUMAN IMMUNODEFICIENCY VIRUS [HIV] DISEASE
O09.291	SUPERVISION OF PREGNANCY WITH OTHER POOR REPRODUCTIVE OR OBSTETRIC HISTORY, FIRST TRIMESTER	SUPRVSN OF PREG W POOR REPRODCTV OR OBSTET HX, FIRST TRI
O09.292	SUPERVISION OF PREGNANCY WITH OTHER POOR REPRODUCTIVE OR OBSTETRIC HISTORY, SECOND TRIMESTER	SUPRVSN OF PREG W POOR REPRODCTV OR OBSTET HX, SECOND TRI
O09.293	SUPERVISION OF PREGNANCY WITH OTHER POOR REPRODUCTIVE OR OBSTETRIC HISTORY, THIRD TRIMESTER	SUPRVSN OF PREG W POOR REPRODCTV OR OBSTET HX, THIRD TRI
O09.299	SUPERVISION OF PREGNANCY WITH OTHER POOR REPRODUCTIVE OR OBSTETRIC HISTORY, UNSPECIFIED TRIMESTER	SUPRVSN OF PREG W POOR REPRODCTV OR OBSTET HISTORY, UNSP TRI
O10.011	PRE-EXISTING ESSENTIAL HYPERTENSION COMPLICATING PREGNANCY, FIRST TRIMESTER	PRE-EXISTING ESSENTIAL HTN COMP PREGNANCY, FIRST TRIMESTER

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O10.012	PRE-EXISTING ESSENTIAL HYPERTENSION COMPLICATING PREGNANCY, SECOND TRIMESTER	PRE-EXISTING ESSENTIAL HTN COMP PREGNANCY, SECOND TRIMESTER
O10.013	PRE-EXISTING ESSENTIAL HYPERTENSION COMPLICATING PREGNANCY, THIRD TRIMESTER	PRE-EXISTING ESSENTIAL HTN COMP PREGNANCY, THIRD TRIMESTER
O10.019	PRE-EXISTING ESSENTIAL HYPERTENSION COMPLICATING PREGNANCY, UNSPECIFIED TRIMESTER	PRE-EXISTING ESSENTIAL HTN COMP PREGNANCY, UNSP TRIMESTER
O10.02	PRE-EXISTING ESSENTIAL HYPERTENSION COMPLICATING CHILDBIRTH	PRE-EXISTING ESSENTIAL HYPERTENSION COMPLICATING CHILDBIRTH
O10.03	PRE-EXISTING ESSENTIAL HYPERTENSION COMPLICATING THE PUERPERIUM	PRE-EXISTING ESSENTIAL HYPERTENSION COMP THE PUERPERIUM
O10.111	PRE-EXISTING HYPERTENSIVE HEART DISEASE COMPLICATING PREGNANCY, FIRST TRIMESTER	PRE-EXIST HYP HEART DISEASE COMP PREGNANCY, FIRST TRIMESTER
O10.112	PRE-EXISTING HYPERTENSIVE HEART DISEASE COMPLICATING PREGNANCY, SECOND TRIMESTER	PRE-EXIST HYP HEART DISEASE COMP PREGNANCY, SECOND TRIMESTER
O10.113	PRE-EXISTING HYPERTENSIVE HEART DISEASE COMPLICATING PREGNANCY, THIRD TRIMESTER	PRE-EXIST HYP HEART DISEASE COMP PREGNANCY, THIRD TRIMESTER
O10.119	PRE-EXISTING HYPERTENSIVE HEART DISEASE COMPLICATING PREGNANCY, UNSPECIFIED TRIMESTER	PRE-EXIST HYP HEART DISEASE COMP PREGNANCY, UNSP TRIMESTER
O10.12	PRE-EXISTING HYPERTENSIVE HEART DISEASE COMPLICATING CHILDBIRTH	PRE-EXISTING HYPERTENSIVE HEART DISEASE COMP CHILDBIRTH
O10.13	PRE-EXISTING HYPERTENSIVE HEART DISEASE COMPLICATING THE PUERPERIUM	PRE-EXISTING HYPERTENSIVE HEART DISEASE COMP THE PUERPERIUM
O10.211	PRE-EXISTING HYPERTENSIVE CHRONIC KIDNEY DISEASE COMPLICATING PREGNANCY, FIRST TRIMESTER	PRE-EXIST HYP CHRONIC KIDNEY DISEASE COMP PREG, FIRST TRI
O10.212	PRE-EXISTING HYPERTENSIVE CHRONIC KIDNEY DISEASE COMPLICATING PREGNANCY, SECOND TRIMESTER	PRE-EXIST HYP CHRONIC KIDNEY DISEASE COMP PREG, SECOND TRI
O10.213	PRE-EXISTING HYPERTENSIVE CHRONIC KIDNEY DISEASE COMPLICATING PREGNANCY, THIRD TRIMESTER	PRE-EXIST HYP CHRONIC KIDNEY DISEASE COMP PREG, THIRD TRI
O10.219	PRE-EXISTING HYPERTENSIVE CHRONIC KIDNEY DISEASE COMPLICATING PREGNANCY, UNSPECIFIED TRIMESTER	PRE-EXIST HYP CHRONIC KIDNEY DISEASE COMP PREG, UNSP TRI
O10.22	PRE-EXISTING HYPERTENSIVE CHRONIC KIDNEY DISEASE COMPLICATING CHILDBIRTH	PRE-EXISTING HYP CHRONIC KIDNEY DISEASE COMP CHILDBIRTH

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O10.23	PRE-EXISTING HYPERTENSIVE CHRONIC KIDNEY DISEASE COMPLICATING THE PUERPERIUM	PRE-EXISTING HYP CHRONIC KIDNEY DISEASE COMP THE PUERPERIUM
O10.311	PRE-EXISTING HYPERTENSIVE HEART AND CHRONIC KIDNEY DISEASE COMPLICATING PREGNANCY, FIRST TRIMESTER	PRE-EXIST HYP HEART AND CHR KIDNEY DIS COMP PREG, FIRST TRI
O10.312	PRE-EXISTING HYPERTENSIVE HEART AND CHRONIC KIDNEY DISEASE COMPLICATING PREGNANCY, SECOND TRIMESTER	PRE-EXIST HYP HEART AND CHR KIDNEY DIS COMP PREG, SECOND TRI
O10.313	PRE-EXISTING HYPERTENSIVE HEART AND CHRONIC KIDNEY DISEASE COMPLICATING PREGNANCY, THIRD TRIMESTER	PRE-EXIST HYP HEART AND CHR KIDNEY DIS COMP PREG, THIRD TRI
O10.319	PRE-EXISTING HYPERTENSIVE HEART AND CHRONIC KIDNEY DISEASE COMPLICATING PREGNANCY, UNSPECIFIED TRIMESTER	PRE-EXIST HYP HEART AND CHR KIDNEY DIS COMP PREG, UNSP TRI
O10.32	PRE-EXISTING HYPERTENSIVE HEART AND CHRONIC KIDNEY DISEASE COMPLICATING CHILDBIRTH	PRE-EXIST HYP HEART AND CHRONIC KIDNEY DISEASE COMP CHLDBRTH
O10.33	PRE-EXISTING HYPERTENSIVE HEART AND CHRONIC KIDNEY DISEASE COMPLICATING THE PUERPERIUM	PRE-EXIST HYP HEART AND CHR KIDNEY DISEASE COMP THE PUERP
O10.411	PRE-EXISTING SECONDARY HYPERTENSION COMPLICATING PREGNANCY, FIRST TRIMESTER	PRE-EXISTING SECONDARY HTN COMP PREGNANCY, FIRST TRIMESTER
O10.412	PRE-EXISTING SECONDARY HYPERTENSION COMPLICATING PREGNANCY, SECOND TRIMESTER	PRE-EXISTING SECONDARY HTN COMP PREGNANCY, SECOND TRIMESTER
O10.413	PRE-EXISTING SECONDARY HYPERTENSION COMPLICATING PREGNANCY, THIRD TRIMESTER	PRE-EXISTING SECONDARY HTN COMP PREGNANCY, THIRD TRIMESTER
O10.419	PRE-EXISTING SECONDARY HYPERTENSION COMPLICATING PREGNANCY, UNSPECIFIED TRIMESTER	PRE-EXISTING SECONDARY HTN COMP PREGNANCY, UNSP TRIMESTER
O10.42	PRE-EXISTING SECONDARY HYPERTENSION COMPLICATING CHILDBIRTH	PRE-EXISTING SECONDARY HYPERTENSION COMPLICATING CHILDBIRTH
O10.43	PRE-EXISTING SECONDARY HYPERTENSION COMPLICATING THE PUERPERIUM	PRE-EXISTING SECONDARY HYPERTENSION COMP THE PUERPERIUM
O10.911	UNSPECIFIED PRE-EXISTING HYPERTENSION COMPLICATING PREGNANCY, FIRST TRIMESTER	UNSP PRE-EXISTING HTN COMP PREGNANCY, FIRST TRIMESTER
O10.912	UNSPECIFIED PRE-EXISTING HYPERTENSION COMPLICATING PREGNANCY, SECOND TRIMESTER	UNSP PRE-EXISTING HTN COMP PREGNANCY, SECOND TRIMESTER

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O10.913	UNSPECIFIED PRE-EXISTING HYPERTENSION COMPLICATING PREGNANCY, THIRD TRIMESTER	UNSP PRE-EXISTING HTN COMP PREGNANCY, THIRD TRIMESTER
O10.919	UNSPECIFIED PRE-EXISTING HYPERTENSION COMPLICATING PREGNANCY, UNSPECIFIED TRIMESTER	UNSP PRE-EXISTING HTN COMP PREGNANCY, UNSP TRIMESTER
O10.92	UNSPECIFIED PRE-EXISTING HYPERTENSION COMPLICATING CHILDBIRTH	UNSP PRE-EXISTING HYPERTENSION COMPLICATING CHILDBIRTH
O10.93	UNSPECIFIED PRE-EXISTING HYPERTENSION COMPLICATING THE PUERPERIUM	UNSP PRE-EXISTING HYPERTENSION COMPLICATING THE PUERPERIUM
O11.1	PRE-EXISTING HYPERTENSION WITH PRE-ECLAMPSIA, FIRST TRIMESTER	PRE-EXISTING HYPERTENSION W PRE-ECLAMPSIA, FIRST TRIMESTER
O11.2	PRE-EXISTING HYPERTENSION WITH PRE-ECLAMPSIA, SECOND TRIMESTER	PRE-EXISTING HYPERTENSION W PRE-ECLAMPSIA, SECOND TRIMESTER
O11.3	PRE-EXISTING HYPERTENSION WITH PRE-ECLAMPSIA, THIRD TRIMESTER	PRE-EXISTING HYPERTENSION W PRE-ECLAMPSIA, THIRD TRIMESTER
O11.9	PRE-EXISTING HYPERTENSION WITH PRE-ECLAMPSIA, UNSPECIFIED TRIMESTER	PRE-EXISTING HYPERTENSION WITH PRE-ECLAMPSIA, UNSP TRIMESTER
O12.10	GESTATIONAL PROTEINURIA, UNSPECIFIED TRIMESTER	GESTATIONAL PROTEINURIA, UNSPECIFIED TRIMESTER
O12.11	GESTATIONAL PROTEINURIA, FIRST TRIMESTER	GESTATIONAL PROTEINURIA, FIRST TRIMESTER
O12.12	GESTATIONAL PROTEINURIA, SECOND TRIMESTER	GESTATIONAL PROTEINURIA, SECOND TRIMESTER
O12.13	GESTATIONAL PROTEINURIA, THIRD TRIMESTER	GESTATIONAL PROTEINURIA, THIRD TRIMESTER
O12.20	GESTATIONAL EDEMA WITH PROTEINURIA, UNSPECIFIED TRIMESTER	GESTATIONAL EDEMA WITH PROTEINURIA, UNSPECIFIED TRIMESTER
O12.21	GESTATIONAL EDEMA WITH PROTEINURIA, FIRST TRIMESTER	GESTATIONAL EDEMA WITH PROTEINURIA, FIRST TRIMESTER
O12.22	GESTATIONAL EDEMA WITH PROTEINURIA, SECOND TRIMESTER	GESTATIONAL EDEMA WITH PROTEINURIA, SECOND TRIMESTER
O12.23	GESTATIONAL EDEMA WITH PROTEINURIA, THIRD TRIMESTER	GESTATIONAL EDEMA WITH PROTEINURIA, THIRD TRIMESTER
O13.1	GESTATIONAL [PREGNANCY-INDUCED] HYPERTENSION WITHOUT SIGNIFICANT PROTEINURIA, FIRST TRIMESTER	GESTATIONAL HTN W/O SIGNIFICANT PROTEINURIA, FIRST TRIMESTER
O13.2	GESTATIONAL [PREGNANCY-INDUCED] HYPERTENSION WITHOUT SIGNIFICANT PROTEINURIA, SECOND TRIMESTER	GESTATNL HTN W/O SIGNIFICANT PROTEINURIA, SECOND TRIMESTER
O13.3	GESTATIONAL [PREGNANCY-INDUCED] HYPERTENSION WITHOUT SIGNIFICANT	GESTATIONAL HTN W/O SIGNIFICANT PROTEINURIA, THIRD TRIMESTER

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
	PROTEINURIA, THIRD TRIMESTER	
O13.9	GESTATIONAL [PREGNANCY-INDUCED] HYPERTENSION WITHOUT SIGNIFICANT PROTEINURIA, UNSPECIFIED TRIMESTER	GESTATIONAL HTN W/O SIGNIFICANT PROTEINURIA, UNSP TRIMESTER
O14.00	MILD TO MODERATE PRE-ECLAMPSIA, UNSPECIFIED TRIMESTER	MILD TO MODERATE PRE-ECLAMPSIA, UNSPECIFIED TRIMESTER
O14.02	MILD TO MODERATE PRE-ECLAMPSIA, SECOND TRIMESTER	MILD TO MODERATE PRE-ECLAMPSIA, SECOND TRIMESTER
O14.03	MILD TO MODERATE PRE-ECLAMPSIA, THIRD TRIMESTER	MILD TO MODERATE PRE-ECLAMPSIA, THIRD TRIMESTER
O14.10	SEVERE PRE-ECLAMPSIA, UNSPECIFIED TRIMESTER	SEVERE PRE-ECLAMPSIA, UNSPECIFIED TRIMESTER
O14.12	SEVERE PRE-ECLAMPSIA, SECOND TRIMESTER	SEVERE PRE-ECLAMPSIA, SECOND TRIMESTER
O14.13	SEVERE PRE-ECLAMPSIA, THIRD TRIMESTER	SEVERE PRE-ECLAMPSIA, THIRD TRIMESTER
O14.20	HELLP SYNDROME (HELLP), UNSPECIFIED TRIMESTER	HELLP SYNDROME (HELLP), UNSPECIFIED TRIMESTER
O14.22	HELLP SYNDROME (HELLP), SECOND TRIMESTER	HELLP SYNDROME (HELLP), SECOND TRIMESTER
O14.23	HELLP SYNDROME (HELLP), THIRD TRIMESTER	HELLP SYNDROME (HELLP), THIRD TRIMESTER
O14.90	UNSPECIFIED PRE-ECLAMPSIA, UNSPECIFIED TRIMESTER	UNSPECIFIED PRE-ECLAMPSIA, UNSPECIFIED TRIMESTER
O14.92	UNSPECIFIED PRE-ECLAMPSIA, SECOND TRIMESTER	UNSPECIFIED PRE-ECLAMPSIA, SECOND TRIMESTER
O14.93	UNSPECIFIED PRE-ECLAMPSIA, THIRD TRIMESTER	UNSPECIFIED PRE-ECLAMPSIA, THIRD TRIMESTER
O15.00	ECLAMPSIA IN PREGNANCY, UNSPECIFIED TRIMESTER	ECLAMPSIA IN PREGNANCY, UNSPECIFIED TRIMESTER
O15.02	ECLAMPSIA IN PREGNANCY, SECOND TRIMESTER	ECLAMPSIA IN PREGNANCY, SECOND TRIMESTER
O15.03	ECLAMPSIA IN PREGNANCY, THIRD TRIMESTER	ECLAMPSIA IN PREGNANCY, THIRD TRIMESTER
O15.1	ECLAMPSIA IN LABOR	ECLAMPSIA IN LABOR
O15.2	ECLAMPSIA IN THE PUERPERIUM	ECLAMPSIA IN THE PUERPERIUM
O15.9	ECLAMPSIA, UNSPECIFIED AS TO TIME PERIOD	ECLAMPSIA, UNSPECIFIED AS TO TIME PERIOD
O16.1	UNSPECIFIED MATERNAL HYPERTENSION, FIRST TRIMESTER	UNSPECIFIED MATERNAL HYPERTENSION, FIRST TRIMESTER
O16.2	UNSPECIFIED MATERNAL HYPERTENSION,	UNSPECIFIED MATERNAL

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
	SECOND TRIMESTER	HYPERTENSION, SECOND TRIMESTER
O16.3	UNSPECIFIED MATERNAL HYPERTENSION, THIRD TRIMESTER	UNSPECIFIED MATERNAL HYPERTENSION, THIRD TRIMESTER
O16.9	UNSPECIFIED MATERNAL HYPERTENSION, UNSPECIFIED TRIMESTER	UNSPECIFIED MATERNAL HYPERTENSION, UNSPECIFIED TRIMESTER
O24.410	GESTATIONAL DIABETES MELLITUS IN PREGNANCY, DIET CONTROLLED	GESTATIONAL DIABETES MELLITUS IN PREGNANCY, DIET CONTROLLED
O24.414	GESTATIONAL DIABETES MELLITUS IN PREGNANCY, INSULIN CONTROLLED	GESTATIONAL DIABETES IN PREGNANCY, INSULIN CONTROLLED
O24.419	GESTATIONAL DIABETES MELLITUS IN PREGNANCY, UNSPECIFIED CONTROL	GESTATIONAL DIABETES MELLITUS IN PREGNANCY, UNSP CONTROL
O24.420	GESTATIONAL DIABETES MELLITUS IN CHILDBIRTH, DIET CONTROLLED	GESTATIONAL DIABETES MELLITUS IN CHILDBIRTH, DIET CONTROLLED
O24.424	GESTATIONAL DIABETES MELLITUS IN CHILDBIRTH, INSULIN CONTROLLED	GESTATIONAL DIABETES IN CHILDBIRTH, INSULIN CONTROLLED
O24.429	GESTATIONAL DIABETES MELLITUS IN CHILDBIRTH, UNSPECIFIED CONTROL	GESTATIONAL DIABETES MELLITUS IN CHILDBIRTH, UNSP CONTROL
O24.430	GESTATIONAL DIABETES MELLITUS IN THE PUERPERIUM, DIET CONTROLLED	GESTATIONAL DIABETES IN THE PUERPERIUM, DIET CONTROLLED
O24.434	GESTATIONAL DIABETES MELLITUS IN THE PUERPERIUM, INSULIN CONTROLLED	GESTATIONAL DIABETES IN THE PUERPERIUM, INSULIN CONTROLLED
O24.439	GESTATIONAL DIABETES MELLITUS IN THE PUERPERIUM, UNSPECIFIED CONTROL	GESTATIONAL DIABETES IN THE PUERPERIUM, UNSP CONTROL
O24.811	OTHER PRE-EXISTING DIABETES MELLITUS IN PREGNANCY, FIRST TRIMESTER	OTH PRE-EXISTING DIABETES IN PREGNANCY, FIRST TRIMESTER
O24.812	OTHER PRE-EXISTING DIABETES MELLITUS IN PREGNANCY, SECOND TRIMESTER	OTH PRE-EXISTING DIABETES IN PREGNANCY, SECOND TRIMESTER
O24.813	OTHER PRE-EXISTING DIABETES MELLITUS IN PREGNANCY, THIRD TRIMESTER	OTH PRE-EXISTING DIABETES IN PREGNANCY, THIRD TRIMESTER
O24.819	OTHER PRE-EXISTING DIABETES MELLITUS IN PREGNANCY, UNSPECIFIED TRIMESTER	OTH PRE-EXISTING DIABETES IN PREGNANCY, UNSP TRIMESTER
O24.82	OTHER PRE-EXISTING DIABETES MELLITUS IN CHILDBIRTH	OTHER PRE-EXISTING DIABETES MELLITUS IN CHILDBIRTH
O24.83	OTHER PRE-EXISTING DIABETES MELLITUS IN THE PUERPERIUM	OTHER PRE-EXISTING DIABETES MELLITUS IN THE PUERPERIUM
O24.911	UNSPECIFIED DIABETES MELLITUS IN PREGNANCY, FIRST TRIMESTER	UNSPECIFIED DIABETES MELLITUS IN PREGNANCY, FIRST TRIMESTER
O24.912	UNSPECIFIED DIABETES MELLITUS IN PREGNANCY, SECOND TRIMESTER	UNSPECIFIED DIABETES MELLITUS IN PREGNANCY, SECOND TRIMESTER
O24.913	UNSPECIFIED DIABETES MELLITUS IN PREGNANCY, THIRD TRIMESTER	UNSPECIFIED DIABETES MELLITUS IN PREGNANCY, THIRD TRIMESTER

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O24.919	UNSPECIFIED DIABETES MELLITUS IN PREGNANCY, UNSPECIFIED TRIMESTER	UNSP DIABETES MELLITUS IN PREGNANCY, UNSPECIFIED TRIMESTER
O24.92	UNSPECIFIED DIABETES MELLITUS IN CHILDBIRTH	UNSPECIFIED DIABETES MELLITUS IN CHILDBIRTH
O24.93	UNSPECIFIED DIABETES MELLITUS IN THE PUERPERIUM	UNSPECIFIED DIABETES MELLITUS IN THE PUERPERIUM
O26.611	LIVER AND BILIARY TRACT DISORDERS IN PREGNANCY, FIRST TRIMESTER	LIVER AND BILIARY TRACT DISORD IN PREGNANCY, FIRST TRIMESTER
O26.612	LIVER AND BILIARY TRACT DISORDERS IN PREGNANCY, SECOND TRIMESTER	LIVER AND BILIARY TRACT DISORD IN PREG, SECOND TRIMESTER
O26.613	LIVER AND BILIARY TRACT DISORDERS IN PREGNANCY, THIRD TRIMESTER	LIVER AND BILIARY TRACT DISORD IN PREGNANCY, THIRD TRIMESTER
O26.619	LIVER AND BILIARY TRACT DISORDERS IN PREGNANCY, UNSPECIFIED TRIMESTER	LIVER AND BILIARY TRACT DISORD IN PREGNANCY, UNSP TRIMESTER
O26.62	LIVER AND BILIARY TRACT DISORDERS IN CHILDBIRTH	LIVER AND BILIARY TRACT DISORDERS IN CHILDBIRTH
O26.63	LIVER AND BILIARY TRACT DISORDERS IN THE PUERPERIUM	LIVER AND BILIARY TRACT DISORDERS IN THE PUERPERIUM
O26.831	PREGNANCY RELATED RENAL DISEASE, FIRST TRIMESTER	PREGNANCY RELATED RENAL DISEASE, FIRST TRIMESTER
O26.832	PREGNANCY RELATED RENAL DISEASE, SECOND TRIMESTER	PREGNANCY RELATED RENAL DISEASE, SECOND TRIMESTER
O26.833	PREGNANCY RELATED RENAL DISEASE, THIRD TRIMESTER	PREGNANCY RELATED RENAL DISEASE, THIRD TRIMESTER
O26.839	PREGNANCY RELATED RENAL DISEASE, UNSPECIFIED TRIMESTER	PREGNANCY RELATED RENAL DISEASE, UNSPECIFIED TRIMESTER
O30.001	TWIN PREGNANCY, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, FIRST TRIMESTER	TWIN PREG, UNSP NUM PLCNTA & AMNIO SACS, FIRST TRIMESTER
O30.002	TWIN PREGNANCY, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, SECOND TRIMESTER	TWIN PREG, UNSP NUM PLCNTA & AMNIO SACS, SECOND TRIMESTER
O30.003	TWIN PREGNANCY, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, THIRD TRIMESTER	TWIN PREG, UNSP NUM PLCNTA & AMNIO SACS, THIRD TRIMESTER
O30.009	TWIN PREGNANCY, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, UNSPECIFIED TRIMESTER	TWIN PREGNANCY, UNSP NUM PLCNTA & AMNIO SACS, UNSP TRIMESTER
O30.011	TWIN PREGNANCY, MONOCHORIONIC/MONOAMNIOTIC, FIRST TRIMESTER	TWIN PREGNANCY, MONOCHORIONIC/MONOAMNIOTIC, FIRST TRIMESTER
O30.012	TWIN PREGNANCY, MONOCHORIONIC/MONOAMNIOTIC, SECOND	TWIN PREGNANCY, MONOCHORIONIC/MONOAMNIOTIC,

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	TRIMESTER	SECOND TRIMESTER
O30.013	TWIN PREGNANCY, MONOCHORIONIC/MONOAMNIOTIC, THIRD TRIMESTER	TWIN PREGNANCY, MONOCHORIONIC/MONOAMNIOTIC, THIRD TRIMESTER
O30.019	TWIN PREGNANCY, MONOCHORIONIC/MONOAMNIOTIC, UNSPECIFIED TRIMESTER	TWIN PREGNANCY, MONOCHORIONIC/MONOAMNIOTIC, UNSP TRIMESTER
O30.021	CONJOINED TWIN PREGNANCY, FIRST TRIMESTER	CONJOINED TWIN PREGNANCY, FIRST TRIMESTER
O30.022	CONJOINED TWIN PREGNANCY, SECOND TRIMESTER	CONJOINED TWIN PREGNANCY, SECOND TRIMESTER
O30.023	CONJOINED TWIN PREGNANCY, THIRD TRIMESTER	CONJOINED TWIN PREGNANCY, THIRD TRIMESTER
O30.029	CONJOINED TWIN PREGNANCY, UNSPECIFIED TRIMESTER	CONJOINED TWIN PREGNANCY, UNSPECIFIED TRIMESTER
O30.031	TWIN PREGNANCY, MONOCHORIONIC/DIAMNIOTIC, FIRST TRIMESTER	TWIN PREGNANCY, MONOCHORIONIC/DIAMNIOTIC, FIRST TRIMESTER
O30.032	TWIN PREGNANCY, MONOCHORIONIC/DIAMNIOTIC, SECOND TRIMESTER	TWIN PREGNANCY, MONOCHORIONIC/DIAMNIOTIC, SECOND TRIMESTER
O30.033	TWIN PREGNANCY, MONOCHORIONIC/DIAMNIOTIC, THIRD TRIMESTER	TWIN PREGNANCY, MONOCHORIONIC/DIAMNIOTIC, THIRD TRIMESTER
O30.039	TWIN PREGNANCY, MONOCHORIONIC/DIAMNIOTIC, UNSPECIFIED TRIMESTER	TWIN PREGNANCY, MONOCHORIONIC/DIAMNIOTIC, UNSP TRIMESTER
O30.041	TWIN PREGNANCY, DICHORIONIC/DIAMNIOTIC, FIRST TRIMESTER	TWIN PREGNANCY, DICHORIONIC/DIAMNIOTIC, FIRST TRIMESTER
O30.042	TWIN PREGNANCY, DICHORIONIC/DIAMNIOTIC, SECOND TRIMESTER	TWIN PREGNANCY, DICHORIONIC/DIAMNIOTIC, SECOND TRIMESTER
O30.043	TWIN PREGNANCY, DICHORIONIC/DIAMNIOTIC, THIRD TRIMESTER	TWIN PREGNANCY, DICHORIONIC/DIAMNIOTIC, THIRD TRIMESTER
O30.049	TWIN PREGNANCY, DICHORIONIC/DIAMNIOTIC, UNSPECIFIED TRIMESTER	TWIN PREGNANCY, DICHORIONIC/DIAMNIOTIC, UNSP TRIMESTER
O30.091	TWIN PREGNANCY, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, FIRST TRIMESTER	TWIN PREG, UNABLE TO DTRM NUM PLCNTA & AMNIO SACS, FIRST TRI
O30.092	TWIN PREGNANCY, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, SECOND TRIMESTER	TWIN PREG, UNABLE TO DTRM NUM PLCNTA & AMNIO SACS, 2ND TRI

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O30.093	TWIN PREGNANCY, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, THIRD TRIMESTER	TWIN PREG, UNABLE TO DTRM NUM PLCNTA & AMNIO SACS, THIRD TRI
O30.099	TWIN PREGNANCY, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, UNSPECIFIED TRIMESTER	TWIN PREG, UNABLE TO DTRM NUM PLCNTA & AMNIO SACS, UNSP TRI
O30.101	TRIPLET PREGNANCY, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, FIRST TRIMESTER	TRIPLET PREG, UNSP NUM PLCNTA & AMNIO SACS, FIRST TRIMESTER
O30.102	TRIPLET PREGNANCY, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, SECOND TRIMESTER	TRIPLET PREG, UNSP NUM PLCNTA & AMNIO SACS, SECOND TRIMESTER
O30.103	TRIPLET PREGNANCY, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, THIRD TRIMESTER	TRIPLET PREG, UNSP NUM PLCNTA & AMNIO SACS, THIRD TRIMESTER
O30.109	TRIPLET PREGNANCY, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, UNSPECIFIED TRIMESTER	TRIPLET PREG, UNSP NUM PLCNTA & AMNIO SACS, UNSP TRIMESTER
O30.111	TRIPLET PREGNANCY WITH TWO OR MORE MONOCHORIONIC FETUSES, FIRST TRIMESTER	TRIPLET PREG W TWO OR MORE MONOCHORIONIC FETUSES, FIRST TRI
O30.112	TRIPLET PREGNANCY WITH TWO OR MORE MONOCHORIONIC FETUSES, SECOND TRIMESTER	TRIPLET PREG W TWO OR MORE MONOCHORIONIC FETUSES, SECOND TRI
O30.113	TRIPLET PREGNANCY WITH TWO OR MORE MONOCHORIONIC FETUSES, THIRD TRIMESTER	TRIPLET PREG W TWO OR MORE MONOCHORIONIC FETUSES, THIRD TRI
O30.119	TRIPLET PREGNANCY WITH TWO OR MORE MONOCHORIONIC FETUSES, UNSPECIFIED TRIMESTER	TRIPLET PREG W TWO OR MORE MONOCHORIONIC FETUSES, UNSP TRI
O30.121	TRIPLET PREGNANCY WITH TWO OR MORE MONOAMNIOTIC FETUSES, FIRST TRIMESTER	TRIPLET PREG W TWO OR MORE MONOAMNIO FETUSES, FIRST TRI
O30.122	TRIPLET PREGNANCY WITH TWO OR MORE MONOAMNIOTIC FETUSES, SECOND TRIMESTER	TRIPLET PREG W TWO OR MORE MONOAMNIO FETUSES, SECOND TRI
O30.123	TRIPLET PREGNANCY WITH TWO OR MORE MONOAMNIOTIC FETUSES, THIRD TRIMESTER	TRIPLET PREG W TWO OR MORE MONOAMNIO FETUSES, THIRD TRI
O30.129	TRIPLET PREGNANCY WITH TWO OR MORE MONOAMNIOTIC FETUSES, UNSPECIFIED TRIMESTER	TRIPLET PREG W TWO OR MORE MONOAMNIO FETUSES, UNSP TRIMESTER
O30.191	TRIPLET PREGNANCY, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, FIRST TRIMESTER	TRP PREG, UNABLE TO DTRM NUM PLCNTA & AMNIO SACS, FIRST TRI
O30.192	TRIPLET PREGNANCY, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, SECOND TRIMESTER	TRP PREG, UNABLE TO DTRM NUM PLCNTA & AMNIO SACS, SECOND TRI

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ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O30.193	TRIPLET PREGNANCY, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, THIRD TRIMESTER	TRP PREG, UNABLE TO DTRM NUM PLCNTA & AMNIO SACS, THIRD TRI
O30.199	TRIPLET PREGNANCY, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, UNSPECIFIED TRIMESTER	TRP PREG, UNABLE TO DTRM NUM PLCNTA & AMNIO SACS, UNSP TRI
O30.201	QUADRUPLET PREGNANCY, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, FIRST TRIMESTER	QUAD PREG, UNSP NUM PLCNTA & AMNIO SACS, FIRST TRIMESTER
O30.202	QUADRUPLET PREGNANCY, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, SECOND TRIMESTER	QUAD PREG, UNSP NUM PLCNTA & AMNIO SACS, SECOND TRIMESTER
O30.203	QUADRUPLET PREGNANCY, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, THIRD TRIMESTER	QUAD PREG, UNSP NUM PLCNTA & AMNIO SACS, THIRD TRIMESTER
O30.209	QUADRUPLET PREGNANCY, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, UNSPECIFIED TRIMESTER	QUAD PREGNANCY, UNSP NUM PLCNTA & AMNIO SACS, UNSP TRIMESTER
O30.211	QUADRUPLET PREGNANCY WITH TWO OR MORE MONOCHORIONIC FETUSES, FIRST TRIMESTER	QUAD PREG W TWO OR MORE MONOCHORIONIC FETUSES, FIRST TRI
O30.212	QUADRUPLET PREGNANCY WITH TWO OR MORE MONOCHORIONIC FETUSES, SECOND TRIMESTER	QUAD PREG W TWO OR MORE MONOCHORIONIC FETUSES, SECOND TRI
O30.213	QUADRUPLET PREGNANCY WITH TWO OR MORE MONOCHORIONIC FETUSES, THIRD TRIMESTER	QUAD PREG W TWO OR MORE MONOCHORIONIC FETUSES, THIRD TRI
O30.219	QUADRUPLET PREGNANCY WITH TWO OR MORE MONOCHORIONIC FETUSES, UNSPECIFIED TRIMESTER	QUAD PREG W TWO OR MORE MONOCHORIONIC FETUSES, UNSP TRI
O30.221	QUADRUPLET PREGNANCY WITH TWO OR MORE MONOAMNIOTIC FETUSES, FIRST TRIMESTER	QUAD PREG W TWO OR MORE MONOAMNIO FETUSES, FIRST TRIMESTER
O30.222	QUADRUPLET PREGNANCY WITH TWO OR MORE MONOAMNIOTIC FETUSES, SECOND TRIMESTER	QUAD PREG W TWO OR MORE MONOAMNIO FETUSES, SECOND TRIMESTER
O30.223	QUADRUPLET PREGNANCY WITH TWO OR MORE MONOAMNIOTIC FETUSES, THIRD TRIMESTER	QUAD PREG W TWO OR MORE MONOAMNIO FETUSES, THIRD TRIMESTER
O30.229	QUADRUPLET PREGNANCY WITH TWO OR MORE MONOAMNIOTIC FETUSES, UNSPECIFIED TRIMESTER	QUAD PREG W TWO OR MORE MONOAMNIO FETUSES, UNSP TRIMESTER
O30.291	QUADRUPLET PREGNANCY, UNABLE TO	QUAD PREG, UNABLE TO DTRM NUM

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ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
	DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, FIRST TRIMESTER	PLCNTA & AMNIO SACS, FIRST TRI
O30.292	QUADRUPLET PREGNANCY, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, SECOND TRIMESTER	QUAD PREG, UNABLE TO DTRM NUM PLCNTA & AMNIO SACS, 2ND TRI
O30.293	QUADRUPLET PREGNANCY, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, THIRD TRIMESTER	QUAD PREG, UNABLE TO DTRM NUM PLCNTA & AMNIO SACS, THIRD TRI
O30.299	QUADRUPLET PREGNANCY, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, UNSPECIFIED TRIMESTER	QUAD PREG, UNABLE TO DTRM NUM PLCNTA & AMNIO SACS, UNSP TRI
O30.801	OTHER SPECIFIED MULTIPLE GESTATION, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, FIRST TRIMESTER	OTH MULTIPLE GEST, UNSP NUM PLCNTA & AMNIO SACS, FIRST TRI
O30.802	OTHER SPECIFIED MULTIPLE GESTATION, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, SECOND TRIMESTER	OTH MULTIPLE GEST, UNSP NUM PLCNTA & AMNIO SACS, SECOND TRI
O30.803	OTHER SPECIFIED MULTIPLE GESTATION, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, THIRD TRIMESTER	OTH MULTIPLE GEST, UNSP NUM PLCNTA & AMNIO SACS, THIRD TRI
O30.809	OTHER SPECIFIED MULTIPLE GESTATION, UNSPECIFIED NUMBER OF PLACENTA AND UNSPECIFIED NUMBER OF AMNIOTIC SACS, UNSPECIFIED TRIMESTER	OTH MULTIPLE GEST, UNSP NUM PLCNTA & AMNIO SACS, UNSP TRI
O30.811	OTHER SPECIFIED MULTIPLE GESTATION WITH TWO OR MORE MONOCHORIONIC FETUSES, FIRST TRIMESTER	OTH MULT GEST W TWO OR MORE MONOCHORIONIC FETUSES, FIRST TRI
O30.812	OTHER SPECIFIED MULTIPLE GESTATION WITH TWO OR MORE MONOCHORIONIC FETUSES, SECOND TRIMESTER	OTH MULT GEST W TWO OR MORE MONOCHORIONIC FETUSES, 2ND TRI
O30.813	OTHER SPECIFIED MULTIPLE GESTATION WITH TWO OR MORE MONOCHORIONIC FETUSES, THIRD TRIMESTER	OTH MULT GEST W TWO OR MORE MONOCHORIONIC FETUSES, THIRD TRI
O30.819	OTHER SPECIFIED MULTIPLE GESTATION WITH TWO OR MORE MONOCHORIONIC FETUSES, UNSPECIFIED TRIMESTER	OTH MULT GEST W TWO OR MORE MONOCHORIONIC FETUSES, UNSP TRI
O30.821	OTHER SPECIFIED MULTIPLE GESTATION WITH TWO OR MORE MONOAMNIOTIC FETUSES, FIRST TRIMESTER	OTH MULTIPLE GEST W TWO OR MORE MONOAMNIO FETUSES, FIRST TRI
O30.822	OTHER SPECIFIED MULTIPLE GESTATION WITH TWO OR MORE MONOAMNIOTIC FETUSES,	OTH MULT GEST W TWO OR MORE MONOAMNIO FETUSES, SECOND TRI

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	SECOND TRIMESTER	
O30.823	OTHER SPECIFIED MULTIPLE GESTATION WITH TWO OR MORE MONOAMNIOTIC FETUSES, THIRD TRIMESTER	OTH MULTIPLE GEST W TWO OR MORE MONOAMNIO FETUSES, THIRD TRI
O30.829	OTHER SPECIFIED MULTIPLE GESTATION WITH TWO OR MORE MONOAMNIOTIC FETUSES, UNSPECIFIED TRIMESTER	OTH MULTIPLE GEST W TWO OR MORE MONOAMNIO FETUSES, UNSP TRI
O30.891	OTHER SPECIFIED MULTIPLE GESTATION, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, FIRST TRIMESTER	OTH MULT GEST, UNAB TO DTRM NUM PLCNTA & AMNIO SACS, 1ST TRI
O30.892	OTHER SPECIFIED MULTIPLE GESTATION, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, SECOND TRIMESTER	OTH MULT GEST, UNAB TO DTRM NUM PLCNTA & AMNIO SACS, 2ND TRI
O30.893	OTHER SPECIFIED MULTIPLE GESTATION, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, THIRD TRIMESTER	OTH MULT GEST, UNAB TO DTRM NUM PLCNTA & AMNIO SACS, 3RD TRI
O30.899	OTHER SPECIFIED MULTIPLE GESTATION, UNABLE TO DETERMINE NUMBER OF PLACENTA AND NUMBER OF AMNIOTIC SACS, UNSPECIFIED TRIMESTER	OTH MULT GEST,UNAB TO DTRM NUM PLCNTA & AMNIO SACS, UNSP TRI
O30.90	MULTIPLE GESTATION, UNSPECIFIED, UNSPECIFIED TRIMESTER	MULTIPLE GESTATION, UNSPECIFIED, UNSPECIFIED TRIMESTER
O30.91	MULTIPLE GESTATION, UNSPECIFIED, FIRST TRIMESTER	MULTIPLE GESTATION, UNSPECIFIED, FIRST TRIMESTER
O30.92	MULTIPLE GESTATION, UNSPECIFIED, SECOND TRIMESTER	MULTIPLE GESTATION, UNSPECIFIED, SECOND TRIMESTER
O30.93	MULTIPLE GESTATION, UNSPECIFIED, THIRD TRIMESTER	MULTIPLE GESTATION, UNSPECIFIED, THIRD TRIMESTER
O31.10X0	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, UNSP TRI, UNSP
O31.10X1	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 1	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, UNSP TRI, FTS1
O31.10X2	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 2	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, UNSP TRI, FTS2
O31.10X3	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 3	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, UNSP TRI, FTS3
O31.10X4	CONTINUING PREGNANCY AFTER	CONT PREG AFT SPON ABORT OF

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ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
	SPONTANEOUS ABORTION OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 4	ONE FTS OR MORE, UNSP TRI, FTS4
O31.10X5	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 5	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, UNSP TRI, FTS5
O31.10X9	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, OTHER FETUS	CONT PREG AFT SPON ABORT OF ONE FETUS OR MORE, UNSP TRI, OTH
O31.11X0	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, FIRST TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, FIRST TRI, UNSP
O31.11X1	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 1	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, FIRST TRI, FTS1
O31.11X2	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 2	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, FIRST TRI, FTS2
O31.11X3	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 3	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, FIRST TRI, FTS3
O31.11X4	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 4	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, FIRST TRI, FTS4
O31.11X5	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 5	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, FIRST TRI, FTS5
O31.11X9	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, FIRST TRIMESTER, OTHER FETUS	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, FIRST TRI, OTH
O31.12X0	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, SECOND TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	CONT PREG AFT SPON ABORT OF ONE FETUS OR MORE, 2ND TRI, UNSP
O31.12X1	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 1	CONT PREG AFT SPON ABORT OF ONE FETUS OR MORE, 2ND TRI, FTS1
O31.12X2	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 2	CONT PREG AFT SPON ABORT OF ONE FETUS OR MORE, 2ND TRI, FTS2
O31.12X3	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 3	CONT PREG AFT SPON ABORT OF ONE FETUS OR MORE, 2ND TRI, FTS3
O31.12X4	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR	CONT PREG AFT SPON ABORT OF ONE FETUS OR MORE, 2ND TRI, FTS4

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	MORE, SECOND TRIMESTER, FETUS 4	
O31.12X5	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 5	CONT PREG AFT SPON ABORT OF ONE FETUS OR MORE, 2ND TRI, FTS5
O31.12X9	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, SECOND TRIMESTER, OTHER FETUS	CONT PREG AFT SPON ABORT OF ONE FETUS OR MORE, 2ND TRI, OTH
O31.13X0	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, THIRD TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, THIRD TRI, UNSP
O31.13X1	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 1	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, THIRD TRI, FTS1
O31.13X2	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 2	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, THIRD TRI, FTS2
O31.13X3	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 3	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, THIRD TRI, FTS3
O31.13X4	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 4	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, THIRD TRI, FTS4
O31.13X5	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 5	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, THIRD TRI, FTS5
O31.13X9	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION OF ONE FETUS OR MORE, THIRD TRIMESTER, OTHER FETUS	CONT PREG AFT SPON ABORT OF ONE FTS OR MORE, THIRD TRI, OTH
O31.20X0	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, UNSP TRI, UNSP
O31.20X1	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 1	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, UNSP TRI, FTS1
O31.20X2	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 2	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, UNSP TRI, FTS2
O31.20X3	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 3	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, UNSP TRI, FTS3
O31.20X4	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 4	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, UNSP TRI, FTS4

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O31.20X5	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 5	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, UNSP TRI, FTS5
O31.20X9	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, OTHER FETUS	CONT PREG AFT UTERIN DTH OF ONE FETUS OR MORE, UNSP TRI, OTH
O31.21X0	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, FIRST TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, FIRST TRI, UNSP
O31.21X1	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 1	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, FIRST TRI, FTS1
O31.21X2	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 2	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, FIRST TRI, FTS2
O31.21X3	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 3	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, FIRST TRI, FTS3
O31.21X4	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 4	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, FIRST TRI, FTS4
O31.21X5	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 5	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, FIRST TRI, FTS5
O31.21X9	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, FIRST TRIMESTER, OTHER FETUS	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, FIRST TRI, OTH
O31.22X0	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, SECOND TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	CONT PREG AFT UTERIN DTH OF ONE FETUS OR MORE, 2ND TRI, UNSP
O31.22X1	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 1	CONT PREG AFT UTERIN DTH OF ONE FETUS OR MORE, 2ND TRI, FTS1
O31.22X2	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 2	CONT PREG AFT UTERIN DTH OF ONE FETUS OR MORE, 2ND TRI, FTS2
O31.22X3	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 3	CONT PREG AFT UTERIN DTH OF ONE FETUS OR MORE, 2ND TRI, FTS3
O31.22X4	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 4	CONT PREG AFT UTERIN DTH OF ONE FETUS OR MORE, 2ND TRI, FTS4
O31.22X5	CONTINUING PREGNANCY AFTER	CONT PREG AFT UTERIN DTH OF ONE

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	INTRAUTERINE DEATH OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 5	FETUS OR MORE, 2ND TRI, FTS5
O31.22X9	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, SECOND TRIMESTER, OTHER FETUS	CONT PREG AFT UTERIN DTH OF ONE FETUS OR MORE, 2ND TRI, OTH
O31.23X0	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, THIRD TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, THIRD TRI, UNSP
O31.23X1	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 1	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, THIRD TRI, FTS1
O31.23X2	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 2	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, THIRD TRI, FTS2
O31.23X3	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 3	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, THIRD TRI, FTS3
O31.23X4	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 4	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, THIRD TRI, FTS4
O31.23X5	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 5	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, THIRD TRI, FTS5
O31.23X9	CONTINUING PREGNANCY AFTER INTRAUTERINE DEATH OF ONE FETUS OR MORE, THIRD TRIMESTER, OTHER FETUS	CONT PREG AFT UTERIN DTH OF ONE FTS OR MORE, THIRD TRI, OTH
O31.30X0	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,UNSP TRI,UNSP
O31.30X1	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 1	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,UNSP TRI,FTS1
O31.30X2	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 2	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,UNSP TRI,FTS2
O31.30X3	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 3	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,UNSP TRI,FTS3
O31.30X4	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 4	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,UNSP TRI,FTS4
O31.30X5	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, FETUS 5	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,UNSP TRI,FTS5

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O31.30X9	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, UNSPECIFIED TRIMESTER, OTHER FETUS	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,UNSP TRI, OTH
O31.31X0	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, FIRST TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,1ST TRI, UNSP
O31.31X1	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 1	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,1ST TRI, FTS1
O31.31X2	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 2	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,1ST TRI, FTS2
O31.31X3	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 3	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,1ST TRI, FTS3
O31.31X4	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 4	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,1ST TRI, FTS4
O31.31X5	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, FIRST TRIMESTER, FETUS 5	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,1ST TRI, FTS5
O31.31X9	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, FIRST TRIMESTER, OTHER FETUS	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE, 1ST TRI, OTH
O31.32X0	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, SECOND TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,2ND TRI, UNSP
O31.32X1	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 1	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,2ND TRI, FTS1
O31.32X2	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 2	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,2ND TRI, FTS2
O31.32X3	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 3	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,2ND TRI, FTS3
O31.32X4	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 4	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,2ND TRI, FTS4
O31.32X5	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, SECOND TRIMESTER, FETUS 5	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,2ND TRI, FTS5
O31.32X9	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE,	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE, 2ND TRI, OTH

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	SECOND TRIMESTER, OTHER FETUS	
O31.33X0	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, THIRD TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,3RD TRI, UNSP
O31.33X1	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 1	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,3RD TRI, FTS1
O31.33X2	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 2	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,3RD TRI, FTS2
O31.33X3	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 3	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,3RD TRI, FTS3
O31.33X4	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 4	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,3RD TRI, FTS4
O31.33X5	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, THIRD TRIMESTER, FETUS 5	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE,3RD TRI, FTS5
O31.33X9	CONTINUING PREGNANCY AFTER ELECTIVE FETAL REDUCTION OF ONE FETUS OR MORE, THIRD TRIMESTER, OTHER FETUS	CONT PREG AFT ELCTV FETL RDCT OF 1 FTS OR MORE, 3RD TRI, OTH
O31.8X10	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, FIRST TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	OTH COMP SPECIFIC TO MULTIPLE GEST, FIRST TRIMESTER, UNSP
O31.8X11	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, FIRST TRIMESTER, FETUS 1	OTH COMP SPECIFIC TO MULTIPLE GEST, FIRST TRIMESTER, FETUS 1
O31.8X12	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, FIRST TRIMESTER, FETUS 2	OTH COMP SPECIFIC TO MULTIPLE GEST, FIRST TRIMESTER, FETUS 2
O31.8X13	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, FIRST TRIMESTER, FETUS 3	OTH COMP SPECIFIC TO MULTIPLE GEST, FIRST TRIMESTER, FETUS 3
O31.8X14	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, FIRST TRIMESTER, FETUS 4	OTH COMP SPECIFIC TO MULTIPLE GEST, FIRST TRIMESTER, FETUS 4
O31.8X15	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, FIRST TRIMESTER, FETUS 5	OTH COMP SPECIFIC TO MULTIPLE GEST, FIRST TRIMESTER, FETUS 5
O31.8X19	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, FIRST TRIMESTER, OTHER FETUS	OTH COMP SPECIFIC TO MULTIPLE GEST, FIRST TRIMESTER, OTH
O31.8X20	OTHER COMPLICATIONS SPECIFIC TO	OTH COMP SPECIFIC TO MULTIPLE

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	MULTIPLE GESTATION, SECOND TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	GEST, SECOND TRIMESTER, UNSP
O31.8X21	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, SECOND TRIMESTER, FETUS 1	OTH COMP SPECIFIC TO MULTIPLE GEST, SECOND TRI, FETUS 1
O31.8X22	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, SECOND TRIMESTER, FETUS 2	OTH COMP SPECIFIC TO MULTIPLE GEST, SECOND TRI, FETUS 2
O31.8X23	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, SECOND TRIMESTER, FETUS 3	OTH COMP SPECIFIC TO MULTIPLE GEST, SECOND TRI, FETUS 3
O31.8X24	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, SECOND TRIMESTER, FETUS 4	OTH COMP SPECIFIC TO MULTIPLE GEST, SECOND TRI, FETUS 4
O31.8X25	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, SECOND TRIMESTER, FETUS 5	OTH COMP SPECIFIC TO MULTIPLE GEST, SECOND TRI, FETUS 5
O31.8X29	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, SECOND TRIMESTER, OTHER FETUS	OTH COMP SPECIFIC TO MULTIPLE GEST, SECOND TRIMESTER, OTH
O31.8X30	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, THIRD TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	OTH COMP SPECIFIC TO MULTIPLE GEST, THIRD TRIMESTER, UNSP
O31.8X31	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, THIRD TRIMESTER, FETUS 1	OTH COMP SPECIFIC TO MULTIPLE GEST, THIRD TRIMESTER, FETUS 1
O31.8X32	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, THIRD TRIMESTER, FETUS 2	OTH COMP SPECIFIC TO MULTIPLE GEST, THIRD TRIMESTER, FETUS 2
O31.8X33	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, THIRD TRIMESTER, FETUS 3	OTH COMP SPECIFIC TO MULTIPLE GEST, THIRD TRIMESTER, FETUS 3
O31.8X34	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, THIRD TRIMESTER, FETUS 4	OTH COMP SPECIFIC TO MULTIPLE GEST, THIRD TRIMESTER, FETUS 4
O31.8X35	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, THIRD TRIMESTER, FETUS 5	OTH COMP SPECIFIC TO MULTIPLE GEST, THIRD TRIMESTER, FETUS 5
O31.8X39	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, THIRD TRIMESTER, OTHER FETUS	OTH COMP SPECIFIC TO MULTIPLE GEST, THIRD TRIMESTER, OTH
O32.0XX0	MATERNAL CARE FOR UNSTABLE LIE, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR UNSTABLE LIE, NOT APPLICABLE OR UNSP
O32.0XX1	MATERNAL CARE FOR UNSTABLE LIE, FETUS 1	MATERNAL CARE FOR UNSTABLE LIE, FETUS 1

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O32.0XX2	MATERNAL CARE FOR UNSTABLE LIE, FETUS 2	MATERNAL CARE FOR UNSTABLE LIE, FETUS 2
O32.0XX3	MATERNAL CARE FOR UNSTABLE LIE, FETUS 3	MATERNAL CARE FOR UNSTABLE LIE, FETUS 3
O32.0XX4	MATERNAL CARE FOR UNSTABLE LIE, FETUS 4	MATERNAL CARE FOR UNSTABLE LIE, FETUS 4
O32.0XX5	MATERNAL CARE FOR UNSTABLE LIE, FETUS 5	MATERNAL CARE FOR UNSTABLE LIE, FETUS 5
O32.0XX9	MATERNAL CARE FOR UNSTABLE LIE, OTHER FETUS	MATERNAL CARE FOR UNSTABLE LIE, OTHER FETUS
O32.8XX0	MATERNAL CARE FOR OTHER MALPRESENTATION OF FETUS, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR OTH MALPRESENTATION OF FETUS, UNSP
O32.8XX1	MATERNAL CARE FOR OTHER MALPRESENTATION OF FETUS, FETUS 1	MATERNAL CARE FOR OTHER MALPRESENTATION OF FETUS, FETUS 1
O32.8XX2	MATERNAL CARE FOR OTHER MALPRESENTATION OF FETUS, FETUS 2	MATERNAL CARE FOR OTHER MALPRESENTATION OF FETUS, FETUS 2
O32.8XX3	MATERNAL CARE FOR OTHER MALPRESENTATION OF FETUS, FETUS 3	MATERNAL CARE FOR OTHER MALPRESENTATION OF FETUS, FETUS 3
O32.8XX4	MATERNAL CARE FOR OTHER MALPRESENTATION OF FETUS, FETUS 4	MATERNAL CARE FOR OTHER MALPRESENTATION OF FETUS, FETUS 4
O32.8XX5	MATERNAL CARE FOR OTHER MALPRESENTATION OF FETUS, FETUS 5	MATERNAL CARE FOR OTHER MALPRESENTATION OF FETUS, FETUS 5
O32.8XX9	MATERNAL CARE FOR OTHER MALPRESENTATION OF FETUS, OTHER FETUS	MATERNAL CARE FOR OTH MALPRESENTATION OF FETUS, OTHER FETUS
O32.9XX0	MATERNAL CARE FOR MALPRESENTATION OF FETUS, UNSPECIFIED, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR MALPRESENTATION OF FETUS, UNSP, UNSP
O32.9XX1	MATERNAL CARE FOR MALPRESENTATION OF FETUS, UNSPECIFIED, FETUS 1	MATERNAL CARE FOR MALPRESENTATION OF FETUS, UNSP, FETUS 1
O32.9XX2	MATERNAL CARE FOR MALPRESENTATION OF FETUS, UNSPECIFIED, FETUS 2	MATERNAL CARE FOR MALPRESENTATION OF FETUS, UNSP, FETUS 2
O32.9XX3	MATERNAL CARE FOR MALPRESENTATION OF FETUS, UNSPECIFIED, FETUS 3	MATERNAL CARE FOR MALPRESENTATION OF FETUS, UNSP, FETUS 3
O32.9XX4	MATERNAL CARE FOR MALPRESENTATION OF FETUS, UNSPECIFIED, FETUS 4	MATERNAL CARE FOR MALPRESENTATION OF FETUS, UNSP,

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		FETUS 4
O32.9XX5	MATERNAL CARE FOR MALPRESENTATION OF FETUS, UNSPECIFIED, FETUS 5	MATERNAL CARE FOR MALPRESENTATION OF FETUS, UNSP, FETUS 5
O32.9XX9	MATERNAL CARE FOR MALPRESENTATION OF FETUS, UNSPECIFIED, OTHER FETUS	MATERNAL CARE FOR MALPRESENTATION OF FETUS, UNSP, OTH FETUS
O35.0XX0	MATERNAL CARE FOR (SUSPECTED) CENTRAL NERVOUS SYSTEM MALFORMATION IN FETUS, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR (SUSPECTED) CNSL MALFORM IN FETUS, UNSP
O35.0XX1	MATERNAL CARE FOR (SUSPECTED) CENTRAL NERVOUS SYSTEM MALFORMATION IN FETUS, FETUS 1	MATERNAL CARE FOR (SUSPECTED) CNSL MALFORM IN FETUS, FETUS 1
O35.0XX2	MATERNAL CARE FOR (SUSPECTED) CENTRAL NERVOUS SYSTEM MALFORMATION IN FETUS, FETUS 2	MATERNAL CARE FOR (SUSPECTED) CNSL MALFORM IN FETUS, FETUS 2
O35.0XX3	MATERNAL CARE FOR (SUSPECTED) CENTRAL NERVOUS SYSTEM MALFORMATION IN FETUS, FETUS 3	MATERNAL CARE FOR (SUSPECTED) CNSL MALFORM IN FETUS, FETUS 3
O35.0XX4	MATERNAL CARE FOR (SUSPECTED) CENTRAL NERVOUS SYSTEM MALFORMATION IN FETUS, FETUS 4	MATERNAL CARE FOR (SUSPECTED) CNSL MALFORM IN FETUS, FETUS 4
O35.0XX5	MATERNAL CARE FOR (SUSPECTED) CENTRAL NERVOUS SYSTEM MALFORMATION IN FETUS, FETUS 5	MATERNAL CARE FOR (SUSPECTED) CNSL MALFORM IN FETUS, FETUS 5
O35.0XX9	MATERNAL CARE FOR (SUSPECTED) CENTRAL NERVOUS SYSTEM MALFORMATION IN FETUS, OTHER FETUS	MATERNAL CARE FOR (SUSPECTED) CNSL MALFORM IN FETUS, OTH
O35.1XX0	MATERNAL CARE FOR (SUSPECTED) CHROMOSOMAL ABNORMALITY IN FETUS, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR CHROMOSOMAL ABNORMALITY IN FETUS, UNSP
O35.1XX1	MATERNAL CARE FOR (SUSPECTED) CHROMOSOMAL ABNORMALITY IN FETUS, FETUS 1	MATERNAL CARE FOR CHROMOSOMAL ABNORMALITY IN FETUS, FETUS 1
O35.1XX2	MATERNAL CARE FOR (SUSPECTED) CHROMOSOMAL ABNORMALITY IN FETUS, FETUS 2	MATERNAL CARE FOR CHROMOSOMAL ABNORMALITY IN FETUS, FETUS 2
O35.1XX3	MATERNAL CARE FOR (SUSPECTED) CHROMOSOMAL ABNORMALITY IN FETUS, FETUS 3	MATERNAL CARE FOR CHROMOSOMAL ABNORMALITY IN FETUS, FETUS 3
O35.1XX4	MATERNAL CARE FOR (SUSPECTED) CHROMOSOMAL ABNORMALITY IN FETUS, FETUS 4	MATERNAL CARE FOR CHROMOSOMAL ABNORMALITY IN FETUS, FETUS 4
O35.1XX5	MATERNAL CARE FOR (SUSPECTED) CHROMOSOMAL ABNORMALITY IN FETUS,	MATERNAL CARE FOR CHROMOSOMAL ABNORMALITY IN

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	FETUS 5	FETUS, FETUS 5
O35.1XX9	MATERNAL CARE FOR (SUSPECTED) CHROMOSOMAL ABNORMALITY IN FETUS, OTHER FETUS	MATERNAL CARE FOR CHROMOSOMAL ABNORMALITY IN FETUS, OTH
O35.3XX0	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS FROM VIRAL DISEASE IN MOTHER, NOT APPLICABLE OR UNSPECIFIED	MATERN CARE FOR DAMAG TO FTS FROM VIRAL DIS IN MOTHER, UNSP
O35.3XX1	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS FROM VIRAL DISEASE IN MOTHER, FETUS 1	MATERN CARE FOR DAMAG TO FTS FROM VIRAL DIS IN MOTHER, FTS1
O35.3XX2	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS FROM VIRAL DISEASE IN MOTHER, FETUS 2	MATERN CARE FOR DAMAG TO FTS FROM VIRAL DIS IN MOTHER, FTS2
O35.3XX3	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS FROM VIRAL DISEASE IN MOTHER, FETUS 3	MATERN CARE FOR DAMAG TO FTS FROM VIRAL DIS IN MOTHER, FTS3
O35.3XX4	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS FROM VIRAL DISEASE IN MOTHER, FETUS 4	MATERN CARE FOR DAMAG TO FTS FROM VIRAL DIS IN MOTHER, FTS4
O35.3XX5	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS FROM VIRAL DISEASE IN MOTHER, FETUS 5	MATERN CARE FOR DAMAG TO FTS FROM VIRAL DIS IN MOTHER, FTS5
O35.3XX9	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS FROM VIRAL DISEASE IN MOTHER, OTHER FETUS	MATERN CARE FOR DAMAG TO FETUS FROM VIRAL DIS IN MOTHER, OTH
O35.4XX0	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS FROM ALCOHOL, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR DAMAGE TO FETUS FROM ALCOHOL, UNSP
O35.4XX1	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS FROM ALCOHOL, FETUS 1	MATERNAL CARE FOR DAMAGE TO FETUS FROM ALCOHOL, FETUS 1
O35.4XX2	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS FROM ALCOHOL, FETUS 2	MATERNAL CARE FOR DAMAGE TO FETUS FROM ALCOHOL, FETUS 2
O35.4XX3	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS FROM ALCOHOL, FETUS 3	MATERNAL CARE FOR DAMAGE TO FETUS FROM ALCOHOL, FETUS 3
O35.4XX4	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS FROM ALCOHOL, FETUS 4	MATERNAL CARE FOR DAMAGE TO FETUS FROM ALCOHOL, FETUS 4
O35.4XX5	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS FROM ALCOHOL, FETUS 5	MATERNAL CARE FOR DAMAGE TO FETUS FROM ALCOHOL, FETUS 5
O35.4XX9	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS FROM ALCOHOL, OTHER FETUS	MATERNAL CARE FOR DAMAGE TO FETUS FROM ALCOHOL, OTH
O35.5XX0	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY DRUGS, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY DRUGS, UNSP
O35.5XX1	MATERNAL CARE FOR (SUSPECTED) DAMAGE	MATERNAL CARE FOR DAMAGE TO

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	TO FETUS BY DRUGS, FETUS 1	FETUS BY DRUGS, FETUS 1
O35.5XX2	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY DRUGS, FETUS 2	MATERNAL CARE FOR DAMAGE TO FETUS BY DRUGS, FETUS 2
O35.5XX3	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY DRUGS, FETUS 3	MATERNAL CARE FOR DAMAGE TO FETUS BY DRUGS, FETUS 3
O35.5XX4	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY DRUGS, FETUS 4	MATERNAL CARE FOR DAMAGE TO FETUS BY DRUGS, FETUS 4
O35.5XX5	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY DRUGS, FETUS 5	MATERNAL CARE FOR DAMAGE TO FETUS BY DRUGS, FETUS 5
O35.5XX9	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY DRUGS, OTHER FETUS	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY DRUGS, OTH
O35.6XX0	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY RADIATION, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR DAMAGE TO FETUS BY RADIATION, UNSP
O35.6XX1	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY RADIATION, FETUS 1	MATERNAL CARE FOR DAMAGE TO FETUS BY RADIATION, FETUS 1
O35.6XX2	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY RADIATION, FETUS 2	MATERNAL CARE FOR DAMAGE TO FETUS BY RADIATION, FETUS 2
O35.6XX3	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY RADIATION, FETUS 3	MATERNAL CARE FOR DAMAGE TO FETUS BY RADIATION, FETUS 3
O35.6XX4	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY RADIATION, FETUS 4	MATERNAL CARE FOR DAMAGE TO FETUS BY RADIATION, FETUS 4
O35.6XX5	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY RADIATION, FETUS 5	MATERNAL CARE FOR DAMAGE TO FETUS BY RADIATION, FETUS 5
O35.6XX9	MATERNAL CARE FOR (SUSPECTED) DAMAGE TO FETUS BY RADIATION, OTHER FETUS	MATERNAL CARE FOR DAMAGE TO FETUS BY RADIATION, OTH
O36.0110	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, FIRST TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR ANTI-D ANTIBODIES, FIRST TRIMESTER, UNSP
O36.0111	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, FIRST TRIMESTER, FETUS 1	MATERNAL CARE FOR ANTI-D ANTIBODIES, FIRST TRI, FETUS 1
O36.0112	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, FIRST TRIMESTER, FETUS 2	MATERNAL CARE FOR ANTI-D ANTIBODIES, FIRST TRI, FETUS 2
O36.0113	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, FIRST TRIMESTER, FETUS 3	MATERNAL CARE FOR ANTI-D ANTIBODIES, FIRST TRI, FETUS 3
O36.0114	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, FIRST TRIMESTER, FETUS 4	MATERNAL CARE FOR ANTI-D ANTIBODIES, FIRST TRI, FETUS 4
O36.0115	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, FIRST TRIMESTER, FETUS 5	MATERNAL CARE FOR ANTI-D ANTIBODIES, FIRST TRI, FETUS 5
O36.0119	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, FIRST TRIMESTER, OTHER FETUS	MATERNAL CARE FOR ANTI-D ANTIBODIES, FIRST TRIMESTER, OTH
O36.0120	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES,	MATERNAL CARE FOR ANTI-D

SECTION 6 BIRTH OUTCOMES INITIATIVE

BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
	SECOND TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	ANTIBODIES, SECOND TRIMESTER, UNSP
O36.0121	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, SECOND TRIMESTER, FETUS 1	MATERNAL CARE FOR ANTI-D ANTIBODIES, SECOND TRI, FETUS 1
O36.0122	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, SECOND TRIMESTER, FETUS 2	MATERNAL CARE FOR ANTI-D ANTIBODIES, SECOND TRI, FETUS 2
O36.0123	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, SECOND TRIMESTER, FETUS 3	MATERNAL CARE FOR ANTI-D ANTIBODIES, SECOND TRI, FETUS 3
O36.0124	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, SECOND TRIMESTER, FETUS 4	MATERNAL CARE FOR ANTI-D ANTIBODIES, SECOND TRI, FETUS 4
O36.0125	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, SECOND TRIMESTER, FETUS 5	MATERNAL CARE FOR ANTI-D ANTIBODIES, SECOND TRI, FETUS 5
O36.0129	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, SECOND TRIMESTER, OTHER FETUS	MATERNAL CARE FOR ANTI-D ANTIBODIES, SECOND TRIMESTER, OTH
O36.0130	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, THIRD TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR ANTI-D ANTIBODIES, THIRD TRIMESTER, UNSP
O36.0131	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, THIRD TRIMESTER, FETUS 1	MATERNAL CARE FOR ANTI-D ANTIBODIES, THIRD TRI, FETUS 1
O36.0132	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, THIRD TRIMESTER, FETUS 2	MATERNAL CARE FOR ANTI-D ANTIBODIES, THIRD TRI, FETUS 2
O36.0133	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, THIRD TRIMESTER, FETUS 3	MATERNAL CARE FOR ANTI-D ANTIBODIES, THIRD TRI, FETUS 3
O36.0134	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, THIRD TRIMESTER, FETUS 4	MATERNAL CARE FOR ANTI-D ANTIBODIES, THIRD TRI, FETUS 4
O36.0135	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, THIRD TRIMESTER, FETUS 5	MATERNAL CARE FOR ANTI-D ANTIBODIES, THIRD TRI, FETUS 5
O36.0139	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, THIRD TRIMESTER, OTHER FETUS	MATERNAL CARE FOR ANTI-D ANTIBODIES, THIRD TRIMESTER, OTH
O36.0190	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, UNSPECIFIED TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR ANTI-D ANTIBODIES, UNSP TRIMESTER, UNSP
O36.0191	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, UNSPECIFIED TRIMESTER, FETUS 1	MATERNAL CARE FOR ANTI-D ANTIBODIES, UNSP TRIMESTER, FETUS 1
O36.0192	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, UNSPECIFIED TRIMESTER, FETUS 2	MATERNAL CARE FOR ANTI-D ANTIBODIES, UNSP TRIMESTER, FETUS 2
O36.0193	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, UNSPECIFIED TRIMESTER, FETUS 3	MATERNAL CARE FOR ANTI-D ANTIBODIES, UNSP TRIMESTER, FETUS 3
O36.0194	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, UNSPECIFIED TRIMESTER, FETUS 4	MATERNAL CARE FOR ANTI-D ANTIBODIES, UNSP TRIMESTER,

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
		FETUS 4
O36.0195	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, UNSPECIFIED TRIMESTER, FETUS 5	MATERNAL CARE FOR ANTI-D ANTIBODIES, UNSP TRIMESTER, FETUS 5
O36.0199	MATERNAL CARE FOR ANTI-D [RH] ANTIBODIES, UNSPECIFIED TRIMESTER, OTHER FETUS	MATERNAL CARE FOR ANTI-D ANTIBODIES, UNSP TRIMESTER, OTH
O36.0910	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, FIRST TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, FIRST TRIMESTER, UNSP
O36.0911	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, FIRST TRIMESTER, FETUS 1	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, FIRST TRI, FETUS 1
O36.0912	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, FIRST TRIMESTER, FETUS 2	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, FIRST TRI, FETUS 2
O36.0913	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, FIRST TRIMESTER, FETUS 3	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, FIRST TRI, FETUS 3
O36.0914	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, FIRST TRIMESTER, FETUS 4	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, FIRST TRI, FETUS 4
O36.0915	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, FIRST TRIMESTER, FETUS 5	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, FIRST TRI, FETUS 5
O36.0919	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, FIRST TRIMESTER, OTHER FETUS	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, FIRST TRIMESTER, OTH
O36.0920	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, SECOND TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, SECOND TRI, UNSP
O36.0921	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, SECOND TRIMESTER, FETUS 1	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, SECOND TRI, FETUS 1
O36.0922	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, SECOND TRIMESTER, FETUS 2	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, SECOND TRI, FETUS 2
O36.0923	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, SECOND TRIMESTER, FETUS 3	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, SECOND TRI, FETUS 3
O36.0924	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, SECOND TRIMESTER, FETUS 4	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, SECOND TRI, FETUS 4
O36.0925	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, SECOND TRIMESTER, FETUS 5	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, SECOND TRI, FETUS 5
O36.0929	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, SECOND TRIMESTER, OTHER FETUS	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, SECOND TRIMESTER, OTH
O36.0930	MATERNAL CARE FOR OTHER RHESUS	MATERNAL CARE FOR OTH RHESUS

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
	ISOIMMUNIZATION, THIRD TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	ISOIMMUN, THIRD TRIMESTER, UNSP
O36.0931	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, THIRD TRIMESTER, FETUS 1	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, THIRD TRI, FETUS 1
O36.0932	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, THIRD TRIMESTER, FETUS 2	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, THIRD TRI, FETUS 2
O36.0933	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, THIRD TRIMESTER, FETUS 3	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, THIRD TRI, FETUS 3
O36.0934	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, THIRD TRIMESTER, FETUS 4	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, THIRD TRI, FETUS 4
O36.0935	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, THIRD TRIMESTER, FETUS 5	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, THIRD TRI, FETUS 5
O36.0939	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, THIRD TRIMESTER, OTHER FETUS	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, THIRD TRIMESTER, OTH
O36.0990	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, UNSPECIFIED TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, UNSP TRIMESTER, UNSP
O36.0991	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, UNSPECIFIED TRIMESTER, FETUS 1	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, UNSP TRI, FETUS 1
O36.0992	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, UNSPECIFIED TRIMESTER, FETUS 2	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, UNSP TRI, FETUS 2
O36.0993	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, UNSPECIFIED TRIMESTER, FETUS 3	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, UNSP TRI, FETUS 3
O36.0994	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, UNSPECIFIED TRIMESTER, FETUS 4	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, UNSP TRI, FETUS 4
O36.0995	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, UNSPECIFIED TRIMESTER, FETUS 5	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, UNSP TRI, FETUS 5
O36.0999	MATERNAL CARE FOR OTHER RHESUS ISOIMMUNIZATION, UNSPECIFIED TRIMESTER, OTHER FETUS	MATERNAL CARE FOR OTH RHESUS ISOIMMUN, UNSP TRIMESTER, OTH
O36.1110	MATERNAL CARE FOR ANTI-A SENSITIZATION, FIRST TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR ANTI-A SENSITIZATION, FIRST TRI, UNSP
O36.1111	MATERNAL CARE FOR ANTI-A SENSITIZATION, FIRST TRIMESTER, FETUS 1	MATERNAL CARE FOR ANTI-A SENSITIZATION, FIRST TRI, FETUS 1
O36.1112	MATERNAL CARE FOR ANTI-A SENSITIZATION, FIRST TRIMESTER, FETUS 2	MATERNAL CARE FOR ANTI-A SENSITIZATION, FIRST TRI, FETUS 2
O36.1113	MATERNAL CARE FOR ANTI-A SENSITIZATION, FIRST TRIMESTER, FETUS 3	MATERNAL CARE FOR ANTI-A SENSITIZATION, FIRST TRI, FETUS 3

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O36.1114	MATERNAL CARE FOR ANTI-A SENSITIZATION, FIRST TRIMESTER, FETUS 4	MATERNAL CARE FOR ANTI-A SENSITIZATION, FIRST TRI, FETUS 4
O36.1115	MATERNAL CARE FOR ANTI-A SENSITIZATION, FIRST TRIMESTER, FETUS 5	MATERNAL CARE FOR ANTI-A SENSITIZATION, FIRST TRI, FETUS 5
O36.1119	MATERNAL CARE FOR ANTI-A SENSITIZATION, FIRST TRIMESTER, OTHER FETUS	MATERNAL CARE FOR ANTI-A SENSITIZATION, FIRST TRIMESTER, OTH
O36.1120	MATERNAL CARE FOR ANTI-A SENSITIZATION, SECOND TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR ANTI-A SENSITIZATION, SECOND TRI, UNSP
O36.1121	MATERNAL CARE FOR ANTI-A SENSITIZATION, SECOND TRIMESTER, FETUS 1	MATERNAL CARE FOR ANTI-A SENSITIZATION, SECOND TRI, FETUS 1
O36.1122	MATERNAL CARE FOR ANTI-A SENSITIZATION, SECOND TRIMESTER, FETUS 2	MATERNAL CARE FOR ANTI-A SENSITIZATION, SECOND TRI, FETUS 2
O36.1123	MATERNAL CARE FOR ANTI-A SENSITIZATION, SECOND TRIMESTER, FETUS 3	MATERNAL CARE FOR ANTI-A SENSITIZATION, SECOND TRI, FETUS 3
O36.1124	MATERNAL CARE FOR ANTI-A SENSITIZATION, SECOND TRIMESTER, FETUS 4	MATERNAL CARE FOR ANTI-A SENSITIZATION, SECOND TRI, FETUS 4
O36.1125	MATERNAL CARE FOR ANTI-A SENSITIZATION, SECOND TRIMESTER, FETUS 5	MATERNAL CARE FOR ANTI-A SENSITIZATION, SECOND TRI, FETUS 5
O36.1129	MATERNAL CARE FOR ANTI-A SENSITIZATION, SECOND TRIMESTER, OTHER FETUS	MATERNAL CARE FOR ANTI-A SENSITIZATION, SECOND TRI, OTH
O36.1130	MATERNAL CARE FOR ANTI-A SENSITIZATION, THIRD TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR ANTI-A SENSITIZATION, THIRD TRI, UNSP
O36.1131	MATERNAL CARE FOR ANTI-A SENSITIZATION, THIRD TRIMESTER, FETUS 1	MATERNAL CARE FOR ANTI-A SENSITIZATION, THIRD TRI, FETUS 1
O36.1132	MATERNAL CARE FOR ANTI-A SENSITIZATION, THIRD TRIMESTER, FETUS 2	MATERNAL CARE FOR ANTI-A SENSITIZATION, THIRD TRI, FETUS 2
O36.1133	MATERNAL CARE FOR ANTI-A SENSITIZATION, THIRD TRIMESTER, FETUS 3	MATERNAL CARE FOR ANTI-A SENSITIZATION, THIRD TRI, FETUS 3
O36.1134	MATERNAL CARE FOR ANTI-A SENSITIZATION, THIRD TRIMESTER, FETUS 4	MATERNAL CARE FOR ANTI-A SENSITIZATION, THIRD TRI, FETUS 4
O36.1135	MATERNAL CARE FOR ANTI-A SENSITIZATION, THIRD TRIMESTER, FETUS 5	MATERNAL CARE FOR ANTI-A SENSITIZATION, THIRD TRI, FETUS 5
O36.1139	MATERNAL CARE FOR ANTI-A SENSITIZATION, THIRD TRIMESTER, OTHER FETUS	MATERNAL CARE FOR ANTI-A SENSITIZATION, THIRD TRIMESTER, OTH
O36.1190	MATERNAL CARE FOR ANTI-A SENSITIZATION, UNSPECIFIED TRIMESTER, NOT APPLICABLE OR	MATERNAL CARE FOR ANTI-A SENSITIZATION, UNSP TRIMESTER,

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
	UNSPECIFIED	UNSP
O36.1191	MATERNAL CARE FOR ANTI-A SENSITIZATION, UNSPECIFIED TRIMESTER, FETUS 1	MATERNAL CARE FOR ANTI-A SENSITIZATION, UNSP TRI, FETUS 1
O36.1192	MATERNAL CARE FOR ANTI-A SENSITIZATION, UNSPECIFIED TRIMESTER, FETUS 2	MATERNAL CARE FOR ANTI-A SENSITIZATION, UNSP TRI, FETUS 2
O36.1193	MATERNAL CARE FOR ANTI-A SENSITIZATION, UNSPECIFIED TRIMESTER, FETUS 3	MATERNAL CARE FOR ANTI-A SENSITIZATION, UNSP TRI, FETUS 3
O36.1194	MATERNAL CARE FOR ANTI-A SENSITIZATION, UNSPECIFIED TRIMESTER, FETUS 4	MATERNAL CARE FOR ANTI-A SENSITIZATION, UNSP TRI, FETUS 4
O36.1195	MATERNAL CARE FOR ANTI-A SENSITIZATION, UNSPECIFIED TRIMESTER, FETUS 5	MATERNAL CARE FOR ANTI-A SENSITIZATION, UNSP TRI, FETUS 5
O36.1199	MATERNAL CARE FOR ANTI-A SENSITIZATION, UNSPECIFIED TRIMESTER, OTHER FETUS	MATERNAL CARE FOR ANTI-A SENSITIZATION, UNSP TRIMESTER, OTH
O36.1910	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, FIRST TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR OTH ISOIMMUNIZATION, FIRST TRIMESTER, UNSP
O36.1911	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, FIRST TRIMESTER, FETUS 1	MATERNAL CARE FOR OTH ISOIMMUN, FIRST TRIMESTER, FETUS 1
O36.1912	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, FIRST TRIMESTER, FETUS 2	MATERNAL CARE FOR OTH ISOIMMUN, FIRST TRIMESTER, FETUS 2
O36.1913	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, FIRST TRIMESTER, FETUS 3	MATERNAL CARE FOR OTH ISOIMMUN, FIRST TRIMESTER, FETUS 3
O36.1914	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, FIRST TRIMESTER, FETUS 4	MATERNAL CARE FOR OTH ISOIMMUN, FIRST TRIMESTER, FETUS 4
O36.1915	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, FIRST TRIMESTER, FETUS 5	MATERNAL CARE FOR OTH ISOIMMUN, FIRST TRIMESTER, FETUS 5
O36.1919	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, FIRST TRIMESTER, OTHER FETUS	MATERNAL CARE FOR OTH ISOIMMUNIZATION, FIRST TRIMESTER, OTH
O36.1920	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, SECOND TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR OTH ISOIMMUN, SECOND TRIMESTER, UNSP
O36.1921	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, SECOND TRIMESTER, FETUS 1	MATERNAL CARE FOR OTH ISOIMMUN, SECOND TRIMESTER, FETUS 1
O36.1922	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, SECOND TRIMESTER, FETUS 2	MATERNAL CARE FOR OTH ISOIMMUN, SECOND TRIMESTER, FETUS 2

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O36.1923	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, SECOND TRIMESTER, FETUS 3	MATERNAL CARE FOR OTH ISOIMMUN, SECOND TRIMESTER, FETUS 3
O36.1924	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, SECOND TRIMESTER, FETUS 4	MATERNAL CARE FOR OTH ISOIMMUN, SECOND TRIMESTER, FETUS 4
O36.1925	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, SECOND TRIMESTER, FETUS 5	MATERNAL CARE FOR OTH ISOIMMUN, SECOND TRIMESTER, FETUS 5
O36.1929	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, SECOND TRIMESTER, OTHER FETUS	MATERNAL CARE FOR OTH ISOIMMUNIZATION, SECOND TRIMESTER, OTH
O36.1930	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, THIRD TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR OTH ISOIMMUNIZATION, THIRD TRIMESTER, UNSP
O36.1931	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, THIRD TRIMESTER, FETUS 1	MATERNAL CARE FOR OTH ISOIMMUN, THIRD TRIMESTER, FETUS 1
O36.1932	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, THIRD TRIMESTER, FETUS 2	MATERNAL CARE FOR OTH ISOIMMUN, THIRD TRIMESTER, FETUS 2
O36.1933	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, THIRD TRIMESTER, FETUS 3	MATERNAL CARE FOR OTH ISOIMMUN, THIRD TRIMESTER, FETUS 3
O36.1934	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, THIRD TRIMESTER, FETUS 4	MATERNAL CARE FOR OTH ISOIMMUN, THIRD TRIMESTER, FETUS 4
O36.1935	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, THIRD TRIMESTER, FETUS 5	MATERNAL CARE FOR OTH ISOIMMUN, THIRD TRIMESTER, FETUS 5
O36.1939	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, THIRD TRIMESTER, OTHER FETUS	MATERNAL CARE FOR OTH ISOIMMUNIZATION, THIRD TRIMESTER, OTH
O36.1990	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, UNSPECIFIED TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR OTH ISOIMMUNIZATION, UNSP TRIMESTER, UNSP
O36.1991	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, UNSPECIFIED TRIMESTER, FETUS 1	MATERNAL CARE FOR OTH ISOIMMUN, UNSP TRIMESTER, FETUS 1
O36.1992	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, UNSPECIFIED TRIMESTER, FETUS 2	MATERNAL CARE FOR OTH ISOIMMUN, UNSP TRIMESTER, FETUS 2
O36.1993	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, UNSPECIFIED TRIMESTER, FETUS 3	MATERNAL CARE FOR OTH ISOIMMUN, UNSP TRIMESTER, FETUS 3

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O36.1994	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, UNSPECIFIED TRIMESTER, FETUS 4	MATERNAL CARE FOR OTH ISOIMMUN, UNSP TRIMESTER, FETUS 4
O36.1995	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, UNSPECIFIED TRIMESTER, FETUS 5	MATERNAL CARE FOR OTH ISOIMMUN, UNSP TRIMESTER, FETUS 5
O36.1999	MATERNAL CARE FOR OTHER ISOIMMUNIZATION, UNSPECIFIED TRIMESTER, OTHER FETUS	MATERNAL CARE FOR OTH ISOIMMUNIZATION, UNSP TRIMESTER, OTH
O36.4XX0	MATERNAL CARE FOR INTRAUTERINE DEATH, NOT APPLICABLE OR UNSPECIFIED	MATERNAL CARE FOR INTRAUTERINE DEATH, NOT APPLICABLE OR UNSP
O36.4XX1	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 1	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 1
O36.4XX2	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 2	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 2
O36.4XX3	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 3	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 3
O36.4XX4	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 4	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 4
O36.4XX5	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 5	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 5
O36.4XX9	MATERNAL CARE FOR INTRAUTERINE DEATH, OTHER FETUS	MATERNAL CARE FOR INTRAUTERINE DEATH, OTHER FETUS
O36.5110	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, FIRST TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, 1ST TRI, UNSP
O36.5111	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, FIRST TRIMESTER, FETUS 1	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, 1ST TRI, FTS1
O36.5112	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, FIRST TRIMESTER, FETUS 2	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, 1ST TRI, FTS2
O36.5113	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, FIRST TRIMESTER, FETUS 3	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, 1ST TRI, FTS3
O36.5114	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, FIRST TRIMESTER, FETUS 4	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, 1ST TRI, FTS4
O36.5115	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, FIRST TRIMESTER, FETUS 5	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, 1ST TRI, FTS5
O36.5119	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, FIRST TRIMESTER, OTHER FETUS	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, FIRST TRI, OTH

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O36.5120	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, SECOND TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, 2ND TRI, UNSP
O36.5121	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, SECOND TRIMESTER, FETUS 1	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, 2ND TRI, FTS1
O36.5122	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, SECOND TRIMESTER, FETUS 2	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, 2ND TRI, FTS2
O36.5123	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, SECOND TRIMESTER, FETUS 3	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, 2ND TRI, FTS3
O36.5124	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, SECOND TRIMESTER, FETUS 4	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, 2ND TRI, FTS4
O36.5125	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, SECOND TRIMESTER, FETUS 5	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, 2ND TRI, FTS5
O36.5129	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, SECOND TRIMESTER, OTHER FETUS	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, 2ND TRI, OTH
O36.5130	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, THIRD TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERN CARE FOR OR SUSP PLACNTL INSUFF, THIRD TRI, UNSP
O36.5131	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, THIRD TRIMESTER, FETUS 1	MATERN CARE FOR OR SUSP PLACNTL INSUFF, THIRD TRI, FTS1
O36.5132	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, THIRD TRIMESTER, FETUS 2	MATERN CARE FOR OR SUSP PLACNTL INSUFF, THIRD TRI, FTS2
O36.5133	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, THIRD TRIMESTER, FETUS 3	MATERN CARE FOR OR SUSP PLACNTL INSUFF, THIRD TRI, FTS3
O36.5134	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, THIRD TRIMESTER, FETUS 4	MATERN CARE FOR OR SUSP PLACNTL INSUFF, THIRD TRI, FTS4
O36.5135	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, THIRD TRIMESTER, FETUS 5	MATERN CARE FOR OR SUSP PLACNTL INSUFF, THIRD TRI, FTS5
O36.5139	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, THIRD TRIMESTER, OTHER FETUS	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, THIRD TRI, OTH
O36.5190	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, UNSPECIFIED TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, UNSP TRI, UNSP

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O36.5191	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, UNSPECIFIED TRIMESTER, FETUS 1	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, UNSP TRI, FTS1
O36.5192	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, UNSPECIFIED TRIMESTER, FETUS 2	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, UNSP TRI, FTS2
O36.5193	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, UNSPECIFIED TRIMESTER, FETUS 3	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, UNSP TRI, FTS3
O36.5194	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, UNSPECIFIED TRIMESTER, FETUS 4	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, UNSP TRI, FTS4
O36.5195	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, UNSPECIFIED TRIMESTER, FETUS 5	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, UNSP TRI, FTS5
O36.5199	MATERNAL CARE FOR KNOWN OR SUSPECTED PLACENTAL INSUFFICIENCY, UNSPECIFIED TRIMESTER, OTHER FETUS	MATERN CARE FOR KNOWN OR SUSP PLACNTL INSUFF, UNSP TRI, OTH
O36.5910	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, FIRST TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, 1ST TRI, UNSP
O36.5911	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, FIRST TRIMESTER, FETUS 1	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, 1ST TRI, FTS1
O36.5912	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, FIRST TRIMESTER, FETUS 2	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, 1ST TRI, FTS2
O36.5913	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, FIRST TRIMESTER, FETUS 3	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, 1ST TRI, FTS3
O36.5914	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, FIRST TRIMESTER, FETUS 4	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, 1ST TRI, FTS4
O36.5915	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, FIRST TRIMESTER, FETUS 5	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, 1ST TRI, FTS5
O36.5919	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, FIRST TRIMESTER, OTHER FETUS	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, 1ST TRI, OTH
O36.5920	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, SECOND TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, 2ND TRI, UNSP
O36.5921	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, SECOND TRIMESTER, FETUS 1	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, 2ND TRI, FTS1

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ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O36.5922	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, SECOND TRIMESTER, FETUS 2	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, 2ND TRI, FTS2
O36.5923	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, SECOND TRIMESTER, FETUS 3	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, 2ND TRI, FTS3
O36.5924	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, SECOND TRIMESTER, FETUS 4	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, 2ND TRI, FTS4
O36.5925	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, SECOND TRIMESTER, FETUS 5	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, 2ND TRI, FTS5
O36.5929	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, SECOND TRIMESTER, OTHER FETUS	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, 2ND TRI, OTH
O36.5930	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, THIRD TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, THIRD TRI, UNSP
O36.5931	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, THIRD TRIMESTER, FETUS 1	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, THIRD TRI, FTS1
O36.5932	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, THIRD TRIMESTER, FETUS 2	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, THIRD TRI, FTS2
O36.5933	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, THIRD TRIMESTER, FETUS 3	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, THIRD TRI, FTS3
O36.5934	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, THIRD TRIMESTER, FETUS 4	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, THIRD TRI, FTS4
O36.5935	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, THIRD TRIMESTER, FETUS 5	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, THIRD TRI, FTS5
O36.5939	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, THIRD TRIMESTER, OTHER FETUS	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, THIRD TRI, OTH
O36.5990	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, UNSPECIFIED TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, UNSP TRI, UNSP
O36.5991	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, UNSPECIFIED TRIMESTER, FETUS 1	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, UNSP TRI, FTS1
O36.5992	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, UNSPECIFIED TRIMESTER, FETUS 2	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, UNSP TRI, FTS2

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ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O36.5993	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, UNSPECIFIED TRIMESTER, FETUS 3	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, UNSP TRI, FTS3
O36.5994	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, UNSPECIFIED TRIMESTER, FETUS 4	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, UNSP TRI, FTS4
O36.5995	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, UNSPECIFIED TRIMESTER, FETUS 5	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, UNSP TRI, FTS5
O36.5999	MATERNAL CARE FOR OTHER KNOWN OR SUSPECTED POOR FETAL GROWTH, UNSPECIFIED TRIMESTER, OTHER FETUS	MATERN CARE FOR OTH OR SUSP POOR FETL GRTH, UNSP TRI, OTH
O40.1XX0	POLYHYDRAMNIOS, FIRST TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	POLYHYDRAMNIOS, FIRST TRIMESTER, NOT APPLICABLE OR UNSP
O40.1XX1	POLYHYDRAMNIOS, FIRST TRIMESTER, FETUS 1	POLYHYDRAMNIOS, FIRST TRIMESTER, FETUS 1
O40.1XX2	POLYHYDRAMNIOS, FIRST TRIMESTER, FETUS 2	POLYHYDRAMNIOS, FIRST TRIMESTER, FETUS 2
O40.1XX3	POLYHYDRAMNIOS, FIRST TRIMESTER, FETUS 3	POLYHYDRAMNIOS, FIRST TRIMESTER, FETUS 3
O40.1XX4	POLYHYDRAMNIOS, FIRST TRIMESTER, FETUS 4	POLYHYDRAMNIOS, FIRST TRIMESTER, FETUS 4
O40.1XX5	POLYHYDRAMNIOS, FIRST TRIMESTER, FETUS 5	POLYHYDRAMNIOS, FIRST TRIMESTER, FETUS 5
O40.1XX9	POLYHYDRAMNIOS, FIRST TRIMESTER, OTHER FETUS	POLYHYDRAMNIOS, FIRST TRIMESTER, OTHER FETUS
O40.2XX0	POLYHYDRAMNIOS, SECOND TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	POLYHYDRAMNIOS, SECOND TRIMESTER, NOT APPLICABLE OR UNSP
O40.2XX1	POLYHYDRAMNIOS, SECOND TRIMESTER, FETUS 1	POLYHYDRAMNIOS, SECOND TRIMESTER, FETUS 1
O40.2XX2	POLYHYDRAMNIOS, SECOND TRIMESTER, FETUS 2	POLYHYDRAMNIOS, SECOND TRIMESTER, FETUS 2
O40.2XX3	POLYHYDRAMNIOS, SECOND TRIMESTER, FETUS 3	POLYHYDRAMNIOS, SECOND TRIMESTER, FETUS 3
O40.2XX4	POLYHYDRAMNIOS, SECOND TRIMESTER, FETUS 4	POLYHYDRAMNIOS, SECOND TRIMESTER, FETUS 4
O40.2XX5	POLYHYDRAMNIOS, SECOND TRIMESTER, FETUS 5	POLYHYDRAMNIOS, SECOND TRIMESTER, FETUS 5
O40.2XX9	POLYHYDRAMNIOS, SECOND TRIMESTER, OTHER FETUS	POLYHYDRAMNIOS, SECOND TRIMESTER, OTHER FETUS
O40.3XX0	POLYHYDRAMNIOS, THIRD TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	POLYHYDRAMNIOS, THIRD TRIMESTER, NOT APPLICABLE OR

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ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
		UNSP
O40.3XX1	POLYHYDRAMNIOS, THIRD TRIMESTER, FETUS 1	POLYHYDRAMNIOS, THIRD TRIMESTER, FETUS 1
O40.3XX2	POLYHYDRAMNIOS, THIRD TRIMESTER, FETUS 2	POLYHYDRAMNIOS, THIRD TRIMESTER, FETUS 2
O40.3XX3	POLYHYDRAMNIOS, THIRD TRIMESTER, FETUS 3	POLYHYDRAMNIOS, THIRD TRIMESTER, FETUS 3
O40.3XX4	POLYHYDRAMNIOS, THIRD TRIMESTER, FETUS 4	POLYHYDRAMNIOS, THIRD TRIMESTER, FETUS 4
O40.3XX5	POLYHYDRAMNIOS, THIRD TRIMESTER, FETUS 5	POLYHYDRAMNIOS, THIRD TRIMESTER, FETUS 5
O40.3XX9	POLYHYDRAMNIOS, THIRD TRIMESTER, OTHER FETUS	POLYHYDRAMNIOS, THIRD TRIMESTER, OTHER FETUS
O40.9XX0	POLYHYDRAMNIOS, UNSPECIFIED TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	POLYHYDRAMNIOS, UNSP TRIMESTER, NOT APPLICABLE OR UNSP
O40.9XX1	POLYHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 1	POLYHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 1
O40.9XX2	POLYHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 2	POLYHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 2
O40.9XX3	POLYHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 3	POLYHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 3
O40.9XX4	POLYHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 4	POLYHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 4
O40.9XX5	POLYHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 5	POLYHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 5
O40.9XX9	POLYHYDRAMNIOS, UNSPECIFIED TRIMESTER, OTHER FETUS	POLYHYDRAMNIOS, UNSPECIFIED TRIMESTER, OTHER FETUS
O41.00X0	OLIGOHYDRAMNIOS, UNSPECIFIED TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	OLIGOHYDRAMNIOS, UNSP TRIMESTER, NOT APPLICABLE OR UNSP
O41.00X1	OLIGOHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 1	OLIGOHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 1
O41.00X2	OLIGOHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 2	OLIGOHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 2
O41.00X3	OLIGOHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 3	OLIGOHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 3
O41.00X4	OLIGOHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 4	OLIGOHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 4
O41.00X5	OLIGOHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 5	OLIGOHYDRAMNIOS, UNSPECIFIED TRIMESTER, FETUS 5
O41.00X9	OLIGOHYDRAMNIOS, UNSPECIFIED TRIMESTER,	OLIGOHYDRAMNIOS, UNSPECIFIED

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ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
	OTHER FETUS	TRIMESTER, OTHER FETUS
O41.01X0	OLIGOHYDRAMNIOS, FIRST TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	OLIGOHYDRAMNIOS, FIRST TRIMESTER, NOT APPLICABLE OR UNSP
O41.01X1	OLIGOHYDRAMNIOS, FIRST TRIMESTER, FETUS 1	OLIGOHYDRAMNIOS, FIRST TRIMESTER, FETUS 1
O41.01X2	OLIGOHYDRAMNIOS, FIRST TRIMESTER, FETUS 2	OLIGOHYDRAMNIOS, FIRST TRIMESTER, FETUS 2
O41.01X3	OLIGOHYDRAMNIOS, FIRST TRIMESTER, FETUS 3	OLIGOHYDRAMNIOS, FIRST TRIMESTER, FETUS 3
O41.01X4	OLIGOHYDRAMNIOS, FIRST TRIMESTER, FETUS 4	OLIGOHYDRAMNIOS, FIRST TRIMESTER, FETUS 4
O41.01X5	OLIGOHYDRAMNIOS, FIRST TRIMESTER, FETUS 5	OLIGOHYDRAMNIOS, FIRST TRIMESTER, FETUS 5
O41.01X9	OLIGOHYDRAMNIOS, FIRST TRIMESTER, OTHER FETUS	OLIGOHYDRAMNIOS, FIRST TRIMESTER, OTHER FETUS
O41.02X0	OLIGOHYDRAMNIOS, SECOND TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	OLIGOHYDRAMNIOS, SECOND TRIMESTER, NOT APPLICABLE OR UNSP
O41.02X1	OLIGOHYDRAMNIOS, SECOND TRIMESTER, FETUS 1	OLIGOHYDRAMNIOS, SECOND TRIMESTER, FETUS 1
O41.02X2	OLIGOHYDRAMNIOS, SECOND TRIMESTER, FETUS 2	OLIGOHYDRAMNIOS, SECOND TRIMESTER, FETUS 2
O41.02X3	OLIGOHYDRAMNIOS, SECOND TRIMESTER, FETUS 3	OLIGOHYDRAMNIOS, SECOND TRIMESTER, FETUS 3
O41.02X4	OLIGOHYDRAMNIOS, SECOND TRIMESTER, FETUS 4	OLIGOHYDRAMNIOS, SECOND TRIMESTER, FETUS 4
O41.02X5	OLIGOHYDRAMNIOS, SECOND TRIMESTER, FETUS 5	OLIGOHYDRAMNIOS, SECOND TRIMESTER, FETUS 5
O41.02X9	OLIGOHYDRAMNIOS, SECOND TRIMESTER, OTHER FETUS	OLIGOHYDRAMNIOS, SECOND TRIMESTER, OTHER FETUS
O41.03X0	OLIGOHYDRAMNIOS, THIRD TRIMESTER, NOT APPLICABLE OR UNSPECIFIED	OLIGOHYDRAMNIOS, THIRD TRIMESTER, NOT APPLICABLE OR UNSP
O41.03X1	OLIGOHYDRAMNIOS, THIRD TRIMESTER, FETUS 1	OLIGOHYDRAMNIOS, THIRD TRIMESTER, FETUS 1
O41.03X2	OLIGOHYDRAMNIOS, THIRD TRIMESTER, FETUS 2	OLIGOHYDRAMNIOS, THIRD TRIMESTER, FETUS 2
O41.03X3	OLIGOHYDRAMNIOS, THIRD TRIMESTER, FETUS 3	OLIGOHYDRAMNIOS, THIRD TRIMESTER, FETUS 3
O41.03X4	OLIGOHYDRAMNIOS, THIRD TRIMESTER, FETUS 4	OLIGOHYDRAMNIOS, THIRD TRIMESTER, FETUS 4

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O41.03X5	OLIGOHYDRAMNIOS, THIRD TRIMESTER, FETUS 5	OLIGOHYDRAMNIOS, THIRD TRIMESTER, FETUS 5
O41.03X9	OLIGOHYDRAMNIOS, THIRD TRIMESTER, OTHER FETUS	OLIGOHYDRAMNIOS, THIRD TRIMESTER, OTHER FETUS
O42.00	PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR WITHIN 24 HOURS OF RUPTURE, UNSPECIFIED WEEKS OF GESTATION	PREM ROM, ONSET LABOR W/N 24 HR OF RUPT, UNSP WEEKS OF GEST
O42.011	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR WITHIN 24 HOURS OF RUPTURE, FIRST TRIMESTER	PRETRM PREM ROM, ONSET LABOR W/N 24 HOURS OF RUPT, FIRST TRI
O42.012	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR WITHIN 24 HOURS OF RUPTURE, SECOND TRIMESTER	PRETRM PREM ROM, ONSET LABOR W/N 24 HOURS OF RUPT, 2ND TRI
O42.013	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR WITHIN 24 HOURS OF RUPTURE, THIRD TRIMESTER	PRETRM PREM ROM, ONSET LABOR W/N 24 HOURS OF RUPT, THIRD TRI
O42.019	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR WITHIN 24 HOURS OF RUPTURE, UNSPECIFIED TRIMESTER	PRETRM PREM ROM, ONSET LABOR W/N 24 HOURS OF RUPT, UNSP TRI
O42.02	FULL-TERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR WITHIN 24 HOURS OF RUPTURE	FULL-TERM PREM ROM, ONSET LABOR WITHIN 24 HOURS OF RUPTURE
O42.10	PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE, UNSPECIFIED WEEKS OF GESTATION	PREM ROM, ONSET LABOR > 24 HR FOL RUPT, UNSP WEEKS OF GEST
O42.111	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE, FIRST TRIMESTER	PRETRM PREM ROM, ONSET LABOR > 24 HOURS FOL RUPT, FIRST TRI
O42.112	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE, SECOND TRIMESTER	PRETRM PREM ROM, ONSET LABOR > 24 HOURS FOL RUPT, SECOND TRI
O42.113	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE, THIRD TRIMESTER	PRETRM PREM ROM, ONSET LABOR > 24 HOURS FOL RUPT, THIRD TRI
O42.119	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE, UNSPECIFIED TRIMESTER	PRETRM PREM ROM, ONSET LABOR > 24 HOURS FOL RUPT, UNSP TRI
O42.12	FULL-TERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE	FULL-TERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING

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ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
		RUPTURE
O42.90	PREMATURE RUPTURE OF MEMBRANES, UNSPECIFIED AS TO LENGTH OF TIME BETWEEN RUPTURE AND ONSET OF LABOR, UNSPECIFIED WEEKS OF GESTATION	PREM ROM, UNSP AS TO LENGTH OF TIME, BETW RUPT & ONST LABR, UNSP WEEKS OF GEST
O42.911	PRETERM PREMATURE RUPTURE OF MEMBRANES, UNSPECIFIED AS TO LENGTH OF TIME BETWEEN RUPTURE AND ONSET OF LABOR, FIRST TRIMESTER	PRETRM PREM ROM, UNSP TIME BETW RUPT AND ONSET LABR, 1ST TRI
O42.912	PRETERM PREMATURE RUPTURE OF MEMBRANES, UNSPECIFIED AS TO LENGTH OF TIME BETWEEN RUPTURE AND ONSET OF LABOR, SECOND TRIMESTER	PRETRM PREM ROM, UNSP TIME BETW RUPT AND ONSET LABR, 2ND TRI
O42.913	PRETERM PREMATURE RUPTURE OF MEMBRANES, UNSPECIFIED AS TO LENGTH OF TIME BETWEEN RUPTURE AND ONSET OF LABOR, THIRD TRIMESTER	PRETRM PREM ROM, UNSP TIME BETW RUPT AND ONST LABR, 3RD TRI
O42.919	PRETERM PREMATURE RUPTURE OF MEMBRANES, UNSPECIFIED AS TO LENGTH OF TIME BETWEEN RUPTURE AND ONSET OF LABOR, UNSPECIFIED TRIMESTER	PRETRM PREM ROM, UNSP TIME BETW RUPT AND ONST LABR, UNSP TRI
O42.92	FULL-TERM PREMATURE RUPTURE OF MEMBRANES, UNSPECIFIED AS TO LENGTH OF TIME BETWEEN RUPTURE AND ONSET OF LABOR	FULL-TERM PREM ROM, UNSP TIME BETW RUPTURE AND ONSET LABOR
O43.011	FETOMATERNAL PLACENTAL TRANSFUSION SYNDROME, FIRST TRIMESTER	FETOMATERNAL PLACENTAL TRANSFUSION SYNDROME, FIRST TRIMESTER
O43.012	FETOMATERNAL PLACENTAL TRANSFUSION SYNDROME, SECOND TRIMESTER	FETOMATERNAL PLACENTAL TRANSFUSE SYNDROME, SECOND TRIMESTER
O43.013	FETOMATERNAL PLACENTAL TRANSFUSION SYNDROME, THIRD TRIMESTER	FETOMATERNAL PLACENTAL TRANSFUSION SYNDROME, THIRD TRIMESTER
O43.019	FETOMATERNAL PLACENTAL TRANSFUSION SYNDROME, UNSPECIFIED TRIMESTER	FETOMATERNAL PLACENTAL TRANSFUSION SYNDROME, UNSP TRIMESTER
O44.00	PLACENTA PREVIA SPECIFIED AS WITHOUT HEMORRHAGE, UNSPECIFIED TRIMESTER	PLACENTA PREVIA SPECIFIED AS W/O HEMORRHAGE, UNSP TRIMESTER
O44.01	PLACENTA PREVIA SPECIFIED AS WITHOUT HEMORRHAGE, FIRST TRIMESTER	PLACENTA PREVIA SPECIFIED AS W/O HEMORRHAGE, FIRST TRIMESTER
O44.02	PLACENTA PREVIA SPECIFIED AS WITHOUT HEMORRHAGE, SECOND TRIMESTER	PLACENTA PREVIA SPECIFIED AS W/O HEMOR, SECOND TRIMESTER
O44.03	PLACENTA PREVIA SPECIFIED AS WITHOUT HEMORRHAGE, THIRD TRIMESTER	PLACENTA PREVIA SPECIFIED AS W/O HEMORRHAGE, THIRD TRIMESTER

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O44.10	PLACENTA PREVIA WITH HEMORRHAGE, UNSPECIFIED TRIMESTER	PLACENTA PREVIA WITH HEMORRHAGE, UNSPECIFIED TRIMESTER
O44.11	PLACENTA PREVIA WITH HEMORRHAGE, FIRST TRIMESTER	PLACENTA PREVIA WITH HEMORRHAGE, FIRST TRIMESTER
O44.12	PLACENTA PREVIA WITH HEMORRHAGE, SECOND TRIMESTER	PLACENTA PREVIA WITH HEMORRHAGE, SECOND TRIMESTER
O44.13	PLACENTA PREVIA WITH HEMORRHAGE, THIRD TRIMESTER	PLACENTA PREVIA WITH HEMORRHAGE, THIRD TRIMESTER
O45.001	PREMATURE SEPARATION OF PLACENTA WITH COAGULATION DEFECT, UNSPECIFIED, FIRST TRIMESTER	PREM SEPARTN OF PLACENTA W COAG DEFECT, UNSP, FIRST TRI
O45.002	PREMATURE SEPARATION OF PLACENTA WITH COAGULATION DEFECT, UNSPECIFIED, SECOND TRIMESTER	PREM SEPARTN OF PLACENTA W COAG DEFECT, UNSP, SECOND TRI
O45.003	PREMATURE SEPARATION OF PLACENTA WITH COAGULATION DEFECT, UNSPECIFIED, THIRD TRIMESTER	PREM SEPARTN OF PLACENTA W COAG DEFECT, UNSP, THIRD TRI
O45.009	PREMATURE SEPARATION OF PLACENTA WITH COAGULATION DEFECT, UNSPECIFIED, UNSPECIFIED TRIMESTER	PREM SEPARTN OF PLACENTA W COAG DEFECT, UNSP, UNSP TRIMESTER
O45.011	PREMATURE SEPARATION OF PLACENTA WITH AFIBRINOGENEMIA, FIRST TRIMESTER	PREM SEPARTN OF PLACENTA W AFIBRINOGENEMIA, FIRST TRIMESTER
O45.012	PREMATURE SEPARATION OF PLACENTA WITH AFIBRINOGENEMIA, SECOND TRIMESTER	PREM SEPARTN OF PLACENTA W AFIBRINOGENEMIA, SECOND TRIMESTER
O45.013	PREMATURE SEPARATION OF PLACENTA WITH AFIBRINOGENEMIA, THIRD TRIMESTER	PREM SEPARTN OF PLACENTA W AFIBRINOGENEMIA, THIRD TRIMESTER
O45.019	PREMATURE SEPARATION OF PLACENTA WITH AFIBRINOGENEMIA, UNSPECIFIED TRIMESTER	PREM SEPARTN OF PLACENTA W AFIBRINOGENEMIA, UNSP TRIMESTER
O45.021	PREMATURE SEPARATION OF PLACENTA WITH DISSEMINATED INTRAVASCULAR COAGULATION, FIRST TRIMESTER	PREM SEPARTN OF PLACENTA W DISSEM INTRAVASC COAG, FIRST TRI
O45.022	PREMATURE SEPARATION OF PLACENTA WITH DISSEMINATED INTRAVASCULAR COAGULATION, SECOND TRIMESTER	PREM SEPARTN OF PLACENTA W DISSEM INTRAVASC COAG, SECOND TRI
O45.023	PREMATURE SEPARATION OF PLACENTA WITH DISSEMINATED INTRAVASCULAR COAGULATION, THIRD TRIMESTER	PREM SEPARTN OF PLACENTA W DISSEM INTRAVASC COAG, THIRD TRI
O45.029	PREMATURE SEPARATION OF PLACENTA WITH DISSEMINATED INTRAVASCULAR COAGULATION, UNSPECIFIED TRIMESTER	PREM SEPARTN OF PLACENTA W DISSEM INTRAVASC COAG, UNSP TRI

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O45.091	PREMATURE SEPARATION OF PLACENTA WITH OTHER COAGULATION DEFECT, FIRST TRIMESTER	PREM SEPARTN OF PLACENTA W OTH COAG DEFECT, FIRST TRIMESTER
O45.092	PREMATURE SEPARATION OF PLACENTA WITH OTHER COAGULATION DEFECT, SECOND TRIMESTER	PREM SEPARTN OF PLACENTA W OTH COAG DEFECT, SECOND TRIMESTER
O45.093	PREMATURE SEPARATION OF PLACENTA WITH OTHER COAGULATION DEFECT, THIRD TRIMESTER	PREM SEPARTN OF PLACENTA W OTH COAG DEFECT, THIRD TRIMESTER
O45.099	PREMATURE SEPARATION OF PLACENTA WITH OTHER COAGULATION DEFECT, UNSPECIFIED TRIMESTER	PREM SEPARTN OF PLACENTA W OTH COAG DEFECT, UNSP TRIMESTER
O45.8X1	OTHER PREMATURE SEPARATION OF PLACENTA, FIRST TRIMESTER	OTHER PREMATURE SEPARATION OF PLACENTA, FIRST TRIMESTER
O45.8X2	OTHER PREMATURE SEPARATION OF PLACENTA, SECOND TRIMESTER	OTHER PREMATURE SEPARATION OF PLACENTA, SECOND TRIMESTER
O45.8X3	OTHER PREMATURE SEPARATION OF PLACENTA, THIRD TRIMESTER	OTHER PREMATURE SEPARATION OF PLACENTA, THIRD TRIMESTER
O45.8X9	OTHER PREMATURE SEPARATION OF PLACENTA, UNSPECIFIED TRIMESTER	OTHER PREMATURE SEPARATION OF PLACENTA, UNSP TRIMESTER
O45.90	PREMATURE SEPARATION OF PLACENTA, UNSPECIFIED, UNSPECIFIED TRIMESTER	PREMATURE SEPARATION OF PLACENTA, UNSP, UNSP TRIMESTER
O45.91	PREMATURE SEPARATION OF PLACENTA, UNSPECIFIED, FIRST TRIMESTER	PREMATURE SEPARATION OF PLACENTA, UNSP, FIRST TRIMESTER
O45.92	PREMATURE SEPARATION OF PLACENTA, UNSPECIFIED, SECOND TRIMESTER	PREMATURE SEPARATION OF PLACENTA, UNSP, SECOND TRIMESTER
O45.93	PREMATURE SEPARATION OF PLACENTA, UNSPECIFIED, THIRD TRIMESTER	PREMATURE SEPARATION OF PLACENTA, UNSP, THIRD TRIMESTER
O46.001	ANTEPARTUM HEMORRHAGE WITH COAGULATION DEFECT, UNSPECIFIED, FIRST TRIMESTER	ANTEPARTUM HEMORRHAGE W COAG DEFECT, UNSP, FIRST TRIMESTER
O46.002	ANTEPARTUM HEMORRHAGE WITH COAGULATION DEFECT, UNSPECIFIED, SECOND TRIMESTER	ANTEPARTUM HEMORRHAGE W COAG DEFECT, UNSP, SECOND TRIMESTER
O46.003	ANTEPARTUM HEMORRHAGE WITH COAGULATION DEFECT, UNSPECIFIED, THIRD TRIMESTER	ANTEPARTUM HEMORRHAGE W COAG DEFECT, UNSP, THIRD TRIMESTER
O46.009	ANTEPARTUM HEMORRHAGE WITH COAGULATION DEFECT, UNSPECIFIED, UNSPECIFIED TRIMESTER	ANTEPARTUM HEMORRHAGE W COAG DEFECT, UNSP, UNSP TRIMESTER
O46.011	ANTEPARTUM HEMORRHAGE WITH AFIBRINOGENEMIA, FIRST TRIMESTER	ANTEPARTUM HEMORRHAGE WITH AFIBRINOGENEMIA, FIRST TRIMESTER

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O46.012	ANTEPARTUM HEMORRHAGE WITH AFIBRINOGENEMIA, SECOND TRIMESTER	ANTEPARTUM HEMORRHAGE WITH AFIBRINOGENEMIA, SECOND TRIMESTER
O46.013	ANTEPARTUM HEMORRHAGE WITH AFIBRINOGENEMIA, THIRD TRIMESTER	ANTEPARTUM HEMORRHAGE WITH AFIBRINOGENEMIA, THIRD TRIMESTER
O46.019	ANTEPARTUM HEMORRHAGE WITH AFIBRINOGENEMIA, UNSPECIFIED TRIMESTER	ANTEPARTUM HEMORRHAGE WITH AFIBRINOGENEMIA, UNSP TRIMESTER
O46.021	ANTEPARTUM HEMORRHAGE WITH DISSEMINATED INTRAVASCULAR COAGULATION, FIRST TRIMESTER	ANTEPART HEMORRHAGE W DISSEM INTRAVASC COAG, FIRST TRIMESTER
O46.022	ANTEPARTUM HEMORRHAGE WITH DISSEMINATED INTRAVASCULAR COAGULATION, SECOND TRIMESTER	ANTEPART HEMOR W DISSEM INTRAVASC COAG, SECOND TRIMESTER
O46.023	ANTEPARTUM HEMORRHAGE WITH DISSEMINATED INTRAVASCULAR COAGULATION, THIRD TRIMESTER	ANTEPART HEMORRHAGE W DISSEM INTRAVASC COAG, THIRD TRIMESTER
O46.029	ANTEPARTUM HEMORRHAGE WITH DISSEMINATED INTRAVASCULAR COAGULATION, UNSPECIFIED TRIMESTER	ANTEPART HEMORRHAGE W DISSEM INTRAVASC COAG, UNSP TRIMESTER
O46.091	ANTEPARTUM HEMORRHAGE WITH OTHER COAGULATION DEFECT, FIRST TRIMESTER	ANTEPARTUM HEMORRHAGE W OTH COAG DEFECT, FIRST TRIMESTER
O46.092	ANTEPARTUM HEMORRHAGE WITH OTHER COAGULATION DEFECT, SECOND TRIMESTER	ANTEPARTUM HEMORRHAGE W OTH COAG DEFECT, SECOND TRIMESTER
O46.093	ANTEPARTUM HEMORRHAGE WITH OTHER COAGULATION DEFECT, THIRD TRIMESTER	ANTEPARTUM HEMORRHAGE W OTH COAG DEFECT, THIRD TRIMESTER
O46.099	ANTEPARTUM HEMORRHAGE WITH OTHER COAGULATION DEFECT, UNSPECIFIED TRIMESTER	ANTEPARTUM HEMORRHAGE W OTH COAG DEFECT, UNSP TRIMESTER
O46.8X1	OTHER ANTEPARTUM HEMORRHAGE, FIRST TRIMESTER	OTHER ANTEPARTUM HEMORRHAGE, FIRST TRIMESTER
O46.8X2	OTHER ANTEPARTUM HEMORRHAGE, SECOND TRIMESTER	OTHER ANTEPARTUM HEMORRHAGE, SECOND TRIMESTER
O46.8X3	OTHER ANTEPARTUM HEMORRHAGE, THIRD TRIMESTER	OTHER ANTEPARTUM HEMORRHAGE, THIRD TRIMESTER
O46.8X9	OTHER ANTEPARTUM HEMORRHAGE, UNSPECIFIED TRIMESTER	OTHER ANTEPARTUM HEMORRHAGE, UNSPECIFIED TRIMESTER
O46.90	ANTEPARTUM HEMORRHAGE, UNSPECIFIED, UNSPECIFIED TRIMESTER	ANTEPARTUM HEMORRHAGE, UNSPECIFIED, UNSPECIFIED TRIMESTER
O46.91	ANTEPARTUM HEMORRHAGE, UNSPECIFIED, FIRST TRIMESTER	ANTEPARTUM HEMORRHAGE, UNSPECIFIED, FIRST TRIMESTER
O46.92	ANTEPARTUM HEMORRHAGE, UNSPECIFIED, SECOND TRIMESTER	ANTEPARTUM HEMORRHAGE, UNSPECIFIED, SECOND TRIMESTER

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O46.93	ANTEPARTUM HEMORRHAGE, UNSPECIFIED, THIRD TRIMESTER	ANTEPARTUM HEMORRHAGE, UNSPECIFIED, THIRD TRIMESTER
O48.0	POST-TERM PREGNANCY	POST-TERM PREGNANCY
O48.1	PROLONGED PREGNANCY	PROLONGED PREGNANCY
O66.6	OBSTRUCTED LABOR DUE TO OTHER MULTIPLE FETUSES	OBSTRUCTED LABOR DUE TO OTHER MULTIPLE FETUSES
O67.0	INTRAPARTUM HEMORRHAGE WITH COAGULATION DEFECT	INTRAPARTUM HEMORRHAGE WITH COAGULATION DEFECT
O67.8	OTHER INTRAPARTUM HEMORRHAGE	OTHER INTRAPARTUM HEMORRHAGE
O67.9	INTRAPARTUM HEMORRHAGE, UNSPECIFIED	INTRAPARTUM HEMORRHAGE, UNSPECIFIED
O68	LABOR AND DELIVERY COMPLICATED BY ABNORMALITY OF FETAL ACID-BASE BALANCE	LABOR AND DELIVERY COMP BY ABNLT OF FETAL ACID-BASE BALANCE
O69.0XX0	LABOR AND DELIVERY COMPLICATED BY PROLAPSE OF CORD, NOT APPLICABLE OR UNSPECIFIED	LABOR AND DELIVERY COMPLICATED BY PROLAPSE OF CORD, UNSP
O69.0XX1	LABOR AND DELIVERY COMPLICATED BY PROLAPSE OF CORD, FETUS 1	LABOR AND DELIVERY COMPLICATED BY PROLAPSE OF CORD, FETUS 1
O69.0XX2	LABOR AND DELIVERY COMPLICATED BY PROLAPSE OF CORD, FETUS 2	LABOR AND DELIVERY COMPLICATED BY PROLAPSE OF CORD, FETUS 2
O69.0XX3	LABOR AND DELIVERY COMPLICATED BY PROLAPSE OF CORD, FETUS 3	LABOR AND DELIVERY COMPLICATED BY PROLAPSE OF CORD, FETUS 3
O69.0XX4	LABOR AND DELIVERY COMPLICATED BY PROLAPSE OF CORD, FETUS 4	LABOR AND DELIVERY COMPLICATED BY PROLAPSE OF CORD, FETUS 4
O69.0XX5	LABOR AND DELIVERY COMPLICATED BY PROLAPSE OF CORD, FETUS 5	LABOR AND DELIVERY COMPLICATED BY PROLAPSE OF CORD, FETUS 5
O69.0XX9	LABOR AND DELIVERY COMPLICATED BY PROLAPSE OF CORD, OTHER FETUS	LABOR AND DELIVERY COMPLICATED BY PROLAPSE OF CORD, OTH
O69.1XX0	LABOR AND DELIVERY COMPLICATED BY CORD AROUND NECK, WITH COMPRESSION, NOT APPLICABLE OR UNSPECIFIED	LABOR AND DELIVERY COMP BY CORD AROUND NECK, W COMPRSN, UNSP
O69.1XX1	LABOR AND DELIVERY COMPLICATED BY CORD AROUND NECK, WITH COMPRESSION, FETUS 1	LABOR AND DEL COMP BY CORD AROUND NECK, W COMPRSN, FETUS 1
O69.1XX2	LABOR AND DELIVERY COMPLICATED BY CORD AROUND NECK, WITH COMPRESSION, FETUS 2	LABOR AND DEL COMP BY CORD AROUND NECK, W COMPRSN, FETUS 2
O69.1XX3	LABOR AND DELIVERY COMPLICATED BY CORD AROUND NECK, WITH COMPRESSION, FETUS 3	LABOR AND DEL COMP BY CORD AROUND NECK, W COMPRSN, FETUS 3
O69.1XX4	LABOR AND DELIVERY COMPLICATED BY CORD	LABOR AND DEL COMP BY CORD

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
	AROUND NECK, WITH COMPRESSION, FETUS 4	AROUND NECK, W COMPRSN, FETUS 4
O69.1XX5	LABOR AND DELIVERY COMPLICATED BY CORD AROUND NECK, WITH COMPRESSION, FETUS 5	LABOR AND DEL COMP BY CORD AROUND NECK, W COMPRSN, FETUS 5
O69.1XX9	LABOR AND DELIVERY COMPLICATED BY CORD AROUND NECK, WITH COMPRESSION, OTHER FETUS	LABOR AND DELIVERY COMP BY CORD AROUND NECK, W COMPRSN, OTH
O69.2XX0	LABOR AND DELIVERY COMPLICATED BY OTHER CORD ENTANGLEMENT, WITH COMPRESSION, NOT APPLICABLE OR UNSPECIFIED	LABOR AND DEL COMP BY OTH CORD ENTANGLE, W COMPRSN, UNSP
O69.2XX1	LABOR AND DELIVERY COMPLICATED BY OTHER CORD ENTANGLEMENT, WITH COMPRESSION, FETUS 1	LABOR AND DEL COMP BY OTH CORD ENTANGLE, W COMPRSN, FETUS 1
O69.2XX2	LABOR AND DELIVERY COMPLICATED BY OTHER CORD ENTANGLEMENT, WITH COMPRESSION, FETUS 2	LABOR AND DEL COMP BY OTH CORD ENTANGLE, W COMPRSN, FETUS 2
O69.2XX3	LABOR AND DELIVERY COMPLICATED BY OTHER CORD ENTANGLEMENT, WITH COMPRESSION, FETUS 3	LABOR AND DEL COMP BY OTH CORD ENTANGLE, W COMPRSN, FETUS 3
O69.2XX4	LABOR AND DELIVERY COMPLICATED BY OTHER CORD ENTANGLEMENT, WITH COMPRESSION, FETUS 4	LABOR AND DEL COMP BY OTH CORD ENTANGLE, W COMPRSN, FETUS 4
O69.2XX5	LABOR AND DELIVERY COMPLICATED BY OTHER CORD ENTANGLEMENT, WITH COMPRESSION, FETUS 5	LABOR AND DEL COMP BY OTH CORD ENTANGLE, W COMPRSN, FETUS 5
O69.2XX9	LABOR AND DELIVERY COMPLICATED BY OTHER CORD ENTANGLEMENT, WITH COMPRESSION, OTHER FETUS	LABOR AND DELIVERY COMP BY OTH CORD ENTANGLE, W COMPRSN, OTH
O69.3XX0	LABOR AND DELIVERY COMPLICATED BY SHORT CORD, NOT APPLICABLE OR UNSPECIFIED	LABOR AND DELIVERY COMPLICATED BY SHORT CORD, UNSP
O69.3XX1	LABOR AND DELIVERY COMPLICATED BY SHORT CORD, FETUS 1	LABOR AND DELIVERY COMPLICATED BY SHORT CORD, FETUS 1
O69.3XX2	LABOR AND DELIVERY COMPLICATED BY SHORT CORD, FETUS 2	LABOR AND DELIVERY COMPLICATED BY SHORT CORD, FETUS 2
O69.3XX3	LABOR AND DELIVERY COMPLICATED BY SHORT CORD, FETUS 3	LABOR AND DELIVERY COMPLICATED BY SHORT CORD, FETUS 3
O69.3XX4	LABOR AND DELIVERY COMPLICATED BY SHORT CORD, FETUS 4	LABOR AND DELIVERY COMPLICATED BY SHORT CORD, FETUS 4
O69.3XX5	LABOR AND DELIVERY COMPLICATED BY SHORT CORD, FETUS 5	LABOR AND DELIVERY COMPLICATED BY SHORT CORD, FETUS 5
O69.3XX9	LABOR AND DELIVERY COMPLICATED BY SHORT CORD, OTHER FETUS	LABOR AND DELIVERY COMPLICATED BY SHORT CORD, OTHER FETUS

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O69.81X0	LABOR AND DELIVERY COMPLICATED BY CORD AROUND NECK, WITHOUT COMPRESSION, NOT APPLICABLE OR UNSPECIFIED	LABOR AND DEL COMP BY CORD AROUND NECK, W/O COMPRSN, UNSP
O69.81X1	LABOR AND DELIVERY COMPLICATED BY CORD AROUND NECK, WITHOUT COMPRESSION, FETUS 1	LABOR AND DEL COMP BY CORD AROUND NECK, W/O COMPRSN, FETUS 1
O69.81X2	LABOR AND DELIVERY COMPLICATED BY CORD AROUND NECK, WITHOUT COMPRESSION, FETUS 2	LABOR AND DEL COMP BY CORD AROUND NECK, W/O COMPRSN, FETUS 2
O69.81X3	LABOR AND DELIVERY COMPLICATED BY CORD AROUND NECK, WITHOUT COMPRESSION, FETUS 3	LABOR AND DEL COMP BY CORD AROUND NECK, W/O COMPRSN, FETUS 3
O69.81X4	LABOR AND DELIVERY COMPLICATED BY CORD AROUND NECK, WITHOUT COMPRESSION, FETUS 4	LABOR AND DEL COMP BY CORD AROUND NECK, W/O COMPRSN, FETUS 4
O69.81X5	LABOR AND DELIVERY COMPLICATED BY CORD AROUND NECK, WITHOUT COMPRESSION, FETUS 5	LABOR AND DEL COMP BY CORD AROUND NECK, W/O COMPRSN, FETUS 5
O69.81X9	LABOR AND DELIVERY COMPLICATED BY CORD AROUND NECK, WITHOUT COMPRESSION, OTHER FETUS	LABOR AND DEL COMP BY CORD AROUND NECK, W/O COMPRSN, OTH
O69.82X0	LABOR AND DELIVERY COMPLICATED BY OTHER CORD ENTANGLEMENT, WITHOUT COMPRESSION, NOT APPLICABLE OR UNSPECIFIED	LABOR AND DEL COMP BY OTH CORD ENTANGLE, W/O COMPRSN, UNSP
O69.82X1	LABOR AND DELIVERY COMPLICATED BY OTHER CORD ENTANGLEMENT, WITHOUT COMPRESSION, FETUS 1	LABOR AND DEL COMP BY OTH CORD ENTANGLE, W/O COMPRSN, FTS1
O69.82X2	LABOR AND DELIVERY COMPLICATED BY OTHER CORD ENTANGLEMENT, WITHOUT COMPRESSION, FETUS 2	LABOR AND DEL COMP BY OTH CORD ENTANGLE, W/O COMPRSN, FTS2
O69.82X3	LABOR AND DELIVERY COMPLICATED BY OTHER CORD ENTANGLEMENT, WITHOUT COMPRESSION, FETUS 3	LABOR AND DEL COMP BY OTH CORD ENTANGLE, W/O COMPRSN, FTS3
O69.82X4	LABOR AND DELIVERY COMPLICATED BY OTHER CORD ENTANGLEMENT, WITHOUT COMPRESSION, FETUS 4	LABOR AND DEL COMP BY OTH CORD ENTANGLE, W/O COMPRSN, FTS4
O69.82X5	LABOR AND DELIVERY COMPLICATED BY OTHER CORD ENTANGLEMENT, WITHOUT COMPRESSION, FETUS 5	LABOR AND DEL COMP BY OTH CORD ENTANGLE, W/O COMPRSN, FTS5
O69.82X9	LABOR AND DELIVERY COMPLICATED BY OTHER CORD ENTANGLEMENT, WITHOUT COMPRESSION, OTHER FETUS	LABOR AND DEL COMP BY OTH CORD ENTANGLE, W/O COMPRSN, OTH
O69.89X0	LABOR AND DELIVERY COMPLICATED BY OTHER CORD COMPLICATIONS, NOT APPLICABLE OR UNSPECIFIED	LABOR AND DELIVERY COMPLICATED BY OTH CORD COMP, UNSP

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O69.89X1	LABOR AND DELIVERY COMPLICATED BY OTHER CORD COMPLICATIONS, FETUS 1	LABOR AND DELIVERY COMPLICATED BY OTH CORD COMP, FETUS 1
O69.89X2	LABOR AND DELIVERY COMPLICATED BY OTHER CORD COMPLICATIONS, FETUS 2	LABOR AND DELIVERY COMPLICATED BY OTH CORD COMP, FETUS 2
O69.89X3	LABOR AND DELIVERY COMPLICATED BY OTHER CORD COMPLICATIONS, FETUS 3	LABOR AND DELIVERY COMPLICATED BY OTH CORD COMP, FETUS 3
O69.89X4	LABOR AND DELIVERY COMPLICATED BY OTHER CORD COMPLICATIONS, FETUS 4	LABOR AND DELIVERY COMPLICATED BY OTH CORD COMP, FETUS 4
O69.89X5	LABOR AND DELIVERY COMPLICATED BY OTHER CORD COMPLICATIONS, FETUS 5	LABOR AND DELIVERY COMPLICATED BY OTH CORD COMP, FETUS 5
O69.89X9	LABOR AND DELIVERY COMPLICATED BY OTHER CORD COMPLICATIONS, OTHER FETUS	LABOR AND DELIVERY COMPLICATED BY OTH CORD COMP, OTH
O69.9XX0	LABOR AND DELIVERY COMPLICATED BY CORD COMPLICATION, UNSPECIFIED, NOT APPLICABLE OR UNSPECIFIED	LABOR AND DELIVERY COMPLICATED BY CORD COMP, UNSP, UNSP
O69.9XX1	LABOR AND DELIVERY COMPLICATED BY CORD COMPLICATION, UNSPECIFIED, FETUS 1	LABOR AND DELIVERY COMPLICATED BY CORD COMP, UNSP, FETUS 1
O69.9XX2	LABOR AND DELIVERY COMPLICATED BY CORD COMPLICATION, UNSPECIFIED, FETUS 2	LABOR AND DELIVERY COMPLICATED BY CORD COMP, UNSP, FETUS 2
O69.9XX3	LABOR AND DELIVERY COMPLICATED BY CORD COMPLICATION, UNSPECIFIED, FETUS 3	LABOR AND DELIVERY COMPLICATED BY CORD COMP, UNSP, FETUS 3
O69.9XX4	LABOR AND DELIVERY COMPLICATED BY CORD COMPLICATION, UNSPECIFIED, FETUS 4	LABOR AND DELIVERY COMPLICATED BY CORD COMP, UNSP, FETUS 4
O69.9XX5	LABOR AND DELIVERY COMPLICATED BY CORD COMPLICATION, UNSPECIFIED, FETUS 5	LABOR AND DELIVERY COMPLICATED BY CORD COMP, UNSP, FETUS 5
O69.9XX9	LABOR AND DELIVERY COMPLICATED BY CORD COMPLICATION, UNSPECIFIED, OTHER FETUS	LABOR AND DELIVERY COMPLICATED BY CORD COMP, UNSP, OTH
O76	ABNORMALITY IN FETAL HEART RATE AND RHYTHM COMPLICATING LABOR AND DELIVERY	ABNLT IN FETAL HEART RATE AND RHYTHM COMP LABOR AND DELIVERY
O77.0	LABOR AND DELIVERY COMPLICATED BY MECONIUM IN AMNIOTIC FLUID	LABOR AND DELIVERY COMPLICATED BY MECONIUM IN AMNIOTIC FLUID
O77.1	FETAL STRESS IN LABOR OR DELIVERY DUE TO DRUG ADMINISTRATION	FETAL STRESS IN LABOR OR DELIVERY DUE TO DRUG ADMINISTRATION
O77.8	LABOR AND DELIVERY COMPLICATED BY OTHER EVIDENCE OF FETAL STRESS	LABOR AND DELIVERY COMP BY OTH EVIDENCE OF FETAL STRESS
O77.9	LABOR AND DELIVERY COMPLICATED BY FETAL STRESS, UNSPECIFIED	LABOR AND DELIVERY COMPLICATED BY FETAL STRESS, UNSPECIFIED
O99.111	OTHER DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS AND CERTAIN DISORDERS INVOLVING THE IMMUNE MECHANISM COMPLICATING PREGNANCY, FIRST TRIMESTER	OTH DIS OF BLD/BLD-FORM ORG/IMMUN MECHNSM COMP PREG, 1ST TRI

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BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
O99.112	OTHER DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS AND CERTAIN DISORDERS INVOLVING THE IMMUNE MECHANISM COMPLICATING PREGNANCY, SECOND TRIMESTER	OTH DIS OF BLD/BLD-FORM ORG/IMMUN MECHNSM COMP PREG, 2ND TRI
O99.113	OTHER DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS AND CERTAIN DISORDERS INVOLVING THE IMMUNE MECHANISM COMPLICATING PREGNANCY, THIRD TRIMESTER	OTH DIS OF BLD/BLD-FORM ORG/IMMUN MECHNSM COMP PREG, 3RD TRI
O99.119	OTHER DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS AND CERTAIN DISORDERS INVOLVING THE IMMUNE MECHANISM COMPLICATING PREGNANCY, UNSPECIFIED TRIMESTER	OTH DIS OF BLD/BLD-FORM ORG/IMMUN MECHNSM COMP PREG,UNSP TRI
O99.12	OTHER DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS AND CERTAIN DISORDERS INVOLVING THE IMMUNE MECHANISM COMPLICATING CHILDBIRTH	OTH DIS OF THE BLD/BLD-FORM ORG/IMMUN MECHNSM COMP CHLDBRTH
O99.13	OTHER DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS AND CERTAIN DISORDERS INVOLVING THE IMMUNE MECHANISM COMPLICATING THE PUERPERIUM	OTH DIS OF THE BLD/BLD-FORM ORG/IMMUN MECHNSM COMP THE PUERP
O99.411	DISEASES OF THE CIRCULATORY SYSTEM COMPLICATING PREGNANCY, FIRST TRIMESTER	DISEASES OF THE CIRC SYS COMP PREGNANCY, FIRST TRIMESTER
O99.412	DISEASES OF THE CIRCULATORY SYSTEM COMPLICATING PREGNANCY, SECOND TRIMESTER	DISEASES OF THE CIRC SYS COMP PREGNANCY, SECOND TRIMESTER
O99.413	DISEASES OF THE CIRCULATORY SYSTEM COMPLICATING PREGNANCY, THIRD TRIMESTER	DISEASES OF THE CIRC SYS COMP PREGNANCY, THIRD TRIMESTER
O99.419	DISEASES OF THE CIRCULATORY SYSTEM COMPLICATING PREGNANCY, UNSPECIFIED TRIMESTER	DISEASES OF THE CIRC SYS COMP PREGNANCY, UNSP TRIMESTER
O99.42	DISEASES OF THE CIRCULATORY SYSTEM COMPLICATING CHILDBIRTH	DISEASES OF THE CIRCULATORY SYSTEM COMPLICATING CHILDBIRTH
O99.43	DISEASES OF THE CIRCULATORY SYSTEM COMPLICATING THE PUERPERIUM	DISEASES OF THE CIRC SYS COMPLICATING THE PUERPERIUM
O99.810	ABNORMAL GLUCOSE COMPLICATING PREGNANCY	ABNORMAL GLUCOSE COMPLICATING PREGNANCY
O99.814	ABNORMAL GLUCOSE COMPLICATING CHILDBIRTH	ABNORMAL GLUCOSE COMPLICATING CHILDBIRTH
O99.815	ABNORMAL GLUCOSE COMPLICATING THE PUERPERIUM	ABNORMAL GLUCOSE COMPLICATING THE PUERPERIUM
O99.89	OTHER SPECIFIED DISEASES AND CONDITIONS	OTHER SPECIFIED DISEASES AND

SECTION 6 BIRTH OUTCOMES INITIATIVE

BOI APPROVED DELIVERY GUIDELINES

ICD-10 CODE	DESCRIPTION	SHORTEN DESCRIPTION
	COMPLICATING PREGNANCY, CHILDBIRTH AND THE PUERPERIUM	CONDITIONS COMPLICATING PREGNANCY, CHILDBIRTH AND THE PUERPERIUM
Z21	ASYMPTOMATIC HUMAN IMMUNODEFICIENCY VIRUS [HIV] INFECTION STATUS	ASYMPTOMATIC HUMAN IMMUNODEFICIENCY VIRUS INFECTION STATUS
Z37.1	SINGLE STILLBIRTH	SINGLE STILLBIRTH
Z37.3	TWINS, ONE LIVEBORN AND ONE STILLBORN	TWINS, ONE LIVEBORN AND ONE STILLBORN
Z37.4	TWINS, BOTH STILLBORN	TWINS, BOTH STILLBORN
Z37.60	MULTIPLE BIRTHS, UNSPECIFIED, SOME LIVEBORN	MULTIPLE BIRTHS, UNSPECIFIED, SOME LIVEBORN
Z37.61	TRIPLETS, SOME LIVEBORN	TRIPLETS, SOME LIVEBORN
Z37.62	QUADRUPLETS, SOME LIVEBORN	QUADRUPLETS, SOME LIVEBORN
Z37.63	QUINTUPLETS, SOME LIVEBORN	QUINTUPLETS, SOME LIVEBORN
Z37.64	SEXTUPLETS, SOME LIVEBORN	SEXTUPLETS, SOME LIVEBORN
Z37.69	OTHER MULTIPLE BIRTHS, SOME LIVEBORN	OTHER MULTIPLE BIRTHS, SOME LIVEBORN
Z37.7	OTHER MULTIPLE BIRTHS, ALL STILLBORN	OTHER MULTIPLE BIRTHS, ALL STILLBORN

SECTION 6 BIRTH OUTCOMES INITIATIVE

BOI APPROVED DELIVERY GUIDELINES

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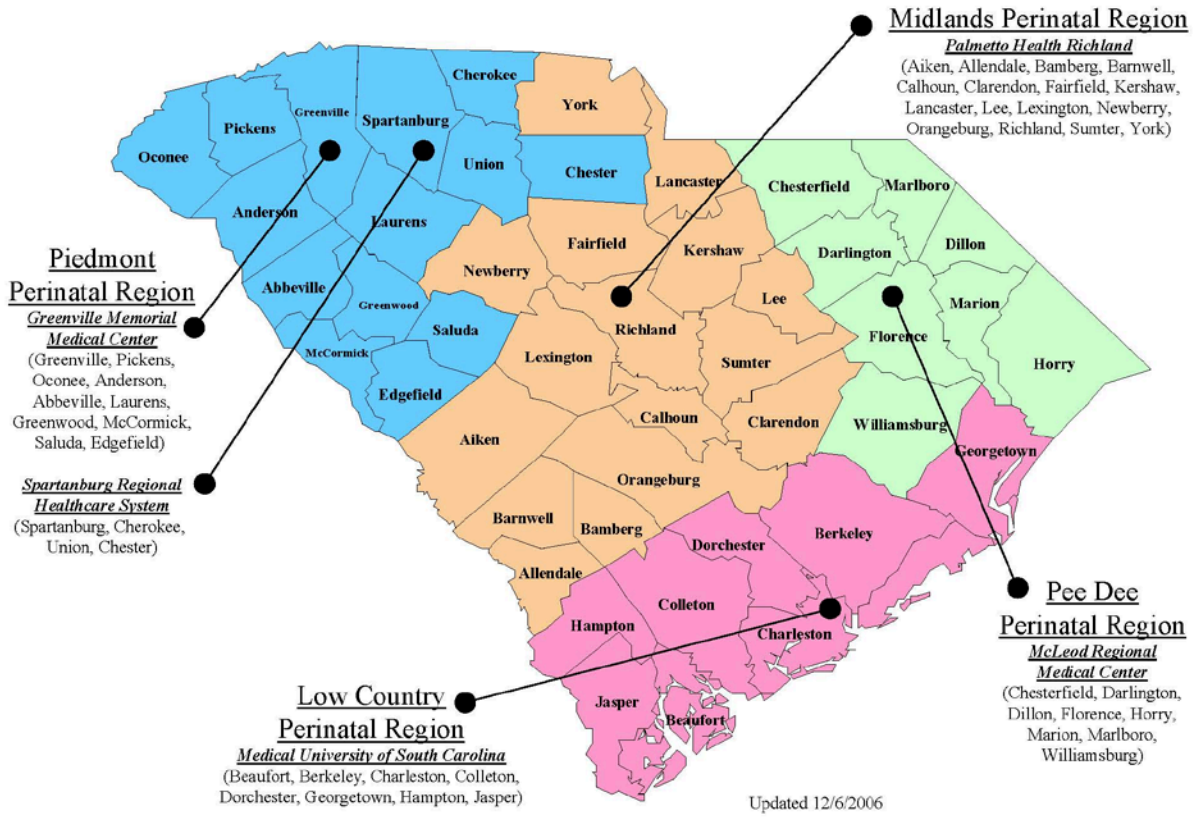
SECTION 6 BIRTH OUTCOMES INITIATIVE

SOUTH CAROLINA PERINATAL REGIONS



SECTION 6 BIRTH OUTCOMES INITIATIVE

SOUTH CAROLINA PERINATAL REGIONS

South Carolina Perinatal Regionalization Care System				
Regional Center	Counties	Regional System Developer	Outreach Education	Transport
LOW COUNTRY REGION MUSC Medical Center 165 Ashley Avenue MSC 917 Charleston, SC 29425 Phone: (843) 792-5179 Fax: (843) 792-8801	Beaufort Dorchester Berkeley Hampton Charleston Jasper Colleton Georgetown	***Kathy Ray, RN, MSN*** MUSC/Dept. of Pediatrics Division of Neonatology 165 Ashley Avenue MSC 917 Charleston, SC 29425 Phone: (843) 792-2602 Fax: (843) 792-8801 Beeper: (843) 792-0590 ID#12413 E-mail: rayk@musc.edu	***Mary Ernst, RNC*** - OB Phone: (843) 792-6395 Fax: (843) 762-3490 Beeper: (843) 792-0590 ID#13010 E-mail: ernstm@musc.edu ***Ron'a Cushman, MS, APRN, NNP*** - Neo Phone: (843) 792-7784 Fax: (843) 792-8801 Beeper: (843) 792-0590 ID#12530 E-mail: cushman@musc.edu	*MEDUCARE (Neonatal):* 1-800-423-1330 Local: (843) 792-3311 *Meduline (Maternal):* 1-800-922-5250
MIDLANDS REGION Palmetto Health Richland 5 Medical Park Columbia, SC 29203 NICU: (803) 434-7151 Fax: (803) 434-6401 L&D: (803) 434-6333 Fax: (803) 434-6334	Aiken Lancaster Allendale Lee Bamberg Lexington Barnwell Newberry Calhoun Orangeburg Clarendon Richland Fairfield Sumter Kershaw York	***Amy Nienhuis, LISW-CP, MSW*** 3 Medical Park, Suite 400 Columbia, SC 29203 Phone: (803) 434-6961 Fax: (803) 434-4309 Cell: (803) 397-8828 Beeper: (803) 352-0363 E-mail: Amy.Nienhuis@palmettohealth.org	***Michelle Flanagan, RN, BSN*** - OB 3 Medical Park, Suite 400 Phone: (803) 434-7243 Fax: (803) 434-4309 Beeper: (803) 352-1997 E-mail: Michelle.Flanagan@palmettohealth.org ***Chaka Davis, MSN, MPH*** - Neo 3 Medical Park, Suite 400 Phone: (803) 434-2913 Fax: (803) 434-4309 Beeper: (803) 352-0362 E-mail: Chaka.Davis@palmettohealth.org	To arrange *Maternal Transport:* Call L&D: (803) 434-6333 or MFM pager: 888-527-0174 To arrange *Neonatal Transport:* call: NICU @ (803) 434-7151
PEE DEE REGION McLeod Regional Med Center 555 East Cheves Street Florence, SC 29506-2617 PO Box 100551 Florence, SC 29502-0551 NICU: (843) 777-8379 Fax: (843) 777-8345 L&D: (843) 777-8450 Fax: (843) 777-2499	Chesterfield Horry Darlington Marion Dillon Marlboro Florence Williamsburg	***Jeannie Thompson, RNC, BSN*** McLeod Regional Medical Center PO Box 100551 Florence, SC 29502-0551 Phone: (843) 777-5059 Fax: (843) 777-8172 E-mail: jthompson@mcleodhealth.org	***Helen Hokanson, RN*** - OB Phone: (843) 777-8461 Fax: (843) 777-8474 E-mail: hhokanson@mcleodhealth.org ***Heather Heape, RN*** - Neo Phone: (843) 777-5027 Fax: (843) 777-8474 E-mail: hheape@mcleodhealth.org	*Neonatal Transport:* Call: NICU @ (843) 777-8380 *Maternal Transport:* Call: Hotline @ 1-866-678-3889

SECTION 6 BIRTH OUTCOMES INITIATIVE

SOUTH CAROLINA PERINATAL REGIONS

South Carolina Perinatal Regionalization Care System				
Regional Center	Counties	Regional System Developer	Outreach Education	Transport
PIEDMONT REGION Greenville Hospital System 701 Grove Road Greenville, SC 29605 NICU: (864) 455-7165 L&D: (864) 455-7164 Fax: (864) 455-8434	Abbeville Oconee Anderson Pickens Greenville Laurens Edgefield McCormick Greenwood Saluda	***Meg Jewell, MA*** Dept. of Perinatal Development 701 Grove Rd., Attn: 6th Floor Greenville, SC 29605 Phone: (864) 455-8441 Fax: (864) 455-5075 Beeper: (864) 996-4898 E-mail: mjewell@ghs.org	***Danny Dearybury, RNC, BHS*** - OB Phone: (864) 455-3063 Fax: (864) 455-5075 Beeper: (864) 996-0738 E-mail: ddearybury@ghs.org ***Bridget Allen, RNC, MS*** - Neo Phone: (864) 455-7059 Fax: (864) 455-8368 Beeper: (864) 996-4912 E-mail: ballen@ghs.org	*Neonatal Transport:* *Jennifer Griffin, RN* Phone: (864) 455-7165 Beeper: (864) 455-7000 NICU: (864) 455-7165 *Maternal Transport:* Phone: (864) 455-1640 or (864) 455-7164
PIEDMONT REGION Spartanburg Regional Health Care System 101 East Wood Street Spartanburg, SC 29303 Phone: (864) 560-6000 Fax: (864) 560-6010	Cherokee Spartanburg Chester Union	***Meg Jewell, MA*** Dept. of Perinatal Development 701 Grove Rd., Attn: 6th Floor Greenville, SC 29605 Phone: (864) 455-8441 Fax: (864) 455-5075 Beeper: (864) 996-4898 E-mail: mjewell@ghs.org	***Ann Clayton, RNC, BSN*** - OB Voice Mail: (864) 560-2243 Cell Phone: (864) 809-1003 Fax: (864) 560-2295 E-mail: vclayton@srhs.com ***Alicia Whiteside, RNC, BSN*** - Neo Phone: (864) 560-6516 Cell: (864) 809-7016 Fax: (864) 560-6010 E-mail: awhiteside@srhs.com	*Arrange Neonatal Transport:* (864) 560-6297 *Arrange Maternal Transport:* L&D Triage: (864) 560-2275 MFM: (864) 560-1618 Dr. Scardo pager: (864) 253-7889 Dr. Vermillon pager: (864) 253-2458 OB Resident on call pager: (864) 620-6460
SC DHEC CENTRAL OFFICE ***Kathy Swanson, MSPH*** Director Division of Perinatal Systems 1751 Calhoun Street Columbia, SC 29201		Phone: (803) 898-0734 Fax: (803) 898-2065 E-mail: swanskm@dhec.sc.gov		Revised: July 7, 2008

SECTION 6 BIRTH OUTCOMES INITIATIVE

SOUTH CAROLINA PERINATAL REGIONS

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SECTION 6 BIRTH OUTCOMES INITIATIVE

ACOG PATIENT SAFETY CHECKLIST FOR SCHEDULING INDUCTION OF LABOR

The American College of Obstetricians and Gynecologists
Women's Health Care Physicians

Patient Safety Checklist ✓ Number 5 • December 2011
(Replaces Patient Safety Checklist No. 1, November 2011)

SCHEDULING INDUCTION OF LABOR

Date_____ Patient _____ Date of birth_____ MR # _____

Physician or certified nurse–midwife _____ Last menstrual period _____

Gravidity/Parity_____

Estimated date of delivery_____ Best estimated gestational age at delivery _____

Proposed induction date _____ Proposed admission time _____

❑ Gestational age of 39 0/7 weeks or older confirmed by either of the following criteria (1):

- ❑ Ultrasound measurement at less than 20 weeks of gestation supports gestational age of 39 weeks or greater
- ❑ Fetal heart tones have been documented as present for 30 weeks of gestation by Doppler ultrasonography

Indication for induction: (choose one)

- ❑ Medical complication or condition (1): Diagnosis: _____
- ❑ Nonmedically indicated (1–3): Circumstances: _____

Patient counseled about risks, benefits, and alternatives to induction of labor (1)

- ❑ Consent form signed as required by institution

Bishop Score (see below) (1): _____

Bishop Scoring System

	Factor				
Score	Dilation (cm)	Position of Cervix	Effacement (%)	Station*	Cervical Consistency
0	Closed	Posterior	0–30	-3	Firm
1	1–2	Midposition	40–50	-2	Medium
2	3–4	Anterior	60–70	-1, 0	Soft
3	5–6	—	80	+1, +2	—

*Station reflects a −3 to +3 scale.
Modified from Bishop EH. Pelvic scoring for elective induction. Obstet Gynecol 1964;24:266–8.

- ❑ Pertinent prenatal laboratory test results (eg, group B streptococci or hematocrit) available (4, 5)
- ❑ Special concerns (eg, allergies, medical problems, and special needs): _____

To be completed by reviewer:

- ❑ Approved induction after 39 0/7 weeks of gestation by aforementioned dating criteria
- ❑ Approved induction before 39 0/7 weeks of gestation (medical indication)
- ❑ **HARD STOP** – gestational age, indication, consent, or other issues prevent initiating induction without further information or consultation with department chair

SECTION 6 BIRTH OUTCOMES INITIATIVE

ACOG PATIENT SAFETY CHECKLIST FOR SCHEDULING INDUCTION OF LABOR

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SECTION 6 BIRTH OUTCOMES INITIATIVE

ACOG PATIENT SAFETY CHECKLIST FOR PLANNED CESAREAN DELIVERY

The American College of Obstetricians and Gynecologists
Women's Health Care Physicians

Patient Safety Checklist ✓ Number 3 • December 2011

SCHEDULING PLANNED CESAREAN DELIVERY

Date_____ Patient _____ Date of birth_____ MR # _____

Physician or certified nurse–midwife _____ Last menstrual period _____

Gravidity/Parity_____

Estimated date of delivery_____ Best estimated gestational age (at admission)_____

Proposed cesarean delivery date _____

Indication (choose one):

- ❑ Medically indicated: Diagnosis:_____
- ❑ Repeat cesarean delivery (choose one) (1, 2):
  - ❑ Trial of labor not appropriate: Reason:_____
  - ❑ Trial of labor offered
    - ❑ Yes
    - ❑ No: Reason:_____
  - ❑ Patient counseled about risks and benefits of cesarean delivery versus trial of labor and vaginal delivery (1, 3)
    - ❑ Consent form signed as required by the institution
  - ❑ Repeat cesarean delivery for logistical reasons: Circumstances:_____
- ❑ Elective primary cesarean delivery at maternal request (4):
  - ❑ Patient counseled about risks and benefits of cesarean delivery versus vaginal delivery (1, 3)
    - ❑ Consent form signed as requested by institution
- ❑ Gestational age of 39 0/7 weeks or greater confirmed by either of the following criteria (5):
  - ❑ Ultrasound measurement at less than 20 weeks of gestation supports gestational age of 39 weeks or greater
  - ❑ Fetal heart tones have been documented as present for 30 weeks of gestation by Doppler ultrasonography

If this is an elective cesarean delivery and gestational age is 39 0/7 weeks or less, reason for variance:

_____

Results of amniocentesis (if performed): _____

- ❑ Preoperative and pertinent prenatal laboratory test results (eg, group B streptococci or hematocrit) available (2)
- ❑ Special concerns (eg, allergies, medical problems, and special needs)_____
- ❑ Pertinent comorbid risk factors (maternal and fetal) _____

To be completed by reviewer:

- ❑ Approved cesarean delivery for gestational age equal to or greater than 39 0/7 weeks by the afore-mentioned dating criteria
- ❑ Approved cesarean delivery before 39 0/7 weeks of gestation (medical indication)
- ❑ **HARD STOP** – gestational age, indication, consent, or other issues prevent initiating planned cesarean delivery without further information or consultation with department chair

SECTION 6 BIRTH OUTCOMES INITIATIVE

ACOG PATIENT SAFETY CHECKLIST FOR PLANNED CESAREAN DELIVERY

References

1. Vaginal birth after cesarean delivery. Practice Bulletin No. 115. American College of Obstetricians and Gynecologists. Obstet Gynecol 2010;116:786–90.
2. American Academy of Pediatrics, American College of Obstetricians and Gynecologists. Intrapartum and postpartum care. In: Guidelines for perinatal care. 6th ed. Elk Grove Village (IL): AAP; Washington, DC: ACOG; 2007. p. 139–74.
3. Surgery and patient choice. ACOG Committee Opinion No. 395. American College of Obstetricians and Gynecologists. Obstet Gynecol 2008;111:243–7.
4. Cesarean delivery on maternal request. ACOG Committee Opinion No. 394. American College of Obstetricians and Gynecologists. Obstet Gynecol 2007;110:1501.
5. Fetal lung maturity. ACOG Practice Bulletin No. 97. American College of Obstetricians and Gynecologists. Obstet Gynecol 2008;112:717–26.

Standardization of health care processes and reduced variation has been shown to improve outcomes and quality of care. The American College of Obstetricians and Gynecologists has developed a series of patient safety checklists to help facilitate the standardization process. This checklist reflects emerging clinical, scientific, and patient safety advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed. Although the components of a particular checklist may be adapted to local resources, standardization of checklists within an institution is strongly encouraged.

How to Use This Checklist

The Patient Safety Checklist on Scheduling Planned Cesarean Delivery should be completed by the health care provider and submitted to the respective hospital to schedule a planned cesarean delivery. The hospital should establish procedures to review the appropriateness of the scheduling based on the information contained in the checklist. A hard stop should be called if there are questions that arise that require further information or consultation with the department chair.

Scheduling planned cesarean delivery. Patient Safety Checklist No. 3. American College of Obstetricians and Gynecologists. Obstet Gynecol 2011;118:1469–70.

FORMS

Number	Name	Revision Date
DHHS 126	Confidential Complaint	06/2007
DHHS 130	Claim Adjustment Form 130	03/2007
DHHS 205	Medicaid Refunds	01/2008
DHHS 931	Health Insurance Information Referral Form	02/2018
	Reasonable Effort Documentation	04/2014
	Electronic Funds Transfer (EFT) Authorization Agreement	09/2017
	Duplicate Remittance Advice Request Form	09/2017
	Claim Reconsideration Form	11/2018
CMS-1500 (02/12)	Sample Claim Showing TPL Payment with NPI	02/2012
	Sample Remittance Advice (four pages)	04/2014
	Healthy Mothers, Healthy Futures Maternity Health Education Checklist (two pages)	
	Alcohol and Drug Medical Assessment (two pages)	09/1990
	DHHS Pediatric Sub-Specialists Certification Form	06/2015
	Abortion Statement	
DHHS 687	Consent For Sterilization (two pages)	05/2019
	Surgical Justification Review for Hysterectomy	07/2017
	Request for Prior Approval Review	06/2012
	Allied Profession Supervision Form	08/2013
	OOS Referral Package (four pages)	05/2014
	Transplant Prior Authorization Request Form & Instructions (two pages)	08/2012
	Mental Health Form	09/2013
	Psychiatric Prior Authorization Form – Inpatient	06/2012
	Circumcision Prior Authorization Form	02/2011
	BOI Universal Screening Tool	04/2017
	Universal 17-P Authorization Form	12/2013
	SCDHHS Behavioral Health Referral and Feedback Form	12/2013

STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

CONFIDENTIAL COMPLAINT

SEND TO: DIRECTOR, DIVISION OF PROGRAM INTEGRITY
DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. BOX 100210, 1801 MAIN STREET, COLUMBIA, SOUTH CAROLINA 29202-3210

PROGRAM INTEGRITY

THIS REPORT IS DESIGNED FOR THE REPORTING OF POSSIBLE ABUSE BY MEDICAID PROVIDERS AND/OR RECIPIENTS. USE THE SPACE BELOW TO EXPLAIN IN DETAIL YOUR COMPLAINT. PLEASE IDENTIFY YOURSELF AND WHERE YOU CAN BE REACHED FOR FUTURE REFERENCES. UNLESS OTHERWISE INDICATED, ALL INFORMATION SHOULD BE PRINTED OR TYPED.

YOUR COMPLAINT WILL REMAIN CONFIDENTIAL.

SUSPECTED INDIVIDUAL OR INDIVIDUALS:	
NPI or MEDICAID PROVIDER ID: (if applicable)	MEDICAID RECIPIENT ID NUMBER: (if applicable)
ADDRESS OF SUSPECT:	LOCATION OF INCIDENT:
	DATE OF INCIDENT:
COMPLAINT:	

NAME OF PERSON REPORTING: (Please print)	SIGNATURE OF PERSON REPORTING:	DATE OF REPORT

ADDRESS OF PERSON REPORTING:	TELEPHONE NUMBER OF PERSON REPORTING:
	SIGNATURE: (SCDHHS Representative Receiving Report)

South Carolina Department of Health and Human Services - Claim Adjustment Form 130

Provider Name: (Please use black or blue ink when completing form)

Provider Address :

Provider City , State, Zip:

Total paid amount on the original claim:

Original CCN:

Provider ID:

NPI:

Recipient ID:

Adjustment Type:

◯ Void ◯ Void/Replace

Originator:

◯ DHHS ◯ MCCS ◯ Provider ◯ MIVS

Reason For Adjustment: (Fill One Only)

- ◯ Insurance payment different than original claim
- ◯ Keying errors
- ◯ Incorrect recipient billed
- ◯ Voluntary provider refund due to health insurance
- ◯ Voluntary provider refund due to casualty
- ◯ Voluntary provider refund due to Medicare
- ◯ Medicaid paid twice - void only
- ◯ Incorrect provider paid
- ◯ Incorrect dates of service paid
- ◯ Provider filing error
- ◯ Medicare adjusted the claim
- ◯ Other

For Agency Use Only

Analyst ID:

- ◯ Hospital/Office Visit included in Surgical Package
- ◯ Independent lab should be paid for service
- ◯ Assistant surgeon paid as primary surgeon
- ◯ Multiple surgery claims submitted for the same DOS
- ◯ MMIS claims processing error
- ◯ Rate change
- ◯ Web Tool error
- ◯ Reference File error
- ◯ MCCS processing error
- ◯ Claim review by Appeals

Comments:

Signature:_____ Date:_____

Phone:_____

DHHS Form 130 Revision date: 03-13-2007

South Carolina Department of Health and Human Services
Form for Medicaid Refunds

Purpose: This form is to be used for all refund checks made to Medicaid. This form gives the information needed to properly account for the refund. If the form is incomplete, the provider will be contacted for the additional information.

Items 1, 2 or 3, 4, 5, 6, & 7 must be completed. **Attach appropriate document(s) as listed in item 8.**

1. Provider Name: _____

2. Medicaid Legacy Provider # ☐☐☐☐☐☐
(Six Characters)

OR

3. NPI# ☐☐☐☐☐☐☐☐☐☐ **& Taxonomy** ☐☐☐☐☐☐☐☐☐☐

4. Person to Contact: _____ **5. Telephone Number:** _____

6. Reason for Refund: [check appropriate box]

☐ Other Insurance Paid (please complete **a – f** below and attach insurance EOMB)
- **a** Type of Insurance: ( ) Accident/Auto Liability ( ) Health/Hospitalization
- **b** Insurance Company Name _____
- **c** Policy #:_____
- **d** Policyholder: _____
- **e** Group Name/Group: _____
- **f** Amount Insurance Paid:_____

☐ Medicare
- ( ) Full payment made by Medicare
- ( ) Deductible not due
- ( ) Adjustment made by Medicare

☐ Requested by DHHS (please attach a copy of the request)

☐ Other, describe in detail reason for refund:

_____
_____
_____
_____

7. Patient/Service Identification:

Patient Name	Medicaid I.D.# (10 digits)	Date(s) of Service	Amount of Medicaid Payment	Amount of Refund

8. Attachment(s): [Check appropriate box]

☐ Medicaid Remittance Advice (required)

☐ Explanation of Benefits (EOMB) from Insurance Company (if applicable)

☐ Explanation of Benefits (EOMB) from Medicare (if applicable)

☐ Refund check

Make all checks payable to: South Carolina Department of Health and Human Services
Mail to: SC Department of Health and Human Services
Cash Receipts
Post Office Box 8355
Columbia, SC 29202-8355

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID HEALTH INSURANCE INFORMATION REFERRAL FORM

Provider or Department Name: _____ Provider ID or NPI: _____

Contact Person: _____ Phone #: _____ Date: _____

I ADD INSURANCE FOR A MEDICAID BENEFICIARY WITH NO INSURANCE IN THE MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) – ALLOW 25 DAYS

Beneficiary Name: _____ Date Referral Completed: _____

Medicaid ID#: _____ Policy Number: _____

Insurance Company Name: _____ Group Number: _____

Insured's Name: _____ Insured SSN: _____

Employer's Name/Address: _____

II CHANGES TO AN INSURANCE RECORD THAT IS IN THE MMIS – MIVS SHALL WORK WITHIN 5 DAYS

_____ a. beneficiary has never been covered by the policy – close insurance.

_____ b. beneficiary coverage ended - terminate coverage (date) _____

_____ c. subscriber coverage lapsed - terminate coverage (date) _____

_____ d. subscriber changed plans under employer - new carrier is _____

- new policy number is _____

_____ e. beneficiary to add to insurance already in MMIS for subscriber or other family member.

(name) _____

ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.

Submit this information to Medicaid Insurance Verification Services (MIVS).

Fax: 803-252-0870 **or** **Mail:** Post Office Box 101110 Columbia, SC 29211-9804

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
REASONABLE EFFORT DOCUMENTATION

PROVIDER _____ **DOS** _____

NPI or MEDICAID PROVIDER ID _____

MEDICAID BENEFICIARY NAME _____

MEDICAID BENEFICIARY ID# _____

INSURANCE COMPANY NAME _____

POLICYHOLDER _____

POLICY NUMBER _____

ORIGINAL DATE FILED TO INSURANCE COMPANY
_____

DATE OF FOLLOW UP ACTIVITY _____

RESULT:

FURTHER ACTION TAKEN:

DATE OF SECOND FOLLOW UP _____

RESULT:

I HAVE EXHAUSTED ALL OPTIONS FOR OBTAINING A PAYMENT OR SUFFICIENT RESPONSE FROM THE PRIMARY INSURER.

_____
(SIGNATURE AND DATE)

ATTACH A COPY OF THE FORM TO A NEW CLAIM AND FORWARD TO YOUR MEDICAID CLAIMS PROCESSING POST OFFICE BOX.

Revised 04/2014

South Carolina Department of Health and Human Services
Electronic Funds Transfer (EFT) Authorization Agreement

PROVIDER INFORMATION

Provider Name _____

Doing Business As Name (DBA) _____

Provider Address

Street _____

City _____ State/Province _____

Zip Code/Postal Code _____ Medicaid Provider Number _____

Provider Federal Identification Number (TIN) or
Employer Identification Number (EIN) _____

National Provider Identifier (NPI) _____

Provider EFT Contact Information

Provider Contact Name _____

Telephone Number _____ Telephone Number Extension _____

Email Address _____

FINANCIAL INSTITUTION INFORMATION

Financial Institution Name _____

Financial Institution Address _____

Street _____

City _____ State/Province _____

Zip Code/Postal Code _____

Financial Institution Routing Number _____

Type of Account at Financial Institution (select one) ☐ Checking ☐ Savings

Provider's Account Number with Financial Institution _____

Account Number Linkage to Provider Identifier (select one)

☐ Provider Tax Identification Number (TIN)

☐ National Provider Identifier (NPI)

REASON FOR SUBMISSION: ☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment

By signing this form, I authorize the Department of Health and Human Services to initiate credit entries and to initiate, if necessary, debit entries for any credit entries in error to the checking or savings account indicated above at the financial institution identified above. Credit entries will pertain only to the Department of Health and Human Services payment obligations resulting from Medicaid services rendered by the provider. In the event of excess payment to this bank account, I authorize the Department of Health and Human Services to make an adjusting debit entry to the account up to the amount of the excess payment. Credit entries to the above account are done with the understanding that payment will be from federal and/or state funds and that any false claims, statements or documents or concealments of a material fact, may be prosecuted under applicable federal or state laws. I certify that the information shown is correct and agree to provide thirty (30) days written notice to the address shown below prior to revoking or revising this authorization.

All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any Medicaid direct deposits are made.

Written Signature of Person Submitting Enrollment _____

Printed Name of Person Submitting Enrollment _____

Submission Date _____

TO PROCESS YOUR EFT ENROLLMENT OR CHANGE EXISTING INFORMATION, PLEASE RETURN THIS COMPLETED FORM ALONG WITH VERIFICATION OF YOUR ELECTRONIC DEPOSIT INFORMATION ON YOUR FINANCIAL INSTITUTION'S LETTERHEAD TO:

Department of Health and Human Services
Medicaid Provider Enrollment
P.O. BOX 8809, COLUMBIA, S.C. 29202-8809
FAX (803) 870-9022

SPECIAL INSTRUCTIONS: For questions regarding the status of your EFT enrollment, please contact the Provider Service Center at 1-888-289-0709. Please refer to the Electronic Funds Transfer (EFT) section of the Provider Enrollment manual found on the SCDHHS Provider web page for instructions on how to complete updates to your EFT information.

Effective January 01, 2014, providers have the capability to link their EFT payment transaction with their electronic remittance advice (ERA) via a matching EFT Reassociation Trace Number. This trace number will automatically be included in your SCDHHS electronic remittance advice. In order for this matching reassociation trace number to appear in your EFT notification, you must contact your financial institution and request the addition of this information. Any questions regarding this matching trace number and your ERA can be directed to the Provider Service Center at 1-888-289-0709.

South Carolina Department of Health and Human Services
Duplicate Remittance Advice Request Form

Purpose: This form is to be used for all requests for duplicate remittance advices from South Carolina Medicaid. The form must be completed in its entirety in order to honor the request. If the form is incomplete, the form will be returned requesting the additional information.

Please contact the SCDHHS Medicaid Provider Service Center (PSC) at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us for instructions on submission of your request.

1. Provider Name: _____

2. Medicaid Legacy Provider # _____ (Six Characters)

   NPI# _____ Taxonomy _____

3. Person to Contact: _____ Telephone Number: _____

4. Please list the date(s) of the remittance advice for which you are requesting a duplicate copy:
   _____
   _____
   _____
   _____
   _____

   Note: Remittance advices are available electronically through the Web Tool. Please check the Web Tool for the availability of the remittance advice date before submitting your request.

5. Street Address for delivery of request:

   Street: _____

   City: _____

   State: _____

   Zip Code: _____

6. Charges for duplicate remittance advice(s) are as follows:

   Request Processing Fee - $20.00

   Page(s) copied - .20 per page

I understand and acknowledge that a charge is associated with this request and will be deducted from my provider's payment by debit adjustment on a future remittance advice.

_____ _____

Authorizing Signature **Date**

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Submit your Claim Reconsideration request to:

Fax: 1-855-563-7086

or

Mail: South Carolina Healthy Connections Medicaid
ATTN: Claim Reconsiderations
Post Office Box 8809
Columbia, SC 29202-8809

CLAIM RECONSIDERATION FORM

Instructions: Complete this form within 30 days of receipt of the remittance advice reflecting the denied claim, and attach all documentation in support of your request. A separate SCDHHS CR form is required for each claim control number (CCN). Allow up to 60 days for a written response. Claim disputes must first be initiated through the Provider Service Center (PSC). Enter the PSC Communication ID in the required field below. For questions, contact the PSC at 1-888-289-0709. **Note:** Timely filing guidelines apply.

Section 1: Beneficiary Information

Name (Last, First, MI): _____

Date of Birth: _____ Medicaid Beneficiary ID: _____

Section 2: Provider Information

Specify your affiliation: ☐ Physician ☐ Hospital ☐ Other (DME, Lab, Home Health Agency, etc.): _____

NPI: _____ Medicaid Provider ID: _____ Facility/Group/Provider Name: _____

Return Mailing Address: _____
Street or Post Office Box *State* *ZIP*

Contact: _____ Email: _____ Telephone #: _____ Fax #: _____

Section 3: Claim Information *(Only one CCN allowed per request.)*

Communication ID: _____ CCN: _____ Date(s) of Service: _____

Section 4: Claim Reconsideration Information

What area is your denial related to? (Please select below)

- ☐ Ambulance Services
- ☐ Autism Spectrum Disorder (ASD) Services
- ☐ Clinic Services
- ☐ Community Long Term Care (CLTC)
- ☐ Community Mental Health Services
- ☐ Department of Disabilities and Special Needs (DDSN) Waivers
- ☐ Durable Medical Equipment (DME)
- ☐ Early Intervention Services
- ☐ Enhanced Services
- ☐ Federally Qualified Health Center (FQHC)
- ☐ Home Health Services
- ☐ Hospice Services
- ☐ Hospital Services
- ☐ Licensed Independent Practitioner's Rehabilitative Services (LIPS)
- ☐ Local Education Agencies (LEA)
- ☐ Medically Complex Children's (MCC) Waivers
- ☐ Nursing Facility Services / Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
- ☐ Optional State Supplementation (OSS)
- ☐ Pharmacy Services
- ☐ Physicians Laboratories, and Other Medical Professionals Specify: _____
- ☐ Private Rehabilitative Therapy and Audiological Services
- ☐ Psychiatric Hospital Services
- ☐ Rehabilitative Behavioral Health Services (RBHS)
- ☐ Rural Health Clinic (RHC)
- ☐ Targeted Case Management (TCM)
- ☐ Other: _____

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Section 5: Desired Outcome

Request submitted by:

Print Name: _____

Signature:_____ Date: _____

Physicians
Sample Claim Showing TPL Denial
with NPI

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)
MEDICARE: [ ] MEDICAID: [X] TRICARE: [ ] CHAMPVA: [ ] GROUP HEALTH PLAN: [X] FECA BLK LUNG: [ ] OTHER: [ ]

1a. INSURED'S I.D. NUMBER (For Program in Item 1)
1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Doe, John A.

3. PATIENT'S BIRTH DATE MM DD YY: 01 01 1947 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)
123 Windy Lane

6. PATIENT RELATIONSHIP TO INSURED
Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Anytown
STATE: SC

8. RESERVED FOR NUCC USE

CITY
STATE

ZIP CODE: 29999
TELEPHONE (Include Area Code): ( )

ZIP CODE
TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER
A123450A

a. EMPLOYMENT? (Current or Previous)
YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX
M [ ] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State)
YES [ ] NO [X]

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE
22

c. OTHER ACCIDENT?
YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME
401

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
YES [ ] NO [ ] If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED Signature on File DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. 250 00 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	01	07	14	01	07	14	11		99213			35 00	1		ZZ	1212121212
															NPI	1234567890
2															NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN
555555555

26. PATIENT'S ACCOUNT NO.
DOE1234

27. ACCEPT ASSIGNMENT? (For gov. claims, see back)
YES [X] NO [ ]

28. TOTAL CHARGE
$ 35 00

29. AMOUNT PAID
$ 22 00

30. Rsvd for NUCC Use
13 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
a. NPI b.

33. BILLING PROVIDER INFO & PH # (555)5555555
Jane Smith, MD
111 Main Street
Anytown, SC 22222-2222
a. 1234567890 b. ZZ1212121212

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Sample Remittance Advice (page 1)

This page of the sample Remittance Advice shows a paid claim, suspended claim and rejected claim.

PROVIDER ID. | DEPT OF HEALTH AND HUMAN SERVICES | PROFESSIONAL SERVICES | PAYMENT DATE | PAGE

AB00080000 | SOUTH CAROLINA MEDICAID PROGRAM | REMITTANCE ADVICE | 02/14/2014 | 1

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	T S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
ABB1AA	1403004803012700A				27.00	6.72	P	1112233333	M CLARK				
	01	101713	71010		27.00	6.72	P			026		0.00	0.00
ABB2AA	1403004804012700A				259.00	0.00	S	1112233333	M CLARK				
	01	101713	74176		259.00	0.00	S			026		0.00	0.00
ABB3AA	1403004805012700A				24.00	0.00	R	1112233333	M CLARK			0.00	
	01	071913	A5120		12.00	0.00	R			000			0.00
	02	071913	A4927		12.00	0.00	R			000			0.00
									Edits: L00 946 L02 852 08/30/13				
	TOTALS	3			310.00							0.00	0.00
						$6.72							

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

CERT. PG TOT	MEDICAID PG TOT
$0.00	$286.46

CERTIFIED AMT	MEDICAID TOTAL
	0.00

CHECK TOTAL | CHECK NUMBER

STATUS CODES:
P = PAYMENT MADE
R = REJECTED
S = IN PROCESS
E = ENCOUNTER

PROVIDER NAME AND ADDRESS

ABC HEALTH PROVIDER
PO BOX 000000
FLORENCE SC 00000

Sample Remittance Advice (page 2)

This page of the sample Remittance Advice shows a paid claim, as well as a Void/Replacement claim for which both the Void and the Replacement processed during the same payment cycle.

PROVIDER ID. AB00080000

DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

PROFESSIONAL SERVICES
REMITTANCE ADVICE

PAYMENT DATE 02/28/2014

PAGE 1

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S T S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
ABB222222	1405200415812200A				1192.00	243.71	P	1112233333	M CLARK			0.00	
	01		021814	S0315	800.00	117.71	P			000			0.00
	02		021814	S9445	392.00	126.00	P			000			0.00
	VOID OF ORIGINAL CCN 13283002244813300A PAID 20131018												
ABB222222	1405200077700000U				1412.00-	273.71-	P	1112233333	M CLARK				
	01		100213	S0315	1112.00-	143.71-	P			000			
	02		100213	S9445	300.00-	130.00-	P			000			
	REPLACEMENT OF ORIGINAL CCN 13047112536704 30A PAID 20131018												
ABB222222	1405200414812200A				1001.50	42.75	P	1112233333	M CLARK			0.00	
	01		100213	S0315	142.50	42.75	P			000			0.00
	02		100313	S9445	859.00	0.00	R			000			0.00
												0.00	0.00
							$286.46						

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

CERT. PG TOT	MEDICAID PG TOT
$0.00	$286.46

CERTIFIED AMT	MEDICAID TOTAL
	0.00

CHECK TOTAL

CHECK NUMBER

STATUS CODES:
P = PAYMENT MADE
R = REJECTED
S = IN PROCESS
E = ENCOUNTER

PROVIDER NAME AND ADDRESS

ABC HEALTH PROVIDER
PO BOX 000000
FLORENCE SC 00000

Sample Remittance Advice (page 3)

This page of the sample Remittance Advice shows a claim-level Void without a corresponding Replacement claim.

PROVIDER ID. AB11110000

DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

CLAIM ADJUSTMENTS

PAYMENT DATE 02/28/2014

PAGE 2

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S T S	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME	F I	M I	M O D	ORG CHECK DATE	ORIGINAL CCN
ABB222222	14052000777000000U				513.00-	197.71-	P	1112233333	CLARK		M		131018	1328300224813300A
	01		100213	S0315	453.00	160.71-	P					000		
	02		100213	S9445	60.00	33.00-	P					000		
	TOTALS	1			513.00-	193.71-								

PROVDER INCENTIVE CREDIT AMOUNT: 0.00

DEBIT BALANCE PRIOR TO THIS REMITTANCE: 0.00

YOUR CURRENT DEBIT BALANCE: 0.00

MEDICAID TOTAL: $243.71

ADJUSTMENTS: $193.71-

CHECK TOTAL: $50.00

CERTIFIED AMT: 0.00

CHECK NUMBER: 4197304

TO BE REFUNDED IN THE FUTURE: 0.00

PROVIDER NAME AND ADDRESS

ABC HEALTH PROVIDER
PO BOX 000000
FLORENCE SC 00000

Sample Remittance Advice (page 4)

This page of the sample Remittance Advice shows four gross-level adjustments.
Gross-level adjustments always appear on the final page of the Remittance Advice.

PROVIDER ID.: AB11110000

DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

ADJUSTMENTS

PAYMENT DATE: 02/28/2014

PAGE: 3

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE DATE(S) MMDDYY	PROC / DRUG CODE	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME F M I	ORIG. CHECK DATE	ORIGINAL PAYMENT	ACTION	DEBIT / CREDIT AMOUNT	EXCESS REFUND
TPL 2	1404900004000100U	-						DEBIT	-2389.05	
TPL 4	1405500076000400U	-						DEBIT	-1949.90	
TPL 5	1404900004000100U	-						DEBIT	-477.25	
TPL 6	1405500076000400U	-						CREDIT	477.25	
							PAGE TOTAL:		4338.95	0.00

PROVDER INCENTIVE CREDIT AMOUNT	DEBIT BALANCE PRIOR TO THIS REMITTANCE	MEDICAID TOTAL	CERTIFIED AMT	TO BE REFUNDED IN THE FUTURE
0.00	0.00	0.00	0.00	0.00

ADJUSTMENTS	CHECK TOTAL	CHECK NUMBER
-4338.95	0.00	

YOUR CURRENT DEBIT BALANCE: 0.00

PROVIDER NAME AND ADDRESS

ABC HEALTH PROVIDER
PO BOX 000000
FLORENCE SC 00000

HEALTHY MOTHERS, HEALTHY FUTURES

Maternity Health Education Checklist

PATIENT'S NAME: _____

INSTRUCTIONS: This format provides for written documentation of providing health education to Medicaid maternity patients and suggests the range of topics that generally would be provided.

TOPIC	COMPLETED	DATE(S)
OFFICE SERVICES AND ROUTINES: Information about hours, appointments, lab tests, and other general procedures.	☐	_____ _____
GENERAL INSTRUCTION ABOUT PREGNANCY: such as hygiene, exercise, sexuality, medication, and importance of prenatal care.	☐	_____ _____
FETAL GROWTH AND DEVELOPMENT: how the baby develops month by month and physical and psychological changes experienced by the mother; including comfort measures.	☐	_____ _____
NUTRITION: including routine prenatal diet instruction. **(Be sure to make referral to WIC PROGRAM)**	☐	_____ _____
EXPLANATION OF EDC: Understanding the due date.	☐	_____ _____
DANGER SIGNS OF PREGNANCY: recognizing the warning signs and signifigance and risk of each; including specific instructions on what to do, who to contact and where to go in an emergency.	☐	_____ _____
RISKY BEHAVIORS: smoking, alcohol, substance use and abuse the risks, consequences to baby and methods for avoiding risks. **NOTE: Possible referral for smoking cessation or substance abuse**	☐	_____ _____
PROCESS OF LABOR AND DELIVERY: discussion of physical process of labor and delivery, including psychological changes experienced.	☐	_____ _____
METHODS OF ANESTHESIA: Information on types of anesthesia with discussion of benefits, risks and alternatives; also pain medication.	☐	_____ _____
CESAREAN SECTION: discussion of what it is and what are the usual indications including risks and benefits	☐	_____ _____
RELAXATION AND BREATHING EXERCISES: preparation for labor including demonstration and practice of exercises and breathing techniques	☐	_____ _____
BREASTFEEDING: factors to consider in decision making and preparation of the breasts **Note: Possible referral to La Leche or Breastfeeding Support**	☐	_____ _____

(Continued on Reverse)

MATERNITY EDUCATION CHECKLIST (Continued)

		DATE(S)	
PREPARATION OF OTHER FAMILY MEMBERS: sibling preparation and needs of other family members before and after birth of child; father suppport and involvement.	☐	_____	_____
DELIVERY ARRANGEMENTS: Hospital tours, expectations and procedures during delivery and hospital stay.	☐	_____	_____
POSTPARTUM CARE: Immediate postpartum needs and six weeks check-up and physical care at home, including psychological needs and adjustments.	☐	_____	_____
FAMILY PLANNING: Importance of family planning; risks of short inter-conceptional period and discussion of all methods.	☐	_____	_____
INFANT CARE AND PARENT EDUCATION: Routine infant care needs including preventive care, safety, expectations for infant development and provision for infant health care provider. Note: possible EPSDT referral.	☐	_____	_____
OTHER: Note special areas covered	☐	_____	_____

REFERRAL:

☐ WIC PROGRAM: Date: _____

☐ HRCP (if applicable)
High Risk Channeling Project Date: _____

☐ OTHER

_____ Date: _____

_____ Date: _____

SIGNATURE: _____

ATTENDING PHYSICIAN

Alcohol and Drug Medical Assessment

Patient's Name (Last, First, MI) and I.D. #	
Medicaid Client #	Date of Medical Assessment
Physician's Name and Address	

1. Brief medical history to include hospital admissions, surgeries, allergies. present medications, information (where appropriate) about shared needles, sexual activity/orientation and history of hepatitis and liver disease.

2. History of patient /family involvement with alcohol/drugs.

3. Assessment of patient nutritional status.

ADMA 9/20/90
SCCADA FORM

4. Physical examination to include, but not be limited to, vital signs, inspection of ears, nose, mouth, teeth and gums. Also, inspection of skin for recent and/or old needle marks/tracking, abscesses or scarring from healed abscesses.

5. General assessment of patient cardiovascular system, respiratory system, gastro-intestinal system abd neurological status.

6. Screening for anemia (hematocrit or hemoglobin may be used when physician has machinery available in office).

7.

It is ordered that _____ receive alcohol/drug rehabilitative services.

Physician's Signature and Date

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

PEDIATRIC SUB-SPECIALISTS CERTIFICATION FORM

SECTION 1: PHYSICIAN DEMOGRAPHIC INFORMATION (*PLEASE PRINT*)		
Name (First, Middle, Last):		NPI#:
Physical Location Address:		Suite/Unit #:
City:	State:	ZIP+4:
E-mail Address:		
Telephone Number:		Fax Number:
Mailing Address (if different from physical location address):		
City:	State:	ZIP+4:

SECTION II: ATTESTATION STATEMENT

Beginning February 1, 2006, the monies appropriated for pediatric physician sub-specialists shall only be available to a physician who: **A)** in his/her medical practice, has at least 85% of their patients who are children 18 years or younger and **B)** practices in one of the following sub-specialties or other pediatric sub-specialty area as may be determined by the Department of Health and Human Services:

PEDIATRIC SUB-SPECIALTIES (CHECK ALL THAT APPLY)

☐ Adolescent Medicine	☐ Emergency Medicine	☐ Nephrology	☐ Pulmonology
☐ Allergy	☐ Endocrinology	☐ Neurology	☐ Radiology
☐ Cardiology	☐ Gastroenterology/Nutrition	☐ Neurological Surgery	☐ Rheumatology
☐ Cardiothoracic Surgery	☐ Genetics	☐ Ophthalmology	☐ Surgery
☐ Child Abuse Pediatrics	☐ Hematology/Oncology	☐ Orthopedic Surgery	☐ Urology
☐ Critical Care	☐ Infectious Disease	☐ Otolaryngology	
☐ Developmental-Behavioral Pediatrics	☐ Neonatology	☐ Psychiatry	

CERTIFICATION

I hereby certify that:

1. I am a physician member in good standing on the medical staff of a hospital.
2. I am qualified in and practice in the pediatric specialty noted in Section II above.
3. At least 85% of my total practice, including after-hours patients, is dedicated to children age 18 years and under.

Patient Heading	As a Group	As an Individual	TOTAL
Number of patients seen			
Number of MediCAID patients			
Number of patients 18 and under			
Number of patients with MediCAID 18 and under			

ATTESTATION/ASSURANCES AND SIGNATURE

I am providing this attestation certificate to the South Carolina Department of Health and Human Services with the request that I be included on the list of pediatric specialists eligible for enhanced reimbursement for selected services provided to children enrolled in the South Carolina Medicaid program. I hereby certify, under penalty of perjury, that the information provided on this certificate is correct as of the date of this certificate.

Physician Signature: Date:

CONTACT PERSON INFORMATION

Contact Person Name (please print):	Contact Email Address:
Contact Telephone Number:	Contact Fax Number:

Please ***FAX*** or ***MAIL*** completed/signed form to:
Medicaid Provider Enrollment
FAX: 803-870-9022
MAIL: POB 8809. Columbia. SC 29202-8809

ABORTION STATEMENT

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

Patient's Name:_____

Patient's Medicaid ID#:_____

Patient's Address:_____

_____

Physician Certification Statement

I, _____ certify that it was necessary to terminate the pregnancy of_____

_____ for the following reason:

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

_____

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

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

_____ _____

Physician's Signature Date

****

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

Patient's Certification Statement

I, _____certify that my pregnancy was the result of an act of rape or incest.

(Patient's Name)

_____ _____

Patient's Signature Date

Both the completed Abortion Statement and appropriate medical records must be submitted with the claim form.

Form Approved: OMB No. 0937-0166
Expiration date: 4/30/2022

CONSENT FOR STERILIZATION

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.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____ (*Doctor or Clinic*). When I first asked for the 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 Temporary Assistance for Needy Families (TANF) 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 _____ (*Specify Type of Operation*). 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: _____ (*Date*)

I, _____, hereby consent of my own free will to be sterilized by _____ (*Doctor or Clinic*) by a method called _____ (*Specify Type of Operation*). 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 the Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ (*Signature*) _____ (*Date*)

_____ (*Medicaid ID*)

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

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (mark one or more):
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

■ 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's Signature*) _____ (*Date*)

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ (*Name of Individual*) signed the consent form, I explained to him/her the nature of sterilization operation _____ (*Specify Type of 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 any 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 consequences of the procedure.

_____ (*Signature of Person Obtaining Consent*) _____ (*Date*)

_____ (*Facility*)

_____ (*Address*)

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon _____ (*Name of Individual*) on _____ (*Date of Sterilization*) 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 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 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 paragraph**: 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 circumstances (check applicable box and fill in information requested):

☐ Premature delivery
Individual's expected date of delivery: _____

☐ Emergency abdominal surgery *(describe circumstances)*:

_____

_____

_____ (*Physician's Signature*) _____ (*Date*)

PAPERWORK REDUCTION ACT STATEMENT

A Federal agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays the currently valid OMB control number. Public reporting burden for this collection of information will vary; however, we estimate an average of one hour per response, including for reviewing instructions, gathering and maintaining the necessary data, and disclosing the information. Send any comment regarding the burden estimate or any other aspect of this collection of information to the OS Reports Clearance Officer, ASBTF/Budget Room 503 HHH Building, 200 Independence Avenue, SW., Washington, DC 20201.

Respondents should be informed that the collection of information requested on this form is authorized by 42 CFR part 50, subpart B, relating to the sterilization of persons in federally assisted public health programs. The purpose of requesting this information is to ensure that individuals requesting sterilization receive information regarding the risks, benefits and consequences, and to assure the voluntary and informed consent of all persons undergoing sterilization procedures in federally assisted public health programs. Although not required, respondents are requested to supply information on their race and ethnicity. Failure to provide the other information requested on this consent form, and to sign this consent form, may result in an inability to receive sterilization procedures funded through federally assisted public health programs.

All information as to personal facts and circumstances obtained through this form will be held confidential, and not disclosed without the individual's consent, pursuant to any applicable confidentiality regulations. [43 FR 52165, Nov. 8, 1978, as amended at 58 FR 33343, June 17, 1993; 68 FR 12308, Mar. 14, 2003]

SOUTH CAROLINA MEDICAID PROGRAM
SURGICAL JUSTIFICATION REVIEW FOR HYSTERECTOMY

THIS COMPLETED FORM AND A SIGNED "CONSENT FOR STERILIZATION" FORM MUST BE RECEIVED 30 DAYS PRIOR TO SCHEDULED SURGERY.

PATIENT

NAME _____ **MEDICAID #** _____
LAST FIRST MI

BIRTHDATE _____ **GRAVITY** _____ **PARITY** _____
MONTH/DAY/YEAR

PROCEDURE CODE: _____ **DX CODE:** _____

HOSPITAL _____ _____
NAME NPI (IF AVAILABLE)

PLANNED ADMISSION DATE _____ **PLANNED SURGERY DATE** _____

TYPE OF HYSTERECTOMY PLANNED _____

GYNECOLOGICAL HISTORY/PHYSICAL EXAM RELATING TO PRINCIPAL DIAGNOSIS:

_____
_____
_____
_____
_____
_____
_____

HCT ____ **HGB** ____ **CHECK ONE: PREMENOPAUSAL** _____ **POSTMENOPAUSAL** _____

CONSERVATIVE TREATMENT/MEDICATION WITH DATES:

_____
_____
_____

PRIOR GYN SURGERY/DIAGNOSTIC PROCEDURES (INCLUDE COPIES OF ALL REPORTS):

_____
_____
_____

OFFICE NOTES AND ALL SUPPORTING DOCUMENTATION (e.g., ULTRASOUND, OPERATIVE AND PATH REPORTS, ETC.) ARE REQUIRED FOR APPROVAL AND SHOULD BE ATTACHED TO THIS FORM.

ATTENDING PHYSICIAN'S NAME _____ _____
LAST FIRST MI NPI

ADDRESS _____

CONTACT PERSON _____ **TELEPHONE (_____)** _____
FAX (_____) _____

SIGNATURE _____ **DATE** _____
ATTENDING PHYSICIAN

APPROVALS ARE VALID FOR 180 DAYS FROM DATE OF ISSUE.

Revised: 06/01/12

SOUTH CAROLINA MEDICAID PROGRAM
REQUEST FOR PRIOR APPROVAL REVIEW BY KEPRO

PATIENT NAME _____
LAST FIRST MI

BIRTHDATE _____ ***MEDICAID#** _____
MONTH/DAY/YEAR

PROCEDURE _____ CODE _____

DX CODE:_____

FACILITY _____ _____
NAME NPI #

PLANNED SURGERY DATE _____

*TO AVOID THE RISK OF NON–PAYMENT, PROVIDERS SHOULD CHECK ELIGIBILITY OF RECIPIENT PRIOR TO REQUEST FOR PRIOR APPROVAL REVIEW. IF THE RECIPIENT IS MANAGED CARE, PRIOR APPROVAL MUST BE OBTAINED THROUGH THE MANAGED CARE PROVIDER.

PHYSICIAN'S NAME _____
LAST FIRST MI

ADDRESS _____

_____ NPI: _____

CONTACT PERSON _____ TELEPHONE (_____) _____

DATE _____ FAX NUMBER (_____) _____

- **OFFICE NOTES DOCUMENTING THE REQUESTED INFORMATION MUST BE ATTACHED**
- **ALL PERTINENT DOCUMENTATION FOR THE PROCEDURE SHOULD BE MAILED TOGETHER**
- **PROVIDERS WILL BE NOTIFIED OF DETERMINATION VIA MAIL**

APPROVALS ARE VALID FOR 180 DAYS FROM DATE OF ISSUE

Revised: 06/01/12

State of South Carolina
Department of Health and Human Services

Please return signed original certificate to:

Mailing Address:
SC Dept. of Health and Human Services
Behavioral Health Services
Post Office Box 8206
Columbia, South Carolina 29202-8206
Fax: (803) 255-8204

Section I: Demographic Information

Please Print:

Supervising Clinician Name:	
Address:	
Telephone:	
National Provider Identifier Number (NPI)	
Fax:	
Email:	

Section II: Allied Professional Update Form

The Licensed Master Social Workers (LMSW) listed below are under my supervision and services rendered and billed to South Carolina Medicaid will be in compliance with the guidelines as provided in the South Carolina Medicaid Physicians and other Medical Professions Manual

LMSW Name (as it appears on their license):	
License Number & Expiration Date:	
LMSW Name (as it appears on their license):	
License Number & Expiration Date:	
LMSW Name (as it appears on their license):	
License Number & Expiration Date:	

Should there be changes to this list, the professional's qualifications, and/or licensure, I will notify South Carolina Medicaid utilizing this form within thirty days (30). Failure to comply may result in the recoupment for services rendered. All allied professionals must be listed each time this form is submitted and a maximum of three allied professionals are permitted.

I hereby certify, that the information provided in the certificate is correct as of the date of this certificate.

Physician Signature _____ Date _____

South Carolina
Department of Health and Human Services
P O Box 1412
Columbia, South Carolina 29202-1416
www.scdhhs.gov

Policy for medical treatment outside of the South Carolina Medical Service Area

This serves to clarify our policy for reimbursement of services rendered to a South Carolina Medicaid beneficiary outside the South Carolina Medical Service Area (SCMSA). The service area includes all of South Carolina and regions of North Carolina and Georgia that are within 25 miles of the South Carolina border. All services performed outside of the SCMSA require prior approval. Prior approval guidelines are listed below.

The South Carolina Department of Health and Human Services (SCDHHS) provides compensation to medical providers outside the SCMSA for services rendered to beneficiaries only in the following situations:

- When emergency medical services, pregnancy related services and/or delivery are necessary to protect the health of the beneficiary traveling outside the SCMSA.

- When a SCMSA physician certifies that needed services are not available within the SCMSA and follows SCDHHS protocol in referring the beneficiary to an out-of-state provider. All available resources must have been considered and indicated in the request to SCDHHS for the out-of-state referral. The following guidelines outline the requirements for an out-of-state referral.

Prior to contacting SCDHHS, the referring physician must contact the out of state provider rendering service to the beneficiary and inform them of the beneficiary's Medicaid status. The out-of-state provider must confirm, in writing, that they will enroll in the South Carolina Medicaid program and will accept the Medicaid reimbursement as payment in full. The written confirmation must be submitted to SCDHHS along with a completed Referral Request Form (attached) for out-of-state services.

The written request for out-of-state referrals must include the following information:

- ✓ Beneficiary's name and South Carolina Medicaid identification number
- ✓ Date of Service (state as "tentative" if unscheduled at the time of request)
- ✓ Name, address, telephone number and fax number of the out-of-state provider(s) who will render the medical services (i.e. hospital and physician(s) involved in the beneficiary's medical treatment)
- ✓ An explanation why these services must be rendered out-of-state versus within the SCMSA
- ✓ Identification of any services that are considered experimental and/or investigational, sponsored under a research program, or performed in few medical centers across the United States
- ✓ A copy of the beneficiary's medical records for the past year relating to the treatment of the condition

Services outside of SCMSA *will not* be approved if:

- ✓ All information on the referral form is not provided
- ✓ The provider rendering the service(s) will not enroll in the South Carolina Medicaid program and adhere to the enrollment criteria
- ✓ The provider rendering the service(s) will not accept the South Carolina Medicaid reimbursement as payment in full

For out-of-state referrals, the referring physician may fax the attached Referral Request Form with supporting documentation to (803) 255-8255 or mail the information to the following address:

SCDHHS
Claims, Operations and Provider Relations
ATTN: Out-Of-State Coordinator
P O Box 1412
Columbia, South Carolina 29202-1416

For information concerning enrollment and claims submission for out-of-state **hospital** providers see section 2, "Out-of-State Hospitals" in the Hospitals Services Provider Manual.

When a beneficiary is in one of the Managed Care Organizations (MCO) the request for out-of-state services needs to be completed through the MCO.

For a complete copy of current policy, please refer to the Physicians, Laboratories and Other Medical Professionals Provider Manual. The most current version of the provider manual is maintained on the SCDHHS web site at www.scdhhs.gov. Section two (2), Policies and Procedures outline the Out-of-State policy and further detail. If you have any additional questions, please contact the Provider Service Center at 1-888-289-0709, submit an online inquiry at http://www.scdhhs.gov/contact-us, or your Managed Care program representative at (803) 898-4614.

South Carolina
Department of Health and Human Services
P O Box 1416
Columbia, South Carolina 29202-1416
www.scdhhs.gov

Referral Request Form for Out-of-State Services

BENEFICIARY INFORMATION

NAME: _____

SC MEDICAID ID#: _____ DATE OF BIRTH: _____

NAME OF GUARDIAN: _____

CONTACT NUMBER: _____

REFERRING PHYSICIAN

NAME: _____

NPI#: _____ SC MEDICAID #: _____

PATIENT IS BEING REFERRED TO: _____
NAME OF FACILITY AND/OR PHYSICIAN (S)

CONDITION REQUIRING TREATMENT: _____

DIAGNOSIS CODE (S): _____

PROCEDURE CODE (S): _____

DATE OF SERVICE: _____ DATE OF RETURN: _____

Medicaid patients, as well as their escort, being referred out-of-state may be provided transportation when necessary. Adequate advance notice, as well as prior approval from SCDHHS, is mandatory in order to make the necessary travel arrangements. Call the Provider Service Center at 888-289-0709 for additional questions.

WILL THE BENEFICIARY REQUIRE LODGING, MEAL REIMBURSEMENT and TRANSPORTATION? **YES**_____**NO**_____

RECOMMENDED MODE OF TRANSPORTATION: _____

Please include as an attachment, an explanation why these services must be rendered out-of-state instead of within the SCMSA. You must identify any services that are considered experimental and/or investigational, sponsored under a research program, or performed in few medical centers across the United States. Also, a copy of the beneficiary's medical records, relating to treatment of the condition, for the past year must be included.

I certify that contact has been made with the out-of-state provider. I certify that these services are not available and cannot be provided within the South Carolina service area, which includes North Carolina and Georgia (within 25 miles of the South Carolina border).

_____ _____
SIGNATURE OF REFERRING PHYSICIAN DATE

South Carolina

Department of Health and Human Services
P O Box 1416
Columbia, South Carolina 29202-1416
www.scdhhs.gov

Referral Request Form for Out-of-State Services

OUT-OF-STATE PROVIDER

NAME: _____
NAME OF PHYSICIAN (S) AND/OR FACILITY

ADDRESS: _____

_____

TELEPHONE#: _____ FAX#: _____

I certify that I have agreed to enroll in the South Carolina Medicaid program and I am willing to accept South Carolina Medicaid reimbursement as payment in full.

_____ _____
SIGNATURE OF OUT-OF-STATE PHYSICIAN DATE

TRANSPLANT PRIOR AUTHORIZATION REQUEST FORM INSTRUCTIONS

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

When submitting a completed Transplant Prior Authorization Request Form:

1. The referring South Carolina (SC) Medicaid provider must complete the form.

2. All fields on the form must be completed.

3. Include supporting clinical documentation *(e.g.,* clinical notes, diagnostic studies, lab results)

4. This is not an authorization for payment. Payments are made subject to the beneficiary's eligibility and benefits on the day of service.

5. Providers seeking reimbursement for services must be credentialed with SC Medicaid.

6. You must provide sufficient information to allow us to make a decision regarding your request.

7. If the transplant service is available in state and this case is being referred outside of the South Carolina Medical Service Area (SCMSA), you must indicate why.

8. Requests for prior authorizations from KePRO may be submitted using one of the following methods.

KePRO Customer Service:	1-855-326-5219
KePRO Fax #	1-855-300-0082
For Provider Issues email:	atrezzoissues@Kepro.com

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

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

South Carolina
Department of Health and Human Services

Post Office Box 8206
Columbia, South Carolina 29202-8206

Transplant Prior Authorization Request Form

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

NAME OF BENEFICIARY: _____ DATE OF BIRTH: _____

SC MEDICAID ID#: _____

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

REFERRING PHYSICIAN: _____

NPI: _____ _____ SC MEDICAID #: _____

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

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

WILL THE BENEFICARY REQUIRE TRANSPORTATION? **YES** _____ **NO** _____

RECOMMENDED MODE OF TRANSPORTATION: _____

Medicaid patients, as well as their escort, may be provided transportation when necessary. Prior approval is mandatory in order to make the necessary travel arrangements. Contact the SCDHHS Provider Service Center at 1-888-289-0709 to make travel arrangements.

RENDERING PHYSICIANS/FACILITY

PATIENT REFERRED TO: _____
NAME OF FACILITY AND/OR PHYSICIAN (S)

ADDRESS: _____

TELEPHONE: _____ FAX: _____

NAME OF CONTACT PERSON/COORDINATOR: _____

REQUIRED DOCUMENTATION

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

PLEASE ANSWER THE FOLLOWING QUESTIONS

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

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

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

_____ _____
SIGNATURE OF REFERRING PHYSICIAN **DATE**

South Carolina
Department of Health and Human Services
Mental Health Form

FILL OUT COMPLETELY TO AVOID DELAYS

Beneficiary Information	
Beneficiary's Name:	
Medicaid ID #:	
Date of Birth:	

Provider Information	
Individual NPI:	
Organization NPI:	
Service Location Address:	
City & State:	

DSM-IV TR Diagnosis

Axis I _____/_____/_____ Axis II _____/_____ Axis III _____/_____

Date first seen: _____ **Date of last service:** _____ **# of additional visits requested:** _____

Current Clinical Information: (Circle each. Scale 0=None, 1=Mild, 2=Moderate, 3=Severe, 4=Extreme)

Aggression	0 1 2 3 4	Depressions	0 1 2 3 4	Relationship Problems	0 1 2 3 4
Alcohol/Substance Use	0 1 2 3 4	Hallucinations	0 1 2 3 4	Side Effects	0 1 2 3 4
Anxiety/Panic	0 1 2 3 4	Impulsivity	0 1 2 3 4	Sleep Effects	0 1 2 3 4
Appetite Disturbance	0 1 2 3 4	Job/School Problems	0 1 2 3 4	Sleep Disturbance	0 1 2 3 4
Attention/Concentration	0 1 2 3 4	Mania	0 1 2 3 4	Weight Loss	0 1 2 3 4
Deficit in ADLs	0 1 2 3 4	Medical Illness	0 1 2 3 4	Other	0 1 2 3 4
Delusions	0 1 2 3 4	Memory	0 1 2 3 4	Current Stressors	0 1 2 3 4

Services

◇ 90833 ◇ 90846 ◇ 90853 ◇ 90837

◇ 90836 ◇ 90847 ◇ 90832 ◇ 96102

◇ 90838 ◇ 96101 ◇ 90834

Current Medications	**Name**	**Dose**	**Frequency**	**Side Effects**
◇ **New**	**1.**			
◇ **New**	**2.**			
◇ **New**	**3.**			
◇ **New**	**4.**			

Compliance ◇ **>90%** ◇ **50-90%** ◇ **<50%**

Reasons for Noncompliance:	

_____ (___)_____ (___)_____

Physician Name Phone: Fax

_____ _____

Physician Signature Date

Clinical documentation must be submitted with this request and submitted to the QIO using one of the following methods:
KePRO FAX#: 1-855-300-0082, KePRO Customer Service Phone#: 1-855-326-5216, KePRO website: http://scdhhs.Kepro.com.

Disclaimer: Authorization indicates that SCDHHS determined that medical necessity has been met for the requested service(s) but does not guarantee payment. Payment is contingent upon the beneficiary's eligibility and benefit limitations at the time services are rendered. The Physician Assistant is not authorized to sign this form.

Behavioral Health Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

SOUTH CAROLINA MEDICAID PROGRAM
PSYCHIATRIC PRIOR AUTHORIZATION

*TO AVOID THE RISK OF NON-PAYMENT, PROVIDERS SHOULD CHECK ELIGIBILITY OF RECIPIENT PRIOR TO REQUEST FOR PRIOR APPROVAL REVIEW. IF THE RECIPIENT IS MANAGED CARE, PRIOR APPROVAL MUST BE OBTAINED THROUGH THE MANAGED CARE PROVIDER.

FAX TO: KePRO 1-855-300-0082

DATE: _____

PATIENT NAME: _____ MEDICAID #: _____
LAST FIRST MI

BIRTH DATE: _____ INPATIENT _____ OUTPATIENT _____
MONTH/DAY/YEAR

PRIMARY DX: (CIRCLE ONE→) OPPOSITIONAL DEFIANCE DISORDER OR CONDUCT DISORDER

DX CODE(S): _____

PLANNED ADMISSION DATE: _____

HOSPITAL: _____ _____
NAME MEDICAID ID #

INFORMATION NEEDED (PLEASE CIRCLE ALL INCLUDED):

HISTORY & PHYSICAL:

OFFICE NOTES - PCP AND/OR SPECIALIST

PREVIOUS TREATMENTS:

MEDICATION

CURRENT CLINICAL NOTES DOCUMENTING THE REASON FOR ADMISSION INCLUDING ABOVE INFORMATION MUST BE ATTACHED

PHYSICIAN'S NAME: _____ _____
LAST FIRST MI MEDICAID PROVIDER ID #:

ADDRESS: _____

CONTACT PERSON: _____ PHONE #: _____

SOUTH CAROLINA MEDICAID PROGRAM
CIRCUMCISION
REQUEST FOR PRIOR APPROVAL REVIEW

SEND COMPLETED REQUEST FORM WITH MEDICAL RECORDS TO:

SCDHHS
CIRCUMCISION PRIOR APPROVAL REVIEW
FAX: (803) 255-8255

PATIENT NAME _____
LAST FIRST MI

BIRTHDATE _____ *MEDICAID# _____
MONTH/DAY/YEAR

PROCEDURE _____ CODE _____

DX CODE:_____

FACILITY _____ _____
NAME NPI #

PLANNED SURGERY DATE _____

*TO AVOID THE RISK OF NON–PAYMENT, PROVIDERS SHOULD CHECK ELIGIBILITY OF RECIPIENT PRIOR TO REQUEST FOR PRIOR APPROVAL REVIEW. IF THE RECIPIENT IS MANAGED CARE, PRIOR APPROVAL MUST BE OBTAINED THROUGH THE MANAGED CARE PROVIDER.

PHYSICIAN'S NAME _____
LAST FIRST MI

ADDRESS _____

_____ NPI: _____

CONTACT PERSON _____ TELEPHONE (_____) _____

DATE _____ FAX NUMBER (_____) _____

- **OFFICE NOTES DOCUMENTING THE REQUESTED INFORMATION MUST BE ATTACHED**
- **ALL PERTINENT DOCUMENTATION FOR THE PROCEDURE SHOULD BE MAILED TOGETHER**
- **PROVIDERS WILL BE NOTIFIED OF DETERMINATION VIA FAX**

APPROVALS ARE VALID FOR 180 DAYS FROM DATE OF ISSUE

Revised: 02/01/11

SOUTH CAROLINA Healthy Connections MEDICAID

SBIRT INTEGRATED SCREENING TOOL

BlueCross BlueShield of South Carolina and BlueChoice HealthPlan of South Carolina

*** Fax the COMPLETED form to the patient's plan and referral site and keep a copy in patient file**

☐ Absolute Total Care Fax: 877-285-3226	☐ BlueChoice HealthPlan Medicaid Fax: 855-580-2810	☐ Molina Fax: 866-423-3889	☐ Wellcare Fax: 866-455-6562
☐ Advicare Fax: 888-781-4316	☐ First Choice by Select Health Fax: 866-533-5493	☐ SCDHHS (Fee-For-Service) Fax: 803-255-8247	☐ BlueCross BlueShield of South Carolina & BlueChoice HealthPlan Fax: 803-870-9884

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Language:	Race:	Ethnicity:	Expected due date:
Phone no: ( )	Street address:		Member ID no:			

PROVIDER INFORMATION

Practice name:	Group NPI:	Individual NPI:	Screening provider's name:	Phone no: ( )

PATIENT SCREENING INFORMATION

Parents Did any of your parents have a problem with alcohol or drug use?	○ YES				○ NO
Peers Do any of your friends have a problem with alcohol or other drug use?	○ YES				○ NO
Partner Does your partner have a problem with alcohol or other drug use?			○ YES		○ NO
Violence Are you feeling at all unsafe in any way in your relationship with your current partner?		○ YES			○ NO
Emotional Health Over the last few weeks, has worry, anxiety, depression or sadness made it difficult for you to do your work, get along with people or take care of things at home?				○ YES	○ NO
Past In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications?			○ YES		○ NO
Present In the past month, have you drunk any alcohol or used other drugs? 1. How many **days per month** do you drink? _____ 2. How many **drinks** on **any given day**? _____ 3. How often did you have **4 or more drinks per day** in the last **month**? _____ 4. In the past month have you taken any prescription drugs?			○ YES		○ NO
Smoking Have you smoked any cigarettes in the past three months?			○ YES		○ NO
Please provide additional details for any "yes" responses:	↓ Review risk	↓ Review domestic violence resources	↓ Review substance use, set healthy goals	↓ Consider mental evaluation	

ADVICE FOR BRIEF INTERVENTION

	Y	N	N/A
Did you **S**tate your medical concern?			
Did you **A**dvise to abstain or reduce use?			
Did you **C**heck patient's reaction?			
Did you **R**efer for future assessment?			

At Risk Drinking	
Non-Pregnant	**Pregnant/Planning Pregnancy**
7+ drinks/week 3+ drinks/day	**Any Use is Risky Drinking**

CONFIDENTIAL SBIRT REFERRAL INFORMATION

Patient referred to: (Check all that apply)	☐ DMH	☐ DAODAS	☐ DHEC Quitline Fax: 800-483-3114	☐ Private provider (Name & NPI)	☐ Domestic violence 803-256-2900
Date of referral appointment (DD/MM/YY):	Date screened:	☐ Patient refused referral	☐ Referral not warranted		☐ Patient requested assistance

Women's health can be affected by emotional problems, alcohol, tobacco, other drug use and domestic violence. Women's health is also affected when those same problems are presented in people close to us. By "alcohol," we mean beer, wine, wine coolers or liquor.

Physician's Signature: _____

**Adapted from Institute for Health & Recovery, (2015)*

Universal 17-P Authorization Form

*Fax the COMPLETED form OR call the plan with the requested information.

☐Absolute Total Care	☐BlueChoice HealthPlan	☐First Choice by Select Health	☐WellCare Health Plan, Inc.
P: 803-933-3689 F: 866-918-4451	P: 866-902-1689 F: 800-823-5520	P: 888-559-1010 x55251 F: 866-533-5493	P: 888-588-9842 F: 866-458-9245

☐Advicare	☐Molina Healthcare, Inc.
P: 888- 781-4371 F: 888- 781-4316	P: 855- 237-6178 F: 855- 571-3011

Date of Request for Authorization _____

Patient/Member Name _____ DOB _____
First Middle Last

Address (Street, Apt.#) _____ City/State/Zip _____

Phone _____ Medicaid Number _____ MCO ID Number _____

☐Pregnancy Information and History

G___ T ___ P___ A ___ L ___ (Note: A= abortion (spontaneous and medically induced) EDC _____

Last menstrual period _____ EDD _____ Current Gestational age _____ weeks

Bed Rest ☐Yes ☐No Experiencing Preterm Labor ☐Yes☐ No
(Home administration available if on bed rest)

☐Singleton Pregnancy ☐Multiple Pregnancy

At least 16 weeks gestation ☐Yes ☐No** Major Fetal or Uterine Anomaly ☐Yes ☐No

Patient has a history of prior spontaneous singleton preterm birth between 20-36.6 weeks ☐Yes ☐No

Delivery was due to preterm labor or PPROM even if it resulted in C-section ☐Yes ☐No

Delivery was not due to medical indication, e.g. preeclampsia, abruption, etc. ☐Yes ☐No

Medication Allergies _____ ☐No known drug allergies

Other Pertinent Clinical Information: _____

☐Pharmacy Information

☐Ship to patient's home address End Date of Service _____

☐Ship to provider's address End Date of Service _____

Shipping Preference: ☐Regular Mail ☐Ground ☐Overnight

Ordering Physician's Signature: _____ Makena or 17-P Compound _____

☐Provider Information

Ordering Provider Name _____
(Please Print)

Ordering Provider NPI _____ Tax ID _____

Address _____ City/State/Zip _____

Phone _____ Fax _____

Provider Type: ☐OB/GYN ☐Family Medicine ☐MFM/Perinatology ☐Other

Practice Name: _____ Practice NPI: _____

Contact Person: _____ Phone: _____ Fax: _____

FOR MCO USE ONLY:

☐Approved ☐Denied Authorization # _____ Number of Injections _____

Date of Notification to Provider: _____ Reviewer(s) name & title: _____

Please note that our review applies only to the authorization of medical necessity and benefit coverage. This authorization is not a guarantee of payment unless the member is eligible at the time the services are rendered.

** Prescription may be written prior to 16 weeks, but the vial shipment may be withheld by the pharmacy until the 15th week

SCDHHS Behavioral Health Referral & Feedback Form

Physician Referral for Licensed Independent Practitioner Services

Date: _____ ( ) Initial ( ) Follow-up

Referring Physician Name: _____

Address: _____
(Street/PO Box) City State Zip

Fax: (___) _____ Phone: (____) _____

Patient's Name: _____ DOB: _____

Parent's Name (if minor): _____ Address: _____ Phone: _____

Date(s) Patient Seen: _____

Reason(s) for Referral: _____

_____

Any Specific Questions or Requests: _____

_____

_____
Referring Physician's Printed Name/Signature

Thank you for evaluating this patient. To facilitate communication and treatment, please make copies of the following form to retain in the patient's record; complete a form after initial assessment; complete additional forms periodically during treatment (as indicated) and when treatment is terminated; and mail or fax completed form(s) to the physician listed above. This is not a request for copies of psychotherapy notes, which require a signed consent to release. Thank you for your collaboration.

Licensed Independent Practitioner's Report

Date(s) Patient Seen: _____

- ❑ Patient did not make appointment.
- ❑ Patient made an appointment but did not keep appointment.
- ❑ Patient not seen within 60 days.

Initial Diagnoses:

1. _____
2. _____
3. _____

Recommendations: _____

_____

Medications Prescribed: _____

_____

Follow-up Arranged or Provided by Consultant:

- ❑ Further diagnostic testing _____
- ❑ Individual psychotherapy
- ❑ Family psychotherapy
- ❑ Medication management
- ❑ Group psychotherapy
- ❑ Lab tests
- ❑ Return visit _____

Other Care Needed:

- ❑ Medication management by PCP
- ❑ Referrals recommended _____
- ❑ Follow-up recommended _____
- ❑ Other: _____

_____
Name (type or print) Signature

FAX to _____
Contact Person

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Review the resolution instructions below for the edit code(s) that apply to your claim. **Submit a new claim with the corrected information and attach documentation when necessary or applicable to complete the processing of the claim.** If the claim does not require corrections, but needs to be reprocessed as a result of a system update, submit a new claim for processing after the system has been updated. **Remittance Advice pages are not an acceptable form to correct claim errors and will be disregarded.**

Note: For dates of service on or before **September 30, 2015**, the ICD-9-CM manual should be referenced for ICD coding guidance. For dates of service on or after **October 1, 2015**, the ICD-10-CM manual should be referenced for ICD coding guidance.

Edit Code	Description	CARC	RARC	Resolution
007	PAT DAILY INCOME RATE MORE THAN HOME RATE	45 – Charge exceeds fee schedule/maximum allowable or contracted/ legislated fee arrangement.		Patient's daily recurring income is greater than the nursing facility's daily rate. If the recurring income is incorrect, make the appropriate correction and submit a new claim. If the recurring income is correct, contact the PSC.
050	DATE OF BIRTH/ DATE OF SERV. INCONSISTENT	14 – The date of birth follows the date of service.		The date of birth and/or date of service are inconsistent. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1 A), date of birth (field 3), date of service (field 24 A unshaded) **UB CLAIM:** Medicaid ID (field 60), date of birth (field 10), date of service (field 6) If the date of birth is correct according to your records, contact the local county Medicaid office to update the system. After verifying that the system has been updated, submit a new claim.
051	DATE OF DEATH/ DATE OF SERV INCONSISTENT	13 – The date of death precedes the date of service.		The date of death and/or date of service are inconsistent. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1 A), date of service (field 24 A unshaded) **UB CLAIM:** Medicaid ID (field 60), date of service (field 6) **NH CLAIM:** Submit termination DHHS Form 181 with monthly billing. If the date of death is correct according to your records, contact the local county Medicaid office to see if there is an error with the patient's date of death. After verifying that the system has been updated, submit a new claim.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
052	ID/RD WAIVER CLM FOR NON ID/RD WAIVER RECIP	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	The claim was submitted with an ID/RD waiver-specific procedure code, but the recipient was not a participant in the ID/RD waiver. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), date of service (field 24A unshaded), procedure code (field 24D unshaded) If the recipient's Medicaid ID is correct, the procedure code is correct, and an ID/RD waiver form has been obtained, contact the service coordinator listed at the bottom of the waiver form. After the system has been updated, submit a new claim.
053	NON ID/RD WAIVER CLM FOR ID/RD WAIVER RECIP	A1 – Claim/service denied.	N34 – Incorrect claim/format for this service.	The claim was submitted for an ID/RD waiver recipient, but the procedure code is not an ID/RD waiver procedure code. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), date of service (field 24 A unshaded), procedure code (field 24 D unshaded)
055	MEDICARE B ONLY SUFFIX WITH A COVERAGE	16 – Claim/service lacks information which is needed for adjudication.	MA04 – Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	**UB CLAIM:** Submit a claim to Medicare Part A.
056	MEDICARE B ONLY SUFFIX/NO A COV/NO 620	16 – Claim/service lacks information which is needed for adjudication.	M56 – Incomplete/invalid provider payer identification.	**UB CLAIM:** Enter Medicare carrier code 620, Part A - Mutual of Omaha carrier code 635, or Part B - Mutual of Omaha carrier code 636 (fields 50 A-C). Enter the Medicare Part B payment (fields 54 A-C). Enter the Medicare ID number (fields 60 A-C). The carrier code, payment, and ID number should be entered on the same lettered line, A, B, or C.
057	MEDICARE B ONLY SUFFIX/NO A COV/NO $	107 – Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.		**UB CLAIM:** Enter Medicare carrier code 620, Part A - Mutual of Omaha carrier code 635, or Part B - Mutual of Omaha carrier code 636 (fields 54 A – C) which corresponds with the line on which you entered the Medicare carrier code (fields 50 A – C).
058	RECIP NOT ELIG FOR MED. COMPLEX CHILDREN'S WAIVER SVCS	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	The edit cannot be manually corrected. The provider needs to submit billing through the Care Call System.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
059	MED. COMPLEX CHILDREN'S WAIVER RECIP SVCS REQUIRE PA	16 – Claim/service lacks information or has submission/billing error(s).	M62 – Missing/incomplete/invalid treatment authorization code.	The edit cannot be manually corrected. The provider needs to submit billing through the Care Call System. Contact recipient's PCP to obtain authorization for this service.
060	MED.COMPLEX CHILDREN'S WAIVER, CLAIM TYPE NOT ALLOWED	16 – Claim/service lacks information which is needed for adjudication.	N34 – Incorrect claim form/format for this service.	The edit cannot be manually corrected. The provider needs to submit billing through the Care Call System.
061	INMATE RECIP ELIG FOR EMER INST SVC ONLY	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	The recipient is eligible for emergency institutional services only. If the service was not directly related to emergency institutional services, service is non-covered. Verify that the claim information was billed correctly. **UB CLAIM:** Only inpatient claims will be reimbursed.
062	HEALTHY CONNECTIONS KIDS (HCK) – RECIPIENT in MCO Plan/Service Covered by MCO	24 – Charges are covered under a capitation agreement/ managed care plan.		This recipient is in the Healthy Connections Kids (HCK) Program and enrolled with an MCO. These services are covered by the MCO. Bill the MCO.
063	NH RECIPIENT NOT COMPLEX CARE	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Contact the Nursing Facility program area to obtain the authorization for the service. Submit the complex care authorization form or complex care termination form with the monthly billing.
079	PRIVATE REHAB UNITS EXCEEDED	273 – Coverage/ program guidelines were exceeded.		The number of units billed for this procedure code exceeds the authorized limit. Refer to the Prior Authorization letter from the QIO to determine the number of units authorized. If the prior authorization unit number is correct, attach the QIO prior authorization letter to the NEW claim for review and consideration for payment. Make corrections to the field(s) below. **CMS-1500 CLAIM**: Date of service (field 24A unshaded), procedure code (field 24D unshaded), units (field 24G unshaded) **UB CLAIM:** Date of service (field 45), procedure code (field 44), units (field 46)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
080	SERVICES NON-COVERED FOR RECIPIENTS OVER 21 YEARS OF AGE	6 – The procedure/ revenue code is inconsistent with the patient's age.	N129 – Not eligible due to the patient's age.	These services are non-covered for South Carolina Medicaid Eligible recipients over the age of 21.Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), date of birth (field 3), procedure code (field 24D unshaded) If the date of birth is correct according to your records, contact the local county Medicaid office to update the system. After verifying that the system has been updated, submit a new claim.
101	INTERIM BILL	135 – Claim denied. Interim bills cannot be processed.		**UB CLAIM:** Verify the bill type (field 4) and the discharge status (field 17). Medicaid does not process interim bills. Please do not file a claim until the recipient is discharged from acute care.
110	PROCEDURE CODE REQUIRES OBESITY PRIMARY DIAGNOSIS	16 – Claim/service lacks information which is needed for adjudication.	M76 - Missing/incomplete/invalid diagnosis or condition.	Verify that the correct procedure code and diagnosis code were billed. Check the current version of the ICD-CM manual for correct coding. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Diagnosis code (field 21), procedure code (field 24D unshaded)
117	DRG 469 - PRIN DIAG NOT EXACT ENOUGH	16 – Claim/service lacks information which is needed for adjudication.	M81 –You are required to code to the highest level of specificity.	This is a non-covered DRG. Verify the diagnoses and procedure codes and make corrections to the field(s) below. **UB CLAIM:** Diagnosis code (field 67), procedure code (field 74)
118	DRG 470 - PRINCIPAL DIAGNOSIS INVALID	16 – Claim/service lacks information which is needed for adjudication.	MA63 – Missing/incomplete/ invalid principal diagnosis.	Resolution is the same as for edit code 117.
119	INVALID PRINCIPAL DIAGNOSIS	16 – Claim/service lacks information which is needed for adjudication.	MA63 – Missing/incomplete/ invalid principal diagnosis.	This claim contains an invalid principal diagnosis. Verify the valid diagnosis in the current ICD-CM manual and make corrections to the field(s) below. **UB CLAIM:** Diagnosis code (field 67)
120	CLM DATA INADEQUATE CRITERIA FOR ANY DRG	A8 – Claim Denied ungroupable DRG.		**UB CLAIM:** Verify data with the medical records department.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
121	INVALID AGE	6 – Procedure/revenue code inconsistent with age.		Validate recipient's date of birth on the claim. If there is a discrepancy on the recipient's file, contact the county Medicaid Eligibility office for correction. If the recipient's date of birth is correct, verify that the correct diagnosis code is billed. Check the most current edition of the ICD-CM manual for the correct gestational age range and weight combination. Make corrections to the field(s) below and submit a new claim. **UB CLAIM:** Date of Birth (field 10), Diagnosis code (fields 67 A-Q)
122	INVALID SEX	16 – Claim/service lacks information which is needed for adjudication.	MA39 – Missing/incomplete/ invalid gender.	This claim contains an invalid sex. Make corrections to the field(s) below. **UB CLAIM:** Sex (field 11) Contact your county Medicaid Eligibility office to correct the sex on the recipient's file if there is a discrepancy according to your records. After the county Medicaid Eligibility office has made the correction and updated the system, submit a new claim.
123	INVALID DISCHARGE STATUS	16 – Claim/service lacks information which is needed for adjudication.	N50 – Missing/incomplete/invalid discharge information.	This claim contains an invalid discharge status code. Check the most current edition of the NUBC manual for a list and descriptions of valid discharge status codes. Make corrections to the field(s) below. **UB CLAIM:** Status (field 17)
125	PPS PROVIDER RECORD NOT ON FILE	CARC B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.		**UB CLAIM:** The prospective payment system (PPS) provider record is not on file to display the reimbursement for the facilities. The provider is not enrolled with Medicaid and will not be considered for payment.
127	PPS STATEWIDE RECORD NOT ON FILE	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.		**UB CLAIM:** The prospective payment system (PPS) statewide record is not on file to display the reimbursement for the facilities. The provider is not enrolled with Medicaid and will not be considered for payment.
128	DRG PRICING RECORD NOT ON FILE	A8 – Claim denied ungroupable DRG.		This DRG is not currently priced by Medicaid. Verify the diagnoses and procedure codes and make corrections to the field(s) below. **UB CLAIM:** Diagnosis code (fields 67 A-Q), procedure code (field 74)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
150	TPL COVER VERIFIED/FILING NOT IND ON CLM	22 - This care may be covered by another payer per coordination of benefits.		Please see INSURANCE POLICY INFORMATION for the three-character carrier code that identifies the insurance company, as well as the policy number and the policyholder's name. Identify the insurance company by referencing the numeric carrier code list in the applicable provider manual or on the DHHS website. File the claim(s) with the primary insurance before re-filing to Medicaid. If the carrier that has been billed is not the insurance for which the claim received the edit 150, the provider must file with the insurance carrier that is indicated. If the system needs to be updated, contact the TPL office. After verifying that the system has been updated, submit a new claim. Verify that the information in the fields below was billed correctly. **CMS 1500 CLAIM:** Enter the carrier code (fields 9D and 11C), policy number (fields 9A and 11). If payment is made, enter the total amount(s) paid (fields 9C, 11B and 29). Adjust the balance due (field 30). If payment is denied (i.e., applied to the deductible, policy lapsed, etc.) by the other insurance company, put a "1" (denial indicator) (field 10D). **UB CLAIM:** Enter the carrier code (field 50). Enter the policy number (field 60). If payment is made, enter the amount paid (field 54). If payment is denied, enter 0.00 (field 54) and also enter code 24 and the date of denial in the Occurrence Code (fields 31-34 A-B). **NOTE:** Please refer to the Medicaid Web-based Claims Submission Tool (Web Tool) to verify insurance information. Click here for additional resolutions tips at MedicaideLearning.com.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
151	MULTIPLE INS POL/NOT ALL FILED-CALL TPL	22 - This care may be covered by another payer per coordination of benefits.		Eliminate any duplicate primary insurance policy entries ensuring one carrier per block. Medicaid coverage should not be entered in either primary block. If there is no duplicate information, refer to the INSURANCE POLICY INFORMATION, and file the claim(s) with each insurance company listed before re-filing to Medicaid. Documentation must show that each policy has been billed, and that proper coordination of benefits has been followed, *e.g.,* bill primary carrier first, then bill second carrier for the difference. If there are three or more separate third-party payers, the claim must be processed by the Third-Party Liability, attach the documentation to your new claim. Verify that the information in the field(s) below was billed correctly. **CMS 1500 CLAIM:** Insurance carrier number (fields 9D and 11C), policy number (fields 9A and 11) **UB CLAIM:** Insurance information (field 50) **NOTE:** Please refer to the Medicaid Web-based Claims Submission Tool (Web Tool) to verify insurance information.
155	POSS NOT POSITIVE INS MATCH/OTHER ERRORS	22 - This care may be covered by another payer per coordination of benefits.		Bill the primary insurer(s) according to the resolution instructions for edit code 150.
156	TPL VERIFIED/FILING NOT INDICATED ON CLM	22 - This care may be covered by another payer per coordination of benefits.		File a claim with the insurance company listed under INSURANCE POLICY INFORMATION. Identify the insurance company by referencing the numeric carrier code list in the applicable provider manual or on the DHHS website. If the insurance company denies payment or makes a partial payment, attach a copy of the explanation of benefits with your claim. If the insurance carrier pays the claim in full, no further action is necessary. **NOTE:** Please refer to the Medicaid Web-based Claims Submission Tool (Web Tool) to verify insurance information.
165	TPL BALANCE DUE/ PATIENT RESPONSIBILITY MUST BE PRESENT/NUMERIC	16-Claim/service lacks information which is needed for adjudication.	MA92 – Missing plan information for other insurance.	When there is a third party payer on the claim that is primary to Medicaid, the "patient responsibility", entered in the "balance due" and the co-pay, coinsurance and deductible for the third party payer, cannot be blank or nonnumeric. Verify that the information in the field(s) below was billed correctly. **CMS 1500 CLAIM:** Amount paid (field 29), balance due (field 30)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
170	LAB PROC BILLED/NO CLIA # ON FILE	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Attach a copy of your CLIA certification to the new claim.
171	NON-WAIVER PROC/PROV HAS CERT OF WAIVER	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Our records indicate that your CLIA certificate of waiver allows Medicaid reimbursement for waivered procedures only. Lab services billed are not waivered procedures. If your CLIA certification has changed, attach a copy of your updated CLIA certificate from CMS to a new claim.
172	D.O.S. NONCOVERED ON CLIA CERT DATE	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Medicaid will not reimburse for services outside CLIA certification dates. If your CLIA certification has been renewed, attach a copy of your updated CLIA certificate from CMS to a new claim. Contact your lab director or CMS for current CLIA certificate information.
174	NON-PPMP PROC/PROV HAS PPMP CERT	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Our records indicate that your CLIA certificate of PPMP allows Medicaid reimbursement for PPMP procedures only. Lab services billed are not PPMP procedures. If your CLIA certification has changed, attach a copy of your updated CLIA certificate from CMS to a new claim.
201	MISSING RECIPIENT ID NUMBER	31 – Claim denied, as patient cannot be identified as our insured.		The recipient's 10-digit Medicaid ID number must be entered. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A) **UB CLAIM:** Medicaid ID (field 60)
202	MISSING NATIONAL DRUG CODE (NDC)	16 – Claim/service lacks information which is needed for adjudication.	M119 - Missing/incomplete/ invalid/deactivated/withdrawn National Drug Code (NDC).	The NDC is missing from the claim. Make corrections to the field(s) below. **CMS 1500 CLAIM:** NDC (field 24A shaded) **UB CLAIM:** NDC (field 43)
206	MISSING DATE OF SERVICE	16 – Claim/service lacks information which is needed for adjudication.	M59 – Missing/incomplete/invalid "to" date(s) of service.	The date of service is missing. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24A unshaded) **UB CLAIM:** Date of service (field 45)
207	MISSING SERVICE CODE	16 – Claim/service lacks information which is needed for adjudication.	M51 – Missing/incomplete/invalid procedure codes.	The code for the service/procedure is missing. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
208	NO LINES ON CLAIM	16 – Claim/service lacks information which is needed for adjudication.	N34 – Incorrect claim form/ format for this service.	Submit a new claim with the billable services.
209	MISSING LINE ITEM SUBMITTED CHARGE	16 – Claim/service lacks information which is needed for adjudication.	M79 – Missing/incomplete/invalid charge.	The line item submitted charge is missing. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Charges (field 24F unshaded) **UB CLAIM:** Charges (field 47)
210	MISSING TAXONOMY CODE	16 – Claim/service lacks information which is needed for adjudication.	N255 – Missing/incomplete/invalid billing provider taxonomy.	The taxonomy code is missing from the claim. Taxonomy codes are required when an NPI is shared by multiple legacy provider numbers. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Taxonomy code (field 24J shaded) or (field 33B) **UB CLAIM**: Taxonomy code (field 81 A-D)
213	LINE ITEM MILES OF SERVICE MISSING	16 – Claim/service lacks information which is needed for adjudication.	M22 – Missing/incomplete/invalid number of miles traveled.	The number of miles of service is missing from the line item. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Units (field 24G unshaded)
219	PRESENT ON ADMISSION (POA) INDICATOR IS MISSING, DIAGNOSIS IS NOT EXEMPT	A1 – Claim/service denied.	N434 – Missing/incomplete/invalid Present on Admission indicator.	This edit code cannot be manually corrected. Submit a new claim with the corrected information.
225	FUND CODE NOT ASSIGNED	16 – Claim/service lacks information which is needed for adjudication.	M56 – Missing/incomplete/invalid payer identifier.	The system is unable to crosswalk the information on the claim to an assigned fund code. Verify the correct procedure code, modifier, NPI and/or legacy number was submitted. Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Provider ID (field 33A & 33B), procedure code (field 24D unshaded), modifier (field 24D unshaded) **UB CLAIM**: Provider ID (field 56), procedure code, modifier (field 44 or 74) **Note:** Fund codes may identify specific procedure codes, modifiers, and provider type/provider specialties. If these are submitted in the wrong combination or entered incorrectly, the system searches but cannot find the appropriate fund code and is unable to process the claim.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
227	MISSING LEVEL OF CARE	16 – Claim/service lacks information which is needed for adjudication.	N188 – The approved level of care does not match the procedure code submitted.	The level of care is a required field. Enter the corrected information on a new claim.
233	PRIMARY DIAGNOSIS CODE IS MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA63 – Missing/incomplete/ invalid principal diagnosis.	The primary diagnosis code is missing. Enter a primary diagnosis code from the current edition of the ICD-CM manual. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Primary diagnosis code (field 21)
234	PLACE OF SERVICE MISSING	16 – Claim/service lacks information which is needed for adjudication.	M77-Missing/incomplete/invalid place of service.	The place of service is missing from the claim. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Place of service (24B unshaded)
239	MISSING LINE NET CHARGE	16 – Claim/service lacks information which is needed for adjudication.	M79-Missing/incomplete/invalid charge.	The line net charge is a required field. Enter the corrected information on a new claim.
243	ADMISSION DATE/START OF CARE MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA40 – Missing/incomplete/ invalid admission date.	**UB CLAIM:** Enter the admission date/start of care date (field 12).
244	PRINCIPAL DIAGNOSIS CODE MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA63 – Missing/incomplete/ invalid principal diagnosis.	**UB CLAIM:** Enter the principal diagnosis code (field 67).
245	TYPE OF BILL MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA30 – Missing/incomplete/ invalid type of bill.	**UB CLAIM:** Refer to the most current edition of the NUBC manual for valid type of bill. Enter a valid Medicaid bill type code (field 4).
246	FIRST DATE OF SERVICE MISSING	16 – Claim/service lacks information which is needed for adjudication.	M52 – Missing/incomplete/invalid "from" date(s) of service.	**UB CLAIM**: Enter the first date of service (field 6).
247	MISSING LAST DATE OF SERVICE	16 – Claim/service lacks information which is needed for adjudication.	M59 – Missing/incomplete/invalid "to" date(s) of service.	**UB CLAIM:** Enter the last date of service (field 6).
248	TYPE OF ADMISSION MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA41 – Missing/incomplete/ invalid admission type.	**UB CLAIM:** Refer to the most current edition of the NUBC manual for valid types of admissions. Enter a valid Medicaid type of admission code (field 14).
249	TOTAL CLAIM CHARGE MISSING	16 – Claim/service lacks information which is needed for adjudication.	M54 – Missing/incomplete/invalid total charges.	**UB CLAIM:** Enter revenue code 001 on the total charges line (field 42). This revenue code must be listed as the last field.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
252	PATIENT STATUS MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA43 – Missing/incomplete/ invalid patient status.	**UB CLAIM:** Refer to the most current edition of the NUBC manual for patient status. Enter the valid Medicaid patient status code (field 17).
253	SOURCE OF ADMISSION MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA42 – Missing incomplete/ invalid admission source.	**UB CLAIM:** Refer to the most current edition of the NUBC Manual for source of admission. Enter a valid Medicaid source of admission code (field 15).
263	MISSING TOTAL DAYS	16 – Claim/service lacks information which is needed for adjudication.	M53 – Missing/incomplete/invalid days or unit(s) of service.	Make the appropriate correction to the claim by entering or correcting the total number of days.
270	DOS/DISCH REQUIRES ICD-9 CODES/ICD-9 INDICATOR	16 – Claim/service lacks information which is needed for adjudication.	N517 – Resubmit a new claim with the requested information.	The DOS/ICD Indicator is inconsistent with the diagnosis or ICD surgical procedure code billed. For claims containing ICD-9 codes, the dates of service must be prior to 10/1/2015. The ICD Indicator field is required and must contain a "9" or be left blank (which will default to a 9) to indicate this is an ICD-9 claim. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24-A), ICD Indicator (field 21) **UB CLAIM:** Date of service/date of discharge (field 6), ICD Indicator (field 66)
271	DOS/DISCH REQUIRES ICD-10 CODES/ICD-10 INDICATOR	16 – Claim/service lacks information which is needed for adjudication.	N517 – Resubmit a new claim with the requested information.	The DOS/ICD Indicator is inconsistent with the diagnosis or ICD surgical procedure code billed. For claims containing ICD-10 codes, the dates of service must be on or after 10/1/2015. The ICD Indicator field is required and must contain a "0" to indicate this is an ICD-10 claim. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24-A), ICD Indicator (field 21) **UB CLAIM:** Date of service/date of discharge (field 6), ICD Indicator (field 66)
281	PROCEDURE CODE MODIFIER MISSING	4 – The procedure code is inconsistent with the modifier used, or a required modifier is missing.		The modifier of the billed procedure code is missing. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded), modifier (field 24D unshaded)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
300	UB82 FORM NO LONGER ACCEPTED	16 – Claim/service lacks information which is needed for adjudication.	N34 – Incorrect claim/format for this service.	Submit claim on appropriate claim form.
304	TOTAL CLAIM CHARGE NOT NUMERIC	16 – Claim/service lacks information which is needed for adjudication.	M54 – Missing/incomplete/invalid total charges.	The total claim charge is missing or not numeric. Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Total charge (field 28)
305	INVALID TAXONOMY CODE	16 – Claim/service lacks information that is needed for adjudication.	N255 – Missing/incomplete/invalid billing provider taxonomy.	Taxonomy code must be valid. Update the taxonomy code on the claim to the one that the provider registered with SCDHHS or contact Provider Enrollment to add the taxonomy code that is being used on the claim. After Provider Enrollment has updated the system, submit a new claim. Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Taxonomy code (field 24J shaded) or (field 33B) **UB CLAIM**: Taxonomy code (field 81 A-D) Please visit http://www.wpc-edi.com/codes/taxonomy for valid taxonomy codes.
308	INVALID PROCEDURE CODE MODIFIER	4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.	N519 – Invalid combination of HCPCS modifiers.	The modifier for the line item service/procedure is invalid. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Modifier (field 24D unshaded)
309	INVALID LINE ITEM MILES OF SERVICE	16 – Claim/service lacks information which is needed for adjudication.	M22 – Missing/incomplete/invalid number of miles traveled.	The number of miles is invalid. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Units (field 24G unshaded)
310	INVALID PLACE OF SERVICE	16 – Claim/service lacks information which is needed for adjudication.	M77 – Incomplete/invalid place of service(s).	Medicaid requires the numeric coding for place of service. Enter the appropriate place of service code. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Place of service (24B unshaded)
311	INVALID LINE ITEM SUBMITTED CHARGE	16 – Claim/service lacks information which is needed for adjudication.	M79 – Missing/incomplete/invalid charge.	The line item submitted charge is invalid. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Charges (field 24F unshaded) **UB CLAIM:** Charges (field 47)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
312	MODIFIER NON-COVERED BY MEDICAID	4 – The procedure code is inconsistent with the modifier used, or a required modifier is missing.	N519 – Invalid combination of HCPCS modifiers.	A modifier not accepted by Medicaid has been filed. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Modifier (field 24D unshaded)
316	THIRD PARTY CODE INVALID	16 – Claim/service lacks information which is needed for adjudication.	MA92 – Missing plan information for other insurance.	Incorrect third party code was used. Correct coding would be “1” for denial or “6” for crime victim. If a third party payer is not involved with this claim, the field should be blank. Make corrections to the field(s) below. **CMS-1500 CLAIM:** TPL code (field 10D)
317	INVALID INJURY CODE	16 – Claim/service lacks information which is needed for adjudication.	M76 – Missing/incomplete/invalid diagnosis or condition.	Incorrect injury code was used. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Injury code (field 10 A-C) Correct coding would be "2" for work related accident, "4" for automobile accident, or "6" for other accident.
318	INVALID EMERGENCY INDICATOR / EPSDT REFERRAL CODE	16 – Claim/service lacks information that is needed for adjudication.	M76 – Missing/incomplete/invalid diagnosis or condition.	Verify that the emergency indicator/EPSDT referral code is valid. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Emergency indicator (field 24C unshaded)
322	INVALID AMT RECEIVED FROM OTHER RESOURCE	16 – Claim/service lacks information which is needed for adjudication.	M49 – Missing/incomplete/invalid value code(s) and/or amount(s).	Enter a valid number amount in "amount other sources". Make corrections to the field(s) below. **CMS-1500 CLAIM:** Amount Paid (field 29)
323	INVALID LINE ITEM UNITS OF SERVICE	16 – Claim/service lacks information which is needed for adjudication.	M53 - Missing/incomplete/invalid days or unit(s) of service.	The units of service for the line item are invalid. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Units (field 24G unshaded) **UB CLAIM:** Units (field 46)
330	INVALID LINE ITEM DATE OF SERVICE	16 – Claim/service lacks information which is needed for adjudication.	M52 – Missing/incomplete/invalid “from” date(s) of service.	The date of service for the line item is invalid. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24A unshaded) **UB CLAIM:** Date of service (field 45)
334	ERRONEOUS SURGERY – DO NOT PAY	233 – Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.		Services/Treatment is related to a hospital-acquired condition and no payment is due.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
339	PRESENT ON ADMISSION (POA) INDICATOR IS INVALID	A1- Claim/Service denied.	N434 – Missing/incomplete/ invalid Present on Admission indicator.	This edit code cannot be manually corrected. Submit a new claim with the corrected information.
349	INVALID LEVEL OF CARE	150 – Payer deems the information submitted does not support this level of service.		This claim contains an invalid level of care. Enter the corrected information on a new claim.
354	TOOTH NUMBER NOT VALID LETTER OR NUMBER	16 – Claim/service lacks information which is needed for adjudication.	N39 – Procedure code is not compatible with tooth number/ letter.	Enter the valid tooth number or letter (field 15). Verify tooth number or letter with procedure code.
355	TOOTH SURFACE CODE INVALID	16 – Claim/service lacks information which is needed for adjudication.	N75 – Missing or invalid tooth surface information.	Enter the correct tooth surface code (field 16).
356	IMMUNIZATION AND ADMINISTRATION CODES MUST BE INCLUDED ON CLAIM	272 – Coverage/ program guidelines were not met.		Medicaid requires that immunization and administration codes must be on the claim. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded)
357	MAXIMUM OF THREE ADMINISTRATION UNITS CAN BE BILLED PER DATE OF SERVICE	272 – Coverage/ program guidelines were not met.		Claim exceeds administration units. If there are unit errors, make the appropriate corrections to the field(s) below. If there are no unit errors, the claim will not be considered for payment. **CMS-1500 CLAIM:** Units (field 24G unshaded)
358	SECONDARY ADMINISTRATION CPT CODE NOT ALLOWED PRIOR TO PRIMARY CODE	B15 – This service/ procedure requires that a qualifying service/ procedure be received and covered. The qualifying other service/ procedure has not been received/adjudicated.	N20 – Service not payable with other service rendered on the same date.	If the qualifying "primary" service/procedure has been rendered, complete or enter accurately the required information in the field(s) below. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
361	SECONDARY PROC CODE NOT ALLOWED PRIOR TO PRIMARY PROC CODE	B15 – This service/ procedure requires that a qualifying service/ procedure be received and covered. The qualifying other service/ procedure has not been received/adjudicated.	N20 – Service not payable with other service rendered on the same date.	If the qualifying "primary" service/procedure has been rendered, complete or enter accurately the required information in the field(s) below. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded)
367	ADMISSION DATE/START OF CARE INVALID	16 – Claim/service lacks information which is needed for adjudication.	MA40 – Missing/incomplete/ invalid admission date.	The admission date/start of care date is invalid. Date must be six digits and numeric. Make corrections to the field(s) below. **UB CLAIM:** Admission date (field 12)
368	TYPE OF ADMISSION NOT VALID	16 – Claim/service lacks information which is needed for adjudication.	MA41 – Missing/incomplete/ invalid admission type.	Refer to the most current edition of the NUBC manual for valid type of admission. Enter a valid Medicaid type of admission code in the field(s) below. **UB CLAIM:** Admission type (field 14)
369	MONTHLY INCURRED EXPENSES MUST BE VALID	16 – Claim/service lacks information which is needed for adjudication.	M79 – Missing/incomplete/invalid charge.	This claim contains an invalid monthly expense. Enter the corrected information on a new claim.
370	SOURCE OF ADMISSION INVALID	16 – Claim/service lacks information which is needed for adjudication.	MA42 – Missing/incomplete/ invalid admission source.	Refer to the most current edition of the NUBC manual for valid source of admission. Enter a valid Medicaid source of admission code in the field below. **UB CLAIM:** Admission source (field 15)
373	PRINCIPAL SURG PROCEDURE DATE INVALID	16 – Claim/service lacks information which is needed for adjudication.	MA66 – Missing/incomplete/ invalid principal procedure code.	The principal surgical procedure date is invalid. Date must be six digits and numeric. Make corrections to the field(s) below. **UB CLAIM:** Principal procedure date (field 74)
375	OTHER SURGICAL PROCEDURE DATE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M67 – Missing/incomplete/invalid other procedure code(s).	The other surgical procedure date is invalid. Date must be six digits and numeric. Make corrections to the field(s) below. **UB CLAIM:** Other procedure date (field 74 A-E)
376	TYPE OF BILL NOT VALID FOR MEDICAID	16 – Claim/service lacks information which is needed for adjudication.	MA30 – Missing/incomplete/ invalid type of bill.	Refer to the most current edition of the NUBC manual for valid type of bill. Enter a valid Medicaid type of bill in the field(s) below. **UB CLAIM:** Type of bill (field 4)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
377	FIRST DATE OF SERVICE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M52 – Missing/incomplete/invalid "from" date(s) of service.	The first date of service is invalid. Date must be six digits and numeric. Make corrections to the field(s) below. **UB CLAIM:** Date (field 6)
378	LAST DATE OF SERVICE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M59 – Missing/incomplete/invalid "to" date(s) of service.	The last date of service is invalid. Date must be six digits and numeric. Make corrections to the field(s) below. **UB CLAIM:** Date (field 6)
379	VALUE CODE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M49 – Missing/incomplete/invalid value code(s) and/or amount(s).	This claim contains an invalid value code. Refer to the most current edition of the NUBC manual for valid value codes. Make corrections to the field(s) below. **UB CLAIM:** Value code (fields 39 – 41 A-D)
380	VALUE AMOUNT INVALID	16 – Claim/service lacks information which is needed for adjudication.	M49 – Missing/incomplete/invalid value code(s) and/or amount(s).	This claim contains an invalid value amount. Make corrections to the field(s) below **UB CLAIM:** Value amount (fields 39 – 41 A-D)
381	OCCURRENCE DATE INVALID	16 – Claim/service lacks information which is needed for adjudication.	N299 – Missing/incomplete/ invalid occurrence date(s).	This claim contains invalid occurrence date(s). Dates must be six digits and numeric. Make corrections to the field(s) below **UB CLAIM:** Occurrence date (fields 31 – 34 A-B)
382	PATIENT STATUS NOT VALID FOR MEDICAID	16 – Claim/service lacks information which is needed for adjudication.	MA43 – Missing/incomplete/ invalid patient status.	**UB CLAIM:** Refer to the most current edition of the NUBC manual for valid status codes. Enter a valid Medicaid patient status code (field 17).
383	OCCURR.CODE, INCL. SPAN CODES, INVALID	16 – Claim/service lacks information which is needed for adjudication.	M45 – Missing/incomplete/invalid occurrence codes.	**UB CLAIM:** Refer to the most current edition of the NUBC manual for valid occurrence codes and occurrence span codes. Enter the valid Medicaid occurrence codes (fields 31 – 34, A – B) and the occurrence span codes (fields 35-36, A – B).
384	CONDITION CODE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M44 – Missing/incomplete/invalid condition code.	**UB CLAIM:** Refer to the most current edition of the NUBC manual for valid condition codes. Enter a valid Medicaid condition code (fields 18 – 28).
385	TOTAL CHARGE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M54 – Missing/incomplete/invalid total charges.	**UB CLAIM:** Total charge must be numeric. Enter the correct numeric total charge (field 47).
387	NON COVERED CHARGE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M54 – Missing/incomplete/invalid total charges.	**UB CLAIM:** Charges must be numeric. Enter the correct charge (field 48).

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
390	TPL PAYMENT AMT NOT NUMERIC	16 – Claim/service lacks information which is needed for adjudication.	M49 – Missing/incomplete/invalid value code(s) and/or amount(s).	Enter the numeric payment amount from all primary insurance companies in the field(s) below. Enter 0.00 if no payment was received. If the claim denied by the other insurance company, put a "1" (denial indicator) – see field below. If no third party was involved, delete information entered in the field(s). **CMS 1500 CLAIM:** Third party payment amount (fields - 9C, 11B and 29). If payment is denied by other insurance, put a "1" (denial indicator) (field 10D). **UB CLAIM:** Third party payment amount (field 54). If payment is denied, enter 0.00 (field 54) and also enter code 24 and the date of denial in the Occurrence Code (fields 31-34 A and B).
391	PATIENT PRIOR PAYMENT AMT NOT NUMERIC	16 – Claim/service lacks information which is needed for adjudication.	M49 – Missing/incomplete/invalid value code(s) and/or amount(s).	**UB CLAIM:** Verify the payment amount and enter the correct numeric amount (field 54).
394	OCCURRENCE SPAN CODES"FROM"DATE INVALID	16 – Claim/service lacks information which is needed for adjudication.	N300– Missing/incomplete/invalid occurrence span dates.	The claim contains an invalid occurrence span code "from" date. Dates must be six digits and numeric. Make corrections to the field(s) below. **UB CLAIM:** Occurrence span date (fields 35 – 36 A-B)
395	OCCURRENCE SPAN CODES"THRU"DATE INVALID	16 – Claim/service lacks information which is needed for adjudication.	N300– Missing/incomplete/invalid occurrence span dates.	The claim contains an invalid occurrence span code "thru" date. Date must be six digits and numeric. Make corrections to the field(s) below. **UB CLAIM:** Occurrence span date (fields 35 – 36 A-B)
400	TPL CARR and POLICY # MUST BOTH BE PRESENT	22 – This care may be covered by another payer per coordination of benefits.		Enter a valid carrier code and a valid policy number. Make sure to indicate whether the primary insurance denied or paid the claim as noted in the 150 resolution. **CMS-1500 CLAIM:** Carrier code (fields 9D and 11C), policy number (fields 9A and 11) and denial indicator (field 10D) **UB CLAIM:** Carrier code (field 50), policy number (field 60) and denial indicator (field 31 A-34 B).

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
401	AMT IN OTHER SOURCES/NO TPL CARRIER CODE	22 – This care may be covered by another payer per coordination of benefits.		Enter the applicable third party insurance information for the carrier code, policy number and amount paid. If there are more than two other insurance companies that have paid, enter the total combined amounts paid by all insurance companies. The total combined amounts should be equal to all amounts received from insurance. Make sure to indicate whether the primary insurance denied or paid the claim as noted in the 150 resolution. If the insurance company denied payment, put the denial indicator "1" in the TPL field. If there is no third party involved, be sure all third party fields are deleted of information. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Carrier code (fields 9D and 11C), policy number (fields 9A and 11), amount insurance paid (fields 9C and 11B), total combined insurance amount received (field 29), TPL indicator (field 10D)
402	DEDUCTIBLE EXCEEDS CALENDAR YEAR LIMIT	1 - Deductible amount		**UB CLAIM:** Refer to the EOMB for the deductible amount (including blood deductible). If the amount entered is incorrect, submit a new claim with the corrected information. If it matches, attach the EOMB/Medicare electronic printout to the new claim for review and consideration of payment. Do not add professional fees in the deductible amount. Professional fees should be filed separately on a CMS-1500 form under the hospital-based physician provider number.
403	INCURRED EXPENSES NOT ALLOWED	45 – Charge exceeds fee schedule/maximum allowable or contracted/ legislated fee arrangement.		Verify the requested charge amount. If the charge amount is incorrect, submit a new claim with the corrected information.
411	ANESTHESIA PROC REQUIRES ANES. MODIFIER	4 – The procedure code is inconsistent with the modifier used, or a required modifier is missing.	N519 – Invalid combination of HCPCS modifiers.	An anesthesia procedure requires an anesthesia modifier. Refer to the current list of anesthesia modifiers found in section 2 of your provider manual. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Modifier (field 24D unshaded)
412	SURG PROC NOT VALID W/ANES. MODIFIER	4 – The procedure code is inconsistent with the modifier used, or a required modifier is missing.	N519 – Invalid combination of HCPCS modifiers.	Enter the appropriate anesthesia procedure when an anesthesiologist administers anesthesia during a surgical procedure. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded) **UB CLAIM:** Procedure code (field 44)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
450	ASD SRVC/PROV OR RECIP DOES NOT MATCH	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Recipient is not designated for ASD state plan services. Verify that the Medicaid ID number matches the patient served. Check the procedure code(s) to ensure the correct codes were billed. Submit a new claim with the corrected information. **CMS-1500 CLAIM:** Medicaid ID (field 1A), procedure code (field 24D unshaded)
460	PROCEDURE CODE / INVOICE TYPE INCONSISTENT	16 – Claim/service lacks information which is needed for adjudication.	MA30 – Missing/incomplete/ invalid type of bill.	Oral & Maxillofacial Surgeons must file CPT procedure codes on the CMS-1500 and CDT procedure codes on the ADA Claim Form.
463	INVALID TOTAL DAYS	16 – Claim/service lacks information which is needed for adjudication.	M59 – Missing/incomplete/invalid "to" date(s) of service.	The total days entered on the claim are invalid. Submit a new claim with the corrected information.
468	CARRIER CODE 619 (MEDICAID) LISTED TWICE	16 – Claim/service lacks information which is needed for adjudication.	M56 – Missing/incomplete/invalid payer identification.	**UB CLAIM:** Carrier code 619 is listed twice on either the first or second "other payer" line (field 50). Submit a new claim with the corrected information. Do not remove the 619 after "Medicaid Carrier ID."
469	INVALID LINE NET CHARGE	16 – Claim/service lacks information which is needed for adjudication.	M49 – Missing/incomplete/invalid value code(s) and/or amount(s).	This claim contains an invalid line net charge. Submit a new claim with the corrected information.
501	INVALID DATE ON REVENUE LINE	16 – Claim/service lacks information which is needed for adjudication.	N301 – Missing/incomplete/ invalid procedure date(s).	**UB CLAIM:** This claim contains an invalid date on the revenue line. Enter the correct date (field 45).
502	DOS AFTER THE ENTRY DATE/ JULIAN DATE	110 – Billing date predates service date.		Verify the date of service. A claim cannot be submitted prior to the date of service. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24A unshaded)
504	PROVIDER TYPE AND INVOICE INCONSISTENT	170 – Payment is denied when performed/billed by this type of provider.	N95 – This provider type/provider specialty may not bill this service.	Provider has filed the wrong claim form. Please refer to your provider manual for information on claims filing.
505	MISSING DATE ON REVENUE LINE	16 – Claim/service lacks information which is needed for adjudication.	N301 – Missing/incomplete/invalid procedure date(s).	**UB CLAIM**: The date is missing from the revenue line. Enter the date (field 45).

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
506	PANEL CODE and REVENUE CODE BILLED	16 – Claim/service lacks information which is needed for adjudication.	M50 – Missing/incomplete/ invalid revenue code(s).	**UB CLAIM:** Individual panel code and procedure codes included in the panel cannot be billed in combination on the claim for the same dates of service. Submit a new claim with the corrected information.
507	MANUAL PRICING REQUIRED	133 - The disposition of the claim/service is pending further review.		Submit a new claim and attach appropriate clinical documentation (i.e., QIO prior authorization, manufacture pricing, invoices, etc.). Please refer to the appropriate section in your provider manual.
508	NO LINE ITEM RECORD	16 – Claim/service lacks information which is needed for adjudication.	N34 – Incorrect claim form/ format for this service.	This claim cannot be processed because there is no line item information. Submit a new claim with the corrected information.
509	DOS OVER 2 YRS XOVER/ EXT CARE CLM ONLY	29 – The time limit for filing has expired.	N30 – Patient ineligible for this service.	Claims for payment of Medicare cost sharing amounts must be received and entered into the claims processing system within two years from the date of service or date of discharge, or up to six months following the date of Medicare payment, whichever is later. Attach appropriate documentation (Medicare EOMB) to each claim **NURSING HOME PROVIDERS:** Submit claim and appropriate documentation to : MCCS Nursing Facility Claims Post Office Box 100112 Columbia, SC 29202 Refer to the timely filing guidelines in the appropriate section of your provider manual.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
510	DOS IS MORE THAN 1 YEAR OLD	29 – The time limit for filing has expired.	N30 – Patient ineligible for this service.	Claims for retroactive eligibility must be received and entered into the claims processing system within six months of the recipient's eligibility being added to the Medicaid eligibility system AND be received within three years from the date of service or date of discharge (for hospital claims). If the above time frames are met, attach one of the following documents listed below with each claim. 1) DHHS Form 945, which is a statement verifying the retroactive determination furnished by the eligibility worker, or 2) The computer generated Medicaid eligibility approval letter notifying the recipient that Medicaid benefits have been approved. This can be furnished by the recipient or the eligibility worker. (This is different from the Certificate of Creditable Coverage.) **For NURSING HOME PROVIDERS:** Submit claim and appropriate documentation to: MCCS Nursing Facility Claims Post Office Box 100112 Columbia, SC 29202 Refer to the timely filing guidelines in the appropriate section of your provider manual.
513	INCONSISTENT MEDICARE CARRIER CODE	16 – Claim/service lacks information which is needed for adjudication.	M56 – Missing/incomplete/invalid payer identification.	Enter the correct Medicare Part A or Part B carrier code in the field(s) below. **CMS-1500 CLAIM:** Carrier code (fields 9D and 11C) **UB CLAIM:** Carrier code (field 50)
514	PROC RATE/MILE X MILES NOT=SUBMIT CHRG	16 – Claim/service lacks information which is needed for adjudication.	M79 – Missing/incomplete/invalid charge.	Check the calculations for the rates, miles and submitted changes. Submit a new claim with the corrected information.
515	AMBUL/ITP TRANS. MILEAGE LIMITATION	16 – Claim/service lacks information which is needed for adjudication.	M22-Missing/incomplete/invalid number of miles traveled.	Check the mileage entered on the claim. If corrections are needed, submit a new claim with the corrected information. For review and consideration of payment, attach clinical documentation to the new claim to substantiate the mileage being billed.
517	WAIVER SERVICE BILLED. RECIPIENT NOT IN A WAIVER.	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	The claim was submitted for a waiver-specific procedure code, but the recipient was not a participant in a Medicaid waiver Verify that the correct procedure code and Medicaid ID were billed. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), procedure code (field 24D unshaded)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
518	PROCEDURE CODE COMBINATION NON-COVERED OR INVALID	16 – Claim/service lacks information which is needed for adjudication.	N56 – Procedure code billed is not correct/valid for the services billed or the date of service billed.	For further assistance, contact DentaQuest at 1-888-307-6553.
519	CMS REBATE TERM DATE HAS EXPIRED/ENDED	29 – The time limit for filing has expired.	N30 – Patient ineligible for this service.	If the National Drug Code (NDC) end date has not expired for that particular date of service, make the appropriate correction and attach a copy of drug label indicating the NDC number billed, as well as the expiration date of the drug administered. Make corrections to the field(s) below. **CMS-1500 CLAIM:** NDC (field 24A shaded)
527	WAIVER RECIPIENT/REQUIRES WAIVER CASE MANAGEMENT (WCM) PROVIDER	A1 – Claims/service denied.	N30 – Patient ineligible for this service	This claim was submitted for a waiver recipient, but the provider is not a Waiver Case Management (WCM) provider. Verify that the Medicaid ID, Provider ID and/or NPI and procedure code(s) were billed correctly. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), procedure code (field 24D unshaded), Provider ID# (field 24J/field 33)
528	PRTF WAIVER RECIPIENT BUT NOT WAIVER SERVICE	A1 – Claim/service denied.	N379 – Claim level information does not match line level information.	The claim was submitted with a procedure code/service that is not in the PRTF service array. Enter the correct procedure code in the field(s) below. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded)
529	REVENUE CODE BEING BILLED OVER 15 TIMES PER CLAIM	A1 – Claim/service denied.	M50 – Missing/incomplete/invalid revenue code(s).	**UB CLAIM:** This edit code cannot be manually corrected. A new claim must be submitted.
532	RECIPIENT NOT ELIGIBLE FOR NFP WAIVER SERVICES	A1 – Claims/service denied.	N30 – Patient ineligible for this service	The claim was submitted with a Nurse Family Partnership (NFP) Waiver specific procedure code, but the recipient was not eligible for NFP Waiver services. Verify that the correct procedure code and Medicaid ID were billed. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), procedure code (field 24D unshaded)
533	DOS IS MORE THAN 3 YEARS OLD	29 – The time limit for filing has expired.	N30 – Patient ineligible for this service.	Claim exceeds timely filing limits and will not be considered for payment. Refer to the timely filing guidelines in the appropriate section of your provider manual.

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Edit Code	Description	CARC	RARC	Resolution
534	PROVIDER/CCN DO NOT MATCH FOR ADJUSTMENT	16 – Claim/service lacks information which is needed for adjudication.	M47 –Missing/incomplete/invalid internal or document control number.	Review the original claim and verify the provider number from that claim. Make sure that the correct original provider number is entered on the adjustment claim.
536	PROCEDURE-MODIFIER NOT COVERED ON DOS	182 – Procedure modifier was invalid on the date of service.	N517 – Resubmit a new claim with the requested information.	The procedure code and the modifier are not covered for the date of service billed on the claim. Verify that the correct date of service, procedure code and modifier combination were entered. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24A unshaded), procedure code and modifier (field 24D unshaded)
537	PROC-MOD COMBINATION NON-COVERED/INVALID	4 – The procedure code is inconsistent with the modifier used, or a required modifier is missing.	N519 – Invalid combination of HCPCS modifiers.	The procedure code and modifier combination are not covered or invalid. Verify that the correct procedure code and modifier combination were entered. Make corrections to the field(s) below. **CMS-1500 CLAIM**: Procedure code and modifier (field 24D unshaded) **Note:** If reimbursement is for an assistant surgeon OR multiple births **ONLY** use the Modifier (GB or CG) on the applicable lines(s); attach appropriate clinical documentation (i.e., discharge summary, operative notes, etc.) to the **NEW** claim for review and consideration for payment.
538	PATIENT PAYMENT EXCEEDS MED NON-COVERED	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.		Verify that the prior payment and the total non-covered amounts were entered correctly. A Medicaid recipient is not liable for charges unless they are non-covered services. Make corrections to the field(s) below. **UB CLAIM:** Prior payments (field 54), Non-covered charges (field 48)
539	MEDICAID NOT LISTED AS PAYER	31 – Patient cannot be identified as our insured.		**UB CLAIM:** Enter Medicaid payer code 619 (field 50 A - C) which corresponds with the line on which you entered the Medicaid ID number (field 60 A – C).
540	ACCOM REVENUE CODE/OP CLAIM INCONSIST	16 – Claim/service lacks information which is needed for adjudication.	M56 – Missing/incomplete/invalid payer identification.	**UB CLAIM:** Room accommodation revenue codes cannot be used on an outpatient claim. If the room accommodation revenue codes are correct, check the bill type (field 4) and the Health Plan ID (field 51).
541	MISSING LINE ITEM/REVENUE CODE	16 – Claim/service lacks information which is needed for adjudication.	M50 – Missing/incomplete/invalid revenue code (s).	**UB CLAIM:** The revenue code for the line item is missing. The two digits before the edit code tell you on which line the revenue code is missing. Enter the correct revenue code (field 42) for that line.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
542	BOTH OCCUR CODE and DATE NEC INC SPAN CODE	16 – Claim/service lacks information which is needed for adjudication.	M46 – Missing/incomplete/invalid occurrence span codes.	**UB CLAIM:** If you have entered an occurrence code (fields 31 – 36 A and B), an occurrence date must be entered. If you have entered an occurrence date in any of these fields, an occurrence code must also be entered.
543	VALUE CODE/AMOUNT MUST BOTH BE PRESENT	16 – Claim/service lacks information which is needed for adjudication.	M49 – Missing/incomplete/invalid value code(s) and/or amount(s).	**UB CLAIM:** If you have entered a value code (fields 39 through 41 A - D), a value amount must also be entered. If you have entered a value amount in these fields, a value code must also be entered
544	NURSING HOME CLAIMS SUBMITTED VIA 837	16 – Claim/service lacks information which is needed for adjudication.	N34 – Incorrect claim form/format for this service.	For further assistance, contact South Carolina Medicaid EDI Support Center at 1-888-289-0709.
545	NO PROCESSABLE LINES ON CLAIM	16 – Claim/service lacks information which is needed for adjudication.	N34 – Incorrect claim form/format for this service.	All lines on the claim have been rejected or deleted. This edit cannot be manually corrected. Submit a new claim with the corrected information.
546	SURGICAL PROCEDURE MUST BE REPORTED AT THE REVENUE CODE LINE LEVEL	16 – Claim/service lacks information which is needed for adjudication.	M20 – Missing/incomplete/invalid HCPCS.	**UB CLAIM:** This claim is incomplete. Enter the surgical procedure code(s) on the claim at the revenue code line level (field 44).
547	PRINCIPAL SURG PROC AND DTE REQUIRED	16 – Claim/service lacks information which is needed for adjudication.	MA66 – Missing/incomplete/ invalid principal procedure code.	**UB CLAIM:** This claim is incomplete. Enter the surgical procedure code and date (field 74).
548	OTHER SURG PROC AND DATE MUST BE PRESENT	16 – Claim/service lacks information which is needed for adjudication.	M67 – Missing/incomplete/invalid other procedure code(s).	**UB CLAIM:** This claim is incomplete. Enter the other surgical procedure codes and dates (fields 74 A – E).
550	REPLACE/VOID BILL/ORIGINAL CCN MISSING	16 – Claim/service lacks information which is needed for adjudication.	M47 – Missing/incomplete/invalid internal or document control number.	**UB CLAIM:** Check the remittance advice for the paid claim you are trying to replace or cancel to find the CCN. Enter the CCN (field 64).
551	TYPE ADMISSION/SOURCE CODE INCONSISTENT	16 – Claim/service lacks information which is needed for adjudication.	MA41 – Missing/incomplete/ invalid admission type.	Check the most current edition of the NUBC manual for valid codes for the type of admission and source of admission. Enter the valid Medicaid codes in the field(s) below and submit a new claim. **UB CLAIM:** Admission type (field 14), admission source (field 15)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
552	MEDICARE INDICATED/NO MEDICAID LIABILITY	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.		Medicare coverage was indicated on the claim form. Enter the correct and complete insurance information in the field(s) below. **CMS-1500 CLAIM:** Insurance carrier code (fields 9D and 11C), policy number (field 9A and 11), insurance amount paid (fields 9C and 11B) **UB CLAIM:** Insurance carrier code (field 50), policy number (field 60), insurance amount paid (field 54)
553	ALLOW AMT=ZERO/UNABLE TO DETERMINE PYMT	16 – Claim/service lacks information which is needed for adjudication.	M79 – Missing/incomplete/invalid charge.	**UB CLAIM:** Information is incorrect or missing which is necessary to allow the Medicaid system to calculate the payment for the claim. Check for errors in the following fields: revenue codes (field 42), CPT codes (field 44), ICD surgical codes (field 74), diagnosis codes (field 67), condition codes (fields 18 – 28) and value codes (fields 39-41 A-D) as applicable. If this edit code appears with other edit codes, it may be resolved by correcting the other edit codes first
554	VALUE CODE/3RD PARTY PAYMENT INCONSISTENT	16 – Claim/service lacks information which is needed for adjudication.	MA92 – Missing plan information for other insurance.	**UB CLAIM:** If you have entered value code 14 (fields 39 through 41 A – D), you must also enter a prior payment (field 54).
555	TPL PAYMENT > PAYMENT DUE FROM MEDICAID	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.		**UB CLAIM:** Correct the payment amount you have entered in prior payment (field 54). If the amount is correct, no payment from Medicaid is due. Do not submit a new claim.
557	CARR PYMTS MUST = OTHER SOURCES PYMTS	22 – This care may be covered by another payer per coordination of benefits.		If any amount appears in the amount received from insurance field, you must indicate a third party payment. If there is no third party insurance involved, delete information entered in the insurance fields. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Insurance amount paid (fields 9C and 11B), amount rec'd insurance (field 29)
558	REVENUE CHGS NOT WITHIN +- $1 OF TOTAL	16 – Claim/service lacks information which is needed for adjudication.	M54 – Missing/incomplete/invalid total charges.	**UB CLAIM:** Recalculate your revenue charges (field 47). If a line has been deleted by you on a previous claim submission the charges on these lines should no longer be added into the total charges.
559	MEDICAID PRIOR PAYMENT NOT ALLOWED	B13 – Previously paid. Payment for this claim/ service may have been provided in a previous payment.		**UB CLAIM:** Prior payment from Medicaid (field 54 A - C) should never be indicated on a claim. Make the appropriate correction.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
560	REVENUE CODES INCONSISTENT	16 – Claim/service lacks information which is needed for adjudication.	M50 – Missing/incomplete/invalid revenue code(s).	**UB CLAIM:** Check for revenue code errors (field 42). Revenue code 100 is an all-inclusive revenue code and cannot be used with any other revenue code except 001, which is the total charges revenue code.
561	CLAIM ALREADY DEBITED (RETRO-MEDICARE), CANNOT ADJUST	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.		Retroactive Medicare claim already debited or scheduled for debit. Cannot adjust this claim. Contact the PSC.
562	CLAIM ALREADY DEBITED (HEALTH CLAIM), CANNOT ADJUST	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.		Retroactive Healthcare claim already debited or scheduled for debit. Cannot adjust this claim. Contact the PSC.
563	CLAIM ALREADY DEBITED (PAY & CHASE CLAIM), CANNOT ADJUST	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.		Medicaid Pay & Chase claim already debited or scheduled for debit. Cannot adjust this claim. Contact the PSC.
564	OP REV 450,459,510,511 COMB NOT ALLOWED	16 – Claim/service lacks information which is needed for adjudication.	M50- Missing/incomplete/invalid revenue code(s).	**UB CLAIM:** These revenue codes should never appear in combination on the same claim. If a recipient was seen in the emergency room, clinic, and treatment room (field 14) on the same date of service for the same or related condition, charges for both visits should be combined under either revenue code 450, 510, or 761 (field 42). If the recipient was seen in the ER and clinic on the same date of service for unrelated conditions, both visits should be billed on separate claims using the correct revenue code. If the recipient is a PEP member, and was triaged in the ER, the submitted claim should be filed with only revenue code 459. No other revenue codes should be filed with revenue code 459.
565	THIRD PARTY PAYMENT/NO 3RD PARTY ID	22 - This care may be covered by another payer per coordination of benefits.		**UB CLAIM:** If a prior payment is entered (field 54), information in all other TPL-related fields (50 and 60) must also be entered.
567	NONCOV CHARGES > OR = TOTAL CHARGES	16 – Claim/service lacks information which is needed for adjudication.	M54 – Missing/incomplete/invalid total charges.	**UB CLAIM:** Check the total of non-covered charges (field 48) and total charges (field 47) to see if they were entered correctly. If they are correct, no payment from Medicaid is due. If incorrect, submit a new claim.

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Edit Code	Description	CARC	RARC	Resolution
568	CORRESPONDING ADJUSTMENT (VOID) IS SUSPENDED OR DENIED	107 –The related or qualifying claim/service was not previously paid or identified on this claim.		Review the edit code assigned to the void adjustment claim to determine if it can be corrected. If the void adjustment claim can be corrected, make the necessary changes and submit a new claim
569	ORIGINAL CCN IS INVALID OR ADJUSTMENT CLAIM	16 – Claim/service lacks information which is needed for adjudication.	M47 – Missing/incomplete/invalid internal or document number.	Check the original CCN on the Form 130 as it is either invalid or a CCN for an adjustment claim. Correct the Form 130 and resubmit.
570	OP REV 760 762, 769 COMB NOT ALLOWED	16 – Claim/service lacks information which is needed for adjudication.	M50- Missing/incomplete/invalid revenue code(s).	**UB CLAIM:** These revenue codes (field 42) cannot be used in combination for the same day (field 45); bill either revenue code 762 or 769 on an outpatient claim.
575	REPLACE/VOID CLM/CCN INDICATED NOT FOUND	16 – Claim/service lacks information which is needed for adjudication.	M47 – Missing/incomplete/invalid internal or document control number.	**NOTE:** Only paid claims can be replaced or voided. Review the original claim and verify the claim control number (CCN) and recipient Medicaid ID number from that claim. Make sure that the correct original CCN and recipient Medicaid ID number are on the new claim. **UB CLAIM:** Check the CCN you have entered (field 64 A – C) with the CCN on the remittance advice of the paid claim you want to replace or void. If this edit appears with other edits, it may be corrected by correcting the other edit codes. If edit code 575 and 863 are the only edits on the replacement claim (new claim), the replacement claim criteria have not been met (see Section 3 on replacement claims).
576	TYPE OF BILL AND PROVIDER TYPE INCONSISTENT	16 – Claim/service lacks information which is needed for adjudication.	MA30 – Missing/incomplete invalid type of bill.	**UB CLAIM:** If the bill type you have entered (field 4) is 131 or 141, you must use your outpatient number (field 51). If the bill type is 111 (field 4), you must use your inpatient number.
584	NATIVE AMERICAN HEALTH SERVICE PROCEDURE-MODIFIER COMBINATION NON-COV/INVALID	4 - The procedure code is inconsistent with the modifier used or a required modifier is missing.	N519 – Invalid combination of HCPCS modifiers.	The procedure code and modifier combination are not covered or invalid. Verify that the correct procedure code and modifier combination were entered. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Procedure code and modifier (field 24D unshaded)
587	1ST DATE OF SERV SUBSEQUENT TO LAST DOS	16 – Claim/service lacks information which is needed for adjudication.	MA31- Missing/incomplete/invalid beginning and ending dates of the period billed.	**UB CLAIM:** Correct the "from" and "through" dates (field 6). "From" date must be before "through" date. Be sure you check the year closely.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
588	1ST DOS SUBSEQUENT TO ENTRY DATE	16 – Claim/service lacks information which is needed for adjudication.	MA31- Missing/incomplete/invalid beginning and ending dates of the period billed.	**UB CLAIM:** Correct the "from" date of service (field 6). Be sure to check the year closely.
589	LAST DOS SUBSEQUENT TO DATE OF RECEIPT	16 – Claim/service lacks information which is needed for adjudication.	MA31- Missing/incomplete/invalid beginning and ending dates of the period billed.	**UB CLAIM:** Correct the "through" date of service (field 6). Be sure to check the year closely.
590	NO DISCHARGE DATE ON FINAL BILL	16 – Claim/service lacks information which is needed for adjudication.	N50 – Missing/incomplete/invalid discharge information.	**UB CLAIM:** Enter the discharge date (field 6). Submit a new claim with the corrected information.
591	NCCI – PROCEDURE CODE COMBINATION NOT ALLOWED	236 - This procedure or procedure/modifier combination is not compatible with another procedure or procedure/ modifier combination provided on the same day according to the National Correct Coding Initiative.		This procedure code combination is not allowed on the same date of service. Therefore, only one procedure code was paid. Note: The National Correct Coding Initiative (NCCI) does not allow the rendering or payment of certain procedure codes on the same date of service. For NCCI guidelines and specific code combinations; please refer to Medicaid bulletins about NCCI edits or the CMS website.
594	FINAL BILL/DISCHRG DTE BEFORE LAST DOS	16 – Claim/service lacks information which is needed for adjudication.	N50 – Missing/incomplete/invalid discharge information.	**UB CLAIM:** Check the occurrence code 42 and date (fields 31 through 34 A and B), and the "through" date (field 6). These dates must be the same.
597	ACCOMODATION UNITS/STMT PERIOD INCONSISTENT	16 – Claim/service lacks information which is needed for adjudication.	MA31- Missing/incomplete/invalid beginning and ending dates of the period billed.	**UB CLAIM:** Check the dates entered (field 6); the covered days calculated (field 7); the discharge date (fields 31 through 34 A – B) and the units entered for accommodation revenue codes (field 42) the discharge date and "through" date must be the same). If the dates (field 6) are correct, the system calculated the correct number of days, so the units for accommodation revenue codes should be changed. If the dates are incorrect, correcting the dates will correct the edit.
598	QIO INDICATOR 3/ APPROVAL DATES REQUIRED	16 – Claim/service lacks information which is needed for adjudication.	M52 – Missing/incomplete/invalid "from" date(s) of service.	**UB CLAIM:** If condition code C3 is entered (fields 31 through 34 A – B), the approved dates must be entered in occurrence span, (fields 35-36 A or B).
599	QIO DATES/OCCUR SPAN DATES N/SEQUENCED	16 – Claim/service lacks information which is needed for adjudication.	M52 – Missing/incomplete/invalid "from" date(s) of service.	**UB CLAIM:** The dates which have been entered (fields 35 - 36 A or B) (occurrence span), do not coincide with any date in the statement covers dates (field 6). There must be at least one date in common in these two fields.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
600	QIO DATE/STATEMENT COVERS DATES DON'T OVERLAP	16 – Claim/service lacks information which is needed for adjudication.	M52 – Missing/incomplete/invalid "from" date(s) of service.	**UB CLAIM:** The date(s) of service do not coincide with statement covers dates (field 6). Verify the approved date(s) received from the QIO are correct.
603	REVENUE/CONDITION/ VALUE CODES INCONSISTENT	16 – Claim/service lacks information which is needed for adjudication.	M49 – Missing/incomplete/invalid value code(s) and/or amount(s).	Medicaid only sponsors a semi-private room. When a private room revenue code is used, condition code 39 or value codes 01 or 02 and value amounts must be on the claim. See current NUBC manual for definition of codes. Make corrections to the field(s) below. **UB CLAIM:** Condition codes (fields 18-28), value codes (39-41 A-D), revenue codes (field 42)
605	NCCI - UNITS OF SERVICE EXCEED LIMIT	273 – Coverage/ program guidelines were exceeded.		The number of units billed on the specified line exceeds the allowable limit based on NCCI guidelines. **Note:** For NCCI guidelines, please refer to Medicaid bulletins about NCCI edits or the CMS website.
606	CASE MANAGEMENT PROVIDER/SERVICE NOT CASE MANAGEMENT	170 – Payment is denied when performed/billed by this type of provider.	N95 – This provider type/provider specialty may not bill this service.	Verify that the correct taxonomy code has been entered on the claim. Submit a new claim with the corrected information. Make corrections to the field below: **CMS-1500 CLAIM:** Taxonomy code (field 24J shaded)
636	COPAYMENT AMOUNT EXCEEDS ALLOWED AMOUNT	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.		The Medicaid recipient is responsible for a Medicaid copayment for this service/date of service. The allowed payment amount is less than the recipient's copayment amount; therefore no payment is due from Medicaid. Please collect the copayment from the Medicaid recipient. Do not submit a new claim.
637	COINS AMT GREATER THAN PAY AMT	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.		**UB CLAIM:** Correct the coinsurance amount (fields 39 A-41 D). If the coinsurance amount is correct, attach a copy of the Medicare EOMB.
642	MEDICARE COST SHARING REQUIRES COINS/DEDUCTIBLE	16 – Claim/Service lacks information which is needed for adjustment.	N479 – Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	**UB CLAIM:** For Medicaid to consider payment of the claim, the Medicare coinsurance and deductible (fields 39 – 41 A-D) must be present.
672	NET CHRG/TOTAL DAYS X DAILY RATE UNEQUAL	16 – Claim/service lacks information which is needed for adjudication.	M54 – Missing/incomplete/invalid total charges.	Make the appropriate correction(s) to calculations on the claim.

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Edit Code	Description	CARC	RARC	Resolution
673	REJECT LOC 6 - EXCLUDES SWING BEDS	96 – Non-covered charge(s).	N188 – The approved level of care does not match the procedure code submitted.	If there is a recurring income change that impacts the coinsurance payment, submit a new claim and attach appropriate documentation (Form 181, EOMB).
674	NH RATE - PAT DAY INC NOT = PAT DAY RATE	16 – Claim/service lacks information which is needed for adjudication.	N153 – Missing/incomplete/invalid room and board rate.	Make the appropriate corrections to the rate amounts on the claim.
690	OTHER SOURCES AMT MORE THAN MEDICAID AMT	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.		Verify and correct the dollar amounts entered in the insurance payment field(s) below. If the amounts are correct, no payment is due from Medicaid. Do not submit a new claim. **CMS-1500 CLAIM:** Insurance amount paid (fields 9C and 11B), amount rec'd insurance (field 29)
693	MENTAL HEALTH VISIT LIMIT EXCEEDED	273 – Coverage/ program guidelines were exceeded.		Additional services require Prior Authorization from the QIO. If the authorization number is incorrect, submit a new claim with the corrected information. Contact the QIO for review and consideration of authorization for additional visits.
700	PRIMARY/PRINCIPAL DIAG CODE NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	MA63 – Missing/incomplete/ invalid principal diagnosis.	Medicaid requires the complete diagnosis code as specified in the current edition of Volume I of the ICD-CM manual, (including fifth digit sub-classification when listed). Check for valid diagnosis code in Volume I of the ICD-CM manual and make corrections to the field (s) below. **CMS-1500 CLAIM:** Diagnosis code (field 21) **UB CLAIM:** Diagnosis code (field 67)
701	SECONDARY/ OTHER DIAG CODE NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	M64 – Missing/incomplete/invalid other diagnosis.	Follow the resolution for edit code 700 and submit a new claim. The secondary diagnosis code appears in the fields below. **CMS-1500 CLAIM:** Diagnosis code (field 21) **UB CLAIM:** Diagnosis code (fields 67 A-Q)

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Edit Code	Description	CARC	RARC	Resolution
703	RECIP AGE/PRIM/PRINCIPAL DIAG INCONSISTENT	9 – The diagnosis is inconsistent with the patient's age.	N517 – Resubmit a new claim with the requested information.	The recipient's age is not consistent with the diagnosis code being billed. Check the patient's Medicaid ID number. A common error is entering another family member's number. Make sure the number matches the patient served. Verify that the correct diagnosis code and date of birth are entered on the claim. The date of birth in our system is based on the claim run date. Contact your county Medicaid Eligibility office if your records indicate a different date of birth. After the county Medicaid Eligibility office has updated the system, submit a new claim. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), date of birth (field 3), diagnosis code (field 21) **UB CLAIM:** Medicaid ID (field 60), date of birth (field 10), diagnosis code (field 67)
704	RECIP AGE/SECONDARY/OTHER DIAG INCONSISTENT	9 – The diagnosis is inconsistent with the patient's age.	N517 – Resubmit a new claim with the requested information.	Follow the resolution for edit code 703 and submit a new claim with corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), date of birth (field 3), diagnosis code (field 21) **UB CLAIM:** Medicaid ID (field 60), date of birth (field 10), diagnosis code (fields 67 A-Q)
705	RECIP SEX/PRIM/PRINCIPAL DIAG INCONSISTENT	10 – The diagnosis is inconsistent with the patient's gender.	N517 – Resubmit a new claim with the requested information.	The recipient's sex is not consistent with the diagnosis code being billed. Check the patient's Medicaid ID number. A common error is entering another family member's number. Make sure the number matches the patient served. Verify that the correct diagnosis code and sex are entered on the claim. Contact your county Medicaid Eligibility office if your records indicate a different sex. After the county Medicaid Eligibility office has updated the system, submit a new claim. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), sex (field 3), diagnosis code (field 21) **UB CLAIM:** Medicaid ID (field 60), sex (field 11), diagnosis code (field 67)
706	RECIP SEX/SECONDARY/OTHER DIAG INCONSISTENT	10 – The diagnosis is inconsistent with the patient's gender.	N517 – Resubmit a new claim with the requested information.	Follow the resolution for edit code 705 and submit a new claim with corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), sex (field 3), diagnosis code (field 21) **UB CLAIM:** Medicaid ID (field 60), sex (field 11), diagnosis code (fields 67 A-Q)

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Edit Code	Description	CARC	RARC	Resolution
707	PRIN. DIAG. NOW REQUIRES 4TH OR 5TH DIGIT	16 – Claim/service lacks information which is needed for adjudication.	MA63 – Missing/incomplete/ invalid principal diagnosis.	Medicaid requires a complete diagnosis code as specified in the current edition of the ICD-CM manual. The diagnosis code requires a fourth or fifth digit. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Diagnosis code (field 21) **UB CLAIM:** Diagnosis code (field 67)
708	SEC. DIAG. NOW REQUIRES 4TH OR 5TH DIGIT	16 – Claim/service lacks information which is needed for adjudication.	M64 – Missing/incomplete/invalid other diagnosis.	Follow the resolution for edit code 707 with corrections to the field(s) below. **CMS-1500 CLAIM:** Diagnosis code (field 21) **UB CLAIM:** Diagnosis code (fields 67 A-Q)
709	SERV/PROC CODE NOT ON REFERENCE FILE	16 – Claim/service lacks information which is needed for adjudication.	N65 – Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	Check the most current applicable provider manual to verify that the correct procedure code is being billed. If the procedure code is incorrect, submit a new corrected claim. If the code is correct, attach appropriate documentation to your new claim for review and consideration for payment.
710	SERV/PROC/DRUG REQUIRES PA-NO NUM ON CLM	16 – Claim/service lacks information or has submission/billing error(s).	M62 – Missing/incomplete/invalid treatment authorization code.	The claim is missing the required prior authorization number. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Prior authorization number (field 23) **UB CLAIM:** Treatment authorization code (field 63) **NOTE**: If the prior authorization number was not obtained prior to rendering the service, you will not be considered for payment.
711	RECIP SEX - SERV/PROC/DRUG INCONSISTENT	16 – Claim/service lacks information which is needed for adjudication.	MA39 – Missing/incomplete/ invalid gender.	The recipient's sex is not consistent with the procedure code being billed. Check the patient's Medicaid ID number. A common error is entering another family member's number. Make sure the number matches the patient served. Verify that the correct procedure code and sex are entered on the claim. Contact your county Medicaid Eligibility office if your records indicate a different sex. After the county Medicaid Eligibility office has updated the system, submit a new claim. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), sex (field 3), procedure code (field 24D unshaded) **UB CLAIM:** Medicaid ID (field 60), sex (field 11), procedure code (field 44)

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Edit Code	Description	CARC	RARC	Resolution
712	RECIP AGE-PROC INCONSIST/NOT ID/RD RECIP	6 – The procedure/ revenue code is inconsistent with the patient's age.	N517 – Resubmit a new claim with the requested information.	The recipient's age is not consistent with the procedure code being billed. Check the patient's Medicaid ID number. A common error is entering another family member's number. Make sure the number matches the patient served. Verify that the correct procedure code and date of birth are entered on the claim. Contact your county Medicaid Eligibility office if your records indicate a different date of birth. After the county Medicaid Eligibility office has updated the system, submit a new claim. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), date of birth (field 3), procedure code (field 24D unshaded) **UB CLAIM:** Medicaid ID (field 60), date of birth (field 10), procedure code (field 44)
713	NUM OF BILLINGS FOR SERV EXCEEDS LIMIT	151 – Payment adjusted because the payer deems the information submitted does not support this many/ frequency of services.		Check the number of units on the specified line to be sure the correct number of units has been entered for service being billed. If the number of units is correct, check the procedure code to be sure it is correct. For review and consideration for payment of additional units, submit a new claim and attach appropriate clinical documentation to substantiate the services being billed. Please refer to the applicable provider policy manual for the specific documentation requirements. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded), units (field 24G unshaded) **UB CLAIM:** Procedure code (field 44), units (field 46).
714	SERV/PROC/DRUG REQUIRES DOC-MAN REVIEW	133 – The disposition of the claim/service is pending further review.		The service/procedure has to be reviewed by Medicaid prior to payment. Attach appropriate clinical documentation (i.e., Sterilization Consent Form 1723, medical records, etc.) to the new claim for manual review. Please refer to the applicable provider policy manual for the specific documentation requirements.
715	PLACE OF SERVICE/PROC CODE INCONSISTENT	5 – The procedure code/bill type is inconsistent with the place of service.	M77 – Missing/incomplete/invalid place of service.	Check the procedure code and the place of service code to be sure that they are correct. If incorrect, make corrections to the field(s) below. If the procedure code is correct, attach appropriate clinical documentation to the new claim for review and consideration for payment verifying where the procedure/service was provided. **CMS-1500 CLAIM:** Place of service (field 24B unshaded), procedure code (field 24D unshaded)

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Edit Code	Description	CARC	RARC	Resolution
716	PROV TYPE INCONSISTENT WITH PROC CODE	8 – The procedure code is inconsistent with the provider type/ specialty (taxonomy).	N95 – This provider type/provider specialty may not bill this service.	The type of provider rendering this service/procedure code is NOT authorized. If the provider type is correct, attach appropriate clinical documentation to the new claim for review and consideration for payment.
717	SERV/PROC/DRUG NOT COVERED ON DOS	A1 – Claim/service denied.	N56 – Procedure code billed is not correct/valid for the services billed or the date of service billed.	The service/procedure is not covered for the date of service billed on the claim. Check the procedure code and the date of service on the indicated line to be sure both are correct. The procedure code may have been deleted from the program or changed to another procedure code.
718	PROC REQUIRES TOOTH NUMBER/SURFACE INFO	16 – Claim/service lacks information which is needed for adjudication.	N37 – Missing/incomplete/ invalid tooth number/letter.	The procedure requires either a tooth number and/or surface information (fields 15 and 16).
719	SERV/PROC/DRUG ON PREPAYMENT REVIEW	133 – The disposition of this claim/service is pending further review.		Check the prior authorization number, procedure code(s) and modifier(s) to ensure that the information on the claim matches the information on the prior approval letter. Attach appropriate documentation to the claim for review and consideration for payment. Refer to the applicable provider policy manual for the specific documentation requirements.
720	MODIFIER 22 REQUIRES ADD'L DOCUMENT	251 – The attachment content received did not contain the content required to process the claim or service.	N29 – Missing documentation/ orders/notes/summary/report/ chart.	For review and consideration for payment, attach appropriate clinical documentation (i.e., medical records, radiology reports, operative notes, anesthesia records, etc.) to the new claim to justify the unusual procedural services, increased intensity indications, difficulty of procedure or severity of patient's condition for review and consideration for payment.
721	CROSSOVER PRICING RECORD NOT FOUND	A1 – Claim/service denied.	N8 - Crossover claim denied by previous payer and complete claim data not forwarded. Resubmit this claim to this payer to provide adequate data to adjudication.	Pricing record not found for the specific procedure code and modifier being billed. Please verify that the correct procedure code and modifier were submitted. If the provider has knowledge that the specific procedure code and modifier being billed is valid and a covered service by Medicaid, submit a new claim, and attach the appropriate clinical documentation (i.e., medical records and pricing information) to have the procedure code/modifier considered for payment and added to the system. **Note:** If the procedure code/modifier is not valid and non-covered by Medicaid, the claim will not be considered for payment. Do not submit a new claim.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
722	PROC MODIFIER and SPEC PRICING NOT ON FILE	4 – The procedure code is inconsistent with the modifier used, or a required modifier is missing.	N517 – Resubmit a new claim with the requested information.	Verify that the correct procedure code and modifier were submitted. If the provider has knowledge that the specific procedure code and modifier being billed is valid and a covered service by Medicaid, submit a new claim, and attach the appropriate clinical documentation (i.e., medical records and pricing information) to have the procedure code/modifier considered for payment and added to the system. **Note:** The Medicaid pricing system is programmed specifically for procedure codes, modifiers, and provider specialties. If these are submitted in the wrong combination, the system searches but cannot "find" a price, and the line will automatically reject with edit code 722. Attaching documentation for review and consideration for payment or system updates is not applicable to all provider types. Please refer to the appropriate policy manual for procedure codes and modifiers that are applicable to your provider type/specialty to ensure that you are using the correct procedure code and modifier. A common error is entering the incorrect modifier or entering no modifier. If the code/modifier is not valid and non-covered by Medicaid, the claim will not be considered for payment.
724	PROCEDURE CODE REQUIRES BILLING IN WHOLE UNITS	16 – Claim/service lacks information which is needed for adjudication.	M53 –Missing/incomplete/invalid days or unit(s) of service.	Verify that the units were billed correctly for the procedure code. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded), units (field 24G unshaded) **UB CLAIM:** Procedure code (field 44), units (field 46).
725	INCONTINENCE MODIFIER INCONSISTENT	4 - The procedure code is inconsistent with the modifier used or a required modifier is missing.	N517 – Resubmit a new claim with the requested information.	Correct the procedure code and modifier. Check the Web Tool for the RSP status of the recipient. Contact the Service Coordinator to verify the correct procedure code and modifier were authorized. Make corrections to the field(s) below. **CMS 1500 CLAIM**: Procedure code (field 24D unshaded) and modifier (24D unshaded)
727	DELETED PROCEDURE CODE/CK CPT MANUAL	16 – Claim/service lacks information which is needed for adjudication.	M51 – Missing/incomplete/invalid, procedure code(s).	Check the procedure code and the date of service to verify their accuracy. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24A unshaded), procedure code (field 24D unshaded) **UB CLAIM:** Procedure code (field 44), date of service (field 45)

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Edit Code	Description	CARC	RARC	Resolution
732	PAYER ID NUMBER NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	M56 – Missing/incomplete/invalid provider payer identifier.	Verify that the correct insurance carrier code information is entered on the claim. To view a complete listing of carrier codes, visit the Provider Information webpage on the DHHS website http://provider.scdhhs.gov. The carrier code listing is also included in the provider manuals. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Insurance carrier number (field 9D and 11C) **UB CLAIM:** Insurance carrier number (field 50)
733	INS INFO CODED, PYMT OR DENIAL MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA83 – Did not indicate whether we are the primary or secondary payer.	**CMS-1500 CLAIM:** If any third-party insurer has not made a payment, there should be a TPL denial indicator. If all carriers have made payments, there should be no TPL denial indicator. If payment is denied (*i.e.,* applied to the deductible, policy lapsed, etc.) by either primary insurance carrier, put a "1" (denial indicator) and 0.00 for the amount insurance paid. If there are multiple insurers and any payer made a 0.00 payment, put a "1" (denial indicator) and 0.00 for the amount the insurance paid. If payment is made, remove the "1" from the TPL indicator field and enter the amount(s) insurance paid and total combined amount received. Adjust the net charge in the balance due. If no third party insurance was involved, delete all information entered in the insurance fields. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Carrier code (fields 9D and 11C), policy number (fields 9A and 11), amount insurance paid (fields 9C and 11B), total combined insurance amount received (field 29), TPL indicator (field 10D) **UB CLAIM:** If any third-party insurer has not made a payment, there should be a TPL occurrence code and date (fields 31-34 A-B). If payment is denied show 0.00 (field 54). If payment is made enter the amount (field 54) and TPL indicator (fields 31 A-34 B).
734	REVENUE CODE REQUIRES UNITS	16 – Claim/service lacks information which is needed for adjudication.	M53 -Missing/incomplete/invalid days or unit(s) of service.	**UB CLAIM:** The revenue code listed (field 42) requires units of service (field 46).
735	REVENUE CODE REQUIRES AN ICD SURGICAL PROCEDURE OR DELIVERY DIAGNOSIS CODE	16 – Claim/service lacks information which is needed for adjudication.	M76 – Missing/incomplete/invalid diagnosis or condition.	**UB CLAIM:** On inpatient claims w/ revenue codes 360 OR, 361 OR-Minor, or 369 OR-Other, an ICD surgical code is required (fields 74 A-E). On inpatient claims w/ revenue codes 370 Anesthesia, 710 Recovery Room, 719 Other Recovery Room or 722 Delivery Room, a delivery diagnosis code is required (fields 67 A-Q) or an ICD surgical code is required (fields 74 A-E).

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Edit Code	Description	CARC	RARC	Resolution
736	PRINCIPAL SURGICAL PROCEDURE NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	MA66 – Missing/incomplete/ invalid principal procedure code.	**UB CLAIM:** Verify the correct procedure code was submitted (field 74). The two digits in front of the edit code on the remittance advice identify which surgical procedure code is not on file.
737	OTHER SURGICAL PROCEDURE NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	M67 – Missing/incomplete/invalid other procedure code(s).	**UB CLAIM:** Follow the resolution for edit code 736, except the procedure code (fields 74 A-E).
738	PRINCIPAL SURG PROC REQUIRES PA/NO PA #	16 – Claim/service lacks information or has submission/billing error(s).	M62 – Missing/incomplete/invalid treatment authorization code.	**UB CLAIM:** Enter the prior authorization number (field 63). If the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment.
739	OTHER SURG PROC REQUIRES PA/NO PA NUMBER	16 – Claim/service lacks information or has submission/billing error(s).	M62 – Missing/incomplete/invalid treatment authorization code.	**UB CLAIM:** Follow the resolution for edit code 738.
740	RECIP SEX/PRINCIPAL SURG PROC INCONSIST	7 – The procedure/ revenue code is inconsistent with the patient's gender.	N517 – Resubmit a new claim with the requested information.	The recipient's sex is not consistent with the principal surgical procedure code being billed. Check the patient's Medicaid ID number. A common error is entering another family member's number. Make sure the number matches the patient served. Verify that the correct principal surgical procedure code and sex are entered on the claim. Contact your county Medicaid Eligibility office if your records indicate a different sex. After the county Medicaid Eligibility office has updated the system, submit a new claim. Make corrections to the field(s) below. **UB CLAIM:** Medicaid ID (field 60), sex (field 11), procedure code (field 74)
741	RECIP SEX/OTHER SURG PROC INCONSISTENT	7 – The procedure/ revenue code is inconsistent with the patient's gender.	N517 – Resubmit a new claim with the requested information.	Follow resolution for edit code 740. The two digits in front of the edit code on the remittance advice identify which other surgical procedure code (fields 74 A - E) is inconsistent with the recipient's sex.

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Edit Code	Description	CARC	RARC	Resolution
742	RECIP AGE/PRINCIPAL SURG PROC INCONSIST	6 – The procedure/ revenue code is inconsistent with the patient's age.	N517 – Resubmit a new claim with the requested information.	The recipient's age is not consistent with the principal surgical procedure code being billed. Check the patient's Medicaid ID number. A common error is entering another family member's number. Make sure the number matches the patient served. Verify that the correct principal surgical procedure code and date of birth are entered on the claim. Contact your county Medicaid Eligibility office if your records indicate a different date of birth. After the county Medicaid Eligibility office has updated the system, submit a new claim. Make corrections to the field(s) below. **UB CLAIM:** Medicaid ID (field 60), date of birth (field 10), procedure code (field 74)
743	RECIPIENT AGE/OTHER SURG PROC INCONSIST	6 – The procedure/ revenue code is inconsistent with the patient's age.	N517 – Resubmit a new claim with the requested information.	Follow the resolution for edit code 742. The two digits in front of the edit code on the remittance advice identify which other surgical procedure code (fields 74 A - E) is inconsistent with the recipient's age.
746	PRINCIPAL SURG PROC EXCEEDS FREQ LIMIT	96 – Non-covered charge(s).	N435 – Exceeds number/ frequency approved /allowed within time period without support documentation.	**UB CLAIM:** The system has already paid for the procedure entered (field 74). Verify the procedure code is correct. If there is a correction needed; submit a new claim. If this is a replacement claim (new claim), attach appropriate clinical documentation to the claim for review and consideration for payment. If the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment.
747	OTHER SURG PROC EXCEEDS FREQ LIMIT	96 – Non-covered charge(s).	N435 – Exceeds number/ frequency approved /allowed within time period without support documentation.	Follow the resolution for edit code 746. The two digits in front of the edit code on the remittance advice identify which other surgical procedure (fields 74 A - E) exceeded the frequency limitation.
748	PRINCIPAL SURG PROC REQUIRES DOC	251 – The attachment content received did not contain the content required to process the claim or service.	N29 – Missing documentation /orders/notes/summary/ report/chart.	**UB CLAIM:** The principal surgical procedure (field 74) requires documentation. Attach appropriate clinical documentation (i.e., discharge summary, operative note, etc.) to the new claim for review and consideration for payment. Documentation will not be reviewed or retained by Medicaid until the provider corrects all other edits. Refer to the appropriate policy manual for specific Medicaid coverage guidelines and documentation requirements.
749	OTHER SURG PROC REQUIRES DOC/MAN REVIEW	251 – The attachment content received did not contain the content required to process the claim or service.	N29 – Missing documentation /orders/notes/summary/ report/chart.	Follow the resolution for edit code 748. The two digits in front of the edit code on the remittance advice identify which other surgical procedure (fields 74 A - E) requires documentation for manual review.

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Edit Code	Description	CARC	RARC	Resolution
750	PRIN SURG PROC NOT COV OR NOT COV ON DOS	96 – Non-covered charge(s).	N56 – Procedure code billed is not correct/valid for the services billed or the date of service billed.	**UB CLAIM:** Check the principal surgical procedure code and date (field 74) to verify their accuracy. Check to see if the principal surgical procedure code is listed on the non-covered surgical procedures list in the appropriate provider policy manual. Check the most recent edition of the ICD-CM manual to be sure the code you are using has not been deleted or changed to another code. If corrections are needed; submit a new claim.
751	OTHER SURG PROC NOT COV/NOT COV ON DOS	96 – Non-covered charge(s).	N56 – Procedure code billed is not correct/valid for the services billed or the date of service billed.	Follow the resolution for edit code 750. The two digits in front of the edit code on the remittance advice identify which other surgical procedure code (fields 74 A – E) is not covered on the date of service.
752	PRINCIPAL SURGICAL PROCEDURE ON REVIEW	133 – The disposition of this claim/service is pending further review.		**UB CLAIM:** For review and consideration for payment, attach appropriate clinical documentation (i.e., discharge summary, operative notes, etc.) to the new claim which supports the principal surgical procedure (field 74).
753	OTHER SURGICAL PROCEDURE ON REVIEW	133 – The disposition of this claim/service is pending further review.		Follow the resolution for edit code 752. The two digits in front of the edit code on the remittance advice identify which other surgical procedure code (fields 74 A – E) is on review.
754	REVENUE CODE NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	M50 – Missing/incomplete/invalid revenue code(s).	**UB CLAIM:** The revenue code is invalid. Correct the revenue code (field 42).
755	REVENUE CODE REQUIRES PA/PEND FOR REVIEW	133 – The disposition of this claim/service is pending further review.		**UB CLAIM:** A revenue code (field 42) requires a prior authorization number. Enter the prior authorization number (field 63).
757	OTHER DIAG REQUIRES PA/NO PA NUMBER	16 – Claim/service lacks information or has submission/billing error(s).	M62 – Missing/incomplete/invalid treatment authorization code.	**UB CLAIM:** The other diagnosis (fields 67 A-Q) requires a prior authorization number. Enter the prior authorization number (field 63).
758	PRIM/PRINCIPAL DIAG REQUIRES DOC	251 – The attachment content received did not contain the content required to process the claim or service.	N29 – Missing documentation/ orders/notes/summary/report/ chart.	The primary/principal diagnosis requires documentation. If the primary/principal diagnosis is correct, attach appropriate clinical documentation (i.e., operative report, chart notes, etc.) to the new claim along with the PA letter if prior authorization was obtained for review and consideration for payment. Refer to the applicable provider policy manual for documentation requirements.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
759	SEC/OTHER DIAG REQUIRES DOC/MAN REVIEW	251 – The attachment content received did not contain the content required to process the claim or service.	N29 – Missing documentation/ orders/ notes/summary/report/ chart.	The secondary/other diagnosis requires documentation. Follow the resolution for edit code 758 using the secondary/other diagnosis code.
760	PRIMARY DIAG CODE NOT COVERED ON DOS	16 – Claim/service lacks information which is needed for adjudication.	MA63 – Missing/incomplete/ invalid principal diagnosis.	Check the current ICD-CM manual to verify that the primary diagnosis is correctly coded and correct date of service was billed. If there are corrections needed; submit a new claim. If the diagnosis code and the date of service are correct, then it is not covered and will not be considered for payment.
761	SEC/OTHER DIAG CODE NOT COVERED ON DOS	16 – Claim/service lacks information which is needed for adjudication.	M64 – Missing/incomplete/invalid other diagnosis.	The secondary/other diagnosis code is not covered for the date of service billed. Follow the resolution for edit code 760 using the secondary/other diagnosis code.
762	PRINCIPAL DIAG ON REVIEW/MANUAL REVIEW	133 – The disposition of this claim/service is pending further review.		**UB CLAIM:** The principal diagnosis code (field 67) requires manual review. Attach appropriate clinical documentation (i.e., history, physical, and discharge summary, etc.) to the new claim for review and consideration for payment. Refer to the applicable provider policy manual for documentation requirements.
763	OTHER DIAG ON REVIEW/MANUAL REVIEW	133 – The disposition of this claim/service is pending further review.		Follow the resolution for edit code 762. The two digits before the edit code on the remittance advice identify which other diagnosis code (fields 67 A-Q) requires manual review.
764	REVENUE CODE REQUIRES DOC/MANUAL REVIEW	133 – The disposition of this claim/service is pending further review.		**UB CLAIM:** The revenue code (field 42) requires manual review. Attach appropriate clinical documentation to the new claim for review and consideration for payment. Refer to the applicable provider policy manual for documentation requirements.

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Edit Code	Description	CARC	RARC	Resolution
765	RECIPIENT AGE/REVENUE CODE INCONSIST	6 – The procedure/ revenue code is inconsistent with the patient's age	N517 – Resubmit a new claim with the requested information.	The recipient's age is not consistent with the revenue code being billed. Check the patient's Medicaid ID number. A common error is entering another family member's number. Make sure the number matches the patient served. Verify that the correct revenue code and date of birth are entered on the claim. Contact your county Medicaid Eligibility office if your records indicate a different date of birth. After the county Medicaid Eligibility office has updated the system, submit a new claim. Make corrections to the field(s) below. **UB CLAIM:** Medicaid ID (field 60), date of birth (field 10), revenue code (field 42)
766	NEED TO PRICE OP SURG	16 – Claim/service lacks information which is needed for adjudication.	M79 – Missing/incomplete/invalid charge.	**UB CLAIM:** Verify that the correct procedure code was entered (field 44). If the code is correct, attach appropriate clinical documentation (i.e., discharge summary, operative notes, etc.) to the new claim for review and consideration for payment.
768	ADMIT DIAGNOSIS CODE NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	MA65 – Missing/incomplete/ invalid admitting diagnosis.	**UB CLAIM:** Verify and correct the admit diagnosis code that was entered on the claim. Medicaid requires the complete diagnosis code as specified in the current edition of the ICD-CM manual, (including fifth digit sub-classification when listed).
769	ASST. SURGEON NOT ALLOWED FOR PROC CODE	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Procedure does not allow reimbursement for an assistant surgeon. If the edit appears unjustified or an assistant surgeon was medically necessary due to unforeseen circumstances, attach clinical documentation (i.e., operative report, chart notes, etc.) to the new claim to justify the assistant surgeon. Refer to the applicable provider policy manual for documentation requirements.
771	PROV NOT CERTIFIED TO PERFORM THIS SERV	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Medicaid does not have an FDA certificate on file for the rendering provider. Verify that the procedure code is correctly coded and make corrections to the field(s) below. If applicable, attach the FDA certificate to the new claim. If you are not a certified mammography provider, or a lab provider, this edit code is not correctable. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded)
773	INAPPROPRIATE PROCEDURE CODE USED	16 – Claim/service lacks information which is needed for adjudication.	M51 – Missing/incomplete/invalid procedure code(s).	Verify that an appropriate procedure code is used and make corrections to the field(s) below. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded)

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Edit Code	Description	CARC	RARC	Resolution
774	LINE ITEM SERV CROSSES STATE FISCAL YEAR	16 – Claim/service lacks information which is needed for adjudication.	N63 – Rebill services on separate claim lines.	Change the units in the field(s) below to reflect days billed on or before 6/30. Add a line to the claim to reflect days billed on or after 07/01. **CMS-1500 CLAIM:** Units (field 24G unshaded)
775	EARLY DELIVERY < 39 WEEKS NOT MEDICALLY NECESSARY	50 – These are non-covered services because this is not deemed a "medical necessity" by the payer.	N180 – This item or service does not meet the criteria for the category under which it was billed.	**CMS 1500 CLAIM:** Verify that the correct procedure code and modifier were billed. For review and consideration for payment, attach appropriate clinical documentation (i.e., medical necessity, entire obstetrical records, radiology, laboratory, and pharmacy records, ACOG Patient Safety Checklist or comparable patient safety justification form, etc.) to the new claim to substantiate the services being billed. Refer to the applicable provider policy manual for documentation requirements.
778	SEC CARRIER PRIOR PAYMENT NOT ALLOWED	16 – Claim/service lacks information which is needed for adjudication.	MA04 – Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	**UB CLAIM:** Prior payment for a carrier secondary to Medicaid should not appear on claim. Correct prior payment (field 54).
780	REVENUE CODE REQUIRES PROCEDURE CODE	16 – Claim/service lacks information which is needed for adjudication.	M51 – Missing/incomplete/invalid procedure code(s).	**UB CLAIM:** Some revenue codes require a CPT/HCPCS code. Enter the appropriate revenue code (field 42) and CPT/HCPCS code (field 44). A list of revenue codes that require a CPT/HCPCS code is located in Section 4 of the applicable provider manual.
786	ELECTIVE ADMIT,PROC REQ PRE-SURG JUSTIFY	197 – Precertification/ authorization/ notification/ pretreatment absent.		**UB CLAIM:** When type of admission (field 14) is elective, and the procedure requires prior authorization, a prior authorization number from QIO must be entered (field 63). If the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment. Contact the QIO for consideration for payment for retroactive eligibility and emergency services.
790	TB RECIP / SERVICE IS NOT TB	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Recipient is eligible for TB services only. Verify that the Medicaid ID number matches the patient served. Check the procedure code(s) and/or modifier to ensure the correct codes were billed. Submit a new claim with the corrected information.

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Edit Code	Description	CARC	RARC	Resolution
794	PRINCIPAL MINOR SURGICAL PROCEDURE REQUIRES QIO APPROVAL	A1 – Claim/service denied.	N175 – Missing review organization approval.	**UB CLAIM:** Prior authorization is required from QIO. Enter PA number (field 63). If the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment. Contact the QIO for consideration for payment for retroactive eligibility and emergency services.
795	SURG RATE CLASS/NOT ON FILE-NOT COV DOS	16 – Claim/service lacks information which is needed for adjudication.	N65 – Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	**UB CLAIM:** Verify that the procedure code (field 44) and date of service (field 45) were entered correctly. If correct, attach appropriate clinical documentation (i.e., discharge summary, operative notes, etc.) to the new claim for review and consideration for payment.
796	PRINC DIAG NOT ASSIGNED LEVEL-MAN REVIEW	133 – The disposition of this claim/service is pending further review.		**UB CLAIM:** Verify that the diagnosis code (field 67) was submitted correctly. If correct, attach appropriate clinical documentation to support the diagnosis to the new claim for review and consideration for payment.
797	OTHER DIAG NOT ASSIGNED LEVEL-MAN REVIEW	133 – The disposition of this claim/service is pending further review.		Follow the resolution for edit code 796. The two digits in front of the edit code on the remittance advice identify which other diagnosis code (fields 67 A-Q) has not been assigned a level.
798	SURGERY PROCEDURE REQUIRES PA# FROM QIO	A1 – Claim/service denied.	N175 – Missing review organization approval.	A prior authorization from the QIO is required for the surgery procedure billed. Contact the QIO for the authorization number and submit a new claim. If the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Prior authorization number (field 23) **UB CLAIM:** Treatment authorization code (field 63) Contact the QIO for consideration for payment for retroactive eligibility and emergency services.
799	OP PRIN/OTHER PROC REQ QIO APPROVAL	A1 – Claim/service denied.	N175 – Missing review organization approval.	Follow the UB claim resolution for edit code 798. The two digits in front of the edit code on the remittance advice identify which principal/other procedure requires QIO prior authorization (field 63).
801	PROCEDURE CODE COMBINATION NOT ALLOWED – SAME DOS/CLAIM	16 – Claim/service lacks information which is needed for adjudication.	N56 – Procedure code billed is not correct/valid for the services billed or the date of service billed.	The provider should review the remittance advice for the procedure codes not allowed on the same date of service. If two or more of the RBHS Community Support Services (CSS) procedure codes were rendered on the same date of service, Medicaid will only reimburse one of the procedures rendered. Submit a new claim with one procedure code rendered, per one date of service, provided that the

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Edit Code	Description	CARC	RARC	Resolution
				clinical documentation supports the service billed. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded), date of service (field 24A) Refer to the Same Day Service Restrictions policy for Community Support Services in Section 2 of the RBHS provider manual.
802	PROCEDURE CODE COMBINATION NOT ALLOWED – SAME DOS/DIFFERENT CLAIM	16 – Claim/service lacks information which is needed for adjudication.	N56 – Procedure code billed is not correct/valid for the services billed or the date of service billed.	Medicaid will not reimburse the same or multiple providers for rendering RBHS Community Support Services (CSS) procedure codes on the same day. If another provider was paid for the same or another RBHS CSS for the same date of service, the second billing provider will not be paid. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded), date of service (field 24A) Refer to the Same Day Service Restrictions policy for Community Support Services in Section 2 of the RBHS provider manual.
808	HEALTH OPPORTUNITY ACCOUNT (HOA) IN DEDUCTIBLE PERIOD	119 – Benefit maximum for this time period or occurrence has been reached.	N435 – Exceeds number/ frequency approved/allowed within time period without support documentation.	Attach supporting documentation to the new claim to indicate the recipient's HOA status and deductible payments for review and consideration for payment.
820	SERVICES REQUIRE ICORE PA - PA MISSING OR NOT ON FILE	16 – Claim/service lacks information or has submission/billing error(s).	M62 – Missing/incomplete/invalid treatment authorization code.	Service Requires Prior Authorization from ICORE prior to rendering the service. No prior authorization number is on the claim or the prior authorization number on the claim is not on file for the recipient. If the prior authorization number is missing, submit a new claim with the prior authorization number provided by ICORE. If a valid prior authorization number is on the claim, contact ICORE for the system to be updated. After ICORE has updated the system, submit a new claim with the valid prior authorization number and attach a copy of the ICORE PA letter for review and consideration for payment. Make corrections to the field(s) below. CMS-1500 CLAIM: Prior authorization number (field 23) Notes: If Medicaid is primary and the prior authorization number was not obtained from ICORE prior to rendering the service, you will not be considered for payment. If Medicaid is Secondary, a prior authorization does not need to be obtained from ICORE prior to rendering the service. Contact ICORE for consideration for payment for retroactive eligibility and emergency services.

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Edit Code	Description	CARC	RARC	Resolution
821	SERVICES REQUIRE ICORE PA – PA ON CLAIM NOT VALID	16 – Claim/service lacks information or has submission/billing error(s).	M62 – Missing/incomplete/ invalid treatment authorization code.	Service Requires Prior Authorization from ICORE and the Prior Authorization information on the claim is not valid. Compare the Prior Authorization information received from ICORE to the claim to determine if there are any differences. For example, verify the PA number, check the date(s) of service to see if they are within the service authorization dates for the PA, and verify the NPI of the rendering provider, the procedures codes billed and that the units billed do not exceed the limit ICORE has authorized. If changes are needed, submit a new claim with the corrected information in the field(s) below. If you have verified that all prior authorization information on the claim matches the information on the ICORE PA letter, contact ICORE for further assistance. After ICORE has resolved the validity issue, submit a new claim with the valid prior authorization information. **CMS-1500 CLAIM**: Prior authorization number (field 23), date of service (field 24A unshaded), procedure code (field 24D unshaded), units (field 24G unshaded), line provider NPI (field 24J unshaded). **Notes**: If **Medicaid** is primary and the prior authorization number was not obtained from ICORE prior to rendering the service, you will not be considered for payment. If **Medicaid** is Secondary, a prior authorization does not need to be obtained from ICORE prior to rendering the service. If the service is denied, a request must be submitted to ICORE for prior authorization. A new claim with the corrected information must be submitted. Contact ICORE for consideration for payment for retroactive eligibility and emergency services.
837	SERVICE REQUIRES QIO PA–PA MISSING OR NOT ON FILE	16 – Claim/service lacks information or has submission/billing error(s).	M62 – Missing/incomplete/invalid treatment authorization code.	Service Requires Prior Authorization from the QIO prior to rendering the service. No authorization number is on the claim or the authorization number is not on file for the recipient on the claim. If the authorization number is missing, make corrections to the field(s) below. If an authorization number is on the claim, the number needs to be reviewed and updated; contact the QIO. After the QIO has updated the system, submit a new claim. **CMS-1500 CLAIM:** Prior authorization number (field 23) **UB CLAIM:** Treatment authorization code (field 63) **Notes:** If **Medicaid** is primary and the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment. If **Medicaid** is Secondary, a prior authorization does not need to be

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Edit Code	Description	CARC	RARC	Resolution
				obtained from the QIO prior to rendering the service. If the service is denied, a request must be submitted to QIO for prior authorization. A new claim with the corrected information must be submitted. For UB claims (Inpatient only): If beneficiary is partially eligible for the dates of service on the claim; attach the DHHS Form 945 Verification of Medicaid Eligibility Letter to the **NEW** claim for review and consideration for payment. Contact the QIO for consideration for payment for retroactive eligibility and emergency services.
838	SERVICE REQUIRES QIO PA – PA ON CLAIM NOT VALID	16 – Claim/service lacks information or has submission/billing error(s).	M62 – Missing/incomplete/invalid treatment authorization code.	Service Requires Prior Authorization from the QIO and the Prior Authorization on claim is not valid. Compare the Prior Authorization received from the QIO to the claim to determine if there are any differences. For example, verify that the PA number on the claim matches PA number on the QIO letter, check the date(s) of service/date of admission to see if they are within the service authorization dates for the PA, and verify the NPI of the rendering provider, the procedures codes billed and that the units billed do not exceed the limit authorized. If changes are needed, submit a new claim with the corrected information in the field(s) below. If you have verified that all prior authorization information on the claim matches the information on the QIO PA letter, attach the QIO PA letter to the new claim for review and consideration for payment. **CMS-1500 CLAIM:** Prior authorization number (field 23), date of service (field 24A unshaded), procedure code (field 24D unshaded), units (field 24G unshaded), line provider NPI (field 24J unshaded) **UB CLAIM:** Treatment authorization code (field 63), date of admission (field 12), procedure code (field 44 or 74), units (field 46) **Notes:** If **Medicaid** is primary and the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment. If **Medicaid** is Secondary, a prior authorization does not need to be obtained from the QIO prior to rendering the service. If the service is denied, a request must be submitted to QIO for prior authorization. A new claim with the corrected information must be submitted For UB claims (Inpatient only): If beneficiary is partially eligible for the dates of service on the claim; attach the DHHS Form 945 Verification of Medicaid Eligibility Letter to the **NEW** claim for review and consideration for payment. Contact the QIO for consideration for payment for retroactive eligibility and emergency services.

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Edit Code	Description	CARC	RARC	Resolution
839	IP ADMISSION REQUIRES QIO PA – PA MISSING OR NOT ON FILE	16 – Claim/service lacks information or has submission/billing error(s).	M62 – Missing/incomplete/invalid treatment authorization code.	**UB CLAIM:** IP Admission Requires Prior Authorization (field 63) from the QIO. No prior authorization number on the claim or authorization number is not on file for the recipient. If the authorization number is missing, add it to a new claim and resubmit. If an authorization number is on the claim, the number needs to be reviewed and updated. Contact the QIO. After the QIO has updated the system, submit a new claim. **Notes:** If **Medicaid** is primary **or** the beneficiary has **Medicare PART B ONLY** and the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment. If Medicaid is **Secondary**, a prior authorization does not need to be obtained from the QIO prior to rendering the service. If the service is denied, a request must be submitted to QIO for prior authorization. A new claim with the corrected information must be submitted. **For UB claims (Inpatient only):** If beneficiary is partially eligible for the dates of service on the claim; attach the DHHS Form 945, Verification of Medicaid Eligibility Letter, to the **NEW** claim for review and consideration for payment. For retroactive eligibility, contact the QIO for authorization.
843	RTF SERVICES REQUIRE PA	16 – Claim/service lacks information or has submission/billing error(s).	M62 – Missing/incomplete/invalid treatment authorization code.	**UB CLAIM:** RTF services require Prior Authorization (field 63) from the QIO. If the authorization number is missing, add it to a new claim and resubmit. If an authorization is on the claim, the number needs to be reviewed and updated. Contact the QIO. After the QIO has updated the system, submit a new claim. **Notes:** If **Medicaid** is primary and the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment. If Medicaid is **Secondary**, a prior authorization does not need to be obtained from the QIO prior to rendering the service. For UB claims (Inpatient only): If beneficiary is partially eligible for the dates of service on the claim; attach the DHHS Form 945 Verification of Medicaid Eligibility Letter to the **NEW** claim for review and consideration for payment. For retroactive eligibility, contact the QIO for authorization.

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Edit Code	Description	CARC	RARC	Resolution
844	IMD SERVICES REQUIRE PA	16 – Claim/service lacks information or has submission/billing error(s).	M62 – Missing/incomplete/invalid treatment authorization code.	**UB CLAIM:** IMD services require Prior Authorization (field 63) from the QIO. If the authorization number is missing, add it to a new claim and resubmit. If an authorization is on the claim, the number needs to be reviewed and updated. Contact the QIO. After the QIO has updated the system, submit a new claim. **Notes:** If **Medicaid** is primary and the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment. If Medicaid is **Secondary**, a prior authorization does not need to be obtained from the QIO prior to rendering the service. For UB claims (Inpatient only): If beneficiary is partially eligible for the dates of service on the claim; attach the DHHS Form 945 Verification of Medicaid Eligibility Letter to the **NEW** claim for review and consideration for payment. For retroactive eligibility, contact the QIO for authorization.
850	HOME HEALTH VISITS FREQUENCY EXCEEDED	B1 – Non-Covered visits.	N30 – Patient ineligible for this service.	**CMS 1500 CLAIM:** The frequency for visits has exceeded the allowed amount and prior authorization is required by the QIO. If there is an error, make the appropriate correction to the claim. Refer to the applicable provider policy manual. If the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment.
851	DUP SERVICE, PROVIDER SPEC and DIAGNOSIS	18 – Exact duplicate claim/ service.	N522 – Duplicate of a claim processed, or to be processed, as a crossover claim.	Verify that the procedure code and the diagnosis code were billed correctly. If incorrect, make corrections to the field(s) below. If correct, the first provider will be paid. The second provider of the same practice specialty will not be reimbursed for services rendered for the same diagnosis. If the 2nd provider should be reviewed and considered for payment, attach appropriate clinical documentation to the new claim which substantiates the services rendered. **CMS-1500 CLAIM:** Diagnosis code (field 21), procedure code (field 24D unshaded)

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852	DUPLICATE PROV/ SERV FOR DATE OF SERVICE	B13 – Previously paid. Payment for this claim/ service may have been provided in a previous payment.		1. Review the remittance advice for the duplicate payment date. 2. Check the patient's financial record to see whether payment was received. 3. If two or more of the same procedures were performed on the same date of service and you only received payment for the first date of service, initiate a void to void the original paid claim. Submit a new claim (replacement claim) with the corrected information. 4. If two or more of the same procedures were performed on the same date of service by different individual providers, attach appropriate clinical documentation (i.e., operative notes, clinical service notes, physician orders, etc.) to the claim for review and consideration for payment. When applicable if two or more of the same procedure were performed on the same date of service and only one procedure was paid, make the appropriate correction to the modifier (field 24D unshaded) on the claim to indicate a repeat procedure. Refer to your manual for applicable repeat modifiers. For further instructions on Void and Replacement claims, refer to Section 3 of the applicable provider policy manual.
853	DUPLICATE SERV/DOS FROM MULTIPLE PROV	B20 – Procedure/ service was partially or fully furnished by another provider.		Medicaid will not reimburse a physician if the procedure was also performed by a laboratory, radiologist, or a cardiologist. If none of the above circumstances apply, attach appropriate clinical documentation (i.e., operative notes, clinical service notes, physician orders, etc.) to the new claim for review and consideration for payment. Verify that the procedure code (field 24D unshaded on the claim) and date of service (field 24A on the claim) were billed correctly. If incorrect, make the appropriate corrections and submit a new claim. If correct, this indicates that the first provider was paid and additional providers should attach appropriate clinical documentation (i.e., operative notes, clinical service notes, physician orders, etc.) to the new claim for review and consideration for payment.
854	VISIT WITHIN SURG PKG TIME LIMITATION	A1 – Claim/service denied.	M144 – Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	If the visit is related to the surgery and is the only line on the claim. The visit will not be paid. If the visit is related to the surgery and is on the claim with other payable lines, remove the line with the 854 edit and submit a new claim. This indicates you do not expect payment for this line. If the visit is unrelated to the surgical package, enter the appropriate modifier, 24 or 25, on the new claim (field 24D unshaded).

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Edit Code	Description	CARC	RARC	Resolution
855	SURG PROC/PAID VISIT/TIME LIMIT CONFLICT	151 – Payment adjusted because the payer deems the information submitted does not support this many/ frequency of services.		If the visit and surgery are related, request recoupment of the visit to pay the surgery. If the visit and surgery are non-related, attach clinical documentation (i.e., operative notes, clinical service notes, physician orders, etc.) to the new claim to justify the circumstances for review and consideration of payment.
856	2 PRIM SURGEON BILLING FOR SAME PROC/DOS	B20 – Procedure/ service was partially or fully furnished by another provider.		Check to see if individual provider number is correct, and the appropriate modifier is used to indicate different operative session, assistant surgeon, surgical team, etc. Make appropriate changes to the field(s) below and submit a new claim. If no modifier is applicable, and field is correct, attach appropriate clinical documentation (i.e., operative notes, etc.) to the new claim for review and consideration for payment. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded), modifier (field 24D unshaded), line provider NPI (field 24J unshaded)
857	DUP LINE – REV CODE, DOS, PROC CODE, MODIFIER	18 – Exact duplicate claim/service.	N522 – Duplicate of a claim processed, or to be processed, as a crossover claim.	**UB CLAIM:** The two-digit number in front of the edit code on the remittance advice identifies which line of field 42 or 44 contains the duplicate code. Make the appropriate correction to the new claim. Duplicate revenue or CPT/HCPCS codes should be combined into one line by deleting the whole duplicate line and adding the units and charges to the other line.
858	TRANSFER TO ANOTHER INSTITUTION DETECTED	B20 –Procedure/ service was partially or fully furnished by another provider.		Check to make sure the dates of service are correct. If there are errors, make the appropriate correction to the new claim.
859	DUPLICATE PROVIDER FOR DATES OF SERVICE	B20 – Procedure/ service was partially or fully furnished by another provider.		**UB CLAIM:** Check the remittance advice for the dates of previous payments that conflict with this claim. If this is a duplicate claim or if the additional charges do not change the payment amount, disregard the rejection. If additional services were performed on the same day and will result in a different payment amount, complete a replacement claim (new claim). If services were not done on the same date of service, a new claim should be filed with the correct date of service. Attach clinical documentation (i.e., operative notes, physician orders, etc.) for both the paid claim and new claim(s) explaining the situation.

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Edit Code	Description	CARC	RARC	Resolution
860	RECIP SERV FROM MULTI PROV FOR SAME DOS	B20 – Procedure/ service was partially or fully furnished by another provider.		**UB CLAIM:** This edit most frequently occurs with a transfer from one hospital to another. One or both of the hospitals entered the wrong "from" or "through" dates (field 6). Verify the date(s) of service. If incorrect, enter the correct dates of service the new claim. If the dates are correct, attach appropriate clinical documentation (i.e., discharge summary, transfer document, ambulance document, etc.) to the new claim for review and consideration for payment. If the claim has a 618 carrier code (field 50), the claim may be duplicating against another provider's Medicare primary inpatient or outpatient claim, or against the provider's own Medicare primary inpatient or outpatient claim. If either situation occurs, attach the Medicare EOMB to the new claim for review and consideration for payment.
863	DUPLICATE PROV/SERV FOR DATES OF SERVICE	B13 – Previously paid. Payment for this claim/ service may have been provided in a previous payment.		**UB CLAIM:** Check the remittance advice for the dates of service for the paid claims that conflict with this claim. If all charges are paid for the date(s) of service, disregard the rejection. Submit a new claim, if it will result in a different payment amount. **Note:** Payment changes usually occurs when there is a change in the inpatient DRG or reimbursement type, or a change in the outpatient reimbursement type.
865	DUP PROC/SAME DOS/DIFF ANES MOD	B13 – Previously paid. Payment for this claim/ service may have been provided in a previous payment.		You have been paid for this procedure with a different modifier. Verify by the anesthesia record the correct modifier. Make appropriate corrections, if applicable, and submit a new claim. If the paid claim is correct, discard the rejection. If this procedure should be paid, attach appropriate clinical documentation to the new claim for review and consideration for payment. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded), modifier (field 24D unshaded)
866	NURS HOME CLAIM DATES OF SERVICE OVERLAP	B13 – Previously paid. Payment for this claim/ service may have been provided in a previous payment.		Check the remittance advice for the dates of service for the paid claims that conflict with this claim. If all charges are paid for the date(s) of service, discard the claim. Submit a new DHHS Form 181 with monthly billing, if it will result in a different payment amount and different dates of service.
867	DUPLICATE ADJ - ORIGINAL CLM ALRDY VOIDED	18 – Exact duplicate claim/service.	N522 – Duplicate of a claim processed, or to be processed, as a crossover claim.	Provider has submitted an adjustment claim for an original claim that has already been voided. An adjustment cannot be made on a previously voided claim. Discard the claim.

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Edit Code	Description	CARC	RARC	Resolution
877	SURGICAL PROCS ON SEPERATE CLMS/SAME DOS	B13 – Previously paid. Payment for this claim/ service may have been provided in a previous payment.		This edit indicates payment has been made for a primary surgical procedure at 100%. The system has identified that another surgical procedure for the same date of service was paid after manual pricing and approval. This indicates a review is necessary to ensure correct payment of the submitted claim. Make corrections to the claim by entering appropriate modifiers to indicate different operative sessions, assistant surgeon, surgical team, etc., and attach appropriate clinical documentation to the new claim for review and consideration for payment. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded), date of service (field 24A unshaded)
883	CARE CALL SERVICE BILLED OUTSIDE THE CARE CALL SYSTEM	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	This edit cannot be manually corrected. The provider needs to submit billing through the Care Call System.
884	OVERLAPPING PROCEDURES (SERVICES) SAME DOS/SAME PROVIDER	B13 – Previously paid. Payment for this claim/ service may have been provided in a previous payment.		Check the remittance advice for the dates of service for the paid claims that conflict with this claim. Check the patient's financial records to see whether payment was received. If payment was received, discard the rejection. If the claim/service is incorrect, void the claim and submit a new claim with the corrected information. If the procedures (services) overlap, attach appropriate clinical documentation to the new claim to substantiate the services being billed for review and consideration for payment.
885	PROVIDER BILLED AS ASST and PRIMARY SURGEON	B13 – Previously paid. Payment for this claim/ service may have been provided in a previous payment.		Verify which surgeon was primary and which was the assistant. Check the individual provider number. The modifier may need correcting to indicate different operative sessions, surgical team, etc. Attach applicable clinical documentation to the new claim for review and consideration for payment, if applicable, to determine which surgeon was primary and which was the assistant surgeon. If you have been paid incorrectly as a primary and/or assistant surgeon, void the paid claim and submit a new claim with the corrected information. Make appropriate corrections to the field(s) below. **CMS-1500 CLAIM:** Individual provider ID (field 24J unshaded), modifier (field 24D unshaded)

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Edit Code	Description	CARC	RARC	Resolution
887	PROV SUBMITTING MULT CLAIMS FOR SURGERY	B13 – Previously paid. Payment for this claim/ service may have been provided in a previous payment		**CMS 1500 CLAIM:** First check your records to see if this claim has been paid. If it has, discard the rejection. If multiple procedures were performed and some have been paid, attach appropriate clinical documentation (i.e., Medicare EOB, sterilization consent forms, etc.), and remittance advice from original claim to the new claim for review and consideration for payment. If two surgical procedures were performed at different times on this DOS (two different operative sessions), enter the modifier 78 or 79 (field 24D unshaded) on the new claim.
888	DUP DATES OF SERVICE FOR EXTENDED NH CLM	B13 – Previously Paid. Payment for this claim/ service may have been provided in a previous payment.		Check your records to see if this claim has been paid. If this is a duplicate claim, disregard the rejection. If dates of service are different or payment amount is different, submit a corrected DHHS Form 181 and EOMB with a new claim.
889	PROVIDER PREVIOUSLY PD AS AN ASST SURGEON	B13 – Previously paid. Payment for this claim/ service may have been provided in a previous payment.		**CMS 1500 CLAIM:** Verify which surgeon was primary and which was the assistant. If the surgeon has been paid as the assistant, and was the primary surgeon, void the paid claim and submit a new claim with the corrected information. If a review is needed, attach applicable clinical documentation (i.e., operative notes, surgical team, etc.) to the new claim for review and consideration for payment.
892	DUP DATE OF SERVICE,PROC/MOD ON SAME CLM	18 – Exact duplicate claim/service.	N522 – Duplicate of a claim processed, or to be processed, as a crossover claim.	If duplicate services were not provided, delete the duplicate line from the claim. If duplicate services were provided and the correct duplicate modifier was billed, attach support clinical documentation to the new claim for review and consideration for payment. Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Modifier (field 24D unshaded) **Note**: If reimbursement is for an assistant surgeon OR multiple births**;** use the Modifier (GB or CG) on the applicable lines(s).
893	CONFLICTING AA/QK MOD SUBMITTED SAME DOS	B20 – Procedure/ service was partially or fully furnished by another provider.		Claims are conflicting for the same date of service regardless of the procedure code, one with AA modifier and one with QK/QY modifier. Verify the correct modifier and/or procedure code for the date of service by the anesthesia record. Attach applicable clinical documentation to the new claim for review and consideration for payment. Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24A unshaded), Procedure code (field 24D unshaded), Modifier (field 24D unshaded),

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Edit Code	Description	CARC	RARC	Resolution
894	CONFLICTING QX/QZ MOD SUBMITTED SAME DOS	B20 – Procedure/ service was partially or fully furnished by another provider.		Claims are conflicting for the same date of service regardless of the procedure code, one with QX modifier and one with QZ modifier. Verify by the anesthesia record if the procedure was rendered by a supervised or independent CRNA. Attach applicable clinical documentation to the new claim for review and consideration for payment. Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24A unshaded), Procedure code (field 24D unshaded), Modifier (field 24D unshaded),
895	CONFLICTING AA and QX/QZ MOD SAME PROC/DOS	B20 – Procedure/ service was partially or fully furnished by another provider.		Claims have been submitted by an anesthesiologist as personally performed anesthesia services and a CRNA has also submitted a claim. Verify by the anesthesia record the correct modifier for the procedure code on the date of service. Attach applicable clinical documentation to the new claim for review and consideration for payment. Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24A unshaded), Procedure code (field 24D unshaded), Modifier (field 24D unshaded),
897	MULT. SURGERIES ON CONFLICTING CLM/DOS	59 – Processed based on multiple or concurrent procedure rules.		**CMS 1500 CLAIM:** First check your records to see if this claim has been paid. If it has, discard the rejection. If multiple procedures were performed and some have been paid, attach appropriate clinical documentation (i.e., operative note and remittance from original claim, etc.) to the new claim for review and consideration for payment. If two surgical procedures were performed at different times on this DOS (two different operative sessions), enter the correct modifier 78 or 79 (field 24D unshaded) on the new claim.
899	CONFLICTING QK/QZ MOD FOR SAME DOS	B20 – Procedure/ service was partially or fully furnished by another provider.		Verify by the anesthesia record the correct modifier and procedure code for the date of service. If this procedure was rendered by an anesthesia team, the supervising physician should bill with QK modifier and the supervised CRNA should bill with the QX modifier. The QY modifier indicates the physician was supervising a single procedure. Attach applicable clinical documentation to the new claim for review and consideration for payment. Refer to the applicable policy manual for clinical documentation guidelines. Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24A unshaded), Procedure code (field 24D unshaded), Modifier (field 24D unshaded),

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Edit Code	Description	CARC	RARC	Resolution
900	PROVIDER ID IS NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	N77 – Missing/incomplete/invalid designated provider number.	Check your records to make sure that the provider ID number on the claim is correct. Make the appropriate correction to the new claim For assistance, contact Provider Enrollment at 1-888-289-0709.
901	INDIVIDUAL PROVIDER ID NUM NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	N77 – Missing/incomplete/invalid designated provider number.	Check your records to make sure that the individual provider ID number is correct. Submit a new claim with the corrected information. For assistance, contact Provider Enrollment at 1-888-289-0709. Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Individual provider ID (field 24J unshaded),
902	PROVIDER NOT ELIGIBLE ON DATE OF SERVICE	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Pay-to-provider was not eligible for date of service or was not enrolled when service was rendered. Verify whether the date of service on claim is correct. Submit a new claim with the corrected information. For provider's eligibility status, contact Provider Enrollment at 1-888-289-0709. **Note:** If the provider was not eligible on the date of service, you will not be considered for payment. Discard the rejection.
903	INDIV PROVIDER INELIGIBLE ON DTE OF SERV	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Verify whether the date of service on the claim is correct. Submit a new claim with the corrected information. For provider's eligibility status, contact Provider Enrollment at 1-888-289-0709. **Note:** If the provider was not eligible on the date of service, you will not be considered for payment. Discard the rejection.
904	PROVIDER SUSPENDED ON DATE OF SERVICE	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Verify whether the date of service on the claim is correct. If not, correct and submit a new claim. Direct further questions to SCDHHS Program Integrity at (803) 898-2640.
905	INDIVIDUAL PROVIDER SUSPENDED ON DOS	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Follow the resolution for edit 904.

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Edit Code	Description	CARC	RARC	Resolution
906	PROVIDER ON PREPAYMENT REVIEW	A1 – Claim/service denied.	N35 – Program Integrity/ utilization review decision.	Provider is on Prepayment Review. All claims must be submitted with documentation attached to substantiate the billed service. See document requirements outlined in the applicable provider policy manual. In some instances the provider may be required to submit paper claims. Refer to the Provider Prepayment Claims Review Notice. If you have not yet received notice or have questions regarding the notice, contact Program Integrity at 803-898-2640.
907	INDIVIDUAL PROVIDER ON PREPAYMENT REVIEW	A1 – Claim/service denied.	N35 – Program Integrity/ utilization review decision.	Provider is on Prepayment Review. All claims must be submitted with documentation attached to substantiate the billed service. See document requirements outlined in the applicable provider policy manual. In some instances the provider may be required to submit paper claims. Refer to the Provider Prepayment Claims Review Notice. If you have not yet received notice or have questions regarding the notice, contact Program Integrity at 803-898-2640.
908	PROVIDER TERMINATED ON DATE OF SERVICE	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Follow the resolution for edit 903
909	INDIVIDUAL PROVIDER TERMINATED ON DOS	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Follow the resolution for edit 903.
911	INDIV PROV NOT MEMBER OF BILLING GROUP	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	**CMS 1500 CLAIM:** Verify whether the provider number entered (field 24J) on the claim is correct. If incorrect, submit a new claim with the corrected information. If the provider number is correct, contact Provider Enrollment at 1-888-289-0709 to have the individual provider number added to the billing group ID number. After the system has been updated, submit a new claim.
912	PROV REQUIRES PA/NO PA NUMBER ON CLAIM	16 – Claim/service lacks information or has submission/billing error(s).	M62 – Missing/incomplete/invalid treatment authorization code.	Prior authorization approval is required. If the authorization number is missing, enter the correct PA number on the new claim. If you do not have a PA number, attach the authorization approval letter to the new claim. For emergency services, attach the appropriate clinical documentation to the new claim for review and consideration for payment.

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914	INDIV PROV REQUIRES PA/NO PA NUM ON CLM	16 – Claim/service lacks information or has submission/billing error(s).	M62 – Missing/incomplete/invalid treatment authorization code.	Prior authorization approval is required. If the authorization number is missing, enter the correct PA number on the new claim. If you do not have a PA number, attach the authorization approval letter to the new claim. For emergency services, attach the appropriate clinical documentation to the new claim for review and consideration for payment.
915	GROUP PROV ID/NO INDIV ID ON CLAIM/LINE	16 – Claim/service lacks information which is needed for adjudication.	N77 – Missing/incomplete/invalid designated provider number.	Verify the rendering individual physician and enter his or her provider ID number in the field(s) below and submit a new claim. **CMS-1500 CLAIM:** Provider ID number (field 24J)
916	CRD PRIM DIAG CODE/PROV NOT CERTIFIED	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	**CMS 1500 CLAIM:** Verify and enter the correct primary diagnosis code (field 21) on the new claim. If correct, attach clinical documentation/certification for review and consideration for payment to the new claim, if applicable.
917	CRD SEC DIAG CODE/PROV NOT CERTIFIED	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Follow the resolution for edit 916 according to the secondary diagnosis code.
918	CRD PROCEDURE CODE/PROV NOT CERTIFIED	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	**CMS 1500 CLAIM:** Verify and enter the correct procedure code (field 24D unshaded) and submit a new claim. If correct, attach clinical documentation/certification for review and consideration for payment to the new claim, if applicable.
919	NO PA# ON CLM/PROV OUT OF 25 MILE RADIUS	40 – Charges do not meet qualifications for emergent/urgent care.		Prior authorization approval is required for services outside of the SC Medicaid service area. If the authorization number is missing, enter the correct PA number on the new claim. If you do not have a PA number, attach the authorization approval letter to the new claim. For emergency services, attach the appropriate clinical documentation to the new claim for review and consideration for payment.
920	Transportation Service is covered by Contractual Transportation Broker / not covered fee-for-service	109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/ contractor.	N381 – Consult our contractual agreement for restrictions/ billing/payment information related to these changes.	The transportation service is covered by a Contractual Transportation Broker and not fee-for-service by Medicaid. Contact the recipient's contracted provider for payment.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
921	Ambulance service is payable by Contractual Transportation Broker / not covered fee-for-service	109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/ contractor.	N381 – Consult our contractual agreement for restrictions/ billing/payment information related to these changes.	The ambulance service is covered by a Contractual Ambulance Broker and not fee-for-service by Medicaid. Contact the recipient's contracted provider for payment.
922	URGENT SERVICE/OOS PROVIDER	133 – The disposition of the claim/service is pending further review.		Verify the urgent service/out-of-state provider requirements were followed. Attach the appropriate clinical documentation to the new claim for review and consideration for payment.
923	PROVIDER TYPE / CAT. INCONSIST W/ LEVEL OF CARE	150 – Payer deems the information submitted does not support this level of service.		Verify that the provider information, procedure code and level of care are correct. If there are errors, submit a new claim with the corrected information. Refer to the applicable provider manual for appropriate provider type and level of care.
924	RCF PROV/RECIP PAY CAT NOT 85 OR 86	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Check the recipient's eligibility to verify the payment category for the date of service that was rendered. If there are errors, submit a new claim with corrected DHHS CRCF-01 Form with the monthly billing and other applicable documentation. If the recipient's payment category has been updated to 85 or 86, submit a new claim with the DHHS CRCF-01 Form with the monthly billing.
925	AGES > 21 &< 65 / IMD HOSPITAL NON-COVERED	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Check the claim to make sure the recipient's age is from 21-64. Submit a new claim with the corrected information. If correct, attach appropriate clinical documentation (i.e., admission forms/ psychiatric prior authorizations, etc.), to the new claim for review and consideration for payment.
926	AGE 21-22/MENTAL INST SERV N/C - MAN REV	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Check the claim to make sure the recipient's age is from 21-22. Submit a new claim with the corrected information. If correct, attach appropriate clinical documentation (i.e., admission forms/ psychiatric prior authorizations, etc.), to the new claim for review and consideration for payment.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
927	PROVIDER NOT AUTHORIZED AS HOSPICE PROV	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Provider was not authorized or enrolled as a hospice provider when service was rendered and will not be considered for payment. For provider's enrollment or eligibility status, contact Provider Enrollment at 1-888-289-0709.
928	RECIP UNDER 21/HOSP SERVICE REQUIRES PA	16 – Claim/service lacks information or has submission/billing error(s).	M62 – Missing/incomplete/invalid treatment authorization code.	**UB CLAIM:** No authorization number from the referring state agency is on the claim. Make the appropriate correction and submit a new claim. Attach appropriate clinical documentation to the new claim for review and consideration for payment, if applicable.
929	NON QMB RECIPIENT	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Provider is Medicare only provider attempting to bill for a non-QMB (Medicaid only) recipient. Medicaid does not provide reimbursement to QMB providers for non-QMB recipients.
932	PAY TO PROV NOT GROUP/LINE PROV NOT SAME	16 – Claim/service lacks information which is needed for adjudication.	N77 – Missing/incomplete/invalid designated provider number.	Verify and correct the provider ID and/or NPI to ensure it is the same as the Provider ID and/or NPI on the line(s). Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Provider ID (field 24J) NPI (field 33 A & B)
933	REV CODE 172 OR 175/NO NICU RATE ON FILE	147 – Provider contracted/ negotiated rate expired or not on file.		**UB CLAIM:** Verify the correct revenue code (field 42) was billed. If the revenue code is incorrect, make the appropriate correction to the new claim. If the provider was not contracted when the service was rendered, the negotiated rate expired, or the codes were not on file, the edit is valid and will not be considered for payment.
934	PRIOR AUTHORIZATION NH PROV ID NOT AUTHORIZED	16 – Claim/service lacks information or has submission/billing error(s).	M62 – Missing/incomplete/invalid treatment authorization code.	Enter the correct Nursing Facility Provider number in the Prior Authorization field(s) below. **CMS-1500 CLAIM:** Prior Authorization (field 23)
935	PROVIDER WILL NOT ACCEPT TITLE 18 (MEDICARE) ASSIGNMENT	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Provider cannot bill for services on a beneficiary who is dually eligible. Services can only be billed for beneficiaries who are Medicaid only. Contact Provider Enrollment at 1-888-289-0709 regarding changes to enrollment status.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
936	NON EMERGENCY SERVICE/OOS PROVIDER	40 – Charges do not meet qualifications for emergent/urgent care.		**UB CLAIM:** If diagnosis code (field 67) and surgical procedure codes (field 44 or 74) have been coded correctly, this outpatient service is not covered for out-of-state providers. No payment is due from Medicaid.
938	PROV WILL NOT ACCEPT TITLE 19 (MEDICAID) ASSIGNMENT	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Provider cannot bill for services on a beneficiary who is Medicaid only. Services can only be billed for a beneficiary who is dually eligible. Contact Provider Enrollment at 1-888-289-0709 regarding changes to enrollment status.
939	IND PROV WILL NOT ACCEPT T-19 (MEDICAID) ASSIGNMENT	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Provider cannot bill for services on a beneficiary who is Medicaid only. Services can only be billed for a beneficiary who is dually eligible. Contact Provider Enrollment at 1-888-289-0709 regarding changes to enrollment status.
940	BILLING PROV NOT RECIP IPC PHYSICIAN	170 - Payment is denied when performed/billed by this type of provider.	N95 – This provider type/provider specialty may not bill this service.	Contact that recipient's IPC physician to obtain the authorization for the service. Submit the IPC/OSCAP authorization form or IPC/OSCAP termination form with the monthly billing.
941	NPI ON CLAIM NOT FOUND ON PROVIDER FILE	208 – National Provider Identifier – Not matched.		Check the NPI that was entered on the claim to ensure it is correct. If correct, register the NPI with Provider Enrollment. Medicaid Provider Enrollment Mailing address: PO Box 8809, Columbia, SC 29202-8809 Phone: 1-888-289-0709 Fax: (803) 870-9022
942	INVALID NPI	207 – National Provider Identifier – invalid format.	N257 – Missing/incomplete/ invalid billing provider/supplier primary identifier.	The NPI used on the claim is inconsistent with numbering scheme utilized by NPPES. Submit a new claim with the corrected information.
943	TYPICAL PROVIDER, NO NPI ON CLAIM	206 – National Provider Identifier – missing.		Typical providers must use the NPI and six-character Medicaid Legacy Provider Number or NPI only for each rendering and billing/pay-to provider. When billing with NPI only, the taxonomy code for each rendering and billing/pay-to provider must also be included. Submit a new claim with the corrected information.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
944	TAXONOMY ON CLAIM HAS NOT BEEN REGISTERED WITH PROVIDER ENROLLMENT FOR THE NPI USED ON THE CLAIM	16 – Claim/service lacks information which is needed for adjudication.	N255 – Missing/incomplete/invalid billing provider taxonomy.	Correct the taxonomy on the claim so that it is one that the provider registered with SCDHHS the claim or contact Provider Enrollment to add the taxonomy that is being used on the claim. Once Provider Enrollment has updated the system, submit a new claim. Medicaid Provider Enrollment Mailing address: PO Box 8809, Columbia, SC 29202-8809 Phone: 1-888-289-0709 Fax: (803) 870-9022
945	PROFESSIONAL COMPONENT REQUIRED FOR PROV	A1 – Claim/service denied.	N13 – Payment based on professional/technical component modifier(s).	The services were rendered on an inpatient or outpatient basis. Enter a "26" modifier in field(s) below. Services described in this manual do not require a modifier. **CMS-1500 CLAIM:** Modifier (field 24D unshaded)
946	UNABLE TO CROSSWALK TO LEGACY PROVIDER NUMBER	16 – Claim/service lacks information which is needed for adjudication.	N77 – Missing/incomplete/invalid designated provider number.	The NPI, taxonomy code, and/or zip code + 4 must be entered on the claim and must match the NPI information that the provider registered with SC Medicaid. Submit a new claim with the corrected information. Contact Provider Enrollment at 1-888-289-0709 to verify the NPI information which was registered or to make any updates to the NPI information contained on the provider's file.
947	ATYPICAL PROVIDER AND NPI UTILIZED ON THE CLAIM	16 – Claim/service lacks information which is needed for adjudication.	N77 – Missing/incomplete/invalid designated provider number.	Atypical providers must continue to use their legacy number on the claim. Do not include an NPI if you are an atypical provider. Submit a new claim with the corrected information
948	CONTRACT RATE NOT ON FILE/SERV NC ON DOS	147 – Provider contracted/negotiated rate expired or not on file.		Review your contract to verify if the correct procedure code/rate and date of service were billed. Submit a new claim with the corrected information. If the procedure code/rate needs to be added, attach appropriate documentation to the claim for review and consideration for payment.
949	CONTRACT NOT ON FILE FOR ELECTRONIC CLAIMS	A1 – Claim/service denied.	N51 — Electronic interchange agreement not on file for provider/submitter.	Contact the EDI Support Center at 1-888-289-0709 for further assistance.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
950	RECIPIENT ID NUMBER NOT ON FILE	31 – Patient cannot be identified as our insured.		Check the patient's Medicaid ID number to make sure it was entered correctly. Remember, the patient's Medicaid numbers is 10 digits (no alpha characters). If there is a discrepancy with the patient's Medicaid ID number, contact the Medicaid Eligibility office in the patient's county of residence to correct the number on the patient's file. After the county Medicaid Eligibility office has updated the system, submit a new claim. Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A) **UB CLAIM:** Medicaid ID (field 60)
951	RECIPIENT INELIGIBLE ON DATES OF SERVICE	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Always check the patient's Medicaid eligibility on each date of service. Medicaid eligibility may change. If the patient was eligible, contact your county Medicaid Eligibility office and have them update the patient's Medicaid eligibility on the system. After the county Medicaid Eligibility office has updated, submit a new claim. If the patient was not eligible for Medicaid on the date of service, the patient is responsible for your charges. If the patient was eligible for some but not all of your charges, submit a new claim with the corrected information.
952	RECIPIENT PREPAYMENT REVIEW REQUIRED	16 – Claim/service lacks information or has submission/billing error(s).	M62 – Missing/incomplete/invalid treatment authorization code.	Verify the correct prior authorization number. If the authorization number is incorrect, make the appropriate correction to the new claim. Attach appropriate documentation to the new claim for review and consideration for payment, if applicable.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
953	BUYIN INDICATED - POSSIBLE MEDICARE	22 - This care may be covered by another payer per coordination of benefits.		File with Medicare first. If this has already been done, enter the Medicare carrier code, Medicare number, and Medicare payment in field(s) below and submit a new claim. If no payment was made, on the new claim, enter '1' in the TPL field. **CMS-1500 CLAIM:** Medicare carrier code (field 9D & 11C), Medicare number (field 9A & 11), Medicare payment (fields 9C,11B & 29), and TPL indicator (field 10 D) **UB CLAIM:** (Inpatient/Outpatient): Medicare carrier code (field 50), Medicare number (field 60), and Medicare payment (field 54). If no payment was made, enter 0.00 (field 54) and occurrence code 24 or 25 (fields 31-34 A-B) and the date Medicare denied. **UB CLAIM:** (Inpatient Only): Attach the Medicare EOMB to the claim, if Medicare (Part A) benefits are exhausted or non-existent, prior to admission and patient is still in the same spell of illness, enter the 620 carrier code (field 50), enter the Medicare ancillary payment(s) (field 54 A) and enter the recipient's Medicare ID (field 60 A) the claim with the corrected information. Click here for additional resolutions tips at MedicaideLearning.com.
957	DIALYSIS PROC CODE/PAT NOT CIS ENROLLED	16 – Claim/service lacks information which is needed for adjudication.	N188 – The approved level of care does not match the procedure code submitted.	Attach the ESRD enrollment form (Form 218) for the first date of service to the new claim. Please refer to the applicable policy manual for documentation submission guidelines.
958	IPC DAYS EXCEEDED OR NOT AUTH ON DOS	273 – Coverage/ program guidelines were exceeded.		Integrated Personal Care services/OSCAP are authorized with start and end dates of service. If the start and end dates of service are incorrect, submit a new IPC/OSCAP form with the corrected information on the new claim. If correct, attach a copy of the service provision form and/or any applicable DHHS forms to the new claim for review and consideration for payment. Please refer to the applicable policy manual for documentation submission guidelines
960	EXCEEDS ESRD M'CARE 90 DAY ENROLL PERIOD	16 – Claim/service lacks information which is needed for adjudication.	MA92 – Missing plan information for other insurance.	For review and consideration for payment, attach the denial letter or document from the Social Security Administration (SSA) and Medicare letter denying benefits to the new claim. Please refer to the applicable policy manual for documentation submission guidelines.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
964	FFS CLAIM FOR SLMB/QDWI RECIP NOT CVRD	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Medicaid pays Medicare premiums only for recipients in these Medicaid payment categories. Fee-for-service Medicaid claims are not reimbursed.
965	PCCM RECIP/PROV NOT PCP-PROC REQ REFERAL	243 - Services not authorized by network/ primary care providers.	N95 – This provider type/provider specialty may not bill this service.	Contact the recipient's primary care physician (PCP) and obtain authorization for the procedure. Enter the authorization number provided by the PCP in the field(s) below and submit the new claim. **CMS-1500 CLAIM:** (field 19) **UB CLAIM:** Treatment authorization code (field 63)
966	RECIP NOT ELIG FOR VENT WAIVER SERV	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	**CMS 1500 CLAIM:** The claim was submitted with a Mechanical Ventilator Dependent Waiver (MVDW) specific procedure code, but the patient was not a participant in the MVDW. Verify the procedure code (field 24D unshaded) and Medicaid ID number (field 1A). Make the appropriate corrections on the new claim. If the patient Medicaid ID number is correct, the procedure code is correct and a MVDW form has been obtained, contact the service coordinator listed at the bottom of the waiver form. Once the system has been updated, submit a new claim.
967	RECIP NOT ELIG FOR HD and SPINAL SERVICES	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	The claim was submitted with a Head and Spinal Cord Injured (HASCI) waiver-specific procedure code, but the patient was not a participant in the HASCI waiver. Verify the procedure code (field 24D unshaded) and Medicaid ID number (field 1A). If incorrect, make the appropriate corrections to the new claim. If the patient Medicaid ID number is correct, the procedure code is correct and the HASCI waiver form has been obtained, contact the service coordinator listed at the bottom of the waiver form. Once the system has been updated, submit a new claim.
970	HOSPICE SERV/RECIP NOT ENROLLED FOR DOS	96 – Non-covered charges.	N143 – The patient was not in a hospice program during all or part of the service dates billed.	Service is hospice. Recipient is not enrolled in hospice for the date of service.
974	RECIP IN MCO/MCO COVERS FIRST 90 DAYS	24 – Charges are covered under a capitation agreement/ managed care plan.		If you are a provider with the MCO plan, bill the MCO for the first 90 days.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
975	PACE PARTICIPANT/ALL SERVICES PROVIDED BY PACE	109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/ contractor.	N381 – Consult our contractual agreement for restrictions/billing/payment information related to these charges.	Contact recipient's PACE organization.
976	HOSPICE RECIPIENT/ SERVICE REQUIRES PA	B9 – Patient is enrolled in a Hospice.		Use the SCDHHS Web Tool to determine who the Hospice provider is. Contact the hospice provider to obtain the prior authorization number. Enter the authorization number in the field(s) below and submit a new claim. **CMS 1500 CLAIM:** Prior authorization number/MHN referral Number (field 19) **UB CLAIM:** Prior authorization number (field 63)
977	FREQUENCY FOR AMBULATORY VISITS EXCEEDED	151 – Payment adjusted because the payer deems the information submitted does not support this many/ frequency of services.		Medicaid recipients are allowed 12 ambulatory care visits per year. The ambulatory care visits for this recipient have been exhausted. Verifying the availability of the recipient's ambulatory care visits on the date of service being billed or the day before will reflect the estimated visits remaining at the time of service, but should not be considered a guarantee of payment. Please refer to the Ambulatory Care Visit Guidelines in the applicable provider manual for more information. All timely filing requirements must be met. Provider options: Submit a request to Medicaid for additional ambulatory care visit(s), including appropriate documentation stating the medical reason(s) for the request. Once the authorization is obtained, submit a new claim along with the SCDHHS approval letter, **or** Bill the patient for the non-covered office visit only. Medicaid will reimburse lab work, injections, x-rays, etc., done in addition to the office visit, **or** Change the office visit code to the minimal established office E/M code, 99211, and accept the lower reimbursement. This code does not count toward the ambulatory care visit limit. Exceptions to the 977 edit: Medicaid recipients residing in a nursing home or long-term care facility are exempt from the ACV limit of 12 visits. This applies to claims with a place of service of 31, 32, 33 and 54. A new claim must be submitted within six months of the rejection with a copy of verification of coverage attached indicating ambulatory care visits were available for the date of service being billed. The availability of

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
				ambulatory visits must have been verified on the actual date of service being billed or the day before. If the visit code was a line item rejection and other services paid on the claim, the provider must file a new claim within six months of the rejection with a copy of verification of coverage indicating ambulatory care visits were available for the date of service being billed. The availability of ambulatory visits must have been verified on the actual date of service being billed or the day before. All timely filing requirements must be met.
978	FREQUENCY FOR IP HOSPITAL VISITS EXCEEDED	151 – Payment adjusted because the payer deems the information submitted does not support this many/ frequency of services.		**UB CLAIM:** The frequency for visits has exceeded the allowed amount. If there is an error, make the appropriate correction to the new claim. If correct, for review and consideration for payment of additional visits, attach appropriate clinical documentation to the new claim to substantiate the services being billed.
979	FREQ. FOR CHIROPRACTIC VISITS EXCEEDED	151 – Payment adjusted because the payer deems the information submitted does not support this many/ frequency of services.		The frequency for visits has exceeded the allowed amount. If there is an error, make the appropriate correction to the new claim. **CMS-1500 CLAIM:** Unit(s) (field 24G)
980	H HLTH NURS CARE N/C FOR DUAL ELIG RECIP	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	File your claim with the Medicare intermediary.
984	RECIP LIVING ARR INDICATES MEDICAL FAC	5 – The procedure code/bill type is inconsistent with the place of service.	M77 – Missing/incomplete/invalid place of service.	Verify patient's place of residence on date of service. If there are errors, submit a new claim with the corrected information. If correct, for review and consideration for payment, attach applicable documentation (i.e., insurance EOB) to the new claim which verifies the place of residence.
985	RECIP NOT ELIG FOR CHILDREN'S PCA SERV	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Check to make sure you have billed the correct Medicaid ID number, procedure code and that this client is in the CHPC program. If you have not billed the correct Medicaid ID number or procedure code, or the client is not in the CHPC program, submit a new claim with the corrected information.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
987	RECIP NOT ELIG FOR HIV/AIDS WAIVER SERV	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	The claim was submitted with a HIV/AIDS Waiver-specific procedure code, but the patient was not a participant in the HIV/AIDS Waiver. Check the procedure code and Medicaid ID number. If incorrect, make the appropriate corrections to the new claim. If the patient Medicaid number is correct, the procedure code is correct, and a HIV/AIDS Waiver form has been obtained, contact the service coordinator listed at the bottom of the waiver form. Once the system has been updated, submit a new claim.
988	CRD PROCEDURE/DOS PRIOR TO COVERAGE	26 – Expenses incurred prior to coverage.	N30 – Patient ineligible for this service.	Call PSC representative to see what the recipient's first date of treatment is. If dates of service on the claim are prior to enrollment date, verify enrollment date. If enrollment date is correct, change dates on the new claim If enrollment date is wrong, the recipient's file will need to be updated. Attach a new enrollment form (DHHS Form 218) to the new claim
989	RECIP IN MCO/SERV COVERED BY MCO	24 – Charges are covered under a capitation agreement/ managed care plan.		Recipient is enrolled with a Managed Care Organization (MCO), the MCO is responsible for management of this recipient's medical services. If you are a provider with the MCO, bill the MCO for the medical service. Discard the rejection. SCDHHS Fee for Service (FFS) Medicaid is not responsible for claim payment for this recipient. **UB CLAIM Only:** Attach EOB denial from the MCO, to the **NEW** claim for review and consideration for payment. Click here for additional resolution tips at MedicaideLearning.com.
990	FP RECIP/SERVICE IS NOT FP	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Make sure the Medicaid ID number matches the patient served. Check the diagnosis code(s), procedure code(s), and/or modifier to ensure the correct codes were billed. If incorrect, make the appropriate changes by adding a family planning diagnosis code, procedure code, and/or FP modifier to the new claim. If this service was not directly related to family planning it is non-covered under the Family Planning Waiver and by Medicaid, therefore the patient is responsible for the charges. Click here for additional resolution tips at MedicaideLearning.com.
991	RECIP ISCEDC/COSY-LIMITED SERVS. COVERED	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Limited services are covered for this recipient. This is not a covered service.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
993	RECIP NOT ELIG FOR PACE SERV	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	The recipient was not eligible for PACE when the service was rendered. Verify that the information on the claim is correct. If not correct, submit a new claim with the corrected information. If the recipient's PACE eligibility status has been updated in the system, submit a new claim.
994	RECIP ELIG FOR EMERGENCY SVCS ONLY	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Recipient is eligible for "emergency medical services" only. Transportation services and/or any other non-emergent medical services are non-covered for these recipients and will not be considered for payment.
995	INMATE RECIP ELIG FOR INSTIT. SVCS ONLY	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Recipient eligible for institutional services only. Review the claim to determine if the services were directly related to institutional services. If there are errors, submit a new claim with the corrected information. If the services are not directly related to institutional services, the services are non-covered and will not be considered for payment. **UB CLAIM:** Only inpatient claims will be reimbursed.

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

Effective 01/01/19

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
CO5							
700							
X1T							
C53							
X2C							
X21							
X20							
X2D							
C67							
X25							
C69							
X2E							
X2Q							
A60							
X1Z							
X2N							
C23							
X2I							
X2R							
102							
X0G							
754	1199 SEIU NATIONAL BENEFIT FUND	PO BOX 1007	NEW YORK	NY	101081007	6464739200	
462	1ST MEDICAL NETWORK	PO BOX 724317	ATLANTA	GA	31139	8889806676	CODE ASSIGNED BY SCHA
710	21ST CENTURY HEALTH AND BENEFITS, INC.	PO BOX 5037	CHERRY HILL	NJ	08034	8003234890	
F27	3PADMINISTRATORS	PO BOX 247	ONALASKA	WI	54650	6087793000	DENTAL ONLY
B14	A.C.S. CONSULTING SERVICES, INC.	PO BOX 2000	WINSTON-SALEM	NC	271022000	3367592013	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
B14DN	A.C.S. CONSULTING SERVICES, INC.	PO BOX 2000	WINSTON-SALEM	NC	271022000	3367592013	DENTAL ONLY
650	ABBEVILLE COUNTY						
543	ACHA/CAREINGTON INTERNATIONAL CORP	PO BOX 2568	FRISCO	TX	75034	8002900523	CODE ASSIGNED BY SCHA
266	ACMG ADMINISTRATORS OF SOUTH CAROLINA	2570 TECHNICAL DR.	MIAMISBURG	OH	45342	8002326242	
786	ACS BENEFIT SERVICES, INC.	PO BOX 2000	WINSTON-SALEM	NC	271022000	8008495370	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C49	ACS CONSULTING SERVICES, INC.	PO BOX 2000	WINSTON-SALEM	NC	27102	8008495370	WAS PENN WESTERN
355	ACTIVA HEALTH GROUP	4350 E. CAMELBACK RD. # 200	PHOENIX	AZ	85018	6024689500	
341	ADMINISTRATIVE CONCEPTS, INC.	994 OLD EAGLE SCHOOL RD., STE. 1005	WAYNE	PA	19087	8882939229	
563	ADMINISTRATIVE SERVICE CONSULTANTS	3301 E ROYALTON RD. BLDG. D	BROADVIEW HEIGHTS	OH	44147		
346	ADMINISTRATIVE SERVICES, INC.	2187 NORTHLAKE PARKWAY STE. 106 BLDG #9	TUCKER	GA	30084	7709343953	
829	ADMINISTRATIVE SOLUTIONS	PO BOX 2490	ALPHARETTA	GA	30023	6783390211	
731	ADOVA HEALTH	PO BOX 725549	ATLANTA	GA	31139	8664704959	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C15	ADVANCE PCS	PO BOX 52188	PHOENIX	AZ	850722196	4803914600	SEE CARRIER 471
D11	ADVANCED BENEFIT SOLUTIONS	PO BOX 71490	PHOENIX	AZ	85050	8884191094	CODE NOT REQUESTED BY MEDICAID ASSIGNED BY SCHA MEDICARE SUPPLEMENTAL PLAN
310	ADVANCED DATA SOLUTIONS	PO BOX 723097	ATLANTA	GA	31139	8007425246	
C72	ADVANCED INSURANCE ADMINISTRATION	125 MERRILL DR., STE. 2000	LITTLE ROCK	AR	72211	8882424800	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D33	ADVANTRA FREEDOM	PO BOX 7154	LONDON	KY	407427154	8007135095	MEDICARE ADVANTAGE PLAN
C88	ADVENTIST RISK MANAGEMENT	PO BOX 1928	GRAPEVINE	TX	76099	8006380589	
899	AETNA HEALTH PLANS OF THE CAROLINAS, INC.	3 CENTERVIEW DR.	GREENSBORO	NC	27407	8004591466	HMO PLAN ONLY
A55	AETNA LIFE AND CASUALTY	PO BOX 36890	LOUISVILLE	KY	40232	8004233289	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D16	AETNA MEDICARE OPEN PLAN	PO BOX 14079	LEXINGTON	KY	405124079	8006240756	MEDICARE ADVANTAGE PLAN

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
100RX	AETNA PHARMACY	PO BOX 52444	PHOENIX	AZ	850722444	8002386279	
100	AETNA US HEALTHCARE	PO BOX 14079	LEXINGTON	KY	40512	8003334432	
100DN	AETNA US HEALTHCARE	PO BOX 14094	LEXINGTON	KY	40512	8004517715	
B43	AFFINITY HEALTH PLAN	PO BOX 981726	EL PASO	TX	799981726	8662475678	
776	AFID (ASSO. OF FRANCHISE AND INDEPENDENT DIST.)	1 S. LIMESTONE ST., STE. 301	SPRINGFIELD	OH	45502	8667669016	CODE IN OPEN STATUS BY SCHA
595	AFLAC-AMERICAN FAMILY LIFE ASSO CO	1932 WYNNTON RD.	COLUMBUS	GA	31999	8009923522	
289	AFTRA HEALTH FUND	261 MADISON AVE.	NEW YORK	NY	10016	8005624690	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
E55	AG ADMINISTRATORS	PO BOX 979	VALLEY FORGE	PA	19482	8006348628	
651	AIKEN COUNTY						
455	ALASKA TEAMSTER TRUST	520 E 34TH AVE., STE. 107	ANCHORAGE	AK	995034116	8004784450	CODE ASSIGNED BY SCHA
344	ALIA CLAIMS DEPARTMENT	PO BOX 9060	PHOENIX	AZ	850689060	8008825707	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
299	ALICARE	PO BOX 1447	NEW YORK	NY	10116	2125395115	
200	ALL AMERICAN LIFE INSURANCE CO.	8501 WEST HIGGINS RD.	CHICAGO	IL	60631	7733996645	
199	ALL OTHER CARRIERS						
F54	ALLEGIANCE	PO BOX 3018	MISSOULA	MT	59806	8559992271	ADDED BY SC REVENUE AND FISCAL AFFAIRS
E54	ALLEGIANCE BENEFIT PLAN MANAGEMENT	PO BOX 3018	MISSOULA	MT	598063018	8008771122	
560	ALLEN MEDICAL CLAIMS ADMINISTRATORS	PO BOX 978	FT. VALLEY	GA	310300978	8008255406	
652	ALLENDALE COUNTY						
272	ALLIANCE HEALTH BENEFIT PLAN	PO BOX 6443	ROCKVILLE	MD	20850	8003423289	
521	ALLIANCE PPO, INC.	PO BOX 934	FREDERICK	MD	21705	8002350123	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A33	ALLIANT HEALTH PLANS, INC.	PO BOX 21109	ROANOKE	VA	24108	8002834927	
413	ALLIED BENEFITS SYSTEM	PO BOX 909786-60690	CHICAGO	IL	606909786	8002882078	
135	ALLIED NATIONAL, INC.	PO BOX 419233	KANSAS CITY	MO	641416233	8008257531	CARRIER WAS ALLIED GROUP INSURANCE TRUST
115	ALLSTATE INSURANCE	PO BOX 7068	COLUMBIA	SC	29202	8003668997	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
193	ALLSTATE WORKPLACE DIVISION	PO BOX 853916	RICHARDSON	TX	750853916	8009377039	
581	ALTA RX	PO BOX 30081	SALT LAKE CITY	UT	84130	8009985033	
A02	ALTERNATIVE BENEFITS PLANS, INC.	2920 BRANDYWINE RD., STE. 106	ATLANTA	GA	30341	8002417319	
E44	ALTERNATIVE INSURANCE RESOURCE, INC.	PO BOX 680787	BIRMINGHAM	AL	352660787	8004514318	
B96	ALTERNATIVE RISK MANAGEMENTS (ARM LTD)	814 N.W. HIGHWAY	ARLINGTON HEIGHTS	IL	60004	8003921770	
234	ALWAYSCARE BENEFITS, INC.	PO BOX 80139	BATON ROUGE	LA	70898	8887295433	DENTAL PLAN
161	AMA INSURANCE AGENCY, INC.	PO BOX 804238	CHICAGO	IL	60680	8004585736	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
297	AMALGAMATED LIFE INSURANCE	PO BOX 1451	NEW YORK	NY	101161451	2124735700	
F57	AMBETTER PEACH STATE HEALTH PLAN	PO BOX 5010	FARMINGTON	MD	636405010	8776871180	ADDED BY SC REVENUE AND FISCAL AFFAIRS
C07	AMERIBEN SOLUTIONS	PO BOX 7186	BOISE	ID	83707	8007867930	
309	AMERICAN ADMINISTRATIVE GROUP	PO BOX 5227	LISLE	IL	605325227	6304939252	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
910	AMERICAN ADMINISTRATIVE GROUP	PO BOX 5227	LISLE	IL	605325227	8003545112	WAS GALLAGER & BASSETT SERVICES
469	AMERICAN ASSOCIATION OF RETIRED PERSONS (AARP)	PO BOX 740819	ATLANTA	GA	30374	8005235880	
B61	AMERICAN BEHAVIORAL	3680 GRANDVIEW PARKWAY STE. 100	BIRMINGHAM	AL	35243	8009258327	
968	AMERICAN BENEFIT ADMINISTRATIVE SERVICES	PO BOX 0928	BROOKFIELD	WI	53008	6304161111	
271	AMERICAN BENEFIT PLAN ADMINISTRATOR	2200-B ROSSELLE ST.	JACKSONVILLE	FL	32204	8004685126	
488	AMERICAN BENEFITS MANAGEMENT	8310 PORT JACKSON AVE. NORTHWEST	NORTH CANTON	OH	44720	3309665500	
B44	AMERICAN CHOICE HEALTH PLAN, LLC	PO BOX 922043	HOUSTON	TX	77292	8006334226	
B44DN	AMERICAN CHOICE HEALTH PLAN, LLC	PO BOX 922009	HOUSTON	TX	77292	8005989799	
A93	AMERICAN COLLEGE OF SURGEONS	PO BOX 2522	FORT WORTH	TX	761132522	8004331672	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
778	AMERICAN CONTINENTAL INSURANCE CO	PO BOX 14770	LEXINGTON	KY	40512	8002644000	
D48	AMERICAN CONTINENTAL INSURANCE CO	PO BOX 2368	BRENTWOOD	TN	37024	6153371300	MEDICARE ADVANTAGE PLAN

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
106	AMERICAN FIDELITY ASSURANCE BENEFITS	PO BOX 25160	OKLAHOMA CITY	OK	731250160	8006548489	
150	AMERICAN GENERAL LIFE AND ACCIDENT INS CO	PO BOX 1500	NASHVILLE	TN	372021500	8008882452	
951	AMERICAN GROUP ADMINISTRATORS	101 CONVENTION CENTER DR., STE. 200	LAS VEGAS	NE	89109	8008424742	
A57	AMERICAN GROUP ADMINISTRATORS, INC.	101 CONVENTION CENTER DR., STE. 200	LAS VEGAS	NV	89109	8008424742	CODE ASSIGNED BY SCHA
118	AMERICAN HEALTH & LIFE INSURANCE	300 ST. PAUL PLACE	BALTIMORE	MD	21202	3013323000	
C92	AMERICAN HEALTH CARE	3850 ATHERTON RD.	ROCKLIN	CA	95765	8008728276	
C92DN	AMERICAN HEALTH CARE	3001 DOUGLAS ST.	ROSEVILLE	CA	95661	8008728276	
919	AMERICAN HEALTH GROUP, INC.	PO BOX 1500	MAUMEE	OH	43537	8008728276	
383	AMERICAN HEALTHCARE ALLIANCE	PO BOX 8530	KANSAS CITY	MO	641140530	8772840102	
119	AMERICAN HERITAGE LIFE INSURANCE	1776 AMERICAN HERITAGE LIFE DR.	JACKSONVILLE	FL	32224	8005358086	
840	AMERICAN, INCOME LIFE INSURANCE COMPANY	PO BOX 2608	WACO	TX	76797	8177723050	
B69	AMERICAN INSURANCE ADMINISTRATORS	PO BOX 2348	COLUMBUS	OH	432162348	8009221245	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA.
D38	AMERICAN INSURANCE ADMINISTRATORS	PO BOX 2348	COLUMBUS	OH	43216	8009221245	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
369	AMERICAN INTERNATIONAL GROUP	PO BOX 25050	WILMINGTON	DE	19899	8004687077	
167	AMERICAN INTERNATIONAL GROUP (AIG) ACCIDENT	PO BOX 26050	OVERLAND PARK	KS	66225	8887221668	
A62	AMERICAN MEDICAL AND LIFE INSURANCE (AMLI)	PO BOX 1353	CHICAGO	IL	60690	8882641512	
532	AMERICAN MEDICAL SECURITY	PO BOX 19032	GREEN BAY	WI	543079032	8002325432	
120	AMERICAN NATIONAL INSURANCE COMPANY	PO BOX 1790	GALVESTON	TX	77553	8008996803	
B98	AMERICAN PIONEER LIFE INSURANCE COMPANY	PO BOX 130	PENSACOLA	FL	32591	8005381053	
321	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	PO BOX 188004	CHATTANOOGA	TN	37422	8002222798	
321DN	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	PO BOX 1358	GLEN BURNIE	MD	21060	8002222798	
164	AMERICAN PROGRESSIVE INSURANCE	PO BOX 130	PENSACOLA	FL	325910130	8006268913	
A05	AMERICAN PUBLIC LIFE INSURANCE CO.	PO BOX 925	JACKSON	MS	39205	8002568606	
722	AMERICAN REPUBLIC INSURANCE COMPANY	PO BOX 21670	EAGAN	MN	55121	8002472190	
C70	AMERICAN RETIREMENT LIFE	PO BOX 30010	AUSTIN	TX	757553010	8664591755	REQUESTED BY THE SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
875	AMERICAN SENTINEL	PO BOX 61140	HARRISBURG	PA	171061140	8006927338	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
503	AMERICAN SPECIAL RISK MANAGEMENT	509 SOUTH LENOLA RD., BLDG. TWO	MOORESTOWN	NJ	08057	8003597475	
C82	AMERICAN STANDARD LIFE & ACCIDENT INS. CO.	PO DRAWER 3248, 224 NORTH INDEPENDENT	ENID	OK	73701	4052334000	CODE IN OPEN STATUS BY SCHA
253	AMERICAN STERLING INSURANCE SERVICES	PO BOX 26103	OVERLAND PARK	KS	66225	8772926037	
125	AMERICAN TRAVELERS LIFE INSURANCE COMPANY	3220 TILLMAN DR.	BEN SALEM	PA	19020	2152441600	
275	AMERICAN TRUST ADMINISTRATORS	PO BOX 87	SHAWNEE MISSION	KS	66201	9134514900	
496	AMERICAN VETERINARIAN MEDICINE ASSN.	PO BOX 909720	CHICAGO	IL	606049720	8006216360	
D61	AMERICA'S 1ST CHOICE	PO BOX 210769	COLUMBIA	SC	29210	8663213947	MEDICARE ADVANTAGE PLAN
D23	AMERICA'S HEALTH CHOICE MEDICAL PLANS,(HMO)	762 SOUTH US HWY. ONE PMB 224	VERO BEACH	FL	32962	8003089823	MEDICARE ADVANTAGE PLAN
557	AMERICORP INS. CO	PO BOX 3430	CARMEL	IN	46082	8666994186	
D51	AMERIGROUP COMMUNITY CARE	PO BOX 61010	VIRGINIA BEACH	VA	234661010	8006004441	MEDICAID HMO
D94	AMERIGROUP COMMUNITY CARE	PO BOX 61010	VIRGINIA BEACH	VA	234661010	8006004441	MEDICAID HMO
D60	AMERIGROUP COMMUNITY CARE OF SC	PO BOX 31789	VIRGINIA BEACH	VA	234661789	8006004441	CODE ASSIGNED BY SCHA
284	AMERIHEALTH ADMINISTRATORS	720 BLAIR RD.	HORSHAM	PA	19044	8003454017	
110	AMERIHEALTH HMO, INC.	PO BOX 41574	PHILADELPHIA	PA	191011574	8886323862	CODE ASSIGNED BY SCHA
894	AMERIHEALTH MERCY HEALTH PLAN	PO BOX 7118	LONDON	KY	40742	8889917200	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A10	AMERISCRIPT	4301 DARROW RD., STE. 4200	STOW	OH	44224	8006816912	
210	AMERITAS LIFE INSURANCE	PO BOX 82520	LINCOLN	NE	68501	8002559678	
B08	AMFIRST INSURANCE CO	PO BOX 16708	JACKSON	MS	39236	8888882519	
653	ANDERSON COUNTY						
330	ANNUITY BOARD OF SOUTHERN BAPTIST CONVENTION	PO BOX 2190	NASHVILLE	TN	37234	2147200511	
X0Y	ANTHEM BLUE CROSS AND BLUE SHIELD	PO BOX 105187	ATLANTA	GA	30348	8005529159	
X0YDN	ANTHEM BLUE CROSS AND BLUE SHIELD	PO BOX 659444	SAN ANTONIO	TX	78265	8006224822	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
X0YRX	ANTHEM BLUE CROSS AND BLUE SHIELD	PO BOX 37010	LOUISVILLE	KY	40233	8006224822	
529	ANTHEM HEALTH	3575 KROGER BLVD., STE. 400	DULUTH	GA	30316	8008881966	
579	ANTHEM PRESCRIPTION MANAGEMENT	PO BOX 145433	CINCINNATI	OH	45250	8006620210	USE CARRIER A24
D65	ANTHEM SENIOR ADVANTAGE	PO BOX 37690	LOUISVILLE	KY	402337180	8882909160	MEDICARE ADVANTAGE PLAN
171	AON	PO BOX 66	WINSTON-SALEM	NC	27102	8003683804	
523	APA PARTNERS, INC.	PO BOX 1506	LATHAM	NY	121108006	8008333650	
705	APS HEALTHCARE, INC.	PO BOX 1307	ROCKVILLE	MD	20849	8002218699	
D13	ARCADIAN	PO BOX 4946	COVINA	CA	91723	8007756490	CODE ORIGINALLY ASSIGNED AS MA IN ERROR USE CODE 816 FOR MA PLAN
816	ARCADIAN MEMBER CARE	PO BOX 4946	COVINA	CA	91723	8005738597	MEDICARE ADVANTAGE PLAN
981	ARGUS HEALTH SYSTEMS	PO BOX 419019	KANSAS CITY	MO	64141	8005227487	
A49	ARIZONA FOUNDATION FOR MEDICAL CARE	PO BOX 2909	PHOENIX	AZ	850622909	6022318855	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
X1I	ARKANSAS BLUE CROSS AND BLUE SHIELD, INC.	PO BOX 2181	LITTLE ROCK	AR	72203	5013782010	
B78	ARM GROUP (OMNICARE)	340 QUADRANGLE DR.	BOLINGBROOK	IL	60440	8009687222	
972	ASR CORP (ADMINISTRATION SYSTEM RESEARCH)	PO BOX 6392	GRAND RAPIDS	MI	49516	8009682449	
505	ASSOCIATED ADMINISTRATORS	PO BOX 27806	BALTIMORE	MD	212857806	8006382972	
898	ASSOCIATION & SOCIETY INS. CORP	PO BOX 2510	ROCKVILLE	MD	20847	8006382610	
934	ASSOCIATION & SOCIETY INS. CORP	PO BOX 2510	ROCKVILLE	MD	20847	8006382610	
458	ASSOCIATION BENEFIT PLAN (MEDICARE)	PO BOX 668587	CHARLOTTE	NC	282668587	8006340069	CODE ASSIGNED BY SCHA
386	ASSURANT HEALTH	PO BOX 624	MILWAUKEE	WI	532010624	MILWAUKEE	WAS FORTIS INSURANCE COMPANY
386DN	ASSURANT HEALTH	PO BOX 2940	CLINTON	IA	527332940	8004427742	DHHS INTERNAL RECOVERY CLAIMS BILLING MUST BE FAX TO: 414-224-0472
448	ASSURANT HEALTH INSURANCE	PO BOX 42033	HAZELWOOD	MD	63042	8005537654	CODE ASSIGNED BY SCHA
451	ASSURECARE RISK MANAGEMENT	340 QUADRANGLE BLVD.	BOLINGBROOK	IL	60440	8007597422	
105	ATHENE ANNUITY AND LIFE ASSURANCE COMPANY	PO BOX 19038	GREENVILLE	SC	29602	8646091000	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
971	ATLANTA ADMINISTRATIONS	135 BEAVER ST.	WALTHAM	MA	02452	8005481256	
B34	ATLANTA LIFE INSURANCE COMPANY	100 AUBURN AVE., NE	ATLANTA	GA	30303	4046592100	
122	ATLANTIC COAST LIFE INSURANCE COMPANY	PO BOX 20010	CHARLESTON	SC	294130010	8437638680	
B45	ATLANTICARE	PO BOX 613	HAMMONTON	NJ	08037	8883282287	
526	AULTCARE	PO BOX 6910	CANTON	OH	44706	8003448858	
588	AUTOMATED BENEFIT SERVICES, INC.	PO BOX 321223	DETROIT	MI	482321223	8002751896	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B82	AVANTE HEALTH	1111 E. HERNDON AVE., STE. 308	FRESNO	CA	93720	8664163617	
C40	AVERA HEALTH PLANS	PO BOX 381506	BIRMINGHAM	AL	35238	8883222115	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
494	AVESIS PHARMACY NETWORK	3724 N 3RD ST., STE. 300	PHOENIX	AZ	85012	6022413400	
B58	AVMED HEALTH	PO BOX 569000	MIAMI	FL	332569000	8004528633	
A72	BABB, INC.	850 RIDGE AVE.	PITTSBURGH	PA	15212	8002456102	
358	BAKERY & CONFECTIONERY UNION	10401 CONNECTICUT AVE., STE. 300	KENSINGTON	MD	208953960	3014683742	
654	BAMBERG COUNTY						
987	BANKERS FIDELITY LIFE INS CO	PO BOX 105652	ATLANTA	GA	30348	4042665500	
815	BANKERS FIDELITY LIFE INSURANCE COMPANY	PO BOX 260040	PLANO	TX	75026	8664587499	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
123	BANKERS LIFE & CASUALTY	PO BOX 66927	CHICAGO	IL	606660927	8006213724	
655	BARNWELL COUNTY						
644	BCBS OF GEORGIA	PO BOX 9907	COLUMBUS	GA	31908	8004412273	MEDICARE INTERMEDIARY
X0BDN	BCBS OF GEORGIA DENTAL	PO BOX 659444	SAN ANTONIO	TX	78265	4048428000	
X0MDN	BCBS OF MASSACHUSETTS	PO BOX 986005	BOSTON	MA	02298	8002535210	DENTAL ONLY
867	BCBS OF NC	PO BOX 30087	DURHAM	NC	27702	9194897431	
C62	BCBS OF SC MEDICARE BLUE PRIVATE (PFFS)	PO BOX 100133	COLUMBIA	SC	29202	8006053256	MEDICARE ADVANTAGE PLAN
C63	BCBS OF SC MEDICARE BLUE&MEDICARE BLUE PLUS (PPO)	PO BOX 100133	COLUMBIA	SC	29202	8006053256	MEDICARE ADVANTAGE PLAN
643	BCBS OF TENNESSEE	730 CHESTNUT ST.	CHATTANOOGA	TN	37402	8772966189	MEDICARE INTERMEDIARY

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
656	BEAUFORT COUNTY						
881	BEHAVIORAL HEALTH SYSTEMS	PO BOX 830724	BIRMINGHAM	AL	352830724	8002451150	
C08	BENECARD	PO BOX 2187	CLIFTON	NJ	07015	8007379528	
750	BENEFIT ADMINISTRATIVE SERVICES	PO BOX 4509	ROCKFORD	IL	61110	8159699663	
C79	BENEFIT ADMINISTRATIVE SYSTEM, LTD	PO BOX 17475 JOVANNA DR., STE. 1B	HOMEWOOD	IL	60430	7087997400	
E87	BENEFIT ADMINISTRATIVE SYSTEMS	PO BOX 2920	MILWAUKEE	WI	53201	8005250582	
B37	BENEFIT ADMINISTRATORS	PO BOX 21308	COLUMBIA	SC	29221	8778400936	
B37DN	BENEFIT ADMINISTRATORS	PO BOX 1957	BEATTYVILLE	KY	41311	8003258424	
300	BENEFIT ADMINISTRATORS, INC.	PO BOX 6279	ERIE	PA	16512	8007772524	
300DN	BENEFIT ADMINISTRATORS, INC.	PO BOX 6279	ERIE	PA	16512	8007772524	
475	BENEFIT ASSISTANCE CORP.	PO BOX 950	HURRICANE	WV	25526	3045621913	
319	BENEFIT CONCEPTS	PO BOX 60608	KING OF PRUSSIA	PA	19406	8002202600	
F29DN	BENEFIT COORDINATORS	PO BOX 210546	COLUMBIA	SC	29221	8037220110	DENTAL
F29	BENEFIT COORDINATORS	PO BOX 210546	COLUMBIA	SC	29221	8037220110	
A86	BENEFIT MANAGEMENT CO	PO BOX 269000	WESTON	FL	333269000	8002629175	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C12	BENEFIT MANAGEMENT, INC.	PO BOX 1090	GREAT BEND	KS	66210	8002901368	
301	BENEFIT PLAN ADMINISTRATORS	PO BOX 21392	EAGEN	MN	55121	8002778973	
C28	BENEFIT PLAN MANAGEMENT	PO BOX 536	ROCKLYN	MA	02370	8776427500	
311	BENEFIT PLANNERS, INC.	PO BOX 682010	SAN ANTONIO	TX	78269	2106991872	
980	BENEFIT SUPPORT, INC.	PO BOX 2977	GAINESVILLE	GA	30503	8007774782	
772	BENEFIT SYSTEMS, INC.	PO BOX 6001	INDIANAPOLIS	IN	462066001	8008243216	
127	BENEFITSOURCE, INC.	PO BOX 240	MONROE	MI	48161	8004231028	CODE ASSIGNED BY SCHA
A25	BENESCRIPT	8300 E. MAPLEWOOD AVE.	GREENWOOD VILLAGE	CO	80111	8003453189	
985	BENESIGHT	PO BOX 340	PUEBLO	CO	81002	8003621116	
A81	BENESYS	PO BOX 90082	LUBBOCK	TX	79402	3372341789	
256	BENICOMP	8310 CLINTON PARK DR.	FT. WAYNE	IN	46825	8008377400	CODE ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
380	BENMARK, INC.	PO BOX 16767	JACKSON	MS	39236	6013660596	
481	BENOVATION	3481 CENTRAL PARKWAY, STE. 200	CINCINNATI	OH	45223	8006816912	CODE ASSIGNED BY SCHA
657	BERKELEY COUNTY						
904	BEST CHOICE HEALTH PLAN	PO BOX 21128	FORT LAUDERDALE	FL	33335	8008674446	
E29	BEST LIFE AND HEALTH INSURANCE CO.	PO BOX 890	MERIDIAN	ID	836800890	8004330088	
D08	BIG LOTS ASSOCIATE BENEFIT PLAN	PO BOX 9071	DUBLIN	OH	430170971	8772542363	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
X2X	BLUE CROSS BLUE SHIELD OF HAWAII	PO BOX 44500	HONOLULU	HI	96801	8007764672	
902	BLUE CARE NETWORK OF MI	PO BOX 68710	GRAND RAPID	MI	49516	8006588878	CODE ASSIGNED BY SCHA. THIS IS THE HMO TO CC 504 WHICH IS THE POS
C64	BLUE CHOICE HEALTH PLAN (PPO)	PO BOX 6170	COLUMBIA	SC	29260	8772753256	MEDICARE ADVANTAGE (PPO)
922	BLUE CHOICE HEALTHPLAN	PO BOX 6170	COLUMBIA	SC	292606170	8037868466	WAS COMPANION HEALTHCARE NAME CHANGE EFFECTIVE 7/1/05
403	BLUE CHOICE/MEDICAID	PO BOX 6170	COLUMBIA	SC	29260	8772753256	MEDICAID HMO
X2G	BLUE CROSS & BLUE SHIELD CENTRAL NEW YORK, INC.	PO BOX 4809	SYRACUSE	NY	132214809	3154483801	
X2W	BLUE CROSS & BLUE SHIELD OF ARIZONA, INC.	PO BOX 13466	PHOENIX	AZ	850023466	6028644100	
X1V	BLUE CROSS & BLUE SHIELD OF COLORADO	700 BROADWAY	DENVER	CO	80273	3038312131	
X1H	BLUE CROSS & BLUE SHIELD OF CONNECTICUT, INC.	PO BOX 533	NORTH HAVEN	CT	06473	2032394961	
X0L	BLUE CROSS & BLUE SHIELD OF DELAWARE, INC.	PO BOX 1991	WILMINGTON	DE	19899	3024210260	
X0B	BLUE CROSS & BLUE SHIELD OF GEORGIA/ATLANTA, INC.	PO BOX 9907	COLUMBUS	GA	319086007	4048428000	FOR GEORGIA STATE EMPLOYEES USE CARRIER 419 GEORGIA STATE HEALTH BENEFIT PLAN
X1M	BLUE CROSS & BLUE SHIELD OF KANSAS	1133 SOUTHWEST TOPEKA BLVD.	TOPEKA	KS	66629	7852914180	
X2B	BLUE CROSS & BLUE SHIELD OF KANSAS CITY	PO BOX 419169	KANSAS CITY	MO	641416169	8008926048	
X0U	BLUE CROSS & BLUE SHIELD OF KENTUCKY, INC.	9901 LINN STATION RD.	LOUISVILLE	KY	40223	5024232011	
X1L	BLUE CROSS & BLUE SHIELD OF LOUISIANA	PO BOX 98029	BATON ROUGE	LA	708989029	5042915370	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
X1Q	BLUE CROSS & BLUE SHIELD OF MAINE	2 GANNETT DR.	SOUTH PORTLAND	ME	041066911	2077751550	
X01	BLUE CROSS & BLUE SHIELD OF MARYLAND, INC.	PO BOX 14115	LEXINGTON	KY	40512	8005244555	
X0I	BLUE CROSS & BLUE SHIELD OF MARYLAND, INC.	PO BOX 9836	BALTIMORE	MD	21204	8005244555	USE CARRIER X01
X1K	BLUE CROSS & BLUE SHIELD OF MEMPHIS	85 NORTH DANNY THOMAS BLVD.	MEMPHIS	TN	38103	9015293111	
X0Q	BLUE CROSS & BLUE SHIELD OF MICHIGAN	PO BOX 312500	DETROIT	MI	48231	8004820898	
X0QDN	BLUE CROSS & BLUE SHIELD OF MICHIGAN	PO BOX 49	DETROIT	MI	48231	8888268152	
X1P	BLUE CROSS & BLUE SHIELD OF MINNESOTA	PO BOX 64338	ST. PAUL	MN	55164	8003822000	
X0Z	BLUE CROSS & BLUE SHIELD OF MISSISSIPPI, INC.	PO BOX 1043	JACKSON	MS	39215	6016644590	
X2U	BLUE CROSS & BLUE SHIELD OF MISSOURI	1831 CHESTNUT ST.	ST. LOUIS	MO	63103	3149234444	AKA ALLIANCE BLUE CROSS BLUE SHIELD
X1U	BLUE CROSS & BLUE SHIELD OF NEBRASKA	PO BOX 3248, MAIN PO STATION	OMAHA	NE	681800001	4023901820	
X0S	BLUE CROSS & BLUE SHIELD OF NEW JERSEY, INC.	PO BOX 1219	NEWARK	NJ	07101	8006241110	AKA HORIZON BCBS OF NEW JERSEY
X0SDN	BLUE CROSS & BLUE SHIELD OF NEW JERSEY, INC.	PO BOX 1311	MINNEAPOLIS	MN	55440	8003552583	AKA HORIZON BCBS OF NEW JERSEY
X0C	BLUE CROSS & BLUE SHIELD OF NORTH CAROLINA	PO BOX 35	DURHAM	NC	27702	8002144844	
X0CDN	BLUE CROSS & BLUE SHIELD OF NORTH CAROLINA	PO BOX 2100	WINSTON-SALEM	NC	271022100	9194897431	
X2J	BLUE CROSS & BLUE SHIELD OF NORTH DAKOTA	4510 13TH AVE. SW	FARGO	ND	581210001	8003682312	
X2T	BLUE CROSS & BLUE SHIELD OF OKLAHOMA	PO BOX 3283	TULSA	OK	74102	9185603535	
X1F	BLUE CROSS & BLUE SHIELD OF RHODE ISLAND	500 EXCHANGE ST.	PROVIDENCE	RI	02903	4018317300	
X0P	BLUE CROSS & BLUE SHIELD OF TENNESSEE	1 CAMERON HILL CIRCLE	CHATTANOOGA	TN	374020002	8004689736	
X0PDN	BLUE CROSS & BLUE SHIELD OF TENNESSEE	1 CAMERON HILL CIRCLE STE. 0002	CHATTANOOGA	TN	374020002	8005659140	
X1W	BLUE CROSS & BLUE SHIELD OF UTAH	PO BOX 30270	SALT LAKE CITY	UT	841300270	8013332100	
X2H	BLUE CROSS & BLUE SHIELD OF UTICA-WATERTOWN, INC.	12 RHOADS DR., UTICA BUSINESS DISTRICT	UTICA	NY	13501	3157984238	
X2S	BLUE CROSS & BLUE SHIELD OF VERMONT	PO BOX 2365	SOUTH BURLINGTON	VT	54072365	8022472583	
X0F	BLUE CROSS & BLUE SHIELD OF VIRGINIA	PO BOX 27401	RICHMOND	VA	23279	8009916061	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
X2O	BLUE CROSS & BLUE SHIELD OF WEST VIRGINIA, INC.	PO BOX 1353	CHARLESTON	WV	25325	3043477709	
X1J	BLUE CROSS & BLUE SHIELD OF WESTERN NEW YORK, INC.	PO BOX 80	BUFFALO	NY	142400080	8008880757	
X0H	BLUE CROSS & BLUE SHIELD UNITED OF WISCONSIN	PO BOX 2025	MILWAUKEE	WI	53201	4142246100	
X1D	BLUE CROSS /BLUE SHIELD OF NATIONAL CAPITAL AREA	550 12TH ST. SW	WASHINGTON	DC	20024	2024798000	
X0O	BLUE CROSS AND BLUE SHIELD OF ALABAMA	PO BOX 2294	BIRMINGHAM	AL	35201	8005176425	DO NOT USE FOR MEDICARE. THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE.
X0ODN	BLUE CROSS AND BLUE SHIELD OF ALABAMA	PO BOX 830389	BIRMINGHAM	AL	352830389	8005176425	
X0D	BLUE CROSS AND BLUE SHIELD OF FLORIDA	PO BOX 1798	JACKSONVILLE	FL	322310014	8007272227	
401	BLUE CROSS AND BLUE SHIELD OF SC	PO BOX 100300	COLUMBIA	SC	29202	8037883860	DO NOT USE FOR MEDICARE. THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE. STREET ADDRESS 4101 CERVICAL RD. COLA 29219
401DN	BLUE CROSS AND BLUE SHIELD OF SC	4101 PERCIVAL RD.	COLUMBIA	SC	29219	8037883860	THIS CODE USED ONLY FOR DENTAL CLAIMS WHERE BCBS IS THE INSURANCE CARRIER
X0N	BLUE CROSS AND BLUE SHIELD OF TEXAS	PO BOX 660044	DALLAS	TX	752660044	8004510287	
X0NDN	BLUE CROSS AND BLUE SHIELD OF TEXAS	PO BOX 660247	DALLAS	TX	75266	8004947218	
X2FDN	BLUE CROSS AND BLUE SHIELD OF THE ROCHESTER AREA	PO BOX 22999	ROCHESTER	NY	14692	7163253630	DENTAL
453	BLUE CROSS ANTHEM MEDICARE ADVANTAGE	2100 CORPORATE CENTER	NEWBURY PARK	CA	913201431	8006762583	MEDICARE ADVANTAGE PLAN
X2Y	BLUE CROSS BLUE SHIELD OF MONTANA	PO BOX 5004	GREAT FALLS	MT	59403	4067914000	
X1A	BLUE CROSS BLUE SHIELD OF NEW MEXICO	PO BOX 27630	ALBUQUERQUE	NM	87125	8007113795	
X1FDN	BLUE CROSS BLUE SHIELD OF RHODE ISLAND	PO BOX 69427	HARRISBURG	PA	171069427	8008312400	DENTAL ONLY
F49	BLUE CROSS BLUE SHIELD OF WYOMING	PO BOX 2266	CHEYENNE	WY	82003	8004422376	
F49DN	BLUE CROSS BLUE SHIELD OF WYOMING	PO BOX 2266	CHEYENNE	WY	82003	8004422376	DENTAL ONLY
X0W	BLUE CROSS OF CALIFORNIA	PO BOX 60007	LOS ANGELES	CA	90060	8006776669	
D67	BLUE CROSS OF FLORIDA HEALTH OPTIONS	PO BOX 1798	JACKSONVILLE	FL	32231	8773522583	MEDICARE ADVANTAGE PLAN

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
X0A	BLUE CROSS OF GEORGIA/COLUMBUS, INC.	PO BOX 9907	COLUMBUS	GA	319089907	8004412273	POLICIES SHOULD BE ADDED WITH XOB. BCBS OF OF GA.
X0ARX	BLUE CROSS OF GEORGIA/COLUMBUS, INC.	PO BOX 9907	COLUMBUS	GA	319089907	8004412273	DO NOT USE FOR MEDICARE. THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE.
X2V	BLUE CROSS OF IDAHO HEALTH SERVICE, INC.	PO BOX 7408	BOISE	ID	83707	2083447411	
X2VDN	BLUE CROSS OF IDAHO HEALTH SERVICE	PO BOX 7408	BOISE	ID	83707	2083447411	DENTAL ONLY
X0T	BLUE CROSS OF ILLINOIS	PO BOX 805107	CHICAGO	IL	60680	8006348644	
X0TDN	BLUE CROSS OF ILLINOIS	PO BOX 23059	BELLEVILLE	IL	62223	8668260914	
X0M	BLUE CROSS OF MASSACHUSETTS, INC.	PO BOX 986020	BOSTON	MA	022986020	8002535210	
XOV	BLUE CROSS OF NORTHEASTERN NEW YORK, INC.	PO BOX 15013	ALBANY	NY	12212	5184385500	
X2L	BLUE CROSS OF NORTHEASTERN PENNSYLVANIA	PO BOX 890179	CAMP HILL	PA	170890179	8008298599	
X1X	BLUE CROSS OF OHIO	PO BOX 956	TOLEDO	OH	43696	8003621279	
X1E	BLUE CROSS OF PUERTO RICO	PO BOX 366068	SAN JUAN	PR	009366068	8097599898	
X2M	BLUE CROSS OF WASHINGTON AND ALASKA	PO BOX 91059	SEATTLE	WA	981119159	8007221471	
X1YDN	BLUE SHIELD OF CALIFORNIA	PO BOX 272590	CHICO	CA	959272590	8887024171	
X1Y	BLUE SHIELD OF CALIFORNIA	PO BOX 272540	CHICO	CA	95927	8882351765	
X0V	BLUE SHIELD OF NORTHEASTERN NEW YORK	PO BOX 15013	ALBANY	NY	12212	5184534600	
D41	BLUEGRASS FAMILY HEALTH	PO BOX 22738	LEXINGTON	KY	40522	8007872680	
390	BOARD OF PENSIONS EVANGELICAL LUTHERAN CHURCH	PO BOX 59093	MINNEAPOLIS	MN	554590093	6123337651	
337	BOARD OF PENSIONS OF THE PRESBYTERIAN CHURCH OF	PO BOX 13896	PHILADELPHIA	PA	19101	8007737752	
404	BOB JONES UNIVERSITY	1700 WADE HAMPTON BLVD.	GREENVILLE	SC	29614	8643701800	
190	BOILERMAKERS NATIONAL HEALTH & WELFARE FUND	754 MINNESOTA AVE., STE. 522	KANSAS CITY	KS	661012762	9133426555	
739	BOLLINGER, INC.	PO BOX 727	SHORT HILLS	NJ	07078	8662670092	
702	BOON CHAPMAN BENEFIT ADMINISTRATORS	PO BOX 9201	AUSTIN	TX	787669201	8002529653	CODE ASSIGNED BY SCHA
702DN	BOON CHAPMAN BENEFIT ADMINISTRATORS	PO BOX 9201	AUSTIN	TX	787669201	8002529653	DENTAL ONLY

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
F53	BOON GROUP	PO BOX 559017	AUSTIN	TX	78755	8664750056	ADDED BY SC REVENUE AND FISCAL AFFAIRS
C22	BOSTON MUTUAL LIFE INSURANCE COMPANY	120 ROYALL ST.	CANTON	MA	02021	6178287000	
854	BOYD CARE (BOYD BROTHERS TRANSPORTATION)	PO BOX 70	CLAYTON	AL	36016	3347751284	
D58	BRAVO HEALTH MEDICARE ADVANTAGE	PO BOX 4433	BALTIMORE	MD	21223	8005561570	MEDICARE ADVANTAGE PLAN
294	BRIDGESTONE/FIRESTONE COMPANIES	PO BOX 26605	AKRON	OH	44319	8002378447	
E89	BROADREACH MEDICAL RESOURCES	1350 BROADWAY #410	NEW YORK	NY	10018	8887182375	
852	BUILDERS MUTUAL INSURANCE CO	PO BOX 150006	RALEIGH	NC	276240006	8008094861	
E30	BUSINESS ADMINISTRATORS AND CONSULTANTS, INC.	PO BOX 107	REYNOLDSBURG	OH	43068	8005212654	
304	BUTLER BENEFIT SERVICE, INC.	PO BOX 3310	DAVENPORT	IA	528083310	8669272200	
262	CAIC (CONTINENTAL AMERICAN INS. CO)	PO BOX 6080226	MISSION VIEJO	CA	926906080	8887302244	
658	CALHOUN COUNTY						
973	CAMBRIDGE INTEGRATED SERVICES GROUP, INC.	PO BOX 1687	GRAND RAPIDS	MI	49501	8007669780	USE CARRIER 171 AON
832	CAMERON AND ASSOCIATES	6100 LAKE FOREST DR.	ATLANTA	GA	30328	8003879919	
998	CANADA LIFE ASSURANCE CO.	6201 POWERS FERRY RD., STE. 100	ATLANTA	GA	30348	8003332542	
X2K	CAPITAL BLUE CROSS	PO BOX 211457	EAGAN	MN	551213057	8009622242	
274	CAPITAL DISTRICT PHYSICIANS PLAN	PO BOX 66602	ALBANY	NY	122066602	8009267526	
966	CAPITOL ADMINISTRATORS OF THE SOUTHEAST	PO BOX 188061	CHATTANOOGA	TN	37422	8886506566	
166	CAPITOL AMERICAN LIFE INSURANCE COMPANY	PO BOX 94953	CLEVELAND	OH	441014953	2166966400	
128	CAPITOL LIFE INSURANCE COMPANY	PO BOX 1200	DENVER	CO	80201	8005252115	PER HOSP. ASSO. 07/02, THIS IS STILL A VALID CARRIER
F18	CARE CONNECT	PO BOX 830259	BIRMINGHAM	AL	352830259	8557067545	
D42	CARE IMPROVEMENT PLUS	PO BOX 4347	SCRANTON	PA	18505	8666862506	MEDICARE ADVANTAGE PLAN
764	CARE LINK HEALTH PLAN	PO BOX 7373	LONDON	KY	407427373	8003482922	
B92	CARE SOURCE	ONE SOUTH MAIN	DAYTON	OH	45402	8004880134	
F56	CAREFIRST BLUECHOICE MARYLAND	PO BOX 14116	LEXINGTON	KY	40512	8008425975	ADDED BY SC REVENUE AND FISCAL AFFAIRS
151	CARELINK	PO BOX 7373	LONDON	KY	40742	8003482922	MEDICAID HMO

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
471	CAREMARK	PO BOX 52195	PHOENIX	AZ	850722195	8003030187	
280	CAREMARK PRESCRIPTION SERVICES	PO BOX 52188	PHOENIX	AZ	850722196	8008415550	USE CARRIER 471
903	CAREPLUS HEALTH PLAN	PO BOX 31286	TAMPA	FL	336313286	8008674445	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B04	CARITEN HEALTHCARE	PO BOX 22987	KNOXVILLE	TN	37933	8002840042	CODE IN OPEN STATUS BY SCHA
D21	CARITEN SENIOR HEALTH	PO BOX 22885	KNOXVILLE	TN	37933	8656707790	MEDICARE ADVANTAGE PLAN
945	CAROLINA ATLANTIC MEDICAL SERVICES ORGANIZATION	PO BOX 22528	CHARLESTON	SC	29413	8008100906	DORMANT 8/06
A71	CAROLINA BEHAVIORAL HEALTH ALLIANCE	PO BOX 571137	WINSTON-SALEM	NC	271571137	8004757900	
498	CAROLINA BENEFIT ADMINISTRATORS	PO BOX 3257	SPARTANBURG	SC	29304	8645736937	
445	CAROLINA CARE PLAN/MEDICAL MUTUAL INS. CO. OF OHIO	PO BOX 6018	CLEVELAND	OH	441011018	8003153143	ALSO KNOWN AS SUPERMED ANOTHER PHONE # 800-232-3143
445DN	CAROLINA CARE PLAN/MEDICAL MUTUAL INS. CO.	PO BOX 6018	CLEVELAND	OH	441011018	800315314	DENTAL ONLY
723	CAROLINA CONTINENTAL INSURANCE	PO BOX 427	COLUMBIA	SC	29202	8032566265	
E12	CAROLINA CRESCENT	1201 MAIN ST., STE. 970	COLUMBIA	SC	29201	8032516630	HEALTHY KIDS CONNECTION
559	CAROLINA HOSPITAL SYSTEMS BENEFIT PLAN	PO BOX 100569	FLORENCE	SC	295010659	8436613875	
623	CAROLINA MEDICARE PRIME HMO	201 EXECUTIVE CENTER DR.	COLUMBIA	SC	29210	8037507473	MEDICARE ADVANTAGE PLAN
C77	CARPENTERS HOSPITALIZATION PLAN	3611 CHESTER AVE.	CLEVELAND	OH	44114	8004213959	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
336	CASEBP (CATSKILL AREA SCHOOLS EMPLOYEE PLAN)	PO BOX 968022	SCHAUMBERG	IL	60196	8009626294	
B59	CASTIARX	701 EMERSON RD., STE. 301	CREVE COEUR	MO	63141	8665163121	
CAS	CASUALTY CASE						
366	CATALYST RX	PO BOX 968022	SCHAUMBERG	IL	601968022	8009973784	
572	CATAMARAN	PO BOX 29044	HOT SPRINGS	AR	71093	8778398119	FORMERLY HEALTH TRANS
C66	CATERPILLAR, INC.	PO BOX 62920	COLORADO SPRINGS	CO	809622920	3094942363	
C04	CBA BLUE	PO BOX 9350	SOUTH BURLINGTON	VT	05407	8882229206	DENTAL ONLY

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
B11	CBCA ADMINISTRATORS, INC.	PO BOX 1339	MINNEAPOLIS	MN	55440	8008243882	
339	CELTIC INDIVIDUAL HEALTH	PO BOX 33839	INDIANAPOLIS	IN	462030839	8004777870	
907	CELTIC LIFE INSURANCE CO.	PO BOX 46337	MADISON	WI	53744	8007662525	
X0X	CENTRAL BENEFITS MUTUAL INSURANCE COMPANY	PO BOX 16526	COLUMBUS	OH	43216	6144645870	
273	CENTRAL BENEFITS USA (CENBEN USA)	PO BOX 619059	DALLAS	TX	85261	8007725924	CODE ASSIGNED BY SCHA
C13	CENTRAL RESERVE LIFE OF NORTH AMERICA INSURANCE CO	17800 ROYALTON RD.	STRONGSVILLE	OH	441365197	8003213997	
507	CENTRAL STATES HEALTH & LIFE CO. OF OMAHA	PO BOX 34350	OMAHA	NE	68134	4023971111	
476	CENTRAL STATES, SOUTHEAST & SOUTHWEST	PO BOX 5116	DES PLAINES	IL	60017	8003235000	
476DN	CENTRAL STATES, SOUTHEAST & SOUTHWEST	PO BOX 5116	DES PLAINES	IL	60017	8003235000	
C84	CENTRAL UNITED & CHRISTIAN MUTUAL LIFE INS. CO.	2727 ALLEN PARKWAY	HOUSTON	TX	770192115	7135290045	
A54	CENTURY HEALTHCARE	PO BOX 2256	GRAPEVINE	TX	76099	8884441995	NEIC 30018
813	CENTURY PLANNER	9201 WATSON RD., STE. 350	ST. LOUIS	MO	631261509	8007762453	
604	CHAMPVA	PO BOX 469064	DENVER	CO	80246	3033317599	
659	CHARLESTON COUNTY						
E66	CHCCARE OF SOUTH CAROLINA	140 STONE RIDGE DR.	COLUMBIA	SC	29210	8668022474	
D66	CHCCARES OF SOUTH CAROLINA	140 STONE RIDGE DR.	COLUMBIA	SC	29210	8668022474	MEDICAID HMO
B71	CHCS SERVICES, INC.	PO BOX 12467	PENSACOLA	FL	325912457	8888031780	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
660	CHEROKEE COUNTY						
A99	CHEROKEE INSURANCE	PO BOX 853925	RICHARDSON	TX	750853925	8002010450	
B03	CHESAPEAKE LIFE INS. CO.	PO BOX 809025	DALLAS	TX	753809025	8887563534	
661	CHESTER COUNTY						
662	CHESTERFIELD COUNTY						
992	CHESTERFIELD RESOURCES, INC.	PO BOX 1884	AKRON	OH	44309	8003210935	
541	CHILDRENS REHAB SERVICES	PO BOX 4217	SPARTANBURG	SC	293054217	8645962227	CODE ASSIGNED BY SCHA
E51	CHOICE BENEFITS	3801 OLD GREENWOOD RD.	FT. SMITH	AR	75278	8004516907	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
535	CHP DIRECT/SUPERMED	PO BOX 94648	CLEVELAND	OH	441014648	8007731445	
B91	CHRISTIAN BROTHERS EMPLOYEE BENEFIT TRUST	1205 WINDHAM PARKWAY	ROMEOVILLE	IL	60446	8008070400	
134	CIGNA	PO BOX 182223	CHATTANOOGA	TN	374227223	8008824462	DO NOT USE FOR MEDICARE. THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE
511	CIGNA BEHAVIORAL HEALTH	PO BOX 188022	CHATTANOOGA	TN	37422	8003364091	
134DN	CIGNA CONN GENERAL LIFE INSURANCE	PO BOX 188037	CHATTANOOGA	TN	37422	8002446224	DO NOT USE FOR MEDICARE. THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE
134RX	CIGNA CONN GENERAL LIFE INSURANCE	PO BOX 188053	CHATTANOOGA	TN	374228053	8006225579	USE CARRIER CODE 718
136	CIGNA FLEXCARE	PO BOX 30575	CHARLOTTE	NC	282303211		CODE ASSIGNED BY SCHA
999	CIGNA HEALTHCARE OF SC/HEALTHSOURCE SC	PO BOX 190024	CHARLESTON	SC	294199024	8007203150	BOUGHT BY CIGNA HEALTHCARE CC 134
452	CIGNA INTERNATIONAL EXPATRIATE BENEFITS	PO BOX 15050	WILMINGTON	DE	19850	8004412668	
D57	CIGNA MEDICARE ACCESS	PO BOX 22174	TEMPE	AZ	852852174	8005779410	MEDICARE ADVANTAGE PLAN
718	CIGNA PHARMACY SERVICES	PO BOX 188053	CHATTANOOGA	TN	374228053	8006225579	
646	CIGNA-MEDICARE	PO BOX 671	NASHVILLE	TN	37202	6152445600	MEDICARE INTERMEDIARY
407	CINERGY HEALTH INS.	1844 N. NOB HILL RD. #623	PLANTATION	FL	33322	8008471148	
177	CINERGY HEALTH PREFERRED PLAN	144 N BEVERWYCK RD. #332	LAKE HIAWATHA	NJ	080341997	8008471148	CODE IN OPEN STATUS BY SCHA
A63	CITIZENS INSURANCE	PO BOX 1627	ANDERSON	SC	29622	8643340090	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
F40	CITIZEN'S RX	1144 LAKE ST.	OAK PARK	IL	60301	8775327912	RX ONLY
839	CITIZENS SECURITY LIFE INS.	PO BOX 436149	LOUISVILLE	KY	402536149	5022442420	
D56	CITRUS HEALTH CARE, INC.	PO BOX 20547	TAMPA	FL	33622	8667691157	MEDICARE ADVANTAGE PLAN
574	CITY OF AMARILLO GROUP HEALTH	PO BOX 15130	AMARILLO	TX	79105	8063784235	CODE IN OPEN STATUS BY SCHA
114	CLAIMEDIX, INC.	PO BOX 140067	KANSAS CITY	MO	64114	8009224262	CODE ASSIGNED BY SCHA
A41	CLAIMS MANAGEMENT SERVICES	PO BOX 10888	GREEN BAY	WI	54307	8004727130	
219	CLAIMS PRO	PO BOX 577	SOUTHFIELD	MI	48075	8008379600	RX CARRIER ONLY
A73	CLAIMS TECHNOLOGY, INC.	100 COURT AVE., STE. 306	DES MOINES	IA	50309	8002458813	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
536	CLAIMSWARE MANAGEMED	PO BOX 6125	GREENVILLE	SC	29606	8642348200	
536DN	CLAIMSWARE MANAGEMED	PO BOX 6125	GREENVILLE	SC	29606	8642348200	
663	CLARENDON COUNTY	-	-	-	-		
259	CNA HEALTHCARE PARTNERS	PO BOX 34197	LITTLE ROCK	AK	72203	8005083772	
887	CNIC HEALTH SOLUTIONS	PO BOX 3559	ENGLEWOOD	CO	80155	8004267453	
A51	COAL MINE WORKERS COMP PROGRAM	PO BOX 8300	LONDON	KY	407428300	8663358319	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C14	COASTAL LUMBER CO	PO BOX 1576	WALTERBORO	SC	29488	8435382876	CODE IN OPEN STATUS BY SCHA
664	COLLETON COUNTY						
132	COLONIAL LIFE AND ACCIDENT INSURANCE COMPANY	PO BOX 1365	COLUMBIA	SC	29202	8037987000	
A06	COLONIAL PENN FRANKLIN LIFE INSURANCE COMPANY	1818 MARKET ST.	PHILADELPHIA	PA	191811250	8005234000	THIS CARRIER PART OF CONSECO INSURANCE GROUP
175	COLUMBIA UNIVERSAL LIFE INSURANCE CO.	PO BOX 200225	AUSTIN	TX	787200225	5123453200	
133	COMBINED INSURANCE COMPANY OF AMERICA	PO BOX 6700	SCRANTON	PA	18505	8002254500	
609	COMM FOR BLIND						
974	COMMERCE BENEFIT GROUP	PO BOX 900	ELYRIA	OH	44036	8002239941	
457	COMMERICAL TRAVELERS	70 GENESSE ST.	UTICA	NY	13502	8007563702	CODE ASSIGNED BY SCHA
986	COMMONWEALTH BENEFIT ADMINISTRATORS	115 HANOVER ST.	ASHLAND	VA	23005	8005261677	
F55	COMMONWEALTH CARE ALLIANCE	PO BOX 2280	PORTSMOUTH	NH	14315	8666102273	ADDED BY SC REVENUE AND FISCAL AFFAIRS
B36	COMMONWEALTH INDEMNITY PLAN	PO BOX 9016	ANDOVER	MA	01810	8004429033	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D18	COMMUNITY CARE SENIOR HEALTH PLAN	PO BOX 3249	TULSA	OK	741013249	8006428065	MEDICARE ADVANTAGE PLAN
911	COMMUNITY HEALTH PARTNERS	PO BOX 5787	SPARTANBURG	SC	29304	8889628437	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
287	COMMUNITY HEALTH PLAN	PO BOX 14467	CINCINNATI	OH	45250	8888008717	
X1S	COMMUNITY MUTUAL INSURANCE COMPANY	1351 WILLIAM HOWARD TAFT RD.	CINCINNATI	OH	45206	5132821016	CODE IN OPEN STATUS BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
416	COMPANION BENEFIT ALTERNATIVES	PO BOX 100185	COLUMBIA	SC	29202	8008681032	THIS CARRIER ASSIGNED BY SCHA NOT REQUESTED OR USED BY DHHS.
433	COMPANION LIFE	PO BOX 100102	COLUMBIA	SC	29202	8037880500	
B65	COMPASS ROSE HEALTH PLAN	PO BOX 141501	NASHVILLE	TN	37214	8775311159	
548	COMPBENEFITS INSURANCE CO.	PO BOX 804483	CHICAGO	IL	606804106	8005940977	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C56	COMPDENT	1930 BISHOP LANE STE. 132	LOUISVILLE	KY	40218	8006331262	
A39	COMPLETE BENEFITS SOLUTIONS	6071 CARMEL RD., STE. 305	CHARLOTTE	NC	28226	8662702316	
A58	COMPREHENSIVE BENEFITS	PO BOX 8955	MELVILLE	NY	11747	8008283605	
853	COMPSYCH CORP.	PO BOX 8379	CHICAGO	IL	60680	8775955282	
412	CONNECTICARE	PO BOX 546	FARRINGTON	CT	06034	8002517722	
882	CONNECTICARE	PO BOX 4000	FARMINGTON	CT	06034	8772248230	CODE ASSIGNED BY SCHA
331	CONSECO HEALTH INS. CO	PO BOX 66904	CHICAGO	IL	606660904	8005412254	
525	CONSECO MEDICAL INSURANCE CO.	PO BOX 1205	ROCKFORD	IL	61105	8009470319	USE CODE 282 WASHINGTON NATIONAL
C16	CONSOLIDATED BENEFITS, INC.	PO BOX 23686	COLUMBIA	SC	29224	8037365088	
F22	CONSOLIDATED HEALTH PLANS	2077 ROOSEVELT AVE.	SPRINGFIELD	MA	01104	8006337867	DENTAL
970	CONSOLIDATED WORKERS ASSOCIATION (CWA)	PO BOX 2647	CHINO HILLS	CA	91709	8009195514	CODE ASSIGNED BY SCHA
802	CONSTITUTION LIFE INSURANCE CO	PO BOX 130	PENSACOLA	FL	325910130	8007896364	
A04	CONSULTEC PRESCRIPTION BENEFITS MANAGEMENT	9040 ROSWELL RD., STE. 700	ATLANTA	GA	303501853	8003654944	
154	CONSUMER DRN BENEFITS ASSO.	PO BOX 6080-228	MISSION VIEIO	CA	926906080	8884114208	CODE ASSIGNED BY SCHA
C31	CONSUMER HEALTH SOLUTIONS	PO BOX 3492	SPARTANBURG	SC	29304	8645739541	THE CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
592	CONTEC	525 LOCUS GROVE RD.	SPARTANBURG	SC	29303	8645038333	CODE ASSIGNED BY SCHA
F28	CONTINENTAL BENEFITS	PO BOX 3610	BRANDON	FL	335093610	8553030837	
C39	CONTINENTAL GENERAL INSURANCE COMPANY	PO BOX 247007	OMAHA	NE	681247007	4023973200	
895	CONTINENTAL LIFE INS. OF TENNESSEE	PO BOX 1188	BRENTWOOD	TN	37024	8002644000	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
A07	CONTINENTAL LIFE INSURANCE CO. OF SOUTH CAROLINA	PO BOX 6138	COLUMBIA	SC	29260	8037824947	
830	CONTRACTORS EMPLOYEE BENEFIT ADM. (CEBA)	PO BOX 559017	AUSTIN	TX	78755	8002477724	
192	CONVENTRY HEALTHCARE OF NEBRASKA, INC.	PO BOX 7705	LONDON	KY	40742	8002883343	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
928	COOK INSURANCE	PO BOX 1029	BLOOMINGTON	IN	47402	8005932080	
483	COOPERATIVE BENEFITS ADMINISTRATORS	PO BOX 6249	LINCOLN	NE	68506	4024839250	
551	COOPERATIVE MANAGED CARE SERVICES LLC	PO BOX 502530	INDIANAPOLIS	IN	46250	8668734516	CODE IN OPEN STATUS BY SCHA
211	COORDINATED BENEFIT PLANS, INC.	PO BOX 853925	RICHARDSON	TX	750853925	8007531000	
843	CORE MANAGEMENT RESOURCES GROUP	PO BOX 840	MACON	GA	31202	8887412673	
552	CORESOURCE, INC.	PO BOX 2920	CLINTON	IA	52733	8003275462	
552DN	CORESOURCE, INC.	PO BOX 2920	CLINTON	IA	52733	8003275462	
571	CORESOURCE, INC.	PO BOX 8215	LITTLE ROCK	AR	722218215	8886049397	CODE IN OPEN STATUS BY SCHA
364	CORESTAR	PO BOX 1195	MINNEAPOLIS	MN	55440	8004446965	
857	CORPORATE BENEFIT SERVICES, INC.	PO BOX 211778	EAGAN	MN	55121	7043730447	
857DN	CORPORATE BENEFIT SERVICES, INC.	PO BOX 12954	CHARLOTTE	NC	28220	7043730447	
A98	MERITAIN HEALTH	PO BOX 853921	RICHARDSON	TX	75085	8007654224	
831	CORPORATE BENEFIT SOLUTIONS, INC.	PO BOX 8215	LITTLE ROCK	AR	72221	8886049397	
780	CORPORATE SYSTEMS ADMINISTRATION, INC.	PO BOX 4985	JOHNSON CITY	TN	376024985	8002752847	
213	COVENANT ADMINISTRATORS	PO BOX 105738	ATLANTA	GA	30348	7702396230	
480	COVENTRY HEALTH CARE OF THE CAROLINAS	PO BOX 7715	LONDON	KY	40742	8008891947	COVENTRY HEALTH CARE IS PARENT CO. OF SOUTHERN HEALTH AND WELLPATH
191	COVENTRY HEALTHCARE OF DELAWARE, INC.	PO BOX 7713	LONDON	KY	40742	8008337423	
482	COVENTRY HEALTHCARE OF GEORGIA	PO BOX 7711	LONDON	KY	40742	8667321017	
443	COVENTRY HEALTHCARE OF KANSAS	PO BOX 7109	LONDON	KY	39026	8667858077	CODE ASSIGNED BY SCHA
B22	COVENTRY HEALTHCARE OF VIRGINIA	PO BOX 7704	LONDON	KY	40742	8006274872	
246	COVENTRY HEALTH CARE RX	PO BOX 8400	LONDON	KY	40742	8009476824	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
879	COVENTRY OF THE CAROLINAS	PO BOX 7102	LONDON	KY	40742	8662083610	FORMALLY WELLPATH
245	COVENTRY OF THE CAROLINA'S	PO BOX 7102	LONDON	KY	40742	8009357284	
632	CRIME VICTIMS						
155	CROSSAMERICA HEALTH PLAN	PO BOX 5778	PARSIPPANY	NJ	07054	8663027332	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
169	CROWN CORK & SEAL COMPANY, INC.	930 BEAUMONT AVE.	SPARTANBURG	SC	29303	8645856456	
420	CUNA MUTUAL INSURANCE GROUP	PO BOX 391	MADISON	WI	53701	6082385851	
E93	CUSTOM DESIGN BENEFITS	5589 CHEVIOT RD.	CINCINNATI	OH	45247	8005982929	
194	DAKOTACARE	PO BOX 7406	SIOUX FALLS	SD	571177406	8003255598	CODE ASSIGNED BY SCHA
665	DARLINGTON COUNTY						
D74	DART MANAGEMENT CORP	PO BOX 318	MASON	MI	488540318	8002480457	
A65	DATARX	5920 ODELLE ST.	CUMMINGS	GA	30040	8778231273	
436	DAVIS-GARVIN AGENCY	#1 FERNANDINA CT.	COLUMBIA	SC	29212	8037320060	
B09	DEARBORN NATIONAL	PO BOX 23060	BELLEVILLE	IL	62223	8003484512	
B70	DECARE DENTAL	PO BOX 1348	MINNEAPOLIS	MN	55440	8005876857	
834	DEFINITY HEALTH	PO BOX 9525	AMHERST	NY	14226	8663334648	BROUGHT OUT BY UNITED HEALTHCARE CARRIER 113
500	DELTA DENTAL	PO BOX 1809	ALPHARETTA	GA	30023	8005212651	
370	DELTAHEALTH SYSTEMS	PO BOX 9554	SALT LAKE	UT	84109	8774740605	WAS P5 HEALTH PLUS SOLUTIONS
370DN	DELTAHEALTH SYSTEMS	PO BOX 702500	WEST VALLEY	UT	84170	8774740605	
879DN	DENEX DENTAL	111 ROCKVILLE PIKE STE. 700	ROCKVILLE	MD	20850	8666904908	DENEX DENTAL IS A PLAN UNDER WELLPATH SELECT/COVENTRY
C68	DENTAL BENEFIT PROVIDERS	PO BOX 389	ROCKVILLE	MD	20848	8004459090	
901	DENTAL CARE PLUS	100 CROWNE POINT PLACE	CINCINNATI	OH	45241	8003679466	
F32	DENTAL SELECT	PO BOX 851917	RICHARDSON	TX	75085	8014953000	DENTAL
858	DENTAQUEST	PO BOX 2136	COLUMBIA	SC	29202	8003076553	NAIC 52040 MEDICAID DENTAL CLAIMS PROCESSOR
F13	DENTEGRA	PO BOX 1850	ALPHARETTA	GA	300231850	8772804202	DENTAL

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
621	DEPT CORRECTIONS						
179	DESERET MUTUAL BENEFIT ADMINISTRATOR	PO BOX 45530	SALT LAKE CITY	UT	84145	8007773622	
450	DESERET SECURE	PO BOX 45530	SALT LAKE CITY	UT	841450530	8772200110	MEDICARE ADVANTAGE PLAN
955	DESIGN SAVERS PLAN	2814 SPRING RD., STE. 122	ATLANTA	GA	30339	8006165709	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
611	DHEC C. CHILDREN						
610	DHEC CANCER						
629	DHEC FAMILY PLANNING						
627	DHEC HEART						
628	DHEC HEMOPHILIA						
613	DHEC HIGH RISK MATERNITY						
612	DHEC LOW RISK MATERNITY						
625	DHEC MIGRANT HEALTH						
626	DHEC SICKLE CELL						
615	DHEC STERILIZATION						
630	DHEC TB						
725	DIALYSIS CLINIC, INC.	203 FREEMONT AVE.	SPARTANBURG	SC	29303	8645852046	
554	DIAMOND G EMPLOYEE BENEFIT TRUST	PO BOX 1298	GREENVILLE	TN	37744	4236396145	
666	DILLON COUNTY						
707	DILLON YARN MEDICAL BENEFITS	1019 TITAN RD.	DILLON	SC	29536	8437747353	
516	DIRECT REIMBURSEMENT BENEFIT PLANS	1111 ALDERMAN DR., STE. 420	ALPHARETTA	GA	30202	7706645594	
F37	DISTRICT COUNCIL #37	125 BARCLAY ST.	NEW YORK	NY	10007	2158151600	DENTAL ONLY
258	DIVERSIFIED ADMINISTRATION CORPORATION	PO BOX 299	MARLBOROUGH	CT	06447	8883222524	
474	DIVERSIFIED PHARMACEUTICAL	PO BOX 169052	DULUTH	MN	55816	8002338065	USE CODE 333 EXPRESS SCRIPTS
667	DORCHESTER COUNTY						
849	E.O.S. HEALTH	PO BOX 27088	TEMPE	AZ	85285	8884568417	
567	EASTERN BENEFIT SYSTEMS	200 FREEWAY DR. E	EAST ORANGE	NJ	07018	8005240227	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
B63	EASTERN LIFE AND HEALTH INSURANCE	PO BOX 10188	LANCASTER	PA	17605	8002330307	
A14	EB RX	2045 MIDWAY DR.	TWINSBURG	OH	44087	8008007153	
668	EDGEFIELD COUNTY						
137	EDUCATORS MUTUAL LIFE INSURANCE COMPANY	PO BOX 3149	LANCASTER	PA	17601	7173972751	
C80	ELDER HEALTH (MHN/HMC)	PO BOX 4433	BALTIMORE	MD	21223	8887768851	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D25	ELDER PLAN, INC. (HMO)	PO BOX 199100	BROOKLYN	NY	11219	7189218818	MEDICARE ADVANTAGE
B24	EMBLEM HEALTH CARE CO.	PO BOX 3000	NEW YORK	NY	10116	2125014444	
X0EDN	EMPIRE BCBS DENTAL	PO BOX 791	MINNEAPOLIS	MN	554400791	8007228879	
X0E	EMPIRE BLUE CROSS AND BLUE SHIELD	PO BOX 1407 CHURCH ST. STATION	NEW YORK	NY	10008	8003429816	
D64	EMPIRE HEALTHCHOICE ASSURANCE, INC.	PO BOX 100300 CLAIMS PROCESSING	COLUMBIA	SC	29204	8037888562	MEDICARE ADVANTAGE PLAN
C43	EMPLOYEE BENEFIT ADMINISTRATORS	PO BOX 5150	GREENVILLE	SC	29606	8642356474	
A90	EMPLOYEE BENEFIT CLAIMS, INC.	9501 WEST DEVON	ROSEMONT	IL	60018	3126963660	
499	EMPLOYEE BENEFIT CONSULTANTS	PO BOX 928	FINDLAY	OH	45839	8005587798	
869	EMPLOYEE BENEFIT MANAGEMENT SERVICES	PO BOX 21367	BILLINGS	MT	59104	8007773575	
506	EMPLOYEE BENEFIT PLAN ADMINISTRATORS	PO BOX 2000	EXETER	NH	03833	8002587298	
446	EMPLOYEE BENEFIT SERVICES	PO BOX 9888	SAVANNAH	GA	314120088	8035778051	USE CODE 345 EMPLOYEE BENEFIT SERVICES
345	EMPLOYEE BENEFIT SERVICES, INC.	PO BOX 1929	FORT MILL	SC	29716	8002421510	
345DN	EMPLOYEE BENEFIT SERVICES, INC.	PO BOX 1929	FORT MILL	SC	29716	8002421510	
761	EMPLOYEE BENEFIT STRATEGIES	229 EAST MICHIGAN AVE., STE. 235	KALAMAZOO	MI	49007	8003257477	
317	EMPLOYEE BENEFITS MANAGEMENT CORPORATION	4789 RINGS RD.	DUBLIN	OH	43017	8005520455	
CO9	EMPLOYEE BENEFITS TRUST	PO BOX 1431	WICHITA FALLS	TX	76307	8177617611	CODE ASSIGNED WITH LETTER O INSTEAD OF NUMERIC ZERO.
D79	EMPLOYEE HEALTH INSURANCE MANAGEMENT (EHIM)	26711 NORTHWESTERN HWY STE. 400	SOUTHFIELD	MI	48033	8003113446	
743	EMPLOYEE PLANS, INC.	PO BOX 2362	FT. WAYNE	IN	468012362	2606257500	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
550	EMPLOYEE SECURITY, INC.	7125 THOMAS EDISON DR., STE. 105	COLUMBIA	MD	21046	8006381134	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
247	EMPLOYERS DIRECT HEALTH	5050 SPRING VALLEY RD.	DALLAS	TX	752443909	8008729934	CARRIER WAS FIRST INTEGRATED HEALTH
130	EMPLOYERS LIFE INSURANCE COMPANY	PO BOX 6305	SPARTANBURG	SC	29304	8889628437	CARRIER WAS COASTAL STATE LIFE INS. CO.
C24	ENCOMPASS HEALTH MANAGEMENT SYSTEM	6000 WEST TOWN PARKWAY STE. 350	DES MOINES	IA	50266	8005113389	
824	ENVISION RX OPTIONS	2181 EAST AURORA RD., STE. 201	TWINSBURG	OH	44087	8003614542	
509	EQUITABLE LIFE AND CASUALTY	PO BOX 2460	SALT LAKE CITY	UT	84110	8003525150	
510	EQUITABLE PLAN SERVICES	PO BOX 720460	OKLAHOMA	OK	73172	8007492631	
C94	ERIN GROUP ADMINISTRATORS	PO BOX 7777	LANCASTER	PA	17604	8004333746	ANOTHER PHONE NUMBER 717-581-1300
C94DN	ERIN GROUP ADMINISTRATORS	PO BOX 7777	LANCASTER	PA	17604	8004333746	ANOTHER PHONE NUMBER 717-581-1300
180	ESIS	PO BOX 31122	TAMPA	FL	33631	8008847975	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
461	EVERCARE	PO BOX 31350	SALT LAKE CITY	UT	841310350	8888668298	MEDICARE ADVANTAGE PLAN
C18	EVOLUTIONS HEALTHCARE SYSTEMS	PO BOX 5001	NEW PORT RICHEY	FL	34656	8008814474	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
X2F	EXCELLUS BLUECROSS BLUESHIELD	PO BOX 21146	EAGAN	MN	551210146	8007344069	TO VERIFY DENTAL COVERAGE CALL 1-800-724-1675
D20	EXCELLUS MEDICARE BLUE CHOICE OPTIMUM	PO BOX 41915	ROCHESTER	NY	14604	8778839577	MEDICARE ADVANTAGE PLAN
333	EXPRESS SCRIPTS	PO BOX 14713	LEXINGTON	KY	40512	8004516245	
A35	FABRI-KAL CORPORATION	PO DRAWER C	PIEDMONT	SC	29773	8642991720	CODE IN OPEN STATUS BY SCHA
669	FAIRFIELD COUNTY						
B49	FALLON COMMUNITY HEALTH PLAN	PO BOX 15121	WORCHESTER	MA	01615	8008685200	
A16	FCE BENEFIT ADMINISTRATOR	4615 WALZEM RD., STE. 300	SAN ANTONIO	TX	782181610	8008999355	
402	FEDERAL EMPLOYEE PLAN BLUE CROSS	I-20 AT ALPINE RD.	COLUMBIA	SC	29260	8037883860	
A50	FEDERAL EMPLOYEES COMPENSATION ACT	PO BOX 8300	LONDON	KY	407428300	8663358319	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
441	FEDERAL MOGUL HEALTHCARE	PO BOX 1999	DETROIT	MI	48235	8005220041	
290	FEDERATED MUTUAL INSURANCE COMPANY (REGIONAL)	PO BOX 31716	TAMPA	FL	336313716	8134968100	
769	FEDEX FREIGHTWAYS	PO BOX 840	HARRISON	AR	72602	8008744723	
738	FHA-TPA DIVISION	PO BOX 327810	FT. LAUDERDALE	FL	333329711	8037988698	CODE IN OPEN STATUS BY SCHA
F25	FIDELIO DENTAL INSURANCE COMPANY	2826 MT. CARMEL AVE.	GLENSIDE	PA	19038	8002624949	DENTAL
205	FIDELITY LIFE SECURITY	3130 BROADWAY	KANSAS CITY	MO	641112406	8006488624	
941	FIDELITY SECURITY LIFE INSURANCE CO	419 E MAIN ST.	MIDDLETOWN	NY	10940	8008267531	THE CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A36	FIELDCREST CANNON (CANNON MILLS)	PO BOX 5000	EDEN	NC	272895000	8002223693	
467	FIRSERV HEALTH	PO BOX 182173	COLUMBUS	OH	432182173	8008482664	USE CODE 139
288	FIRST ADMINISTRATORS, INC.	PO BOX 9900	SIOUX CITY	IA	51102	8002060827	
348	FIRST AGENCY, INC.	5071 WEST H AVE.	KALAMAZOO	MI	490098501	2693816630	THIS CODE ASSIGNED BY SCHA 8/28/07
354	FIRST BENEFITS CORP	PO BOX 879	ANDERSON	IN	46015		CODE ASSIGNED BY SCHA
A74	FIRST CAROLINA CARE, INC.	PO BOX 381686	BIRMINGHAM	AL	35238	8008113298	
775	FIRST CHOICE BENEFITS MANAGEMENT	PO BOX 658	BELOIT	WI	535120658	8003035770	
B90	FIRST CHOICE VIP CARE	PO BOX 307	LINTHICUM	MD	210900307	8005750418	THIS IS A MEDICARE ADVANTAGE PLAN.
789	FIRST COMMUNITY HEALTH PLAN, INC.	PO BOX 382947	BIRMINGHAM	AL	35238	8007347826	CODE IN OPEN STATUS BY SCHA
803	FIRST CONTINENTAL LIFE INSURANCE	PO BOX 1911	CARMEL	IN	46032	8005381235	
946	FIRST HEALTH	PO BOX 1377	THOMASVILLE	GA	31799	8668478235	
245RX	FIRST HEALTH	PO BOX 23070	TUCSON	AZ	85734	8005544954	
456	FIRST HEALTH (A COVENTRY HEALTH CARE CO)	PO BOX 21680	EAGAN	MN	551210680	8664775465	
249	FIRST HEALTH WORKERS COMP ONLY	PO BOX 23070	TUCSON	AZ	85735	8005544954	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
351	FISERV	PO BOX 8077	WAUSAU	WI	544028077	8666848090	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
139	FISERV HEALTH	PO BOX 30541	SALT LAKE CITY	UT	841300541	8008269781	WAS WAUSAU INS. CO.

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
352	FISERV HEALTH-COLORADO	PO BOX 720	PUEBLO	CO	810020720	8004468182	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
670	FLORENCE COUNTY						
C75	FLORIDA 1ST SERVICE ADMINISTRATORS, INC.	PO BOX 3607	WINTER HAVEN	FL	338853067	8002263155	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
719	FLORIDA HEALTH ALLIANCE	PO BOX 10269	JACKSONVILLE	FL	322470269	9043548335	
913	FLORIDA HOSPITAL HEALTHCARE SYSTEM	PO BOX 536847	ORLANDO	FL	328536847	8007414810	
B20	FMH BENEFIT SERVICES, INC.	PO BOX 25946	OVERLAND PARK	KS	66225	8009909058	
B05	FOCUS HEALTHCARE MANAGEMENT, INC.	720 COOL SPRINGS BLVD.	FRANKLIN	TN	37067	6157784000	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A94	FORETHOUGHT LIFE INSURANCE COMPANY	PO BOX 981721	EL PASO	TX	79998	8774925870	
C02	FOUNDATION BENEFITS ADMINISTRATORS	6300 BRIDGEPOINT PKWAY, BLDG. 3 #400	AUSTIN	TX	78730	8883687910	
870	FOUNDATION HEALTH	PO BOX 453219	SUNRISE	FL	33345	8004415501	
393	FOUNTAINHEAD ADMINISTRATORS, INC.	PO BOX 13188	BIRMINGHAM	AL	35202	8009919155	
B79	FOX-EVERETT, INC.	PO BOX 6012	RIDGELAND	MI	39158	8774766327	
765	FREEDOM HEALTH	PO BOX 151348	TAMPA	FL	33684	8004012740	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C83	FREEDOM LIFE INSURANCE CO. OF AMERICA	PO BOX 1468	ARLINGTON	TX	76004	8669734647	
F50	FRINGE BENEFIT GROUP	PO BOX 21854	EAGAN	MN	55121	8772201862	ASSIGNED BY SC REVENUE AND FISCAL AFFAIRS OFFICE
A97	FRINGE BENEFIT GROUP	PO BOX 21854	EAGAN	MN	55121	8554951190	
587	FUTURE SCRIPTS	PO BOX 419019	KANSAS CITY	MO	64141	8886787012	
842	GARDNER AND WHITE, INC.	PO BOX 40619	INDIANAPOLIS	IN	462400619	3172579131	
842DN	GARDNER AND WHITE, INC.	PO BOX 40619	INDIANAPOLIS	IN	462400619	3172579131	
D54	GATEWAY HEALTH PLAN MEDICARE ASSURED	PO BOX 11560	ALBANY	NY	122110655	8006855209	MEDICARE ADVANTAGE PLAN
864	GE GROUP ADMINISTRATORS	PO BOX 150809	ARLINGTON	TX	76015	8882558961	
442	GE LIFE & ANNUITY ASSURANCE CO.	PO BOX 6700	LYNCHBURG	VA	24505	8002530856	
845	GEISINGER HEALTH PLAN GOLD	PO BOX 8200	DANVILLE	PA	178218200	8004989731	MEDICARE ADVANTAGE PLAN
C97	GEM GROUP	1200 THREE GATEWAY CENTER	PITTSBURGH	PA	15222	8002428923	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
232	GENERAL ADJUSTMENT BUREAU	PO BOX 81808	ATLANTA	GA	30366	4044579555	CODE ASSIGNED BY SCHA
728	GENERAL PRESCRIPTION PROGRAMS, INC.	305 MADISON AVE. STE. 1166B	NEW YORK	NY	10165	8003412234	
799	GENWORTH FINANCIAL	PO BOX 8021	SAN RAFAEL	CA	949129974	8008764582	WAS GE FINANCIAL SERVICES
997	GENWORTH FINANCIAL	PO BOX 10821	CLEARWATER	FL	33757	8778259337	CODE IN OPEN STATUS BY SCHA
C34	GEOBLUE	933 FIRST AVE.	KING OF PRUSSIA	PA	19406	8552823517	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
671	GEORGETOWN COUNTY						
730	GEORGIA HEALTHCARE PARTNERSHIP	PO BOX 16388	SAVANNAH	GA	314163088	8005666710	
419	GEORGIA STATE HEALTH BENEFIT PLAN	PO BOX 38151	ATLANTA	GA	30334	8006266402	
365	GERBER CHILDRENS WEAR, INC.	PO BOX 2126	GREENVILLE	SC	29602	8649875200	
749	GERBER LIFE INSURANCE COMPANY	PO BOX 2088	GRAND RAPIDS	MI	49501	8002533074	
905	GERBER LIFE MEDICARE SUPPLEMENT	PO BOX 2271	OMAHA	NE	68103	8776565425	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B88	GETTYSBURG HEALTH ADMINISTRATORS	PO BOX 1169	FREDERICK	MD	21702	8004974474	
183	GILSBAR INSURANCE COMPANY	PO BOX 2947	COVINGTON	LA	70434	8002342643	
459	GLASS MOTORS & PLASTIC (GMPA)	5245 BIG PINE WAY, SE 33907	FORT MYERS	FL	33907	8139366242	
A44	GLOBAL MEDICAL MANAGEMENT, INC.	7901 SW 36TH ST., STE. 100	DAVIE	FL	33328	9543706404	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
144	GLOBE LIFE & ACCIDENT INSURANCE	204 N. ROBINSON	OKLAHOMA CITY	OK	73102	9725406542	
145	GMP EMPLOYERS RETIREE TRUST	5245 BIG PINE WAY SE	FORT MYERS	FL	33907	9419366242	
931	GOOD SAMARITAN PROGRAM	5151 WEST HWY 40	BEACHGROVE	IN	46140	3178942000	
379	GOODYEAR TIRE & RUBBER COMPANY	PO BOX 677 DEPT. 609	AKRON	OH	44309	2167966531	
302	GOVERNMENT EMPLOYEE HOSP. ASSN (GEHA)	PO BOX 4665	INDEPENDENCE	MO	640514665	8162575500	
302DN	GOVERNMENT EMPLOYEE HOSP. ASSOC. (GEHA)	PO BOX 2336	INDEPENDENCE	MO	64051		DENTAL COVERAGE
B31	GREAT AMERICAN LIFE INS. CO (GALIC)	PO BOX 559002	AUSTIN	TX	787553010	8008802745	
313	GREAT WEST HEALTHCARE	1000 GREAT WEST DR.	KENNETT	MO	63857	8006638081	
308	GREAT WEST LIFE	PO BOX 188061	CHATTANOOGA	TN	374228061	8006638081	GREAT WEST/CIGNA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
308DN	GREAT WEST LIFE	PO BOX 21542	EAGAN	MN	55121	8774342336	
121	GREATER HEALTHCARE	PO BOX 3400	MONROE	NC	28110	7042258887	
672	GREENVILLE COUNTY						
673	GREENWOOD COUNTY						
B99	GROUP & PENSION ADMINISTRATORS, INC.	PO BOX 749075	DALLAS	TX	75374	8662063224	
181	GROUP ADMINISTRATORS, LTD.	450 E. REMINGTON RD.	SCHAUMBURG	IL	60173	8475191880	
745	GROUP BENEFIT SERVICES	1312 BELLONE AVE.	LUTHERVILLE	MD	21093	8006386085	
343	GROUP BENEFITS ADMINISTRATORS	70 GRAND AVE.	RIVEREDGE	NJ	07661	2013433003	
906	GROUP HEALTH ADMINISTRATOR, INC.	PO BOX 6244	CHARLOTTE	NC	282071018	8002225790	
508	GROUP HEALTH, INC. /EMBLEM HEALTH COMPANY	PO BOX 3000	NEW YORK	NY	101163000	2125014444	
889	GROUP INSURANCE ADMINISTRATION, INC.	3350 PEACHTREE RD. NE STE. 1040	ATLANTA	GA	30326	8006210683	
889DN	GROUP INSURANCE ADMINISTRATION, INC.	3350 PEACHTREE RD. NE STE. 1040	ATLANTA	GA	30326	8006210683	
389	GROUP LINK	PO BOX 20593	INDIANAPOLIS	IN	46220	8003597408	
A83	GROUP RESOURCES, INC.	PO BOX 100043	DULUTH	GA	300969343	7706238383	
D46	GROUPHEALTH OPTIONS, INC.	PO BOX 34585	SEATTLE	WA	98124	8887674670	MEDICARE ADVANTAGE PLAN
727	GUARANTEE MUTUAL LIFE CO.	8801 INDIAN HILLS DR.	OMAHA	NE	68114	8004624660	
236	GUARANTEE TRUST LIFE INSURANCE	PO BOX 1144	GLENVIEW	IL	60025	8476990600	
283	GUARDIAN HEALTHCARE	PO BOX 4197	SCRANTON	PA	77010	8668501256	MEDICARE ADVANTAGE PLAN
362	GUARDIAN HEALTHCARE	PO BOX 4197	SCRANTON	PA	18505	8668501253	MEDICARE ADVANTAGE PLAN
418	GUARDIAN INSURANCE COMPANY	PO BOX 8007	APPLETON	WI	549128007	8006854542	CODE ASSIGNED BY SCHA
237DN	GUARDIAN LIFE INSURANCE CO. OF AMERICA	PO BOX 981572	EL PASO	TX	799981572	8005417846	
237	GUARDIAN LIFE INSURANCE COMPANY OF AMERICA	P O BOX 981572	EL PASO	TX	799981572	6108076000	
176	GUIDESTAR HEALTH SYSTEMS	PO BOX 35238	BIRMINGHAM	AL	35238	8005956949	
674	HAMPTON COUNTY						
A96	HAMRICKS, INC.	742 PEACHOID RD.	GAFFNEY	SC	29340	8644877505	
547	HARRINGTON HEALTH	PO BOX 30544	SALT LAKE CITY	UT	841300544	8777370769	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
146	HARTFORD INSURANCE GROUP	PO BOX 25600	CHARLOTTE	NC	28212	7045366230	
162	HARVARD PILGRIM HEALTHCARE	PO BOX 656653	SAN ANTONIO	TX	82655	8004213550	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A84	HCC LIFE INSURANCE COMPANY	PO BOX 2005	FARMINGTON HILLS	MI	48333	8664004102	
201	HCH ADMINISTRATORS	PO BOX 1986	PEORIA	IL	61656	8003221516	
201DN	HCH ADMINISTRATORS	PO BOX 1986	PEORIA	IL	61656	8003221516	
837	HEALTH ADMINISTRATION SERVICES	PO BOX 6724208	HOUSTON	TX	77267	8008655440	
B87	HEALTH ALLIANCE	PO BOX 6003	URBANA	IL	616036003	8003227451	
823	HEALTH ALLIANCE PLAN	PO BOX 02459	DETROIT	MI	48202	8004224641	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
264	HEALTH AMERICA	PO BOX 7089	LONDON	KY	40742	8007888445	
B25	HEALTH AND WELFARE FUND LOCAL 218	PO BOX 115027	ATLANTA	GA	30310	4047555665	
B84	HEALTH CARE CORPORATION	203 JANDERS RD.	CARY	IL	60013		CODE IN OPEN STATUS BY SCHA
713	HEALTH CARE CREDIT UNION ASSOC. HCCUA	PO BOX 260957	PLANT	TX	750260957	8663736366	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
748	HEALTH CARE SAVINGS, INC.	4530 PARK RD	CHARLOTTE	NC	28209		CODE ASSIGNED BY SCHA
203	HEALTH CARE SUPPORT/PRIVATE HEALTH CARE SYSTEM	29 COLUMBIA HEIGHTS	BROOKLYN	NY	11201	8005544022	CODE ASSIGNED BY SCHA
562	HEALTH CLAIMS SERVICES,INC.	PO BOX 9615	DEERFIELD BEACH	FL	33442	8002223560	
A75	HEALTH COST SOLUTIONS	PO BOX 1439	HENDERSONVILLE	TN	37077	8882295020	WAS LIFECARE CENTERS OF AMERICA
B75	HEALTH DESIGN PLUS	PO BOX 2584	HUDSON	OH	442362584	8008930777	
960	HEALTH EOS	PO BOX 6090	DER PERE	WI	541156090	8004355694	CODE ASSIGNED BY SCHA. NOT REQUESTED BY MEDICAID
286	HEALTH EXCHANGE (TPA FOR CERNER HEALTH)	PO BOX 165750	KANSAS CITY	MO	64116	8002314015	CODE IN OPEN STATUS BY SCHA
B27	HEALTH FIRST (PPO)	PO BOX 17709	GREENVILLE	SC	29606	8642893000	
884	HEALTH FIRST HEALTH PLANS	PO BOX 565001	ROCKLEDGE	FL	329565001	8007167737	CODE IN OPEN STATUS BY SCHA
447	HEALTH NET	PO BOX 14700	LEXINGTON	KY	405125225	9004387886	MEDICARE ADVANTAGE PLAN

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
874	HEALTH NET	PO BOX 14700	LEXINGTON	KY	40512	8887477823	THIS CODE NOT REQUESTED BY SCHA. ASSIGNED BY SCHA
281	HEALTH NETWORK AMERICA/TRIVERIS	PO BOX 307	EATONTOWN	NJ	07724	8003371421	CODE ASSIGNED BY SCHA
220	HEALTH NEW ENGLAND	ONE MONARCH PLACE, STE. 1500	SPRINGFIELD	MA	011441500	8003102835	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B01	HEALTH PARTNERS	PO BOX 1289	MINNEAPOLIS	MN	554401289	8889222313	
B01DN	HEALTH PARTNERS DENTAL	PO BOX 1172	MINNEAPOLIS	MN	55440	8889222313	
C09	HEALTH PLAN ADMINISTRATORS	PO BOX 2638	ROCKFORD	IL	61132	8156335800	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
382	HEALTH PLAN OF NEVADA	PO BOX 15645	LAS VEGAS	NV	891145615	8007771840	MEDICARE ADVANTAGE PLAN
349	HEALTH PLAN SELECT	PO BOX 382767	BIRMINGHAM	AL	352382767	8002936260	
357	HEALTH PLAN SERVICES	PO BOX 30298	TAMPA	FL	33630	8002377767	
126	HEALTH PLAN SERVICES (COVENTRY HEALTH CARE)	PO BOX 24146	SEATTLE	WA	98124	8008610056	CODE ASSIGNED BY SCHA
332	HEALTH PLANS, INC.	PO BOX 5199	WESTBOROUGH	MA	01581	8005327575	
324	HEALTH REIMBURSEMENT MANAGEMENT PARTNERSHIP	5 HUTCHINSON DR.	DANVERS	MA	01923	8889994767	CODE IN OPEN STATUS BY SCHA
F46	HEALTH RESOURCES, INC.	PO BOX 659	EVANSVILLE	IN	47704	8007271444	
F46DN	HEALTH RESOURCES, INC.	PO BOX 659	EVANSVILLE	IN	47704	8007271444	DENTAL ONLY
225	HEALTH SERVICES FOUNDATION	PO BOX 2109	LIVERMORE	CA	94551	5104497070	
A79	HEALTH SPECIAL RISK	4001 N. JOSEY LANE	CARROLLTON	TX	75007	9724926474	
F41	HEALTHCARE HIGHWAYS RX	5904 STONE CREEK DR.	THE COLONY	TX	75056	8446367506	RX ONLY
A27	HEALTHCARE SUPPORT	25 COLUMBIA HEIGHTS	BROOKLYN HEIGHTS	NY	112012482	8005544022	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
758	HEALTHCHOICE	PO BOX 24870	OKLAHOMA	OK	731270870	8004892974	CODE ASSIGNED BY SCHA
814	HEALTHCOMP ADMINISTRATORS	PO BOX 45018	FRESNO	CA	93718	8004427247	
E61	HEALTHEZ	PO BOX 398220	MINNEAPOLIS	MN	55439	8552809638	
524	HEALTHFIRST	PO BOX 130217	TYLER	TX	75713	8004778957	CODE ASSIGNED BY SCHA TPA
D19	HEALTHFIRST 65 PLUS	PO BOX 5196	NEW YORK	NY	10274	8882601010	MEDICARE ADVANTAGE PLAN
639	HEALTHFIRST HMO	255 ENTERPRISE BLVD., STE. 20	GREENVILLE	SC	29615	8644551100	MEDICAID HMO

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
387	HEALTHGRAM	PO BOX 11088	CHARLOTTE	NC	28220	8004465439	HEALTHGRAM FORMERLY PRIMARY PHYSICIAN CARE
387DN	HEALTHGRAM	PO BOX 11088	CHARLOTTE	NC	28220	8004465439	DENTAL - HEALTHGRAM FORMERLY PRIMARY PHYSICIANS CARE
577	HEALTHMARKETS CARE ASSURED	PO BOX 69349	HARRISBURG	PA	17110	8772195460	CODE ASSIGNED BY SCHA
440	HEALTHNET	PO BOX 14702	LEXINGTON	KY	40512	8006417761	
753	HEALTHNET	PO BOX 2226	AUGUSTA	GA	309032226	9009778221	
F20	HEALTHPLEX	PO BOX 9255	UNIONDALE	NY	11553	8004680600	DENTAL
767	HEALTHSCOPE BENEFITS	PO BOX 619055	DALLAS	TX	752619055	8006006212	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A67	HEALTHSCOPE BENEFITS	PO BOX 99005	LUBBOCK	TX	794906831	8009676831	
553DN	HEALTHSCOPE BENEFITS, INC.	PO BOX 99005	LUBBOCK	TX	79490	8009676831	
553	HEALTHSCOPE BENEFITS, INC.	PO BOX 99005	LUBBOCK	TX	79490	8883736102	
305	HEALTHSMART	PO BOX 91608	LUBBOCK	TX	79490	8668695597	
C32DN	HEALTHSMART	PO BOX 91608	LUBBOCK	TX	79490	8004354351	FORMALLY WELLS FARGO
920	HEALTHSMART PREFERRED CARE	PO BOX 53010	LUBBOCK	TX	794533010	8064732500	
876	HEALTHSOURCE OF NC, INC.	PO BOX 28087	RALEIGH	NC	27611	8008499000	USE CODE 134 CIGNA HEALTHCARE
519	HEALTHSOURE ADMINISTRATORS	PO BOX 382617	BIRMINGHAM	AL	35238	8778939294	
D81	HEARTLAND NATIONAL LIFE INSURANCE CO.	PO BOX 2878	SALT LAKE CITY	UT	84110	8008723860	REQUESTED BY THE SCHA
242	HELLER ASSOCIATES	8228 MAYFIELD RD., STE. 5B	CHESTERLANDE	OH	44026	4405272955	CODE IN OPEN STATUS BY SCHA
848	HERITAGE	PO BOX 1730	AUBURNDALE	FL	33823	8002822460	
732	HERTZ CLAIM MANAGEMENT	PO BOX 726	PARK RIDGE	NJ	07656	2013072177	
117	HEWITT COLEMAN AND ASSOCIATES	PO BOX 6708	GREENVILLE	SC	29606	8642405840	
X1R	HIGHMARK BLUE CROSS BLUE SHIELD	PO BOX 890062	CAMPHILL	PA	170890062	4125447000	
D45	HIGHMARK SECURITY BLUE	120 5TH AVE.	PITTSBURGH	PA	15222309	8005473627	MEDICARE ADVANTAGE PLAN
A78	HIGHWAY TO HEALTH (HTH)	PO BOX 968	HORSHAM	PA	19044	8883502002	THIS CODE ASSIGNED BY SCHA. NOT REQUESTED BY MEDICAID

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
B15	HILLCREST BENEFIT ADMINISTRATORS	PO BOX 1516	MT. DORA	FL	32756	8007439264	
502	HIP HEALTH PLAN	PO BOX 2803	NEW YORK	NY	101162803	8004478255	MEDICARE ADVANTAGE PLAN
B81	HM BENEFITS ADMINISTRATORS, INC.	PO BOX 535078	PITTSBURGH	PA	152535078	8002792624	
A13	HOLDEN & COMPANY	PO BOX 10411	SAVANNAH	GA	31412	8004043344	
A68	HOLLINGSWORTH SACO LOWELL CORP.	PO DRAWER 2327	GREENVILLE	SC	29602	8648593211	DORMANT 8/06
984	HOMELAND HEALTHCARE	PO BOX 3726	SEATTLE	WA	98124	8004934240	
D36	HOP/PSERS HEALTH ADMINISTRATION UNIT	PO BOX 2921	CLINTON	IA	52733	8007737725	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
239	HORACE MANN LIFE INSURANCE COMPANY	1 HORACE MANN PLAZA	SPRINGFIELD	IL	62715	2177892500	
238	HORIZON HEALTHCARE	PO BOX 1028	WEST TRENTON	NJ	08628	8007923666	
675	HORRY COUNTY						
782	HOUSING BENEFIT PLAN	PO BOX 542077	DALLAS	TX	753542077	8009372036	
878	HRM CLAIM MANAGEMENT	PO BOX 4022	KALAMAZOO	MI	490034022	8002530966	
836	HUMANA	PO BOX 14601	LEXINGTON	KY	40512	8005584444	
836DN	HUMANA	PO BOX 14601	LEXINGTON	KY	40512	8005584444	
C59	HUMANA CHOICE (PPO)	PO BOX 14605	LEXINGTON	KY	405784602	8004574708	MEDICARE ADVANTAGE PLAN
648	HUMANA GOLD CHOICE (PFFS)	PO BOX 7060	CAMDEN	SC	29020	8775115000	MEDICARE ADVANTAGE PLAN
793	HUMANA GOLD PLUS	PO BOX 14601	LEXINGTON	KY	405124601	8004574708	MEDICARE ADVANTAGE PLAN
216	HUMANA HEALTH INSURANCE OF FLORIDA	PO BOX 19080-F	JACKSONVILLE	FL	32245	8004574708	
752	HYGEIA CORPORATION	15500 NEW BARN RD.	MIAMI LAKES	FL	33014	8005912650	CODE ASSIGNED BY SCHA
371	ICON BENEFIT ADMINISTRATORS, INC.	PO BOX 53010	LUBBOCK	TX	794533070	8006589777	
250	IDEAL SCRIPTS	50 WHITE CAP DR.	NORTH KINGSTOWN	RI	02886	8007176614	
801	IMERICA LIFE AND HEALTH INS. CO	PO BOX 3287	ENGLEWOOD	CO	80155	8882738020	
B26	IMSCO HEALTH PLAN	PO BOX 697	BUCKEYSTOWN	MD	217170697	8009442833	IMSCO - INTERNATIONAL MANAGEMENT SERVICE CO.
716	INDECS CORP	PO BOX 668	LYNDHURST	NJ	07071	8884463327	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A08	INDEPENDENCE AMERICAN INS. CO. (IHC HEALTH SOLUTION)	PO BOX 21456	EAGON	MN	55121	8664290608	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
X1G	INDEPENDENCE BLUE CROSS	PO BOX 211184	EAGAN	MN	551212594	8002752583	
892	INDEPENDENT HEALTH	PO BOX 9066	BUFFALO	NY	14231	8002471466	
D44	INDEPENDENT HEALTH	PO BOX 9066	BUFFALO	NY	14231	8666178585	MEDICARE ADVANTAGE PLAN
975	INFORMED RX	PO BOX 968022	SCHAUMBURG	IL	601968022	8006453332	WAS NATIONAL MEDICAL HEALTH CARD
B51	INNOVIANT	PO BOX 8082	WAUSAU	WI	54402	8775592955	
C60	INSTILL HEALTH SYSTEMS (FFS)	PO BOX 7061	CAMDEN	SC	290207845	8774467845	MEDICARE ADVANTAGE PLAN
C61	INSTILL HEALTH SYSTEMS (PPO)	PO BOX 7061	CAMDEN	SC	290207845	8774467845	MEDICARE ADVANTAGE PLAN
178	INSURANCE & BENEFIT ADVOCATE, INC.	5838 W BRICK RD STE. 106	SOUTH BEND	IN	46628	8662006700	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
863	INSURANCE ADMINISTRATION CORP.	PO BOX 39119	PHOENIX	AZ	85069	8008433106	
D02	INSURANCE ADMINISTRATOR OF AMERICA	PO BOX 5082	MT. LAUREL	NJ	08054	8009896739	
149	INSURANCE COMPANY OF NORTH AMERICA (INA)	195 BROADWAY 11TH FLOOR	NEW YORK	NY	100073100	2126184000	
756	INSURANCE MANAGEMENT ADMINISTRATORS (IMA)	PO BOX 71120	BOSSIER CITY	LA	711719944	8007429944	
726	INSURANCE SERVICE AND BENEFITS	3218 HIGHWAY 67 STE. 218	MESQUITE	TX	75150	8008783157	
F51	INSURANCE TPA	PO BOX 15953	LUBBOCK	TX	79490	8558489591	ASSIGNED BY SC REVENUE AND FISCAL AFFAIRS
C41	INTERNATIONAL BENEFITS ADMINISTRATORS	PO BOX 9306	GARDEN CITY	NY	11530	8004227617	
C41DN	INSUREX BENEFITS ADMINISTRATORS, INC.	PO BOX 41779	MEMPHIS	TN	381741799	9017256435	
B80	INTEGRATED BEHAVIORAL HEALTH/IBH	PO BOX 30018	LAGUNA NIGUEL	CA	92607	8003951616	
735	INTEGRITAS BENEFIT GROUP	PO BOX 1447	CORDOVA	TN	38088	9016858980	
484	INTEGRITY BENEFITS NETWORK	PO BOX 4537	MARIETTA	GA	30061	7704281604	
B72	INTEGRITY NATIONAL LIFE INS.	PO BOX 32350	LOUISVILLE	KY	40232	5024261843	CODE ASSIGNED BY SCHA
A45	INTEQ GROUP	5445 LASIERRA DR., STE. 400	DALLAS	TX	75231	8009593953	
465	INTER CARE BENEFIT SYSTEMS	PO BOX 3559	ENGLEWOOD	CO	801553559	3037705710	
809	INTER VALLEY HEALTH PLAN	300 SOUTH PARK, PO BOX 6002	POMONA	CA	917696002	8002518191	CODE ASSIGNED BY SCHA
C26	INTERACTIVE MEDICAL SYSTEMS, INC.	PO BOX 1349	WAKE FOREST	NC	27588	8004268739	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
C54	INTER-AMERICAS INS. CORP. (OOIDA)	PO BOX 9510	WICHITA	KS	672770510		THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
129	INTERGROUP SERVICES CORPORATION	101 LINDENWOOD DR., STE. 150	MALVERN	PA	19355	8005379389	
D01	INTERLINK HEALTH SERVICES	4950 NE BELNAP CT. #205	HILLSBORO	OR	97124	5036402000	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B76	INTERNATIONAL ASSO. BENEFITS	1747 PENNSYLVANIA AVE. NORTH WEST	WASHINGTON	DC	20006	8002751171	
983	INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS	3901 E. WINSLOW AVE.	PHOENIX	AZ	85040	6022340497	
101	INTERNATIONAL CLAIMS SERVICES	27092 BURBANK ST.	FOOTHILL RANCH	CA	92610	8779167920	ASSIGNED BY SCHA
189	INTERNATIONAL EDUCATION EXCHANGE SERVICES	PO BOX 370	ITHACA	NY	148510307	8664337462	
464	INTERNATIONAL MEDICAL GROUP	407 N. FULTON ST.	INDIANAPOLIS	IN	46202	8006284664	
473	INTERNATIONAL MISSION BOARD (IMB)	PO BOX 6767	RICHMOND	VA	232300767	8042191585	CODE ASSIGNED BY SCHA
454	INTERNATIONAL UNION OF OPERATING ENGINEERS	166 WEST KELLY ST.	METUCHEN	NJ	08840	9085486662	
411	INTERPLAN HEALTH GROUP	PO BOX 90613	ARLINGTON	TX	76006	8665114757	CODE ASSIGNED BY SCHA
A19	ISLAND GROUP ADMINISTRATION, INC.`	3 TOILSOME LANE	EAST HAMPTON	NY	11937	8009262306	CODE ASSIGNED BY SCHA
958	ITPE-NMU HEALTH AND WELFARE FUND	PO BOX 13817	SAVANNAH	GA	31416	9123527169	
958DN	ITPE-NMU HEALTH AND WELFARE FUND	PO BOX 13817	SAVANNAH	GA	31416	9123527169	
757	J C PENNEY LIFE INSURANCE COMPANY	PO BOX 869090	PLANO	TX	750860909	9728816000	
827	J. SMITH LANIER	PO BOX 72749	NEWNAN	GA	30271	8882954864	
996	J.F. MOLLOY & ASSO.	PO BOX 68947	INDIANAPOLIS	IN	46268	8003313287	SEE CARRIER 942 PRINCIPAL FINANCIAL GROUP
335	J.P. FARLEY CORP.	PO BOX 458022	WESTLAKE	OH	441468022	4402504300	
676	JASPER COUNTY						
109	JEFFERSON PILOT INSURANCE COMPANY	PO BOX 26011	GREENSBORO	NC	27420	3366913000	
514	JLT SERVICES (TPA FOR NY LIFE)	PO BOX 1511	LATHAM	NY	12110	8007933773	NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D09	JM FAMILY ENTERPRISES	8019 BAYBERRY RD.	JACKSONVILLE	FL	32256	8008920059	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
885	JOHN ALDEN INSURANCE COMPANY	PO BOX 020270	MIAMI	FL	33102	8003284316	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
885DN	JOHN ALDEN INSURANCE COMPANY	PO BOX 020270	MIAMI	FL	33102	8003284316	
202	JOHN HANCOCK INSURANCE COMPANY	PO BOX 852	BOSTON	MA	02117	8002331449	
B12	JOHN HANCOCK LIFE AND HEALTH INSURANCE	JOHN HANCOCK B5-03 200 BERKELEY ST.	BOSTON	MA	02116	8003777311	
C71	JOHNS HOPKINS HEALTHCARE	6704 CURTIS CT.	GLEN BURNIE	MD	21060	8002612393	
417	JULY PRODUCTS	5 GATEWAY CENTER STE. 60	PITTSBURG	PA	15222	8669008322	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
A69	KAISER FOUNDATION HEALTH PLAN OF SOUTHERN CA	PO BOX 7004	DOWNEY	CA	902427004	8003310420	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
104	KAISER FOUNDATION HEALTH PLAN OF SOUTHERN CA.	PO BOX 7004	DOWNEY	CA	90242	8003903510	CODE ASSIGNED BY SCHA
528	KAISER PERMANENTE	PO BOX 190849	ATLANTA	GA	31119	8006111811	MEDICARE ADVANTAGE PLAN
C78	KAISER PERMANENTE	PO BOX 370010	DENVER	CO	80237	4042612590	
F58	KAISER PERMANENTE MID ATLANTIC STATES	PO BOX 371860	DENVER	CO	802379998	8008104766	ADDED BY REVENUE AND FISCAL AFFAIRS
537	KAISER PERMANENTE-OHIO REGION	PO BOX 5316-9774	CLEVELAND	OH	441010316	8006348816	CODE ASSIGNED BY SCHA
C47	KANAWHA BENEFIT SERVICES	PO BOX 50098	KNOXVILLE	TN	379500098	8008221274	
C47DN	KANAWHA BENEFIT SERVICES	PO BOX 50098	KNOXVILLE	TN	379500098	8008221274	
153	KANAWHA LIFE INSURANCE COMPANY	PO BOX 6000	LANCASTER	SC	29721	8032862440	
153DN	KANAWHA LIFE INSURANCE COMPANY	PO BOX 6000	LANCASTER	SC	29721	8032862440	
868	KANSAS CITY LIFE	PO BOX 9040	AUSTIN	TX	78766	8008745254	
E80	KANSAS INDEPENDENT PHARMACY (KPSC)	4125 SOUTH WEST GAGE CENTER DR., STE. 203	TOPEKA	KS	66604	8002793022	
C30	KEENAN AND COMPANY	PO BOX 11431	TORRANCE	CA	90510	8006533626	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
677	KERSHAW COUNTY						
760	KEY BENEFIT ADMINISTRATORS	PO BOX 3252	MILWAUKEE	WI	53201	8003314757	
936	KEY BENEFITS-TRANSCHOICE PLUS	PO BOX 3252	MILWAUKEE	WI	53201	8668676883	
893	KEYSTON HEALTH PLAN EAST	PO BOX 8339	PHILADELPHIA	PA	19101	8002273116	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
D71	KEYSTONE 65	PO BOX 7799	PHILADELPHIA	PA	191017799	8002273116	MEDICARE ADVANTAGE PLAN
B66	KIRKE-VAN ORSDEL, INC.	PO BOX 9126	DES MOINES	IA	503069126	8002472192	USE CODE 759 MEDIPLUS PER SCHA
318	KLAIS & COMPANY	1867 WEST MARKET ST.	AKRON	OH	443136977	3308678443	
900	KOHLER COMPANY	444 HIGHLAND DR.	KOHLER	WI	530441515	9204574441	
711	LABORERS DISTRICT COUNCIL OF GA AND SC	PO BOX 607	JONESBORO	GA	302370607	4044771888	
320	LAMAR LIFE INSURANCE COMPANY	PO BOX 880	JACKSON	MS	39201	6019493100	
678	LANCASTER COUNTY						
679	LAURENS COUNTY						
D04	LBA HEALTH PLANS, INC./PRIMARY SELECT	PO BOX 17098	OWINGS MILL	MD	211177098	8008158240	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
680	LEE COUNTY						
978	LEGGETT & PLATT	PO BOX 7687	HIGH POINT	NC	27264	8773112150	
D31	LEON MEDICAL CENTER HEALTH PLAN	PO BOX 65-9006	MIAMI	FL	33265	3055595366	MEDICARE ADVANTAGE PLAN
681	LEXINGTON COUNTY						
B62	LIBERTY DENTAL	PO BOX 26110	SANTA ANNA	CA	92799	8889020349	
943	LIBERTY MUTUAL LIFE INSURANCE	5 HUTCHINSON DR.	DANVERS	MA	01923	8889994767	CODE IN OPEN STATUS BY SCHA
540	LIBERTY NATIONAL LIFE INSURANCE COMPANY	PO BOX 2612	BIRMINGHAM	AL	35202	2053252722	
243	LIFE & CASUALTY INSURANCE COMPANY OF TENNESSEE	AMERICAN GENERAL CENTER	NASHVILLE	TN	37250	6157491000	
B02	LIFE INSURANCE CO. OF ALABAMA	PO BOX 349	GADSDEN	AL	35902	8002262371	
156	LIFE INSURANCE COMPANY OF GEORGIA	PO BOX 105006	ATLANTA	GA	303485006	7709805100	
157	LIFE INSURANCE COMPANY OF VIRGINIA, THE	PO BOX 27601	RICHMOND	VA	23230	8042816000	
408	LIFE INVESTORS INSURANCE COMPANY OF AMERICA	PO BOX 8043	LITTLE ROCK	AR	72203	5013760426	AKA AEGON
515	LIFE OF THE SOUTH INSURANCE COMPANY	PO BOX 45237	JACKSONVILLE	FL	32232	8006616385	THIS CODE ASSIGNED BY SCHA NOT A MEDICAID REQUEST
241	LIFE REINSURANCE CO.	PO BOX 792070	SAN ANTONIO	TX	78279	8002291024	
F19	LIFEMAP	PO BOX 783	MILWAUKEE	WI	53201	8002841129	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
D87	LIFESTYLE HEALTHCARE	345 N. RIVERVIEW STE. 600	WICHITA	KS	67203	8668276607	FORMERLY MEDOVA HEALTHCARE
F45	LIFETIME BENEFIT SOLUTIONS	PO BOX 780	LIVERPOOL	NY	13088	8772543132	
F45DN	LIFETIME BENEFIT SOLUTIONS	PO BOX 780	LIVERPOOL	NY	13088	8772543132	DENTAL ONLY
138	LIFEWELL HEALTH PLANS	PO BOX 16203	LUBBOCK	TX	79490	8775433935	SUBSIDIARY OF HEALTHSCOPE
B23	LINCOLN FINANCIAL GROUP	PO BOX 614008	ORLANDO	FL	32861	8004232765	
323	LINCOLN HERITAGE LIFE INSURANCE CO	PO BOX 10843	CLEARWATER	FL	337578843	8885868810	
158	LINCOLN NATIONAL LIFE INSURANCE COMPANY	PO BOX 614008	ORLANDO	FL	32861	8004232765	
796	LINECO	821 PARKVIEW BLVD.	LOMBARD	IL	601483230	8003237268	CODE ASSIGNED BY SCHA
A53	LONGSHORE & HARBOR WORKERS COMP PROGRAM	PO BOX 8300	LONDON	KY	407428300	8663358319	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
367	LOOMIS INSURANCE COMPANY	PO BOX 7011	WYOMISSING	PA	196107011	8007820392	
C85	LOYAL AMERICAN LIFE INSURANCE COMPANY	PO BOX 559004	AUSTIN	TX	78755	8006336752	
492	LT11-LIFETRAC NETWORK	111100 WAYZATA BLVD.	MINNEAPOLIS	MN	55305		CODE ASSIGNED BY SCHA
B18	LUMENOS	PO BOX 69309	HARRISBURG	PA	17106	8774957223	
504	M CARE	PO BOX 130799	ANN ARBOR	MI	481130779	2156578920	CODE IN OPEN STATUS BY SCHA
396	MACY'S HR SERVICES	PO BOX 850958	RICHARDSON	TX	75085	8003372363	CODE ASSIGNED BY SCHA
C11	MAESTRO HEALTH	P O BOX 1178	MATTHEWS	NC	28106	8002281803	
C11DN	MAESTRO HEALTH	P O BOX 1178	MATTHEWS	NC	28106	8002281813	
B16	MAGELLAN RX	11013 W BROAD ST., STE. 500	GLEN ALLEN	VA	23060	8006594112	
A32	MAGELLAN BEHAVIORAL HEALTH	PO BOX 1659	MARYLAND HEIGHTS	MO	63043	8003592422	
B07	MAGNACARE	PO BOX 1001	GARDEN CITY	NY	11530	8666246259	
847	MAHONEY BENEFIT ADMINISTRATORS	PO BOX 7260	FORT LAUDERDALE	FL	33338	8002807093	
327	MAIL HANDLERS BENEFIT PLAN	PO BOX 8402	LONDON	KY	40742	8004107778	
E23	MAINE SENSE	PO BOX 1959	GRAY	ME	04039	8002908559	
159	MAKSIN MANAGEMENT CORP	CN98000	PENNSAUKEN	NJ	08110	8002570625	
438	MAMSI LIFE AND HEALTH INSURANCE CO	PO BOX 993	FREDERICK	MD	21705	8002576458	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
860	MANAGED HEALTH NETWORK	PO BOX 209010	AUSTIN	TX	78720	8008352094	
915	MANAGED HEALTH RESOURCES	PO BOX 30742	CHARLOTTE	NC	28208	7043555200	
835	MANAGED PHARMACY BENEFITS	1100 NORTH LINDBERGH	ST. LOUIS	MO	63132	8006729540	THIS CARRIER BOUGHT OUT BY EXPRESS SCRIPTS.
A15	MANAGED PRESCRIPTIONS SERVICES (MPS)	ONE CITY CENTRE STE. 1100	ST. LOUIS	MO	631016922	8007596959	
932	MANHATTAN INSURANCE GROUP	PO BOX 925309	HOUSTON	TX	772925309	8006699030	CODE ASSIGNED BY SCHA. NOT REQUESTED BY MEDICAID
682	MARION COUNTY						
A26	MARKEL SMART STM	PO BOX 15953	LUBBOCK	TX	79490	8002792290	
683	MARLBORO COUNTY						
268	MARQUETTE NATIONAL LIFE INS. CO.	PO BOX 130	PENSACOLA	FL	32591	8009348203	
709DN	MARSH ADVANTAGEAMERICA	501 NORTH BROADWAY, STE. 500	ST. LOUIS	MO	63102	8008687526	FORMERLY BENEFIT PLAN SERVICES
405	MARSH(INSURANCE TRUST PLAN-DELTA RETIREES)	PO BOX 10432	DES MOINES	IA	503060432	8773257265	CODE ASSIGNED BY SCHA
531	MARY BLACK HEALTHNETWORK	1690 SKYLYN DR., STE. 130	SPARTANBURG	SC	29307	8645733535	
569	MARYLAND PHYSICIANS CARE	PO BOX 61778	PHOENIX	AZ	85082	8009538854	CODE IN OPEN STATUS BY SCHA
226	MASTER HEALTH PLAN	PO BOX 16367	AUGUSTA	GA	303919123	7068635955	
B32	MAXCARE	PO BOX 16430	OKLAHOMA CITY	OK	73113	8002597765	
E99	MAXORPLUS	320 SOUTH POLK ST., STE. 200	AMARILLO	TX	79101	8006870707	
E99RX	MAXORPLUS	320 SOUTH POLK ST., STE. 200	AMARILLO	TX	79101	8006870707	RX ONLY
586	MCA ADMINISTRATORS (MANAGED CARE OF AMERICA)	MANOR OAK TWO, STE 605 1910 COCHRAN RD.	PITTSBURGH	PA	15220	4129220780	WAS DIVERSIFIED GROUP ADMINISTRATORS
684	MCCORMICK COUNTY						
361	MDI GOVERNMENT HEALTH SERVICES	822 HIGHWAY A1A NORTH STE. 310	PONTE VEDRA BEACH	FL	32082	8008416288	CODE ASSIGNED BY SCHA
368	MED BENEFITS SYSTEM	PO BOX 177	SOUTH BEND	IN	46601	2192370560	
206	MED COST BENEFITS SERVICES	PO BOX 25307	WINSTON-SALEM	NC	271145307	8007951023	
206DN	MED COST BENEFITS SERVICES	PO BOX 25987	WINSTON-SALEM	NC	27114	8007951023	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
223	MED COST PREFERRED	PO BOX 25437	WINSTON-SALEM	NC	27114	8008247406	CODE ASSIGNED BY SCHA
B38	MEDBEN	PO BOX 1009	NEWARK	OH	43058	8006868425	
798	MEDCARE INTERNATIONAL	12480 WEST ATLANTIC BLVD., STE. 2	CORAL SPRINGS	FL	33071	9543455650	
873	MEDCO HEALTH	PO BOX 8190	MADISON	WI	537088190	8002217006	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY THE SCHA
C46	MEDCO HEALTH SOLUTIONS	PO BOX 2902	CLINTON	IA	527332902	8002727243	USE CARRIER 333 EXPRESS SCRIPTS
152	MEDICA	PO BOX 30990	SALT LAKE CITY	UT	84130	8009523455	CODE NOT REQUESTED BY MEDICAID ASSIGNED BY SCHA
222	MEDICA	PO BOX 30990	SALT LAKE CITY	UT	84107	8009523455	
619	MEDICAID, SC						
616	MEDICAID-OUT-OF-STATE						
C98	MEDICAL BENEFIT ADM. OF MARYLAND, INC.	PO BOX 950	FORREST HILL	MA	60631	8885323467	
295	MEDICAL BENEFIT ADMINISTRATORS	5940 SEMINOLE CENTER CT.	MADISON	WI	53711	6082731776	
781	MEDICAL CLAIMS MANAGEMENT CORP	PO BOX 25307	WINSTON-SALEM	NC	271145307	8003340609	
781DN	MEDICAL CLAIMS MANAGEMENT CORP	PO BOX 12995	CHARLOTTE	NC	282202995	8003340609	
C25	MEDICAL CLAIMS SERVICES	1 WALL ST., STE. 2A	RAVENSWOOD	WV	26164	8882250522	
822	MEDICAL MUTUAL	PO BOX 6018	CLEVELAND	OH	44101	8002582873	CODE ASSIGNED BY SCHA
539	MEDICAL MUTUAL INSURANCE OF OHIO	PO BOX 94648	CLEVELAND	OH	44101	8003621279	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
X0R	MEDICAL MUTUAL OF OHIO	PO BOX 6018	CLEVELAND	OH	44101	2166877000	
X0RDN	MEDICAL MUTUAL OF OHIO	PO BOX 981800	EL PASO	TX	79998	2166877000	
979	MEDICAL REIMBURSEMENT OF AMERICA	113 SEABOARD LANE	FRANKLIN	TN	37067	6159633826	THIS CODE IS USED BY SCHA NOT AN ACTIVE MEDICAID CODE
207	MEDICAL SAVINGS HEALTH PLAN	419 E. MAIN ST.	MIDDLETON	NY	10940	3173298222	
B39	MEDICAL SAVINGS INSURANCE CO.	5835 WEST 74TH ST.	INDIANAPOLIS	IN	462781758	3173298222	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
X1N	MEDICAL SERVICE CORPORATION OF EASTERN WASHINGTON	PO BOX 3048	SPOKANE	WA	99220	5095364900	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
D99	MEDICARE ADVANTAGE						MEDICARE ADVANTAGE PLAN GENERIC CODE
D32	MEDICARE COMPLETE (UNITED HEALTH CARE)	PO BOX 659735	SAN ANTONIO	TX	782659735	8778423210	MEDICARE ADVANTAGE PLAN
618	MEDICARE PART A						
620	MEDICARE PART B ONLY						
D14	MEDICARE PLUS BLUE (BCBS OF MICHIGAN)	27000 ELEVEN MILE RD.	SOUTHFIELD	MI	48034	8002495103	MEDICARE ADVANTAGE PLAN
617	MEDICARE RAILROAD (PGBA) PROFESSIONAL PART B	PO BOX 10066	AUGUSTA	GA	30999	8772887600	
C99	MEDICO INSURANCE COMPANY	PO BOX 21660	EAGAN	MN	55121	8002286080	CARRIER WAS PREVIOUSLY C35
995	MEDIMPACT	10680 TREENA ST., STOP 5	SAN DIEGO	CA	92131	8007882949	
372	MEDIPLAN	502 VALLEY RD.	WAYNE	NJ	07410	9736963111	
759	MEDIPLUS	PO BOX 9126	DES MOINES	IA	50309	8002472192	AKA TROA
E96	MEDPARTNERS ADMINISTRATIVE	6920 POINT INVERNESS WAY	FORT WAYNE	IN	46804	8883129744	
B56	MEDSAVE USA	3035 LAKELAND HILLS BLVD.	LAKELAND	FL	33805	8002263155	
746	MED-TAC CLAIMS	PO BOX 9110	NEWTON	MA	02160	8003479355	
C96	MEDTRACK SERVICES	7101 COLLEGE BLVD., STE. 1000	OVERLAND PARK	KS	66210	8007714648	
E41	MEDTRAK	7101 COLLEGE BLVD., STE. 1000	OVERLAND PARK	KS	66210	8007714648	
477	MEGA LIFE AND HEALTH INSURANCE COMPANY	PO BOX 981606	EL PASO	TX	79998	8005272845	
B50	MEMBER HEALTH	PO BOX 391180	CLEVELAND	OH	44139	8888685854	
709	MERCER ADMINISTRATION	PO BOX 4546	IOWA CITY	IA	52244	8008687526	
833	MERCY HEALTH PLANS	PO BOX 4568	SPRINGFIELD	MO	658084568	8006472240	
F14	MERIDIANRX	PO BOX 9306	GARDEN CITY	NY	48226	8553234580	RX
377	MERITAIN HEALTH	PO BOX 27267	MINNEAPOLIS	MN	554270267	8009252272	WAS NORTH AMERICAN ADMINISTRATORS, INC.
A29	MERITAN HEALTH	PO BOX 80884	INDIANAPOLIS	IN	46280	8006064841	
108	METROPOLITAN LIFE INSURANCE COMPANY	PO BOX 981282	EL PASO	TX	79998	8006386626	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
916	MHEALTH	PO BOX 742567	HOUSTON	TX	77274	8886425040	
961	MHN (MANAGED HEALTH NETWORK)	PO BOX 27018	LAS VEGAS	NV	89126	8004584642	CODE ASSIGNED BY SCHA
790	MHNET BEHAVIORAL HEALTH	PO BOX 7802	LONDON	KY	40742	8007527242	
988	MID WEST NATIONAL LIFE INS. CO.	PO BOX 981606	EL PASO	TX	799981610	8007331110	
742	MIDA DENTAL PLAN	2000 TOWN CENTER, STE. 2200	SOUTHFIELD	MI	48075	8009376432	
C95	MIDWEST SECURITY	2700 MIDWEST DR.	ONALASKA	WI	54650	8002368672	
D40	MINNESOTA POWER HEALTH PLANS	30 W SUPERIOR ST.	DULUTH	MN	55802	8888128800	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C06	MISSIONARY MEDICAL	PO BOX 45730	SALT LAKE CITY	UT	84145	8007771647	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
820	MMSI MAYO MANAGEMENT SERVICES	4001 41ST ST. WEST	ROCHESTER	NM	41154	8006356671	CODE ASSIGNED BY SCHA SEE CARRIER CODE 536
545	MOLINA HEALTHCARE OF OHIO	PO BOX 22712	LONG BEACH	CA	90801	8006424148	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
774	MOLINA MEDICARE OPTIONS PLUS	PO BOX 22811	LONG BEACH	CA	90801	8006651328	MEDICARE ADVANTAGE PLAN
597	MONARCH DIRECT	PO BOX 9004	SPRINGFIELD	MA	01101	8006289000	
227	MONUMENTAL GENERAL INSURANCE COMPANY	1111 N CHARLES ST.	BALTIMORE	MD	20201	8007529797	
460	MORRIS ASSOCIATES	PO BOX 50440	INDIANAPOLIS	IN	462500440	3175549000	
D24	MOUNT CARMEL HEALTH PLAN (MCHP) MEDIGOLD (HMO)	PO BOX 6111	WESTERVILLE	OH	43086	8002403870	MEDICARE ADVANTAGE PLAN
733	MOUNTAIN CLAIMS MANAGEMENT	PO BOX 1008	FRUITLAND	ID	83619	2084527979	CODE IN OPEN STATUS BY SCHA
A12	MOUNTAIN CLAIMS MANAGEMENT	PO BOX 1008	FRUITLAND	ID	83616	8669527979	
X2P	MOUNTAIN STATE BLUE CROSS & BLUE SHIELD, INC.	PO BOX 1948	PARKERSBERG	WV	26102	3044247700	
993	MPI INTERNATIONAL, INC.	PO BOX 81913	ROCHESTER	MI	483081913	2488539010	
432	M-PLAN CARDINAL HEALTH	PO BOX 357	LINTHICUM	MD	210900357	8006752605	CODE ASSIGNED BY SCHA
A18	MSH MOBILITY BENEFITS	PO BOX 77	BEEBE PLAIN	VT	05823	8888421530	CODE ASSIGNED BY SCHA
564	MULTINATIONAL UNDERWRITERS	PO BOX 863	INDIANAPOLIS	IN	46206	8006052282	CODE ASSIGNED BY SCHA
954	MULTIPLAN	115 5TH AVE.	NEW YORK	NY	100031004	8005463887	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
593	MUTUAL ASSURANCE ADMINISTRATORS, INC.	PO BOX 42096	OKLAHOMA CITY	OK	73123	8006489652	
724	MUTUAL MEDICAL PLANS	PO BOX 689	PEORIA	IL	61652	8004484689	CODE ASSIGNED BY SCHA
107	MUTUAL OF OMAHA	MUTUAL OF OMAHA PLAZA	OMAHA	NE	68175	8002289090	DO NOT USE FOR MED ADV. THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE.
635	MUTUAL OF OMAHA	MUTUAL OF OMAHA PLAZA	OMAHA	NE	68175	4023427600	MEDICARE INTERMEDIARY PART A
636	MUTUAL OF OMAHA	MUTUAL OF OMAHA PLAZA	OMAHA	NE	68175		MEDICARE INTERMEDIARY PART B
C35	MUTUAL PROTECTIVE MEDICO LIFE INSURANCE COMPANIES	1515 S 75TH ST.	OMAHA	NE	68124	8002286080	SEE CODE C99
937	MVP HEALTH CARE	PO BOX 2207	SCHENECTADY	NY	12301	8002295851	NAME CHANGE ONLY 4/09. WAS PREFERRED CARE
937DN	MVP HEALTH CARE	PO BOX 763	SCHENECTADY	NY	12301	8004805640	
291	NALC HEALTH BENEFIT PLAN	20547 WAVERLY CT.	ASHBURN	VA	20149	7037294677	
522	NATIONAL AUTOMATIC SPRINKLER INDUSTRY	800 CORPORATE DR.	LANDOVER	MD	20785	3015771700	
312	NATIONAL BENEFIT ADMINISTRATORS	PO BOX 690903	CHARLOTTE	NC	282277016	8004826736	
312DN	NATIONAL BENEFIT ADMINISTRATORS	PO BOX 690903	CHARLOTTE	NC	282277016	8004826736	
C17	NATIONAL BENEFITS	110 GIBRALTAR RD.	HORSHAM	PA	19044	2154430404	
260	NATIONAL CLAIMS ADMINISTRATIVE SERVICES	PO BOX 10136	FAIRFAX	VA	220388022	8662199292	CODE IN OPEN STATUS BY SCHA
267	NATIONAL CLAIMS ADMINISTRATIVE SERVICES	PO BOX 220887	CHARLOTTE	NC	282220887	7043643865	CODE ASSIGNED BY SCHA
C74	NATIONAL CLAIMS ADMINISTRATIVE SERVICES	PO BOX 981610	EL PASO	TX	799981610	7043643865	
C74DN	NATIONAL CLAIMS ADMINISTRATIVE SERVICES	PO BOX 220887	CHARLOTTE	NC	28222	7043643865	
444	NATIONAL DISASTER MEDICAL SYSTEM						
599	NATIONAL ELEVATOR INDUSTRY HEALTH BENEFITS	PO BOX 477	NEWTOWN SQUARE	PA	190730477	8005234702	
A70	NATIONAL EMPLOYEE BENEFIT ADMINISTRATORS	1920 N. FLORIDA MANGO RD	WEST PALM BEACH	FL	33409	8008225899	
263	NATIONAL FINANCIAL COMPANY	110 WEST 7TH ST., STE. 300	FT WORTH	TX	76102	8007251407	
B53	NATIONAL FOUNDATION LIFE INSURANCE COMPANY	110 WEST 7TH ST., STE. 300	FORT WORTH	TX	76102	8002219039	
472	NATIONAL HEALTH CARE HEALTH BENEFITS PLAN (NHC)	PO BOX 1398	MURFREESBORO	TN	371331398	6158902020	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
929	NATIONAL HEALTH INSURANCE COMPANY	PO BOX 619999	DALLAS/FORT WORTH AIRPORT	TX	752619999	8002371900	
828	NATIONAL PHARMACEUTICAL SERVICES	PO BOX 407	BOYSTOWN	NE	68017	8005465677	
495	NATIONAL PRESCRIPTION ADMINISTRATORS	PO BOX 1981	EAST HANOVER	NJ	079361981	8005226727	BOUGHT OUT BY EXPRESS SCRIPTS CC333
334	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	1750 PENNSYLVANIA AVE., NW	WASHINGTON	DC	20006	8006388432	
C86	NATIONAL STATES INSURANCE COMPANY	PO BOX 27321, 1830 CRAIG PARK CT.	ST. LOUIS	MO	63141	3148780101	
914	NATIONAL TEACHERS ASSO LIFE INSURANCE CO.	PO BOX 2369	ADDISON	TX	75001	8886716771	
414	NATIONAL TELEPHONE COOP. ASSN.	1 WEST PACK SQUARE, STE. 600	ASHEVILLE	NC	28801	8282529776	
558	NATIONAL TRAVELERS LIFE INS. CO.	PO BOX 9197	DES MOINES	IA	50306	8002325818	INACTIVE 8/02
388	NATIONALWAY HEALTHCARE ASSOCIATES	PO BOX 682708	HOUSTON	TX	77268	8008107856	
163	NATIONWIDE LIFE INSURANCE COMPANY	PO BOX 182202	COLUMBUS	OH	432182202	6142497111	
A52	NATIONWIDE SPECIALTY HEALTH CLAIMS	PO BOX 420	SPRINGFIELD	MA	01101	8005174791	
518	NAT'L ASBESTOS WORKERS MED FUND	PO BOX 188004	CHATTANOOGA	TN	37422	8003863632	
B67	NAVITUS HEALTH SOLUTIONS LLC	PO BOX 999	APPLETON	WI	549120999	8662682501	
800	NEBCO (TENNECO)	PO BOX 97	SCRANTON	PA	185040097	8007177562	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
141	NEOA HEALTH BENEFITS FUND	428 E SCOTT AVE., PO BOX 3070	KNOXVILLE	TN	37927		
806	NETWORK HEALTH PLAN	PO BOX 568	MENASHA	WI	54952	9207201300	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
360	NEW ENGLAND FINANCIAL	PO BOX 190019	N. CHARLESTON	SC	29419	8004087681	USE CARRIER 859 NEW ENGLAND GROUP TRUST
859	NEW ENGLAND GROUP TRUST	PO BOX 30466	TAMPA	FL	33630	8006541731	
248	NEW ENGLAND LIFE INSURANCE	25145 COUNTRY CLUB BLVD.	NORTH OLMSTED	OH	440705300	8002558063	
437	NEW ERA LIFE INSURANCE CO	PO BOX 4884	HOUSTON	TX	772104884	2813687200	
520	NEW JERSEY CARPENTERS	PO BOX 7818	EDISON	NJ	088180846	8006243096	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
808	NEW MARKET DIMENSION	PO BOX 1338	COCKEYVILLE	MD	21031	8005706745	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
C89	NEW SOURCES BENEFITS	PO BOX 6305	SPARTANBURG	SC	29304	8004761555	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
165	NEW YORK LIFE INSURANCE COMPANY	PO BOX 105095	ATLANTA	GA	30348	8003884580	
D39	NEW YORK WELFARE FUND	101-49 WOODHAVEN BLVD.	OZONE PARK	NY	11416	7188455800	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
685	NEWBERRY COUNTY						
B54	NGS AMERICAN, INC.	PO BOX 2310	MT. CLEMENS	MI	48046	8107797676	
B97	NIPPON LIFE INSURANCE CO.	PO BOX 25951	SHAWNEE MISSION	KS	662255951	8003741835	
174	NMU PENSION & WELFARE FUND	360 WEST 31ST ST., 3RD FL	NEW YORK	NY	10001	2123374900	
350	NORTH AMERICA ADMINISTRATORS	PO BOX 1984	NASHVILLE	TN	37203	6152563561	
384	NORTH AMERICAN BENEFIT NETWORK	PO BOX 94928	CLEVELAND	OH	441014928	8003214085	
C36	NORTH AMERICAN INSURANCE COMPANY	PO BOX 44160	MADISON	WI	53744	6086621232	
359	NORTH CAROLINA MUTUAL LIFE INSURANCE	411 W. CHAPEL HILL ST.	DURHAM	NC	27701	9196829201	
594	NORWEST FINANCIAL	206 EIGHTH ST.	DES MOINES	IA	50309	5152432131	CODE ASSIGNED BY SCHA
A17	NOVA HEALTHCARE ADMINISTRATORS	2680 GRAND ISLAND BLVD.	GRAND ISLAND	NY	140720308	8003333195	
A64	NTCA (NAT'L TELECOMMUNICATIONS COOPERATIVE ASSO.)	ONE WEST PACK SQUARE STE 600	ASHEVILLE	NC	288013459	8282819000	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
170	OCCIDENTAL LIFE INSURANCE COMPANY OF NC	PO BOX 10324	RALEIGH	NC	27605	9198318189	
686	OCONEE COUNTY						
821	ODS HEALTH PLAN ADVANTAGE	PO BOX 4030	PORTLAND	OR	972084030	8773370650	
982	OFFICE OF GROUP BENEFITS STATE OF LOUISIANA	PO BOX 44036	BATON ROUGE	LA	708044036	8002728451	
591	OLD AMERICAN INSURANCE COMPANY	PO BOX 418573	KANSAS CITY	MO	64141	8167534900	
C37	OLD SURETY LIFE INSURANCE CO	PO BOX 54407	OKLAHOMA CITY	OK	731541407	8002725466	
866	OLYMPIC HEALTH MANAGEMENT	PO BOX 5348	BELLINGHAM	WA	98227	3607349888	
353	ONE HEALTH PLAN OF SC	PO BOX 190019	N CHARLESTON	SC	29419	8003149010	CODE ASSIGNED BY SCHA
583	ONE NATION BENEFIT ADMINISTRATORS	PO BOX 528	COLUMBUS	OH	43216	8008246796	NAME CHANGE WAS ANTHEM BENEFIT ADMINISTRATORS
850	ONENET PPO	PO BOX 934	FREDERICK	MD	217050934	8003423289	CODE ASSIGNED BY SCHA
807	OPTIMA HEALTH PLAN	PO BOX 5028	TROY	MI	460071199	8002291199	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
896	OPTIMED HEALTH PLAN	4 TERRY DR., STE. 1	NEWTOWN	PA	18940	8004828770	
891	OPTIMUM CHOICE OF THE CAROLINAS, INC.	4 TAFT CT.	ROCKVILLE	MD	20850	8003438205	
880	OPTIMUM HEALTH PARTNERS	PO BOX 2243	GREENVILLE	SC	29602	8642134992	
XYZ	OPTUM RX	PO BOX 29044	HOT SPRINGS	AR	71093	8007887871	FORMERLY PRESCRIPTION SOLUTIONS
687	ORANGEBURG COUNTY						
603	OTHER INDIGENT (HOSPITAL CHARITY)			SC			
624	OTHER SPONSOR						
696	OUT-OF-STATE GA						
697	OUT-OF-STATE NC						
698	OUT-OF-STATE OTHER						
215	OXFORD LIFE INSURANCE COMPANY	PO BOX 46518	MADISON	WI	53744	8774693073	
D26	OXFORD MEDICARE ADVANTAGE (HMO)	PO BOX 7082	BRIDGEPORT	CT	06601	8002341228	MEDICARE ADVANTAGE PLAN
394	P5 HEALTH PLAN SOLUTIONS	PO BOX 9554	SALT LAKE CITY	UT	84109	8774740605	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
771	PACIFIC FIDELITY LIFE INSURANCE CO (P.F.L.)	PO BOX 982009	N RICHLAND HILLS	TX	761828009	8176566040	USE CODE 477 MEGA LIFE
784	PACIFIC HEALTH ADMINISTRATORS	PO BOX 620123	ORLANDO	FL	328620123	8007766070	CODE ASSIGNED BY SCHA
399	PACIFIC LIFE AND ANNUITY	PO BOX 34799	PHOENIX	AZ	85067	8007332285	
254	PACIFIC MUTUAL LIFE INSURANCE COMPANY	700 NEWPORT CENTER DR.	NEWPORT BEACH	CA	92660	8004512513	
D03	PACIFIC SOURCE	PO BOX 7068	EUGENE	OR	97401	8006246052	
747	PACIFICARE	PO BOX 6099	CYPRESS	CA	90630	8663169776	CODE ASSIGNED BY SCHA
787	PACIFICARE SENIOR SUPPLEMENT PLAN	PO BOX 6072	CYPRESS	CA	906300072	8008513802	
766	PALMER & CAY/CARSWELL, INC.	PO BOX 1286	SAVANNAH	GA	31402	9122346621	
766DN	PALMER & CAY/CARSWELL, INC.	PO BOX 1286	SAVANNAH	GA	31402	9122346621	
B29	PANAMERICAN BENEFIT SOLUTIONS	PO BOX 981644	EL PASO	TX	799981644	8006949888	WAS US NOW INSURANCE GROUP
255	PAN-AMERICAN LIFE INSURANCE COMPANY	PO BOX 981644	EL PASO	TX	79998	8006949888	
976	PARAGON BENEFITS, INC.	PO BOX 12288	COLUMBUS	GA	31917	7062776710	
293	PARAMOUNT HEALTH CARE	PO BOX 497	TOLEDO	OH	43697	8888912564	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
890	PARTNERS NATIONAL HEALTH PLANS OF NORTH CAROLINA	PO BOX 17368	WINSTON-SALEM	NC	271167368	8009425695	
172	PAUL REVERE LIFE INSURANCE COMPANY	PO BOX 15118	WORCESTER	MA	016150118	5087994441	
E24	PBM PLUS	300 TECHNECENTER DR., STE. C	MILFORD	OH	45150	8002632178	
A21	PC HEALTH PLAN ADMINISTRATION	PO BOX 1377	THOMASVILLE	GA	31799	8884261937	CODE ASSIGNED BY SCHA
363	PEARCE ADMINISTRATION	PO BOX 2437	FLORENCE	SC	29503	8886226001	GM SOUTHWEST IS THE CLAIMS PROCESSOR FOR PEARCE ADMINISTRATION
538	PENN GENERAL SERVICES	PO BOX 72077	ATLANTA	GA	303581535	8004441535	CODE ASSIGNED BY SCHA
805	PENN TREATY NETWORK AMERICA (PTNA)	PO BOX 130	PENSACOLA	FL	325910130	8006357418	CODE ASSIGNED BY SCHA
182	PENN TREATY NETWORK AMERICA INS. CO.	PO BOX 7066	ALLENTOWN	PA	181057066	8003620700	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C49DN	PENN WESTERN BENEFITS, INC.	PO BOX 2000	WINSTON-SALEM	NC	27102	8008465370	
X0J	PENNSYLVANIA BLUE SHIELD	PO BOX 890089	CAMP HILL	PA	17089	8006373493	
173	PENNSYLVANIA LIFE INSURANCE COMPANY	PO BOX 130	PENSACOLA	FL	325910100	8002757366	
770	PEOPLES BENEFIT LIFE INSURANCE	PO BOX 484	VALLEY FORGE	PA	19493	8005237900	
708	PERFORMAX	PO BOX 61505	KING OF PRUSSIA	PA	19406	8885547629	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
862	PERFORMAX	300 CORPORATE PARKWAY	AMHERST	NY	11226	8777776076	
325	PERSONAL CARE	PO BOX 7141	LONDON	KY	40742	8004311211	
740	PHARMACARE	PO BOX 52188	PHOENIX	AZ	850722196	8002376184	AS OF 1/1/08 CO. MERGED WITH CAREMARK (471) ADD NEW POLICIES WITH 471
964	PHARMACEUTICAL CARE NETWORK	9343 TECH CENTER DR.	SACRAMENTO	CA	95826	8007770074	
314	PHARMACY ADVANTAGE NETWORK	50 LENNOX POINTE	ATLANTA	GA	30324	8887275560	SEE CARRIER 366 CATALYST RX
B47	PHARMACY DATA MANAGEMENT, INC.	1170 E WESTERN RESERVE RD.	POLAND	OH	44514	8007740890	
257	PHARMACY NETWORK NATIONAL OF N.C.	4000 OLD WAKEFOREST RD., STE. 101	RALEIGH	NC	27609	8003317108	SEE CARRIER 366 CATALYST RX
B33	PHARMAVAIL DRUG COMPANY	3380 TRICKHUM RD., BLDG. 400, UNIT 100	WOODSTOCK	GA	30188	8009333734	
948	PHILADELPHIA AMERICAN LIFE INS. CO.	PO BOX 2465	HOUSTON	TX	77252	8005527879	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
555	PHILADELPHIA AMERICAN LIFE INSURANCE CO	PO BOX 4884	HOUSTON	TX	772104882	8005527879	CODE ASSIGNED BY SCHA
468	PHOENIX HEALTHCARE	PO BOX 150809	ARLINGTON	TX	76015	8003976241	
561	PHOENIX MUTUAL LIFE INSURANCE COMPANY	ONE AMERICAN ROW	HARTFORD	CT	06115	8004512513	THIS CARRIER PURCHASED BY CC864 GE GROUP ADMINISTRATORS
533	PHYSICIANS CARE NETWORK	PO BOX 101111	COLUMBIA	SC	292111111	8883239271	
326	PHYSICIANS HEALTH PLAN OF MID MICHIGAN	PO BOX 247	ALPHARETTA	GA	300090247	8008329186	
590	PHYSICIANS HEALTH SERVICES	PO BOX 981	BRIDGEPORT	CT	06601	8008484747	
773	PHYSICIANS MUTUAL INSURANCE COMPANY	PO BOX 2018	OMAHA	NE	681032018	8002289100	DO NOT USE THIS CODE FOR MEDICARE ADVANTAGE PLANS OFFERED BY THIS CARRIER
228	PHYSICIANS PLUS INS. CO.	PO BOX 909953	MILWAUKEE	WI	53209	8005455015	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
688	PICKENS COUNTY						
A22	PIEDMONT ADMINISTRATORS	PO BOX 25307	WINSTON-SALEM	NC	271145307	8008527040	
804	PIEDMONT COMMUNITY HEALTHCARE, INC.	PO BOX 14408	CINCINNATI	OH	452500408	8004007247	
434	PIEDMONT HEALTH ALLIANCE	116 BONHAM CT.	ANDERSON	SC	29621	8643759661	
487	PIEDMONT INS COMPANY	PO BOX 979	MARION	SC	29571	8434235541	
B10	PILGRIM HEALTH & LIFE INSURANCE	PO BOX 897	ATLANTA	GA	30303	4046592100	CODE IN OPEN STATUS BY SCHA
395	PINNACLE CLAIMS MANAGEMENT, INC.	1630 E SHAW AVE., STE. 190	FRESNO	CA	93710	8006499121	CODE ASSIGNED BY SCHA
B21	PIONEER HEALTH	PO BOX 6600	HOLYOKE	MA	01041	8004234586	
792	PIONEER LIFE INSURANCE COMPANY OF ILLINOIS	PO BOX 1250	ROCKFORD	IL	611051250	8159875000	USE CODE 282 WASHINGTON NATIONAL
338	PITTMAN & ASSOCIATES, INC.	PO BOX 111047	MEMPHIS	TN	38111	8002381344	
C55	PLAN ADMINISTRATORS (MATURE AMERICAN)	734 15TH ST. NW, STE. 500	WASHINGTON	DC	20005	2023936600	
276	PLAN HANDLERS	930 CANTERBURY PLACE	ESCONDIDO	CA	92025	8005385512	
886	PLANNED ADMINISTRATORS, INC.	PO BOX 6927	COLUMBIA	SC	29260	8037540041	
886DN	PLANNED ADMINISTRATORS, INC.	PO BOX 6927	COLUMBIA	SC	29260	8037540041	
706	PLUMBERS & PIPEFITTERS LOCAL NO. 421	PO BOX 840	MACON	GA	312020840	8887412673	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
585	PLUMBERS & STEAMFITTERS WELFARE FUND	1024 MCKINLEY ST.	PEEKSILL	NY	10566	9147377220	
751	POLARIS BENEFIT ADMINISTRATORS	PO BOX 2010	WESTERVILLE	OH	43086-	8002340225	
751DN	POLARIS BENEFIT ADMINISTRATORS	PO BOX 1008	DELAWARE	OH	43015-	8002340225	
751RX	POLARIS BENEFIT ADMINISTRATORS	PO BOX 1008	DELAWARE	OH	43015-	8002340225	
589	POLY AMERICA LP	2000 W MARSHALL DR.	GRAND PRAIRIE	TX	75051	8007855301	CODE IN OPEN STATUS BY SCHA
391	POMCO	PO BOX 6329	SYRACUSE	NY	13217	8002344393	
385	POSTMASTERS BENEFIT PLAN	1019 N. ROYAL ST.	ALEXANDRIA	VA	22314	7036835585	
A66	PRAIRIE STATES ENTERPRISES, INC.	PO BOX 23	SHEBOYGAN	WI	530820023	8008157020	
168	PRECISE BENEFIT ADMINISTRATORS	PO BOX 9064	JERICHO	NY	11753	5163906000	
877	PRE-EXISTING CONDITION INSURANCE PLAN (PCIP)	PO BOX 300	INDEPENDENCE	MO	640510300	8002207898	
A11	PREFERRED ADMINISTRATORS	15560 NORTH FLW BLVD.	SCOTTSDALE	AZ	85260	8772767198	
486	PREFERRED CARE	PO BOX 22920	ROCHESTER	NY	146922920	8009993920	MEDICARE ADVANTAGE PLAN
347	PREFERRED CARE, INC. (PCI)	1300 VIRGINIA DR., STE. 315	FORT WASHINGTON	PA	19034	8002223085	
909	PREFERRED HEALTH ALLIANCE CORP.	PO BOX 382048	BIRMINGHAM	AL	35238	8007228477	
909DN	PREFERRED HEALTH ALLIANCE CORP.	PO BOX 382048	BIRMINGHAM	AL	35238	2059691155	
270	PREFERRED HEALTH PLAN OF THE CAROLINAS	PO BOX 220397	CHARLOTTE	NC	28222	8666360239	
303	PREFERRED HEALTH PLAN, INC.	PO BOX 24125	LOUISVILLE	KY	40224	5023397500	
933	PREFERRED HEALTHCARE SYSTEMS	620 HOWARD AVE.	ALTOONA	PA	166014899		CODE ASSIGNED BY SCHA
B86	PREFERRED ONE ADMINISTRATIVE SERVICES	PO BOX 59212	MINNEAPOLIS	MN	55459	8009971750	
A43	PREMIER BENEFIT MANAGEMENT, INC.	7070-A KAIGHN AVE.	PENSAUKEN	NJ	08109		CODE ASSIGNED BY SCHA
939	PREMIER HEALTH SYSTEMS	PO BOX 1640	COLUMBIA	SC	292021640	8032968999	CODE ASSIGNED BY SCHA
C65	PRESBYTERIAN HEALTHCARE SERVICES	PO BOX 27489	ALBUQUERQUE	NM	87125	8003562219	
397	PRIME THERAPEUTIC	PO BOX 25136	LEHIGH VALLEY	PA	18002	8886420447	
844	PRIME TIME HEALTH PLAN	PO BOX 6905	CANTON	OH	44706	8006177446	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A42	PRIMERICA LIFE INSURANCE COMPANY	3120 BRECKINRIDGE BLVD.	DULUTH	GA	30199	4043811000	
479	PRIMEXTRA	PO BOX 1088	TWINSBURG	OH	44087	8004334893	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
942	PRINCIPAL FINANCIAL GROUP	PO BOX 10357	DES MOINES	IA	503060357	8002474695	
817	PRIORITY HEALTH	PO BOX 232	GRAND RAPIDS	MI	49501	8004465674	
940	PRIVATE HEALTH CARE SYSTEMS (PHCS)	PO BOX 6090	DEPERE	WI	54115	6087793000	CODE ASSIGNED BY SCHA 6/18/07
F42	PROACT	1126 US HIGHWAY 11	GOUVERNEUR	NY	13642	8662869885	RX ONLY
B35	PROCARE RX PBM	1267 PROFESSIONAL PARKWAY	GAINESVILLE	GA	30507	8006993542	
578	PROFESSIONAL ADMINISTRATORS, INC.	3751 MAGUIRE BLVD., STE. 100	ORLANDO	FL	32814	8007410521	
965	PROFESSIONAL BENEFIT ADMINISTRATORS, INC. (PBA)	PO BOX 4687	OAKBROOK	IL	605223755	6306553755	
A20	PROFESSIONAL CLAIMS MANAGEMENT	PO BOX 35276	CANTON	OH	443155276	8003258424	
A20DN	PROFESSIONAL CLAIMS MANAGEMENT	PO BOX 35276	CANTON	OH	443155276	8003258424	
316	PROFESSIONAL INSURANCE CORPORATION	2610 WYCLIFF RD.	RALEIGH	NC	27607	8002891122	
E102	PROTECTIVE LIFE INSURANCE	PO BOX 12687	BIRMINGHAM	AL	35202	2052687055	CANCER POLICY ONLY
534	PROVANTAGE PRESCRIPTION BENEFIT MANAGEMENT SERVICE	PO BOX 1662	WAUKEHA	WI	53187	2627844600	
A92	PROVIDENT AMERICAN LIFE & HEALTH INS.	PO BOX 29158	SHAWNEE MISSION	KS	66201915	8007535133	
485	PROVIDENT HEALTH PLAN	PO BOX 3125	PORTLAND	OR	972083125	8006283912	CODE ASSIGNED BY SCHA
381	PROVIDENT INDEMNITY LIFE INSURANCE COMPANY	PO BOX 511	NORRISTOWN	PA	19404	8005199175	
110RX	PROVIDENT/CAREMARK	PO BOX 686005	SAN ANTONIO	TX	78268	8008415550	USE CODE 280 CAREMARK
328	PROVIDER SELECT, INC.	PO BOX 330070	FORT WORTH	TX	76163	8667747766	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
111	PRUDENTIAL INSURANCE COMPANY OF AMERICA	841 PRUDENTIAL DR.	JACKSONVILLE	FL	32207	8003463778	THIS CARRIER BOUGHT OUT BY AETNA CC100
251	PYRAMID LIFE INSURANCE CO.	PO BOX 12922	PENSACOLA	FL	325912922	8006581413	CODE IN OPEN STATUS BY SCHA MEDICARE SUPPLEMENTAL PLAN G
D28	PYRAMID LIFE INSURANCE CO (PFFS)	PO BOX 958465	LAKE MARY	FL	327958465	4076281776	MEDICARE ADVANTAGE PLAN
230	PYRAMID LIFE INSURANCE COMPANY	P O BOX 130	PENSACOLA	FL	32591	8004440321	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
221	QUAL CARE	PO BOX 249	PISCATHAWAY	NJ	08855	8009926613	
A85	QUALCHOICE	PO BOX 25610	LITTLE ROCK	AR	722219914	8002357111	
A48	QUALMED OF OREGON	PO BOX 286	CLACKMAS	OR	970150286	8005685628	DORMANT 8/06
X0KRS	REGENCE BCBS OF OREGON	PO BOX 12625 MAILSTOP S4P	SALEM OREGON	OR	97309	8884371508	RX PLAN ONLY MM CODE X0K
X0KRX	REGENCE BCBS OF OREGON	PO BOX 12625 MAILSTOP S4P	SALEM	OR	97309	8884371508	
XOKRX	REGENCE BCBS OF OREGON RX PLAN	PO BOX 12625 MAILSTOP S4P	SALEM	OR	97309	8884371508	RX PLAN ONLY MM PLAN IS X0K
X0K	REGENCE BLUE CROSS BLUE SHIELD OF OREGON	PO BOX 1271	PORTLAND	OR	97207	5032255221	
795	REGIONAL MEDICAL ADMINISTRATORS, INC.	PO BOX 4128	GLEN RAVEN	NC	272150901	3362267950	
187	RELIANCE STANDARD LIFE INS. CO.	PO BOX 82510	LINCOLN	NE	68501	8004977044	
197	RELIANCE STANDARD SPECIALTY PRODUCTS ADM	505 S LENOLA RD., STE. 231	MOORESTOWN	NJ	08057	8663750775	
B19	RENAISSANCE DENTAL	PO BOX 17250	INDIANAPOLIS	IN	46217	8883589484	
296	RESERVE NATIONAL INSURANCE	PO BOX 26620	OKLAHOMA CITY	OK	73126	8006549106	
375	RESTAT	11900 WESTLAKE PARK DR.	MILWAUKEE	WI	53224	8009265858	
A95	REYNOLDS & REYNOLDS	PO BOX 1272	DAYTON	OH	45401	8007363539	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
689	RICHLAND COUNTY						
398	RIGHT CHOICE BENEFITS ADMINISTRATORS	12250 WEBER HILL RD., STE. 100	ST. LOUIS	MO	63127	8003659036	CODE ASSIGNED BY SCHA
214	RISK BENEFIT MANAGEMENT SERVICES, LLC (RBMS)	PO BOX 241569	ANCHORAGE	AK	99524	8007703740	
546	RISK MANAGEMENT SERVICES	PO BOX 6309	SYRACUSE	NY	13217	3154489000	
A30	RMSCO, INC.	PO BOX 678	LIVERPOOL	NY	130880678	8772047086	
A30DN	RMSCO, INC.	PO BOX 678	LIVERPOOL	NY	130880678	8772047086	
218	ROCKY MOUNTAIN HEALTH PLAN (RMHP)	PO BOX 4517	ENGLEWOOD	CO	80155	8884792000	
278	ROCKY MOUNTAIN HEALTH PLAN	PO BOX 10600	GRAND JUNCTION	CO	81502	8008544558	
762	ROYAL NEIGHBORS OF AMERICA	PO BOX 10850	CLEARWATER	FL	337578850	8778158857	CODE ASSIGNED BY SCHA
406	RURAL CARRIER BENEFIT PLAN	PO BOX 7404	LONDON	KY	40742	8006388432	

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CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
A09	RX AMERICA	221 N CHARLES LINDBERG DR.	SALT LAKE CITY	UT	84116	8007708014	
B89	RXEDO	7800 DALLAS PARKWAY STE 460	PLANO	TX	75024	8888797336	
C44	S C MEDICAL ASSOCIATION-MEMBERS INSURANCE TRUST	PO BOX 6927	COLUMBIA	SC	29260	8037986207	
185	S&S HEALTHCARE STRATEGIES	PO BOX 46511	CINCINNATI	OH	45216	8888008717	
410	SAFECO INSURANCE COMPANY	PO BOX 34699	REDMOND	WA	981241699	2068678000	
690	SALUDA COUNTY						
570	SAMBA HEALTH BENEFIT PLAN	11301 OLD GEORGETOWN RD.	ROCKVILLE	MD	20852	8006386589	
231	SAVERS LIFE INSURANCE COMPANY	8064 NORTH POINT BLVD., STE. 201	WINSTON-SALEM	NC	27106	8006420483	
489	SAVRX	PO BOX 8	FREEMONT	NE	68026	8003506714	
142	SC DEPT OF DISABILITIES AND SPECIAL NEEDS	PO BOX 4706	COLUMBIA	SC	29240	8038989795	CODE ASSIGNED BY SCHA
E91	SCOTT AND WHITE HEALTH PLAN	PO BOX 21800	EAGAN	MN	55121	8003217947	
C20	SCREEN ACTORS GUILD-PRODUCERS HEALTH PLAN	PO BOX 7830	BURBANK	CA	915107830	8007774013	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
846	SCRIPT CARE, INC.	6380 FOLSOM DR.	BEAUMONT	TX	77706	8008809988	
435	SEABURY AND SMITH COMPANY, INC.	PO BOX 2545	NASHVILLE	TN	37219	8005822498	
818	SEAFARERS HEALTH & BENEFIT PLAN (SHBP)	PO BOX 380	PINEY POINT	MD	20674	8002524674	
596	SECURE HORIZONS	PO BOX 659787	SAN ANTONIO	TX	782659787	8665798811	MEDICARE ADVANTAGE PLAN
D62	SECURE HORIZONS DIRECT (UNITED HEALTHCARE)	PO BOX 31353	SALT LAKE CITY	UT	84131	8665798774	MEDICARE ADVANTAGE PLAN
D27	SECURE HORIZONS PACIFICARE	PO BOX 25032	SANTA ANA	CA	927995032	7148253828	MEDICARE ADVANTAGE PLAN
D12	SECUREHORIZONS DIRECT PFFS	PO BOX 12466	PENSACOLA	FL	325912466	8882024340	MEDICARE ADVANTAGE PLAN
865	SECURIAN DENTAL PLANS	PO BOX 9385	MINNEAPOLIS	MN	554409385	8002349009	NAIC 93742
184	SECURITY LIFE INSURANCE CO. OF AMERICA	PO BOX 82520	LINCOLN	NE	68501	8003009566	
D15	SECURITYCHOICE ENHANCED PLUS	PO BOX 795180	SAN ANTONIO	TX	78279	8884458916	MEDICARE ADVANTAGE PLAN
C27	SELECT BENEFIT ADMINISTRATORS	PO BOX 3245	MILWAUKEE	WI	53201	8004973699	
C27DN	SELECT BENEFIT ADMINISTRATORS	PO BOX 440	ASHLAND	WI	54806	8004973699	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
E81	SELECT ADMINISTRATIVE SERVICES (SAS)	PO BOX 3209	GULFPORT	MS	39503	8008476621	
B48	SELECT HEALTH	PO BOX 30192	SALT LAKE CITY	UT	84123	8005385038	
E37	SELECT HEALTH	PO BOX 7120	LONDON	KY	40742	8882762020	HEALTHY KIDS CONNECTION
883	SELECT HEALTH OF SOUTH CAROLINA, INC.	7410 NORTHSIDE DR., STE. 208	CHARLESTON	SC	29420	8435691759	CODE IN OPEN STATUS BY SCHA
637	SELECT HEALTH/FIRST CHOICE	PO BOX 7120	LONDON	KY	40742	8882762020	MEDICAID HMO
392	SELF FUNDED GROUP INSURANCE ADMINISTRATORS	PO BOX 1719	KALAMAZOO	MI	490051790	8003421895	
204	SELF INSURED BENEFIT ADMINISTRATORS	18167 US HWY 19N	CLEARWATER	FL	33764	7275320400	
229	SELF INSURED PLANS LLC	1016 COLLIER CENTER WAY STE. 200	LOS ANGELES	CA	90080	8004212342	CODE ASSIGNED BY SCHA
378	SELF INSURERS SERVICE, INC.	2218 SOUTH PRIEST DR.	TEMPE	AZ	85282		
744	SENIOR DIMENSIONS	PO BOX 15645	LAS VAGAS	NV	891145645	8009257455	
930	SENTRY LIFE INSURANCE COMPANY	PO BOX 8025	STEVENS POINT	WI	54481	8004267234	
A23	SERV U PRESCRIPTION	PO BOX 26096-0096	MILWAUKEE	WI	53226	8007593203	
D10	SEVEN CORNERS, INC.	PO BOX 3430	CARMEL	IN	46082	8666994186	
235	SHAW INDUSTRIES	PO BOX 10	DALTON	GA	30722	8003211855	
490	SHEET METAL LOCAL 20	PO BOX 42489	INDIANAPOLIS	IN	43242	8002482141	CODE ASSIGNED BY SCHA
A28	SHENANDOAH LIFE INSURANCE CO	PO BOX 12847	ROANOKE	VA	24029	8008485433	
838	SHESFIELD, OLSON & MCQUEEN	PO BOX 16608	ST. PAUL	MN	55116	8883308408	
631	SHRINERS						
208	SIEBA, LTD	PO BOX 5000	ENDICOTT	NY	13761	8002524624	
D53	SIERRA OPTIMA PLUS CLAIMS	PO BOX 15645	LAS VEGAS	NV	891145645	8882742207	MEDICARE ADVANTAGE PLAN
E97	SIGNATURE CARE	PO BOX 5548	FORT WAYNE	IN	46895	8006664449	
C87	SIHO INSURANCE SERVICES	PO BOX 1787	COLUMBUS	IN	47202	8008732022	
E82	SIMPLE BENEFIT PLANS	2810 PREMIER PARKWAY STE. 400	DULUTH	GA	30097	8002704158	
568	SIMPLIFI	PO BOX 922043	HOUSTON	TX	772922043	8884465710	FORMERLY CBCA ADMINISTRATORS

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
B95	SINCLAIR HEALTH SERVICES	PO BOX 30827	SALT LAKE CITY	UT	84130	8888002230	
576	SIOUX VALLEY HEALTH	PO BOX 91110	SIOUX FALLS	SD	57109	8007525863	
A77	SISCO	PO BOX 389	DUDUQUE	IA	52004	8004574725	
D22	SMART VALUE (BC OF GA) (PFFS)	PO BOX 3897	SCRANTON	PA	18505	8668659329	MEDICARE ADVANTAGE PLAN
478	SMITH ADMINISTRATORS	PO BOX 163289	FORT WORTH	TX	76161	8008672582	
298	SMITH PREMIERE PHARMACY PLAN	PO BOX 5824	SPARTANBURG	SC	29304	8002474526	
329	SMITHFIELD FOODS HEALTHCARE	PO BOX 158	SMITHFIELD	VA	23431	8008095916	
D82	SOLSTICE	PO BOX 14009	LEXINGTON	KY	40512	8777602247	
B06	SOUTHCARE HEALTHCARE PREFERRED	1100 CIRCLE 75 PARKWAY, STE. 1400	ATLANTA	GA	30339	8004702004	
A87	SOUTHEAST COMMUNITY CARE (ARCADIAN HEALTH)	PO BOX 4946	COVINA	CA	91723	8005738597	
D43	SOUTHEAST COMMUNITY CARE BY ARCADIAN HEALTH	PO BOX 4946	COVINA	CA	91723	8005738597	MEDICARE ADVANTAGE PLAN
888	SOUTHEASTERN BENEFIT PLANS, INC.	335 ARCHDALE DR.	CHARLOTTE	NC	282174246	7045295400	
C48	SOUTHERN ADMINISTRATIVE SERVICES	PO BOX 8069	COLUMBUS	GA	31908	8004268803	
897	SOUTHERN BENEFIT ADM.	PO BOX 188006	CHATTANOOGA	TN	37422	8006784656	
897DN	SOUTHERN BENEFITS ADMINISTRATORS DENTAL	5305 VIRGINIA BEACH BLVD.	NORFOLK	VA	23502	7574618091	
B30	SOUTHERN BENEFITS, SOUTHEASTERN PIPE TRADERS	PO BOX 1449	GOODLETTSVILLE	TN	370701449	8008314914	
D06	SOUTHERN CALIFORNIA BAKERY & CONFECTIONARY	PO BOX 22041	COMMERCE	CA	90022	3237227171	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B73	SOUTHERN CALIFORNIA PIPE TRADES TRUST FUND	501 SHATTO PLACE, 5TH FLOOR	LOS ANGELES	CA	90020	2133856161	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
224	SOUTHERN ELEC. HEALTH FUND	3928 VOLUNTEER DR.	CHATTANOOGA	TN	37416	4238992593	
B57	SOUTHERN FARM BUREAU LIFE INS. CO.	PO BOX 78	JACKSON	MS	39205	8004579611	
990	SOUTHERN GROUP ADMINISTRATORS, INC.	200 SOUTH MARSHALL ST.	WINSTON-SALEM	NC	27101	8003348159	
B52	SOUTHERN PLANNED ADMINISTRATORS	PO BOX 218180	HOUSTON	TX	77218	2818291033	
F11	SOUTHERN SCRIPTS	PO BOX 2482	NATCHIPOCHES	LA	71457	8007109341	RX
186	SOUTHLAND LIFE INSURANCE COMPANY	PO BOX 105006	ATLANTA	GA	303485006	7709805100	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
691	SPARTANBURG COUNTY						
811	SPARTANBURG REGIONAL HEALTHCARE SYSTEM	PO BOX 1000	LANCASTER	SC	29721		CODE ASSIGNED BY SCHA
A89	SPECIAL INSURANCE SERVICES (SIS)	PO BOX 250349	PLANO	TX	750250349	8007676811	CODE ASSIGNED BY SCHA
736	SPECTERA	2811 LORD BALTIMORE DR.	BALTIMORE	MD	212442644	8006383120	
741	SPENCER & ASSOCIATES INS.	1 S. LIMESTONE ST., STE. 301	SPRINGFIELD	OH	45502	8667669016	CODE ASSIGNED BY SCHA
573	ST JOHN'S CLAIMS ADMINISTRATION	PO BOX 14409	SPRINGFIELD	MO	65814	8778757700	
512	ST11-STRATEGIC HEALTH	9501 NE 2ND AVE.	MIAMI SHORES	FL	33138		CODE ASSIGNED BY SCHA
A46	STANDARD INSURANCE COMPANY	PO BOX 82622	LINCOLN	NE	68501	5033217000	
C42	STANDARD CORPORATION	1400 MAIN ST., STE. 1300	COLUMBIA	SC	29201	8037716785	
C38	STANDARD LIFE & ACCIDENT INSURANCE COMPANY	PO BOX 1800	GALVESTON	TX	775531800	8883501488	
188	STANDARD LIFE & CASUALTY INSURANCE COMPANY	PO DRAWER 1514	FORT MILL	SC	29716	8035483657	
307	STANDARD SECURITY LIFE INS. CO OF NEW YORK	PO BOX 828	PARK RIDGE	IL	60068	8665131479	
B74	STAR HRG	PO BOX 54150	PHOENIX	AZ	850784150	8002881474	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
240	STARBRIDGE	PO BOX 55270	PHOENIX	AZ	85078	8003085948	POLICIES BEGINNING WITH "R" NEED TO BE "E" INDICATORS AND GO TO PO BOX 188004, CHATTANOOGA, TN 37422. POLICIES WITH PH SSN STAYS AS "C".
952	STARK TRUSS CO., INC.	PO BOX 2080C	STOW	OH	44224	8004564002	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A03	STARMARK	PO BOX 2942	CLINTON	IA	52733	8005221246	THIS CARRIER HANDLES GROUPS WITH LESS THAN 50 EMPLOYEES. SEE CC212 FOR GROUPS OVER 50 EMPLOYEES.
400	STATE EMPLOYEES HEALTH PLAN BLUE CROSS	4101 PERCIVAL RD.	COLUMBIA	SC	29219	8008682520	CLAIMS SHOULD BE SENT TO THE ATTN OF SARAH TOWNES AX-B10
373	STATE FARM INSURANCE COMPANIES	7401 CYPRESS GARDENS BLVD.	WINTER HAVEN	FL	338880007	8633183000	
147	STATE MUTUAL INSURANCE	PO BOX 10811	CLEARWATER	FL	337578811	8887806388	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
B60	STATE MUTUAL LIFE ASSURANCE COMPANY OF AMERICA	1100 31ST ST.	DOWNERS GROVE	IL	60515	8003233359	CODE IN OPEN STATUS BY SCHA
B83	STATE OF LOUISIANA EMPLOYEES	PO BOX 44036	BATON ROUGE	LA	70804	8002728451	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A91	STATES GENERAL LIFE INS. CO	115 WEST 7TH ST., STE. 1200	FORT WORTH	TX	761027012	8007828375	
A47	STATESMAN NATIONAL LIFE INSURANCE COMPANY	3815 MONTROSE BLVD.	HOUSTON	TX	77006	7135266000	
244	STERLING INVESTORS LIFE INS. CO.	PO BOX 10844	CLEARWATER	FL	337578844	8776045240	
233	STERLING LIFE INSURANCE	PO BOX 5348	BELLINGHAM	WA	98227	8006880010	
645	STERLING MEDICARE CHOICE HMO	PO BOX 70	LINTHIEUM	MD	21900	6152445600	MEDICARE ADVANTAGE PLAN
140	STERLING OPTION I (PFFS)	PO BOX 5348	BELLINGHAM	WA	982270010		MEDICARE ADVANTAGE PLAN
374	STONEBRIDGE LIFE INSURANCE CO.	2700 W. PLANO PARKWAY	PLANO	TX	75075	8003319955	
714	STOWE ASSOCIATES	2872 WOODCOCK BLVD. #200	ATLANTA	GA	30341	8005337896	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
734	STRATEGIC OUTBURSTING, INC.	PO BOX 241508	CHARLOTTE	NC	28224	8888367764	CODE NOT REQUESTED BY MEDICAID ASSIGNED BY SCHA
C05	STRATEGIC OUTSOURCING, INC. (SOI)	PO BOX 241508	CHARLOTTE	NC	28224	8888367764	
A40	STRATEGIC RESOURCE COMPANY	PO BOX 14079	LEXINGTON	KY	40512	8887729682	
C93	STUDENT ASSURANCE INSURANCE SERVICES	PO BOX 196	STILL WATER	MN	55085	8003282739	
A61	SUMMACARE HEALTH PLAN	PO BOX 3620	AKRON	OH	743893628	8009968701	
209	SUMMIT AMERICA INSURANCE SERVICES	PO BOX 25936	OVERLAND PARK	KS	662255936	8772466997	
692	SUMTER COUNTY						
342	SUN LIFE INSURANCE COMPANY OF CANADA	ONE SUN LIFE EXECUTIVE PARK	WELLESLEY	MA	02181	8002253950	
861	SUPERIOR ESSEX	PO BOX 724907	ATLANTA	GA	31139	8772917920	
C45	TALL TREE ADMINISTRATORS	PO BOX 71747	SALT LAKE CITY	UT	841710747	8774534201	
C19	TAYLOR BENEFIT RESOURCES, INC.	PO BOX 6580	THOMASVILLE	GA	31758	8883525246	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
712	TDI MANAGED CARE SERVICES	620 EPSILON DR.	PITTSBURG	PA	15238	8005815300	CARRIER BOUGHT OUT BY PHARMACARE CC 740

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
C50	TENNESSEE BENEFIT ADMINISTRATORS	PO BOX 3257	SPARTANBURG	SC	29304		THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C01	TERMINIX SERVICE	PO BOX 2627	COLUMBIA	SC	29202	8037721783	CODE ASSIGNED BY SCHA
497	TEXAS INTERNATIONAL	PO BOX 11007	WINSTON-SALEM	NC	27116	8663074711	
B94	THE CAPELLA GROUP	PO BOX 200368	ARLINGTON	TX	76006	8884113888	
C33	THE DESTINY HEALTH PLAN	PO BOX 4628	OAKBROOK	IL	60522	8668269345	
269	THE EPOCH GROUP	PO BOX 12170	OVERLAND PARK	KS	66212	8002556065	
785	THE HARVEST INSURANCE CO.	PO BOX 956003	LAKE MARY	FL	327950856	8002530856	CODE ASSIGNED BY SCHA
E43	THE HEALTH PLAN INSURANCE CO.	52160 NATIONAL RD. EAST	ST. CLAIRSVILLE	OH	43950	7406996273	
763	THE PROVIDENT	PO BOX 31499	TAMPA	FL	33631	8005257268	
B28	THE STANDARD	PO BOX 82622	LINCOLN	NE	68501	8005479515	
542	THIRD PARTY ADMINISTRATORS/AMERICAN BENEFIT	1733 PARK ST.	NAPERVILLE	IL	60563	8006315917	
315	THOMAS COOPER AND COMPANY	PO BOX 63477	NORTH CHARLESTON	SC	29419	8437222115	
315DN	THOMAS COOPER AND COMPANY	PO BOX 63477	NORTH CHARLESTON	SC	29419	8437222115	
A01	THRIVENT FINANCIAL FOR LUTHERANS	4341 N. BALLARD RD.	APPLETON	WI	54919	8008474836	
463	TIM BAR CORP	PO BOX 449	HANOVER	PA	17331	7176324727	
322	TIME INSURANCE COMPANY	PO BOX 981602	EL PASO	TX	799980624	8005537654	USE 386 ASSURANT HEALTH
265	TODAY'S OPTION	PO BOX 391883	CAMBRIDGE	MA	02139	8662225137	MEDICARE ADVANTAGE PLAN
797	TODAY'S OPTIONS UNIVERSAL AMERICAN	PO BOX 742528	HOUSTON	TX	77274	8664225009	MEDICARE ADVANTAGE PLAN
E46	TOLEDO FIREFIGHTERS HEALTH PLAN	PO BOX 5810	TROY	MI	480075810	4192555314	
755	TOTAL BENEFIT SERVICES, INC.	PO BOX 30180	NEW ORLEANS	LA	70190		
D69	TOTAL CARE/HEALTHSPRING	PO BOX 20000	NASHVILLE	TN	372024070	8007437141	MEDICARE ADVANTAGE PLAN
D55	TOTAL CAROLINA CARE, INC.	1441 MAIN ST.	COLUMBIA	SC	29210	8664336031	MEDICAID HMO
B40	TOTAL CLAIMS SOLUTION (TCS)	PO BOX 10888	GREEN BAY	WI	543070888	8003760110	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B46	TOTAL CLAIMS SOLUTION (TCS)	PO BOX 10888	GREEN BAY	WI	54307	8003760110	
C03	TOTAL PLAN SERVICES, INC.	PO BOX 251369	PLANO	TX	75025	8009695238	
A80	TOTAL SCRIPT	10901 WEST 120TH AVE. STE 110	BROOMFIELD	CO	80021	8007522211	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
D47	TOUCHSTONE HEALTH PSO	PO BOX 33519	INDIANAPOLIS	IN	462030519	8887770204	MEDICARE ADVANTAGE PLAN
A76	TOWER LIFE INS. CO.	310 S. MARY ST.	SAN ANTONIO	TX	78205	8006606077	
X3B	TPA EXCHANGE	PO BOX 4363	ST AUGUSTINE	FL	32085	8885022789	
C52	TPA OF GEORGIA	4574 LAWRENCEVILLE HWY, STE. 201	LILBURN	GA	30047	7704517550	
788	TRANSAMERICA LIFE INSURANCE CO.	PO BOX 97	SCRANTON	PA	185040097	8008203372	CODE ASSIGNED BY SCHA
856	TRANSAMERICA OCCIDENTAL LIFE	PO BOX 2101 TERMINAL ANNEX	LOS ANGELES	CA	90051	2137422111	
148	TRANSAMERICA PREMIER LIFE INSURANCE COMPANY	PO BOX 742502	CINCINNATI	OH	45274	8004445431	
112	TRAVELERS INSURANCE COMPANY	PO BOX 473500	CHARLOTTE	NC	282473500	7045443665	USE CODE 113 UNITED HEALTHCARE INACTIVE 8-02
F43	TRICARE EAST	PO BOX 7981	MADISON	WI	537077981	8004445445	
642	TRICARE FOR LIFE	PO BOX 7890	MADISON	WI	537077890	8667730404	
819	TRICARE OVERSEAS PROGRAM	PO BOX 7985	MADISON	WI	537077985	8009826257	CODE ASSIGNED BY SCHA 6/07/10
614	TRICARE WEST	PO BOX 202112	FLORENCE	SC	295022112	8004033950	INTERNET WWW.TRICARE-WEST.COM
E73	TRISTAR BENEFIT ADMINISTRATORS	PO BOX 65887	WEST DES MOINES	IA	50265	8004564584	
C29	TRUE CHOICE USA	PO BOX 251369	PLANO	TX	75025	8002519665	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
E42	TRUE RX	4 WILLIAMS BROTHERS DR.	WASHINGTON	IN	47501	8669214047	
E95	TRUESCRIPTS	PO BOX 921	WASHINGTON	IN	47501	8442571955	RX
F21	TRUSTEED PLAN SERVICE	PO BOX 2950	TACOMA	WA	98401	2535645611	
212	TRUSTMARK INSURANCE CO.	PO BOX 2942	CLINTON	IA	52733	8476151500	USE THIS CARRIER FOR GROUPS WITH MORE THAN 50 EMPLOYEES. USE CCA03 FOR GROUPS LESS THAN 50 EMPLOYEES
703	TUCKER COMPANY & ADMINISTRATORS	9140 ARROW POINT BLVD. #200	CHARLOTTE	NC	282738102	7045259666	
B85	TUFTS HEALTHCARE	PO BOX 9185	WATERTOWN	MA	02471	8004238080	
376	TUFTS HEATH PLAN	PO BOX 9171	WATERTOWN	MA	024719171	8004620224	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
729	U.A. LOCAL 446 PLUMBERS AND PIPEFITTERS	PO BOX 191030	SACRAMENTO	CA	958191030	9164570821	CODE IN OPEN STATUS BY SCHA
261	UICI ADMINISTRATORS	PO BOX 30087	RENO	NV	895203087	8003153440	
B17	ULTRA BENEFITS	PO BOX 763	WESTBORO	MA	01581	8668587223	
143	UMR	PO BOX 30541	SALT LAKE CITY	UT	841300541	8008269781	
356	UMR	PO BOX 2697	WICHITA	KS	67201	8008269781	USE CODE 139
812	UMR	PO BOX 30541	SALT LAKE CITY	UT	841300541	8008269781	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
139DN	UMR	PO BOX 30541	SALT LAKE CITY	UT	84130	8008269781	WAS WAUSAU INS. CO.
143DN	UMR	PO BOX 30541	SALT LAKE CITY	UT	841300541	8008269781	
B42	UMR	PO BOX 266	ONALASKA	WI	546568764	8002368672	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
967	UNDERWRITERS SAFETY AND CLAIMS	PO BOX 23507	LOUISVILLE	KY	40223	8006781536	
701	UNI-CARE CHOICE HEALTH BENEFITS	PO BOX 51130	SPRINGFIELD	MA	01151	8002888630	
160DN	UNICARE HEALTH AND LIFE INSURANCE	PO BOX 659444	SAN ANTONIO	TX	75265	8772179677	
160	UNI-CARE HEALTH AND LIFE INSURANCE CO	PO BOX 4458	CHICAGO	IL	606804458	8772179677	WAS MASS MUTUAL
D29	UNICARE LIFE & HEALTH INS. CO (PFFS)	233 S WACKER DR., STE. 3900	CHICAGO	IL	68606	3123247000	MEDICARE ADVANTAGE PLAN
556	UNIFIED GROUP SERVICES	PO BOX 10	PENDLETON	IN	46064	7657781535	
566	UNIFIED GROUP SERVICES	PO BOX 10	PENDLETON	IN	46064	7657781535	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
E45	UNIFIED LIFE INSURANCE	PO BOX 25326	OVERLAND	KS	662255326	9136852233	
517	UNIFORM MEDICAL PLAN	PO BOX 34850	SEATTLE	WA	98124	8007626004	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
195	UNION BANKERS INSURANCE COMPANY	PO BOX 655433	DALLAS	TX	752655433	2149547840	
693	UNION COUNTY						
501	UNION FIDELITY INSURANCE COMPANY	4850 ST. RD.	TREVOSE	PA	19049-	8005236599	
306	UNION LABOR LIFE INSURANCE	111 MASSACHUSETTS AVE., NW	WASHINGTON	DC	20001	8004438087	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
C73	UNION PACIFIC RAILROAD EMPLOYEES HEALTH	795 NORTH 400 WEST	SALT LAKE	UT	84103	8005470421	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
439	UNION SECURITY INSURANCE CO	PO BOX 981602	EL PASO	TX	79998	8004446254	USE 386 ASSURANT HEALTH
E38	UNISON HEALTH PLAN	250 BERRYHILL RD.	COLUMBIA	SC	29210	8037985852	HEALTHY KIDS CONNECTION
638	UNISON HEALTH PLAN HMO	250 BERRYHILL RD.	COLUMBIA	SC	29210	8037985852	MEDICAID HMO
449	UNITED SERVICE ASSO. FOR HEALTHCARE	PO BOX 6080-288	MISSION VAIEJO	CA	926906080	8008721187	CODE ASSIGNED BY SCHA
277	UNITED AMERICAN INSURANCE COMPANY	PO BOX 8080	MCKINNEY	TX	750708080	9725295085	
871	UNITED BEHAVIORAL HEALTH	PO BOX 169053	DULUTH	MN	55816	8008776003	CODE ASSIGNED BY SCHA
A37	UNITED BEHAVIORAL/DENTAL SYSTEMS	PO BOX 30755	SALT LAKE CITY	UT	84130	8005575745	
196	UNITED BENEFIT LIFE INSURANCE	3909 HULEN ST.	FT. WORTH	TX	76107	8007320657	
565	UNITED BENEFITS	PO BOX 2480	DAYTONA BEACH	FL	321152480	8004344890	WAS POE & BROWN
103	UNITED CLAIMS SOLUTIONS	10835 N. 25TH AVE. 105	PHOENIX	AZ	85029	8667448482	CODE ASSIGNED BY SCHA
124	UNITED COMMERICAL TRAVELERS OF AMERICA	PO BOX 159019	COLUMBUS	OH	43215	8008480123	
737	UNITED CONCORDIA	PO BOX 69451	HARRISBURG	PA	17106	8003320366	
794	UNITED FAMILY LIFE INSURANCE COMPANY	PO BOX 2204	ATLANTA	GA	30371	4046593300	
704	UNITED FOOD & COMMERICAL WORKERS (UFCW)	1800 PHOENIX BLVD. STE. 310	ATLANTA	GA	30349	8002417701	
421	UNITED FOOD & COMMERICAL WORKER HEALTH&WELFARE	911 RIDGEBROOK RD.	SPARKS	MD	211529451	8006382972	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
340	UNITED HEALTHCARE PLAN OF RIVER VALLEY	3800 23RD AVENUE OF THE CITIES, STE. 200	MOLINE	IL	61265	8002246602	THIS COMPANY BOUGHT OUT JOHN DEERE INS. CO. 6/29/07
715	UNITED HEALTH & LIFE INSURANCE COMPANY	PO BOX 169050	DULUTH	MN	558168200	8005262414	USE CC113 UNITED HEALTHCARE
E90	UNITED HEALTH (MEDICARE SOLUTIONS)	PO BOX 30436	SALT LAKE CITY	UT	84130	8778423210	MEDICARE ADVANTAGE
584	UNITED HEALTH ONE	PO BOX 31374	SALT LAKE CITY	UT	841310374	8006578205	FORMALLY GOLDEN RULE
113	UNITED HEALTHCARE	PO BOX 740800	ATLANTA	GA	303740800	8778423210	
113DN	UNITED HEALTHCARE	PO BOX 30567	SALT LAKE CITY	UT	84130	8005215505	
963	UNITED HEALTHCARE CLAIMS	PO BOX 29130	HOT SPRINGS	AR	71903	8882014111	
825	UNITED HEALTHCARE COMMUNITY PLAN	PO BOX 8207	KINGSTON	NY	12402	8006009007	MEDICARE ADVANTAGE PLAN
923	UNITED HEALTHCARE COMMUNITY PLAN	PO BOX 6170	COLUMBIA	SC	292606170	8008682528	MEDICAID MCO PLAN

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
927	UNITED HEALTHCARE HERITAGE PLUS	UHC OF RIVER VALLEY PO BOX 5230	KINGSTON	NY	124025230	8002246602	
A82	UNITED HEALTHCARE INDEMNITY	PO BOX 740801	ATLANTA	GA	303740801	8008488406	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D30	UNITED HEALTHCARE INS. CO (PPO)	PO BOX 150450	HARTFORD	CT	061150450	8607025000	MEDICARE ADVANTAGE PLAN
A38	UNITED HEALTHCARE OF NC	PO BOX 2604	GREENSBORO	NC	274386304	8009991147	
B77	UNITED HEALTHCARE PLAN ADMINISTRATORS	PO BOX 121212	MARIETTA	GA	300670092	8005627079	USE CODE 985 BENESIGHT
872	UNITED HEALTHCARE PLAN OF RIVER VALLEY	3800 23RD AVE. #200	MOLINE	IL	61215	8002246602	CODE ASSIGNED BY SCHA THESE COMPANY BOUGHT OUT JOHN DEERE INS. CO. THIS WAS THE HMO FOR JOHN DEERE 6/29/07
279	UNITED INSURANCE COMPANY OF AMERICA	1 E WACKER DR.	CHICAGO	IL	60601	8007778467	
B64	UNITED MEDICAL RESOURCES, INC.	PO BOX 30541	SALT LAKE CITY	UT	84130	5136193000	
720	UNITED MINE WORKERS HEALTH & RETIREMENT FUND	ROUTE 2 BOX 218A	BIG STONE GAP	VA	24219	8006549763	
C81	UNITED PAYORS & UNITED PROVIDERS	2273 RESEARCH BLVD.	ROCKVILLE	MD	20850	8002474144	
994	UNITED PROVIDER SERVICES	PO BOX 820277	FORT WORTH	TX	76182	8005198374	CARRIER BOUGHT OUT BY CC 740 PHARMACARE
721	UNITED RESOURCE NETWORK	PO BOX 30758	SALT LAKE CITY	UT	84130	8778013507	CODE ASSIGNED BY SCHA
810	UNITED RESOURCE NETWORK	PO BOX 30758	SALT LAKE CITY	UT	84130	8778013507	CODE ASSIGNED BY SCHA
X3A	UNITED TEACHERS ASSO. INS. CO.	PO BOX 30010	AUSTIN	TX	78755	8008808824	
493	UNITED TEACHERS ASSOCIATION	PO BOX 30010	AUSTIN	TX	787553010	8668808824	
217	UNITED WORLD LIFE INS. CO.	3316 FARNAM ST.	OMAHA	NE	68175	8776175587	
791	UNITEDHEALTH INTEGRATED SERVICES	PO BOX 30783	SALT LAKE CITY	UT	841300786	8665968447	
A31	UNITY HEALTH INSURANCE	PO BOX 610	SAUK CITY	WI	535831374	8003623308	
989	UNIVERA HEALTHCARE	PO BOX 23000	ROCHESTER	NY	14692	8772429464	
D63	UNIVERA SENIOR CHOICE SECURE	PO BOX 23000	ROCHESTER	NY	15692	8006171114	MEDICARE ADVANTAGE PLAN
530	UNIVERSAL BENEFITS CORPORATION	PO BOX 97	SCRANTON	PA	185040097	8007470622	CODE ASSIGNED BY SCHA
198	UNIVERSAL FIDELITY LIFE INS. CO.	PO BOX 1428	DUNCAN	OK	735344	8003668355	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
D34	UNIVERSAL HEALTH CARE	PO BOX 3211	ST. PETERSBURG	FL	33731	8666904842	MEDICARE ADVANTAGE PLAN
B93	UNIVERSITY HEALTH ALLIANCE	700 BISHOP ST., STE. 300	HONOLULU	HI	968134100	8005324000	
855	UNIVERSITY HEALTH PLANS	PO BOX 830926 DEPT 003	BIRMINGHAM	AL	35283	8778780914	
B68	UPMC HEALTH BENEFITS, INC.	PO BOX 2999	PITTSBURGH	PA	15230	8773813764	
D05	UPMC HEALTH BENEFITS, INC.	PO BOX 2999	PITTSBURGH	PA	15230	8773813764	MEDICARE ADVANTAGE PLAN
409	UPSTATE ADMINISTRATIVE SERVICES	PO BOX 6589	SYRACUSE	NY	132176589	3154221533	
D85	US FIRE INSURANCE COMPANY	3195 LINWOOD RD., STE. 201	CINCINNATI	OH	45208	8005132981	
777	US HEALTH AND LIFE	PO BOX 37504	OAK PARK	MI	482370504	8002259674	THIS CODE NOT REQUESTED BY SCHA. ASSIGNED BY SCHA
B55	US SCRIPTS	2425 WEST SHAW AVE.	FRESNO	CA	93711	8004608988	
717	USA HEALTH CARE (MVP HEALTH CARE)	PO BOX 22920	ROCHESTER	NY	146922920	8009993920	CODE ASSIGNED BY SCHA
953	USA HEALTHCARE ORGANIZATION	7301 N. 16TH ST., STE. 201	PHOENIX	AZ	85020	8008723860	CODE ASSIGNED BY SCHA
582	USAA GENERAL INDEMNITY CO.	PO BOX 15506	SACRAMENTO	CA	958521506	8005318222	
131	USI	PO BOX 9888	SAVANNAH	GA	31412	9126911551	THIS CARRIER BOUGHT JONES, HILL & MERCER INS.
513	VALUE OPTIONS	PO BOX 1850	HICKSVILLE	NY	118021850	8002880882	
466	VALUE RX	PO BOX 421150	PLYMOUTH	MN	554420150	8009554879	USE CODE 333 EXPRESS SCRIPTS
633	VETERANS ADMINISTRATION						
962	VICARE PLUS	PO BOX 1710	SUFFOLK	VA	23439	8779344403	
491	VISION SERVICE PLAN	PO BOX 997100	SACRAMENTO	CA	958997100	8006227444	
606	VOCA.REHAB GENERAL						
608	VOCATIONAL REHAB DISABILITY						
E20	VRX PHARMACY SERVICES	PO BOX 9780	SALT LAKE CITY	UT	84109	8778799722	
A56	VULCAN MATERIALS COMPANY	PO BOX 530187	BIRMINGHAM	AL	352530187	8642772371	DORMANT 8/06
B41	VYTRA HEALTHCARE	PO BOX 9091	MELVILLE	NY	11747	8668089399	
549	WAL-MART STORES GROUP HEALTH PLAN	922 W. WALNUT STE. A	ROGERS	AR	72756 320	5016212929	USE CODE 401 BLUE CROSS BLUE SHIELD OF SC
282	WASHINGTON NATIONAL INSURANCE COMPANY	PO BOX 1934	DES PLAINES	IL	60017	8009470319	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
841	WATKINS ASSOCIATED INDUSTRIES	PO BOX 1738	ATLANTA	GA	30301	8003333841	CODE ASSIGNED BY SCHA
139RX	WAUSAU INSURANCE COMPANY	PO BOX 8013	WAUSAU	WI	544028013	8008269781	
B13	WEB TPA	PO BOX 99906	GRAPEVINE	TX	760999706	8007582851	
B13DN	WEB TPA	PO BOX 99906	GRAPEVINE	TX	76099	8007582851	
779	WEB-TPA AMERICAN FIDELITY ASSURANCE CO	PO BOX 99906	GRAPEVINE	TX	760999706	8663932872	DORMANT 8/06
C32	WELL FARGO INSURANCE	PO BOX 91608	LUBBOCK	TX	79490	8004354351	
D17	WELLCARE	PO BOX 795184	SAN ANTONIO	TX	78279	8662352770	MEDICARE ADVANTAGE PLAN
D52	WELLCARE OF GEORGIA	PO BOX 31224	TAMPA	FL	33531	8662311821	MEDICARE ADVANTAGE PLAN
F23	WELLDYNE RX	PO BOX 90369	LAKELAND	FL	33804	8884792000	
292	WELLMARK ADMINISTRATORS	PO BOX 9901	SIOUX CITY	IO	51102	8005265710	
X1O	WELLMARK BLUE CROSS BLUE SHIELD OF IOWA	PO BOX 5023	SIOUX FALLS	SD	57104	5152454500	USE CARRIER CODE X2A
X2A	WELLMARK BLUE CROSS BLUE SHIELD OF IOWA	PO BOX 5023	SIOUX FALLS	SD	571175023	8005268995	
X2ADN	WELLMARK BLUE CROSS BLUE SHIELD OF IOWA	PO BOX 9354	DES MOINES	IA	503069354	8773330164	DENTAL
252	WELLNET HEALTHCARE	57 STREET RD.	SOUTH HAMPTON	PA	18966	8007271733	
A24	WELLPOINT NEXT RX	PO BOX 2902	CLINTON	IA	527332902	8009627378	USE CARRIER 333 EXPRESS SCRIPTS
912	WELLS FARGO TPA-NC OFFICES	PO BOX 2857	FAYETTEVILLE	NC	28302	8003376288	
991	WEST PORT BENEFITS	PO BOX 66743	ST. LOUIS	MO	63166	8883065299	
D37	WEST VIRGINIA LOCAL 152 HEALTH & WELFARE	5 HOT METAL ST., STE. 200	PITTSBURGH	PA	15203	8448517293	DENTAL ONLY
C76	WESTERN AND SOUTHERN GROUPS	PO BOX 5735	CINCINNATI	OH	45201	8004248622	
415	WEYCO, INC.	PO BOX 30132	LANSING	MI	48909	5173497010	
415DN	WEYCO, INC.	PO BOX 30132	LANSING	MI	48909	5173497010	
969	WHP HEALTH INITIATIVE	PO BOX 968022	SCHAUMBERG	IL	601968022	8002072568	
F31	WILLIAM C. EARHART CO., INC.	PO BOX 97208	PORTLAND	OR	97208	8008460611	
F31DN	WILLIAM C. EARHART CO., INC.	PO BOX 4148	PORTLAND	OR	97208	8008460611	DENTAL ONLY
694	WILLIAMSBURG COUNTY						
116	WILLIS CORROON ADMINISTRATIVE SERVICES	PO BOX 305154	NASHVILLE	TN	372305154	8002558109	
826	WILLSE & ASSOCIATES, INC.	PO BOX 1196	BALTIMORE	MD	21203	4105470454	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
D75	WINDSOR MEDICARE EXTRA	PO BOX 269025	PLANO	TX	750269025	8662705223	MEDICARE ADVANTAGE PLAN
A88	WINDSOR STERLING	PO BOX 269003	PLANO	TX	750269003	8888588551	
575	WISCONSIN ELECTRICAL EMPLOYEES	PO BOX 2430	BROOKFIELD	WI	53008	6082769111	CODE IN OPEN STATUS BY SCHA
768	WISCONSIN PHYSICIANS SERVICES	1717 WEST BROADWAY ST.	MADISON	WI	53708	8889154158	
598	WJB DORN VA MEDICAL CENTER	6439 GARNERS FERRY RD.	COLUMBIA	SC	292091639	8037764000	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
285	WOODMAN OF THE WORLD LIFE INSURANCE SOCIETY	1700 FARNAM ST.	OMAHA	NE	68102	8002253108	
A34	WOODS & GROOM	2549 17TH ST.	COLUMBUS	IN	47202	8003683429	DORMANT 8/06
622	WORKMEN'S COMP						
580	WORLD INSURANCE COMPANY	PO BOX 3160	OMAHA	NE	681030160	4024968000	
C57	WORLD TRAVEL PROTECTION	4600 WITMER INDUSTRIAL ESTATES #2	NIAGARA FALLS	NY	14305	8004564553	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
607	WPS TRICARE FOR LIFE	PO BOX 7889	MADISON	WI	537077889	8667730404	
C51	YALEHEALTH PLAN	PO BOX 208217	NEW HAVEN	CT	065208217	2034320250	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
470	YODER BROTHERS	1001 LEBANON RD.	PENDLETON	SC	29670	8646468331	
695	YORK COUNTY						
C10	ZAVATA	PO BOX 1208	AMERICUS	GA	31709	8008417735	WAS PARADIGM CARE PLAN
977	ZENITH ADMINISTRATION	26359	LAS VEGAS	NV	89126	8004265980	DORMANT 8/06

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

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APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

Effective 01/01/19

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
100	AETNA US HEALTHCARE	PO BOX 14079	LEXINGTON	KY	40512	8003334432	
101	INTERNATIONAL CLAIMS SERVICES	27092 BURBANK ST.	FOOTHILL RANCH	CA	92610	8779167920	ASSIGNED BY SCHA
102							
103	UNITED CLAIMS SOLUTIONS	10835 N. 25TH AVE. 105	PHOENIX	AZ	85029	8667448482	CODE ASSIGNED BY SCHA
104	KAISER FOUNDATION HEALTH PLAN OF SOUTHERN CA.	PO BOX 7004	DOWNEY	CA	90242	8003903510	CODE ASSIGNED BY SCHA
105	ATHENE ANNUITY AND LIFE ASSURANCE COMPANY	PO BOX 19038	GREENVILLE	SC	29602	8646091000	
106	AMERICAN FIDELITY ASSURANCE BENEFITS	PO BOX 25160	OKLAHOMA CITY	OK	731250160	8006548489	
107	MUTUAL OF OMAHA	MUTUAL OF OMAHA PLAZA	OMAHA	NE	68175	8002289090	DO NOT USE FOR MED ADV. THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE.
108	METROPOLITAN LIFE INSURANCE COMPANY	PO BOX 981282	EL PASO	TX	79998	8006386626	
109	JEFFERSON PILOT INSURANCE COMPANY	PO BOX 26011	GREENSBORO	NC	27420	3366913000	
110	AMERIHEALTH HMO, INC.	PO BOX 41574	PHILADELPHIA	PA	191011574	8886323862	CODE ASSIGNED BY SCHA
111	PRUDENTIAL INSURANCE COMPANY OF AMERICA	841 PRUDENTIAL DR.	JACKSONVILLE	FL	32207	8003463778	THIS CARRIER BOUGHT OUT BY AETNA CC100
112	TRAVELERS INSURANCE COMPANY	PO BOX 473500	CHARLOTTE	NC	282473500	7045443665	USE CODE 113 UNITED HEALTHCARE INACTIVE 8-02
113	UNITED HEALTHCARE	PO BOX 740800	ATLANTA	GA	303740800	8778423210	
114	CLAIMEDIX, INC.	PO BOX 140067	KANSAS CITY	MO	64114	8009224262	CODE ASSIGNED BY SCHA
115	ALLSTATE INSURANCE	PO BOX 7068	COLUMBIA	SC	29202	8003668997	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
116	WILLIS CORROON ADMINISTRATIVE SERVICES	PO BOX 305154	NASHVILLE	TN	372305154	8002558109	
117	HEWITT COLEMAN AND ASSOCIATES	PO BOX 6708	GREENVILLE	SC	29606	8642405840	
118	AMERICAN HEALTH & LIFE INSURANCE	300 ST. PAUL PLACE	BALTIMORE	MD	21202	3013323000	
119	AMERICAN HERITAGE LIFE INSURANCE	1776 AMERICAN HERITAGE LIFE DR.	JACKSONVILLE	FL	32224	8005358086	
120	AMERICAN NATIONAL INSURANCE COMPANY	PO BOX 1790	GALVESTON	TX	77553	8008996803	
121	GREATER HEALTHCARE	PO BOX 3400	MONROE	NC	28110	7042258887	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
122	ATLANTIC COAST LIFE INSURANCE COMPANY	PO BOX 20010	CHARLESTON	SC	294130010	8437638680	
123	BANKERS LIFE & CASUALTY	PO BOX 66927	CHICAGO	IL	606660927	8006213724	
124	UNITED COMMERICAL TRAVELERS OF AMERICA	PO BOX 159019	COLUMBUS	OH	43215	8008480123	
125	AMERICAN TRAVELERS LIFE INSURANCE COMPANY	3220 TILLMAN DR.	BEN SALEM	PA	19020	2152441600	
126	HEALTH PLAN SERVICES (COVENTRY HEALTH CARE)	PO BOX 24146	SEATTLE	WA	98124	8008610056	CODE ASSIGNED BY SCHA
127	BENEFITSOURCE, INC.	PO BOX 240	MONROE	MI	48161	8004231028	CODE ASSIGNED BY SCHA
128	CAPITOL LIFE INSURANCE COMPANY	PO BOX 1200	DENVER	CO	80201	8005252115	PER HOSP. ASSO. 07/02, THIS IS STILL A VALID CARRIER
129	INTERGROUP SERVICES CORPORATION	101 LINDENWOOD DR., STE. 150	MALVERN	PA	19355	8005379389	
130	EMPLOYERS LIFE INSURANCE COMPANY	PO BOX 6305	SPARTANBURG	SC	29304	8889628437	CARRIER WAS COASTAL STATE LIFE INS. CO.
131	USI	PO BOX 9888	SAVANNAH	GA	31412	9126911551	THIS CARRIER BOUGHT JONES, HILL & MERCER INS.
132	COLONIAL LIFE AND ACCIDENT INSURANCE COMPANY	PO BOX 1365	COLUMBIA	SC	29202	8037987000	
133	COMBINED INSURANCE COMPANY OF AMERICA	PO BOX 6700	SCRANTON	PA	18505	8002254500	
134	CIGNA	PO BOX 182223	CHATTANOOGA	TN	374227223	8008824462	DO NOT USE FOR MEDICARE. THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE
135	ALLIED NATIONAL, INC.	PO BOX 419233	KANSAS CITY	MO	641416233	8008257531	CARRIER WAS ALLIED GROUP INSURANCE TRUST
136	CIGNA FLEXCARE	PO BOX 30575	CHARLOTTE	NC	282303211		CODE ASSIGNED BY SCHA
137	EDUCATORS MUTUAL LIFE INSURANCE COMPANY	PO BOX 3149	LANCASTER	PA	17601	7173972751	
138	LIFEWELL HEALTH PLANS	PO BOX 16203	LUBBOCK	TX	79490	8775433935	SUBSIDIARY OF HEALTHSCOPE
139	FISERV HEALTH	PO BOX 30541	SALT LAKE CITY	UT	841300541	8008269781	WAS WAUSAU INS. CO.
140	STERLING OPTION I (PFFS)	PO BOX 5348	BELLINGHAM	WA	982270010		MEDICARE ADVANTAGE PLAN

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
141	NEOA HEALTH BENEFITS FUND	428 E SCOTT AVE., PO BOX 3070	KNOXVILLE	TN	37927		
142	SC DEPT OF DISABILITIES AND SPECIAL NEEDS	PO BOX 4706	COLUMBIA	SC	29240	8038989795	CODE ASSIGNED BY SCHA
143	UMR	PO BOX 30541	SALT LAKE CITY	UT	841300541	8008269781	
144	GLOBE LIFE & ACCIDENT INSURANCE	204 N. ROBINSON	OKLAHOMA CITY	OK	73102	9725406542	
145	GMP EMPLOYERS RETIREE TRUST	5245 BIG PINE WAY SE	FORT MYERS	FL	33907	9419366242	
146	HARTFORD INSURANCE GROUP	PO BOX 25600	CHARLOTTE	NC	28212	7045366230	
147	STATE MUTUAL INSURANCE	PO BOX 10811	CLEARWATER	FL	337578811	8887806388	
148	TRANSAMERICA PREMIER LIFE INSURANCE COMPANY	PO BOX 742502	CINCINNATI	OH	45274	8004445431	
149	INSURANCE COMPANY OF NORTH AMERICA (INA)	195 BROADWAY 11TH FLOOR	NEW YORK	NY	100073100	2126184000	
150	AMERICAN GENERAL LIFE AND ACCIDENT INS CO	PO BOX 1500	NASHVILLE	TN	372021500	8008882452	
151	CARELINK	PO BOX 7373	LONDON	KY	40742	8003482922	MEDICAID HMO
152	MEDICA	PO BOX 30990	SALT LAKE CITY	UT	84130	8009523455	CODE NOT REQUESTED BY MEDICAID ASSIGNED BY SCHA
153	KANAWHA LIFE INSURANCE COMPANY	PO BOX 6000	LANCASTER	SC	29721	8032862440	
154	CONSUMER DRN BENEFITS ASSO.	PO BOX 6080-228	MISSION VIEIO	CA	926906080	8884114208	CODE ASSIGNED BY SCHA
155	CROSSAMERICA HEALTH PLAN	PO BOX 5778	PARSIPPANY	NJ	07054	8663027332	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
156	LIFE INSURANCE COMPANY OF GEORGIA	PO BOX 105006	ATLANTA	GA	303485006	7709805100	
157	LIFE INSURANCE COMPANY OF VIRGINIA, THE	PO BOX 27601	RICHMOND	VA	23230	8042816000	
158	LINCOLN NATIONAL LIFE INSURANCE COMPANY	PO BOX 614008	ORLANDO	FL	32861	8004232765	
159	MAKSIN MANAGEMENT CORP	CN98000	PENNSAUKEN	NJ	08110	8002570625	
160	UNI-CARE HEALTH AND LIFE INSURANCE CO	PO BOX 4458	CHICAGO	IL	606804458	8772179677	WAS MASS MUTUAL
161	AMA INSURANCE AGENCY, INC.	PO BOX 804238	CHICAGO	IL	60680	8004585736	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
162	HARVARD PILGRIM HEALTHCARE	PO BOX 656653	SAN ANTONIO	TX	82655	8004213550	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
163	NATIONWIDE LIFE INSURANCE COMPANY	PO BOX 182202	COLUMBUS	OH	432182202	6142497111	
164	AMERICAN PROGRESSIVE INSURANCE	PO BOX 130	PENSACOLA	FL	325910130	8006268913	
165	NEW YORK LIFE INSURANCE COMPANY	PO BOX 105095	ATLANTA	GA	30348	8003884580	
166	CAPITOL AMERICAN LIFE INSURANCE COMPANY	PO BOX 94953	CLEVELAND	OH	441014953	2166966400	
167	AMERICAN INTERNATIONAL GROUP (AIG) ACCIDENT	PO BOX 26050	OVERLAND PARK	KS	66225	8887221668	
168	PRECISE BENEFIT ADMINISTRATORS	PO BOX 9064	JERICHO	NY	11753	5163906000	
169	CROWN CORK & SEAL COMPANY, INC.	930 BEAUMONT AVE.	SPARTANBURG	SC	29303	8645856456	
170	OCCIDENTAL LIFE INSURANCE COMPANY OF NC	PO BOX 10324	RALEIGH	NC	27605	9198318189	
171	AON	PO BOX 66	WINSTON-SALEM	NC	27102	8003683804	
172	PAUL REVERE LIFE INSURANCE COMPANY	PO BOX 15118	WORCESTER	MA	016150118	5087994441	
173	PENNSYLVANIA LIFE INSURANCE COMPANY	PO BOX 130	PENSACOLA	FL	325910100	8002757366	
174	NMU PENSION & WELFARE FUND	360 WEST 31ST ST., 3RD FL	NEW YORK	NY	10001	2123374900	
175	COLUMBIA UNIVERSAL LIFE INSURANCE CO.	PO BOX 200225	AUSTIN	TX	787200225	5123453200	
176	GUIDESTAR HEALTH SYSTEMS	PO BOX 35238	BIRMINGHAM	AL	35238	8005956949	
177	CINERGY HEALTH PREFERRED PLAN	144 N BEVERWYCK RD. #332	LAKE HIAWATHA	NJ	080341997	8008471148	CODE IN OPEN STATUS BY SCHA
178	INSURANCE & BENEFIT ADVOCATE, INC.	5838 W BRICK RD STE. 106	SOUTH BEND	IN	46628	8662006700	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
179	DESERET MUTUAL BENEFIT ADMINISTRATOR	PO BOX 45530	SALT LAKE CITY	UT	84145	8007773622	
180	ESIS	PO BOX 31122	TAMPA	FL	33631	8008847975	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
181	GROUP ADMINISTRATORS, LTD.	450 E. REMINGTON RD.	SCHAUMBURG	IL	60173	8475191880	
182	PENN TREATY NETWORK AMERICA INS. CO.	PO BOX 7066	ALLENTOWN	PA	181057066	8003620700	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
183	GILSBAR INSURANCE COMPANY	PO BOX 2947	COVINGTON	LA	70434	8002342643	
184	SECURITY LIFE INSURANCE CO. OF AMERICA	PO BOX 82520	LINCOLN	NE	68501	8003009566	
185	S&S HEALTHCARE STRATEGIES	PO BOX 46511	CINCINNATI	OH	45216	8888008717	
186	SOUTHLAND LIFE INSURANCE COMPANY	PO BOX 105006	ATLANTA	GA	303485006	7709805100	
187	RELIANCE STANDARD LIFE INS. CO.	PO BOX 82510	LINCOLN	NE	68501	8004977044	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
188	STANDARD LIFE & CASUALTY INSURANCE COMPANY	PO DRAWER 1514	FORT MILL	SC	29716	8035483657	
189	INTERNATIONAL EDUCATION EXCHANGE SERVICES	PO BOX 370	ITHACA	NY	148510307	8664337462	
190	BOILERMAKERS NATIONAL HEALTH & WELFARE FUND	754 MINNESOTA AVE., STE. 522	KANSAS CITY	KS	661012762	9133426555	
191	COVENTRY HEALTHCARE OF DELAWARE, INC.	PO BOX 7713	LONDON	KY	40742	8008337423	
192	CONVENTRY HEALTHCARE OF NEBRASKA, INC.	PO BOX 7705	LONDON	KY	40742	8002883343	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
193	ALLSTATE WORKPLACE DIVISION	PO BOX 853916	RICHARDSON	TX	750853916	8009377039	
194	DAKOTACARE	PO BOX 7406	SIOUX FALLS	SD	571177406	8003255598	CODE ASSIGNED BY SCHA
195	UNION BANKERS INSURANCE COMPANY	PO BOX 655433	DALLAS	TX	752655433	2149547840	
196	UNITED BENEFIT LIFE INSURANCE	3909 HULEN ST.	FT. WORTH	TX	76107	8007320657	
197	RELIANCE STANDARD SPECIALTY PRODUCTS ADM	505 S LENOLA RD., STE. 231	MOORESTOWN	NJ	08057	8663750775	
198	UNIVERSAL FIDELITY LIFE INS. CO.	PO BOX 1428	DUNCAN	OK	735344	8003668355	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
199	ALL OTHER CARRIERS						
200	ALL AMERICAN LIFE INSURANCE CO.	8501 WEST HIGGINS RD.	CHICAGO	IL	60631	7733996645	
201	HCH ADMINISTRATORS	PO BOX 1986	PEORIA	IL	61656	8003221516	
202	JOHN HANCOCK INSURANCE COMPANY	PO BOX 852	BOSTON	MA	02117	8002331449	
203	HEALTH CARE SUPPORT/PRIVATE HEALTH CARE SYSTEM	29 COLUMBIA HEIGHTS	BROOKLYN	NY	11201	8005544022	CODE ASSIGNED BY SCHA
204	SELF INSURED BENEFIT ADMINISTRATORS	18167 US HWY 19N	CLEARWATER	FL	33764	7275320400	
205	FIDELITY LIFE SECURITY	3130 BROADWAY	KANSAS CITY	MO	641112406	8006488624	
206	MED COST BENEFITS SERVICES	PO BOX 25307	WINSTON-SALEM	NC	271145307	8007951023	
207	MEDICAL SAVINGS HEALTH PLAN	419 E. MAIN ST.	MIDDLETON	NY	10940	3173298222	
208	SIEBA, LTD	PO BOX 5000	ENDICOTT	NY	13761	8002524624	
209	SUMMIT AMERICA INSURANCE SERVICES	PO BOX 25936	OVERLAND PARK	KS	662255936	8772466997	
210	AMERITAS LIFE INSURANCE	PO BOX 82520	LINCOLN	NE	68501	8002559678	
211	COORDINATED BENEFIT PLANS, INC.	PO BOX 853925	RICHARDSON	TX	750853925	8007531000	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
212	TRUSTMARK INSURANCE CO.	PO BOX 2942	CLINTON	IA	52733	8476151500	USE THIS CARRIER FOR GROUPS WITH MORE THAN 50 EMPLOYEES. USE CCA03 FOR GROUPS LESS THAN 50 EMPLOYEES
213	COVENANT ADMINISTRATORS	PO BOX 105738	ATLANTA	GA	30348	7702396230	
214	RISK BENEFIT MANAGEMENT SERVICES, LLC (RBMS)	PO BOX 241569	ANCHORAGE	AK	99524	8007703740	
215	OXFORD LIFE INSURANCE COMPANY	PO BOX 46518	MADISON	WI	53744	8774693073	
216	HUMANA HEALTH INSURANCE OF FLORIDA	PO BOX 19080-F	JACKSONVILLE	FL	32245	8004574708	
217	UNITED WORLD LIFE INS. CO.	3316 FARNAM ST.	OMAHA	NE	68175	8776175587	
218	ROCKY MOUNTAIN HEALTH PLAN (RMHP)	PO BOX 4517	ENGLEWOOD	CO	80155	8884792000	
219	CLAIMS PRO	PO BOX 577	SOUTHFIELD	MI	48075	8008379600	RX CARRIER ONLY
220	HEALTH NEW ENGLAND	ONE MONARCH PLACE, STE 1500	SPRINGFIELD	MA	011441500	8003102835	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
221	QUAL CARE	PO BOX 249	PISCATHAWAY	NJ	08855	8009926613	
222	MEDICA	PO BOX 30990	SALT LAKE CITY	UT	84107	8009523455	
223	MED COST PREFERRED	PO BOX 25437	WINSTON-SALEM	NC	27114	8008247406	CODE ASSIGNED BY SCHA
224	SOUTHERN ELEC. HEALTH FUND	3928 VOLUNTEER DR.	CHATTANOOGA	TN	37416	4238992593	
225	HEALTH SERVICES FOUNDATION	PO BOX 2109	LIVERMORE	CA	94551	5104497070	
226	MASTER HEALTH PLAN	PO BOX 16367	AUGUSTA	GA	303919123	7068635955	
227	MONUMENTAL GENERAL INSURANCE COMPANY	1111 N CHARLES ST.	BALTIMORE	MD	20201	8007529797	
228	PHYSICIANS PLUS INS. CO.	PO BOX 909953	MILWAUKEE	WI	53209	8005455015	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
229	SELF INSURED PLANS LLC	1016 COLLIER CENTER WAY STE. 200	LOS ANGELES	CA	90080	8004212342	CODE ASSIGNED BY SCHA
230	PYRAMID LIFE INSURANCE COMPANY	P O BOX 130	PENSACOLA	FL	32591	8004440321	
231	SAVERS LIFE INSURANCE COMPANY	8064 NORTH POINT BLVD., STE. 201	WINSTON-SALEM	NC	27106	8006420483	
232	GENERAL ADJUSTMENT BUREAU	PO BOX 81808	ATLANTA	GA	30366	4044579555	CODE ASSIGNED BY SCHA
233	STERLING LIFE INSURANCE	PO BOX 5348	BELLINGHAM	WA	98227	8006880010	
234	ALWAYSCAREBENEFITS, INC.	PO BOX 80139	BATON ROUGE	LA	70898	8887295433	DENTAL PLAN

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
235	SHAW INDUSTRIES	PO BOX 10	DALTON	GA	30722	8003211855	
236	GUARANTEE TRUST LIFE INSURANCE	PO BOX 1144	GLENVIEW	IL	60025	8476990600	
237	GUARDIAN LIFE INSURANCE COMPANY OF AMERICA	P O BOX 981572	EL PASO	TX	799981572	6108076000	
238	HORIZON HEALTHCARE	PO BOX 1028	WEST TRENTON	NJ	08628	8007923666	
239	HORACE MANN LIFE INSURANCE COMPANY	1 HORACE MANN PLAZA	SPRINGFIELD	IL	62715	2177892500	
240	STARBRIDGE	PO BOX 55270	PHOENIX	AZ	85078	8003085948	POLICIES BEGINNING WITH "R" NEED TO BE "E" INDICATORS AND GO TO PO BOX 188004, CHATTANOOGA, TN 37422. POLICIES WITH PH SSN STAYS AS "C".
241	LIFE REINSURANCE CO.	PO BOX 792070	SAN ANTONIO	TX	78279	8002291024	
242	HELLER ASSOCIATES	8228 MAYFIELD RD., STE. 5B	CHESTERLANDE	OH	44026	4405272955	CODE IN OPEN STATUS BY SCHA
243	LIFE & CASUALTY INSURANCE COMPANY OF TENNESSEE	AMERICAN GENERAL CENTER	NASHVILLE	TN	37250	6157491000	
244	STERLING INVESTORS LIFE INS. CO.	PO BOX 10844	CLEARWATER	FL	337578844	8776045240	
245	COVENTRY OF THE CAROLINA'S	PO BOX 7102	LONDON	KY	40742	8009357284	
246	COVENTRY HEALTH CARE RX	PO BOX 8400	LONDON	KY	40742	8009476824	
247	EMPLOYERS DIRECT HEALTH	5050 SPRING VALLEY RD.	DALLAS	TX	752443909	8008729934	CARRIER WAS FIRST INTEGRATED HEALTH
248	NEW ENGLAND LIFE INSURANCE	25145 COUNTRY CLUB BLVD.	NORTH OLMSTED	OH	440705300	8002558063	
249	FIRST HEALTH WORKERS COMP ONLY	PO BOX 23070	TUCSON	AZ	85735	8005544954	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
250	IDEAL SCRIPTS	50 WHITE CAP DR.	NORTH KINGSTOWN	RI	02886	8007176614	
251	PYRAMID LIFE INSURANCE CO.	PO BOX 12922	PENSACOLA	FL	325912922	8006581413	CODE IN OPEN STATUS BY SCHA MEDICARE SUPPLEMENTAL PLAN G
252	WELLNET HEALTHCARE	57 STREET RD.	SOUTH HAMPTON	PA	18966	8007271733	
253	AMERICAN STERLING INSURANCE SERVICES	PO BOX 26103	OVERLAND PARK	KS	66225	8772926037	
254	PACIFIC MUTUAL LIFE INSURANCE COMPANY	700 NEWPORT CENTER DR.	NEWPORT BEACH	CA	92660	8004512513	
255	PAN-AMERICAN LIFE INSURANCE COMPANY	PO BOX 981644	EL PASO	TX	79998	8006949888	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
256	BENICOMP	8310 CLINTON PARK DR.	FT. WAYNE	IN	46825	8008377400	CODE ASSIGNED BY SCHA
257	PHARMACY NETWORK NATIONAL OF N.C.	4000 OLD WAKEFOREST RD., STE. 101	RALEIGH	NC	27609	8003317108	SEE CARRIER 366 CATALYST RX
258	DIVERSIFIED ADMINISTRATION CORPORATION	PO BOX 299	MARLBOROUGH	CT	06447	8883222524	
259	CNA HEALTHCARE PARTNERS	PO BOX 34197	LITTLE ROCK	AK	72203	8005083772	
260	NATIONAL CLAIMS ADMINISTRATIVE SERVICES	PO BOX 10136	FAIRFAX	VA	220388022	8662199292	CODE IN OPEN STATUS BY SCHA
261	UICI ADMINISTRATORS	PO BOX 30087	RENO	NV	895203087	8003153440	
262	CAIC (CONTINENTAL AMERICAN INS. CO)	PO BOX 6080226	MISSION VIEJO	CA	926906080	8887302244	
263	NATIONAL FINANCIAL COMPANY	110 WEST 7TH ST., STE. 300	FT WORTH	TX	76102	8007251407	
264	HEALTH AMERICA	PO BOX 7089	LONDON	KY	40742	8007888445	
265	TODAY'S OPTION	PO BOX 391883	CAMBRIDGE	MA	02139	8662225137	MEDICARE ADVANTAGE PLAN
266	ACMG ADMINISTRATORS OF SOUTH CAROLINA	2570 TECHNICAL DR.	MIAMISBURG	OH	45342	8002326242	
267	NATIONAL CLAIMS ADMINISTRATIVE SERVICES	PO BOX 220887	CHARLOTTE	NC	282220887	7043643865	CODE ASSIGNED BY SCHA
268	MARQUETTE NATIONAL LIFE INS. CO.	PO BOX 130	PENSACOLA	FL	32591	8009348203	
269	THE EPOCH GROUP	PO BOX 12170	OVERLAND PARK	KS	66212	8002556065	
270	PREFERRED HEALTH PLAN OF THE CAROLINAS	PO BOX 220397	CHARLOTTE	NC	28222	8666360239	
271	AMERICAN BENEFIT PLAN ADMINISTRATOR	22OO-B ROSSELLE ST.	JACKSONVILLE	FL	32204	8004685126	
272	ALLIANCE HEALTH BENEFIT PLAN	PO BOX 6443	ROCKVILLE	MD	20850	8003423289	
273	CENTRAL BENEFITS USA (CENBEN USA)	PO BOX 619059	DALLAS	TX	85261	8007725924	CODE ASSIGNED BY SCHA
274	CAPITAL DISTRICT PHYSICIANS PLAN	PO BOX 66602	ALBANY	NY	122066602	8009267526	
275	AMERICAN TRUST ADMINISTRATORS	PO BOX 87	SHAWNEE MISSION	KS	66201	9134514900	
276	PLAN HANDLERS	930 CANTERBURY PLACE	ESCONDIDO	CA	92025	8005385512	
277	UNITED AMERICAN INSURANCE COMPANY	PO BOX 8080	MCKINNEY	TX	750708080	9725295085	
278	ROCKY MOUNTAIN HEALTH PLAN	PO BOX 10600	GRAND JUNCTION	CO	81502	8008544558	
279	UNITED INSURANCE COMPANY OF AMERICA	1 E WACKER DR.	CHICAGO	IL	60601	8007778467	
280	CAREMARK PRESCRIPTION SERVICES	PO BOX 52188	PHOENIX	AZ	850722196	8008415550	USE CARRIER 471
281	HEALTH NETWORK AMERICA/TRIVERIS	PO BOX 307	EATONTOWN	NJ	07724	8003371421	CODE ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
282	WASHINGTON NATIONAL INSURANCE COMPANY	PO BOX 1934	DES PLAINES	IL	60017	8009470319	
283	GUARDIAN HEALTHCARE	PO BOX 4197	SCRANTON	PA	77010	8668501256	MEDICARE ADVANTAGE PLAN
284	AMERIHEALTH ADMINISTRATORS	720 BLAIR RD.	HORSHAM	PA	19044	8003454017	
285	WOODMAN OF THE WORLD LIFE INSURANCE SOCIETY	1700 FARNAM ST.	OMAHA	NE	68102	8002253108	
286	HEALTH EXCHANGE (TPA FOR CERNER HEALTH)	PO BOX 165750	KANSAS CITY	MO	64116	8002314015	CODE IN OPEN STATUS BY SCHA
287	COMMUNITY HEALTH PLAN	PO BOX 14467	CINCINNATI	OH	45250	8888008717	
288	FIRST ADMINISTRATORS, INC.	PO BOX 9900	SIOUX CITY	IA	51102	8002060827	
289	AFTRA HEALTH FUND	261 MADISON AVE.	NEW YORK	NY	10016	8005624690	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
290	FEDERATED MUTUAL INSURANCE COMPANY (REGIONAL)	PO BOX 31716	TAMPA	FL	336313716	8134968100	
291	NALC HEALTH BENEFIT PLAN	20547 WAVERLY CT.	ASHBURN	VA	20149	7037294677	
292	WELLMARK ADMINISTRATORS	PO BOX 9901	SIOUX CITY	IO	51102	8005265710	
293	PARAMOUNT HEALTH CARE	PO BOX 497	TOLEDO	OH	43697	8888912564	
294	BRIDGESTONE/FIRESTONE COMPANIES	PO BOX 26605	AKRON	OH	44319	8002378447	
295	MEDICAL BENEFIT ADMINISTRATORS	5940 SEMINOLE CENTER CT.	MADISON	WI	53711	6082731776	
296	RESERVE NATIONAL INSURANCE	PO BOX 26620	OKLAHOMA CITY	OK	73126	8006549106	
297	AMALGAMATED LIFE INSURANCE	PO BOX 1451	NEW YORK	NY	101161451	2124735700	
298	SMITH PREMIERE PHARMACY PLAN	PO BOX 5824	SPARTANBURG	SC	29304	8002474526	
299	ALICARE	PO BOX 1447	NEW YORK	NY	10116	2125395115	
300	BENEFIT ADMINISTRATORS, INC.	PO BOX 6279	ERIE	PA	16512	8007772524	
301	BENEFIT PLAN ADMINISTRATORS	PO BOX 21392	EAGEN	MN	55121	8002778973	
302	GOVERNMENT EMPLOYEE HOSP. ASSN (GEHA)	PO BOX 4665	INDEPENDENCE	MO	640514665	8162575500	
303	PREFERRED HEALTH PLAN, INC.	PO BOX 24125	LOUISVILLE	KY	40224	5023397500	
304	BUTLER BENEFIT SERVICE, INC.	PO BOX 3310	DAVENPORT	IA	528083310	8669272200	
305	HEALTHSMART	PO BOX 91608	LUBBOCK	TX	79490	8668695597	
306	UNION LABOR LIFE INSURANCE	111 MASSACHUSETTS AVE., NW	WASHINGTON	DC	20001	8004438087	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
307	STANDARD SECURITY LIFE INS. CO OF NEW YORK	PO BOX 828	PARK RIDGE	IL	60068	8665131479	
308	GREAT WEST LIFE	PO BOX 188061	CHATTANOOGA	TN	374228061	8006638081	GREAT WEST/CIGNA
309	AMERICAN ADMINISTRATIVE GROUP	PO BOX 5227	LISLE	IL	605325227	6304939252	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
310	ADVANCED DATA SOLUTIONS	PO BOX 723097	ATLANTA	GA	31139	8007425246	
311	BENEFIT PLANNERS, INC.	PO BOX 682010	SAN ANTONIO	TX	78269	2106991872	
312	NATIONAL BENEFIT ADMINISTRATORS	PO BOX 690903	CHARLOTTE	NC	282277016	8004826736	
313	GREAT WEST HEALTHCARE	1000 GREAT WEST DR.	KENNETT	MO	63857	8006638081	
314	PHARMACY ADVANTAGE NETWORK	50 LENNOX POINTE	ATLANTA	GA	30324	8887275560	SEE CARRIER 366 CATALYST RX
315	THOMAS COOPER AND COMPANY	PO BOX 63477	NORTH CHARLESTON	SC	29419	8437222115	
316	PROFESSIONAL INSURANCE CORPORATION	2610 WYCLIFF RD.	RALEIGH	NC	27607	8002891122	
317	EMPLOYEE BENEFITS MANAGEMENT CORPORATION	4789 RINGS RD.	DUBLIN	OH	43017	8005520455	
318	KLAIS & COMPANY	1867 WEST MARKET ST.	AKRON	OH	443136977	3308678443	
319	BENEFIT CONCEPTS	PO BOX 60608	KING OF PRUSSIA	PA	19406	8002202600	
320	LAMAR LIFE INSURANCE COMPANY	PO BOX 880	JACKSON	MS	39201	6019493100	
321	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	PO BOX 188004	CHATTANOOGA	TN	37422	8002222798	
322	TIME INSURANCE COMPANY	PO BOX 981602	EL PASO	TX	799980624	8005537654	USE 386 ASSURANT HEALTH
323	LINCOLN HERITAGE LIFE INSURANCE CO	PO BOX 10843	CLEARWATER	FL	337578843	8885868810	
324	HEALTH REIMBURSEMENT MANAGEMENT PARTNERSHIP	5 HUTCHINSON DR.	DANVERS	MA	01923	8889994767	CODE IN OPEN STATUS BY SCHA
325	PERSONAL CARE	PO BOX 7141	LONDON	KY	40742	8004311211	
326	PHYSICIANS HEALTH PLAN OF MID MICHIGAN	PO BOX 247	ALPHARETTA	GA	300090247	8008329186	
327	MAIL HANDLERS BENEFIT PLAN	PO BOX 8402	LONDON	KY	40742	8004107778	
328	PROVIDER SELECT, INC.	PO BOX 330070	FORT WORTH	TX	76163	8667747766	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
329	SMITHFIELD FOODS HEALTHCARE	PO BOX 158	SMITHFIELD	VA	23431	8008095916	
330	ANNUITY BOARD OF SOUTHERN BAPTIST CONVENTION	PO BOX 2190	NASHVILLE	TN	37234	2147200511	
331	CONSECO HEALTH INS. CO	PO BOX 66904	CHICAGO	IL	606660904	8005412254	
332	HEALTH PLANS, INC.	PO BOX 5199	WESTBOROUGH	MA	01581	8005327575	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
333	EXPRESS SCRIPTS	PO BOX 14713	LEXINGTON	KY	40512	8004516245	
334	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	1750 PENNSYLVANIA AVE., NW	WASHINGTON	DC	20006	8006388432	
335	J.P. FARLEY CORP.	PO BOX 458022	WESTLAKE	OH	441468022	4402504300	
336	CASEBP (CATSKILL AREA SCHOOLS EMPLOYEE PLAN)	PO BOX 968022	SCHAUMBERG	IL	60196	8009626294	
337	BOARD OF PENSIONS OF THE PRESBYTERIAN CHURCH OF	PO BOX 13896	PHILADELPHIA	PA	19101	8007737752	
338	PITTMAN & ASSOCIATES, INC.	PO BOX 111047	MEMPHIS	TN	38111	8002381344	
339	CELTIC INDIVIDUAL HEALTH	PO BOX 33839	INDIANAPOLIS	IN	462030839	8004777870	
340	UNITED HEALTHCARE PLAN OF RIVER VALLEY	3800 23RD AVENUE OF THE CITIES, STE. 200	MOLINE	IL	61265	8002246602	THIS COMPANY BOUGHT OUT JOHN DEERE INS. CO. 6/29/07
341	ADMINISTRATIVE CONCEPTS, INC.	994 OLD EAGLE SCHOOL RD., STE. 1005	WAYNE	PA	19087	8882939229	
342	SUN LIFE INSURANCE COMPANY OF CANADA	ONE SUN LIFE EXECUTIVE PARK	WELLESLEY	MA	02181	8002253950	
343	GROUP BENEFITS ADMINISTRATORS	70 GRAND AVE.	RIVEREDGE	NJ	07661	2013433003	
344	ALIA CLAIMS DEPARTMENT	PO BOX 9060	PHOENIX	AZ	850689060	8008825707	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
345	EMPLOYEE BENEFIT SERVICES, INC.	PO BOX 1929	FORT MILL	SC	29716	8002421510	
346	ADMINISTRATIVE SERVICES, INC.	2187 NORTHLAKE PARKWAY STE. 106 BLD #9	TUCKER	GA	30084	7709343953	
347	PREFERRED CARE, INC. (PCI)	1300 VIRGINIA DR., STE. 315	FORT WASHINGTON	PA	19034	8002223085	
348	FIRST AGENCY, INC.	5071 WEST H AVE.	KALAMAZOO	MI	490098501	2693816630	THIS CODE ASSIGNED BY SCHA 8/28/07
349	HEALTH PLAN SELECT	PO BOX 382767	BIRMINGHAM	AL	352382767	8002936260	
350	NORTH AMERICA ADMINISTRATORS	PO BOX 1984	NASHVILLE	TN	37203	6152563561	
351	FISERV	PO BOX 8077	WAUSAU	WI	544028077	8666848090	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
352	FISERV HEALTH-COLORADO	PO BOX 720	PUEBLO	CO	810020720	8004468182	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
353	ONE HEALTH PLAN OF SC	PO BOX 190019	N CHARLESTON	SC	29419	8003149010	CODE ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
354	FIRST BENEFITS CORP	PO BOX 879	ANDERSON	IN	46015		CODE ASSIGNED BY SCHA
355	ACTIVA HEALTH GROUP	4350 E. CAMELBACK RD. # 200	PHOENIX	AZ	85018	6024689500	
356	UMR	PO BOX 2697	WICHITA	KS	67201	8008269781	USE CODE 139
357	HEALTH PLAN SERVICES	PO BOX 30298	TAMPA	FL	33630	8002377767	
358	BAKERY & CONFECTIONERY UNION	10401 CONNECTICUT AVE. STE. 300	KENSINGTON	MD	208953960	3014683742	
359	NORTH CAROLINA MUTUAL LIFE INSURANCE	411 W. CHAPEL HILL ST.	DURHAM	NC	27701	9196829201	
360	NEW ENGLAND FINANCIAL	PO BOX 190019	N. CHARLESTON	SC	29419	8004087681	USE CARRIER 859 NEW ENGLAND GROUP TRUST
361	MDI GOVERNMENT HEALTH SERVICES	822 HIGHWAY A1A NORTH STE. 310	PONTE VEDRA BEACH	FL	32082	8008416288	CODE ASSIGNED BY SCHA
362	GUARDIAN HEALTHCARE	PO BOX 4197	SCRANTON	PA	18505	8668501253	MEDICARE ADVANTAGE PLAN
363	PEARCE ADMINISTRATION	PO BOX 2437	FLORENCE	SC	29503	8886226001	GM SOUTHWEST IS THE CLAIMS PROCESSOR FOR PEARCE ADMINISTRATION
364	CORESTAR	PO BOX 1195	MINNEAPOLIS	MN	55440	8004446965	
365	GERBER CHILDRENS WEAR, INC.	PO BOX 2126	GREENVILLE	SC	29602	8649875200	
366	CATALYST RX	PO BOX 968022	SCHAUMBERG	IL	601968022	8009973784	
367	LOOMIS INSURANCE COMPANY	PO BOX 7011	WYOMISSING	PA	196107011	8007820392	
368	MED BENEFITS SYSTEM	PO BOX 177	SOUTH BEND	IN	46601	2192370560	
369	AMERICAN INTERNATIONAL GROUP	PO BOX 25050	WILMINGTON	DE	19899	8004687077	
370	DELTAHEALTH SYSTEMS	PO BOX 9554	SALT LAKE	UT	84109	8774740605	WAS P5 HEALTH PLUS SOLUTIONS
371	ICON BENEFIT ADMINISTRATORS, INC.	PO BOX 53010	LUBBOCK	TX	794533070	8006589777	
372	MEDIPLAN	502 VALLEY RD.	WAYNE	NJ	07410	9736963111	
373	STATE FARM INSURANCE COMPANIES	7401 CYPRESS GARDENS BLVD.	WINTER HAVEN	FL	338880007	8633183000	
374	STONEBRIDGE LIFE INSURANCE CO.	2700 W. PLANO PARKWAY	PLANO	TX	75075	8003319955	
375	RESTAT	11900 WESTLAKE PARK DR.	MILWAUKEE	WI	53224	8009265858	
376	TUFTS HEATH PLAN	PO BOX 9171	WATERTOWN	MA	024719171	8004620224	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
377	MERITAIN HEALTH	PO BOX 27267	MINNEAPOLIS	MN	554270267	8009252272	WAS NORTH AMERICAN ADMINISTRATORS, INC.
378	SELF INSURERS SERVICE, INC.	2218 SOUTH PRIEST DR.	TEMPE	AZ	85282		
379	GOODYEAR TIRE & RUBBER COMPANY	PO BOX 677 DEPT. 609	AKRON	OH	44309	2167966531	
380	BENMARK, INC.	PO BOX 16767	JACKSON	MS	39236	6013660596	
381	PROVIDENT INDEMNITY LIFE INSURANCE COMPANY	PO BOX 511	NORRISTOWN	PA	19404	8005199175	
382	HEALTH PLAN OF NEVADA	PO BOX 15645	LAS VEGAS	NV	891145615	8007771840	MEDICARE ADVANTAGE PLAN
383	AMERICAN HEALTHCARE ALLIANCE	PO BOX 8530	KANSAS CITY	MO	641140530	8772840102	
384	NORTH AMERICAN BENEFIT NETWORK	PO BOX 94928	CLEVELAND	OH	441014928	8003214085	
385	POSTMASTERS BENEFIT PLAN	1019 N. ROYAL ST.	ALEXANDRIA	VA	22314	7036835585	
386	ASSURANT HEALTH	PO BOX 624	MILWAUKEE	WI	532010624	8005537654	WAS FORTIS INSURANCE COMPANY
387	HEALTHGRAM	PO BOX 11088	CHARLOTTE	NC	28220	8004465439	HEALTHGRAM FORMERLY PRIMARY PHYSICIAN CARE
388	NATIONALWAY HEALTHCARE ASSOCIATES	PO BOX 682708	HOUSTON	TX	77268	8008107856	
389	GROUP LINK	PO BOX 20593	INDIANAPOLIS	IN	46220	8003597408	
390	BOARD OF PENSIONS EVANGELICAL LUTHERAN CHURCH	PO BOX 59093	MINNEAPOLIS	MN	554590093	6123337651	
391	POMCO	PO BOX 6329	SYRACUSE	NY	13217	8002344393	
392	SELF FUNDED GROUP INSURANCE ADMINISTRATORS	PO BOX 1719	KALAMAZOO	MI	490051790	8003421895	
393	FOUNTAINHEAD ADMINISTRATORS, INC.	PO BOX 13188	BIRMINGHAM	AL	35202	8009919155	
394	P5 HEALTH PLAN SOLUTIONS	PO BOX 9554	SALT LAKE CITY	UT	84109	8774740605	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
395	PINNACLE CLAIMS MANAGEMENT, INC.	1630 E SHAW AVE., STE. 190	FRESNO	CA	93710	8006499121	CODE ASSIGNED BY SCHA
396	MACY'S HR SERVICES	PO BOX 850958	RICHARDSON	TX	75085	8003372363	CODE ASSIGNED BY SCHA
397	PRIME THERAPEUTIC	PO BOX 25136	LEHIGH VALLEY	PA	18002	8886420447	
398	RIGHT CHOICE BENEFITS ADMINISTRATORS	12250 WEBER HILL RD., STE. 100	ST. LOUIS	MO	63127	8003659036	CODE ASSIGNED BY SCHA
399	PACIFIC LIFE AND ANNUITY	PO BOX 34799	PHOENIX	AZ	85067	8007332285	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
400	STATE EMPLOYEES HEALTH PLAN BLUE CROSS	4101 PERCIVAL RD.	COLUMBIA	SC	29219	8008682520	CLAIMS SHOULD BE SENT TO THE ATTN OF SARAH TOWNES AX-B10
401	BLUE CROSS AND BLUE SHIELD OF SC	PO BOX 100300	COLUMBIA	SC	29202	8037883860	DO NOT USE FOR MEDICARE. THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE. STREET ADDRESS 4101 Percival RD. COLA 29219
402	FEDERAL EMPLOYEE PLAN BLUE CROSS	I-20 AT ALPINE RD.	COLUMBIA	SC	29260	8037883860	
403	BLUE CHOICE/MEDICAID	PO BOX 6170	COLUMBIA	SC	29260	8772753256	MEDICAID HMO
404	BOB JONES UNIVERSITY	1700 WADE HAMPTON BLVD.	GREENVILLE	SC	29614	8643701800	
405	MARSH(INSURANCE TRUST PLAN-DELTA RETIREES)	PO BOX 10432	DES MOINES	IA	503060432	8773257265	CODE ASSIGNED BY SCHA
406	RURAL CARRIER BENEFIT PLAN	PO BOX 7404	LONDON	KY	40742	8006388432	
407	CINERGY HEALTH INS.	1844 N. NOB HILL RD. #623	PLANTATION	FL	33322	8008471148	
408	LIFE INVESTORS INSURANCE COMPANY OF AMERICA	PO BOX 8043	LITTLE ROCK	AR	72203	5013760426	AKA AEGON
409	UPSTATE ADMINISTRATIVE SERVICES	PO BOX 6589	SYRACUSE	NY	132176589	3154221533	
410	SAFECO INSURANCE COMPANY	PO BOX 34699	REDMOND	WA	981241699	2068678000	
411	INTERPLAN HEALTH GROUP	PO BOX 90613	ARLINGTON	TX	76006	8665114757	CODE ASSIGNED BY SCHA
412	CONNECTICARE	PO BOX 546	FARRINGTON	CT	06034	8002517722	
413	ALLIED BENEFITS SYSTEM	PO BOX 909786-60690	CHICAGO	IL	606909786	8002882078	
414	NATIONAL TELEPHONE COOP. ASSN.	1 WEST PACK SQUARE, STE. 600	ASHEVILLE	NC	28801	8282529776	
415	WEYCO, INC.	PO BOX 30132	LANSING	MI	48909	5173497010	
416	COMPANION BENEFIT ALTERNATIVES	PO BOX 100185	COLUMBIA	SC	29202	8008681032	THIS CARRIER ASSIGNED BY SCHA NOT REQUESTED OR USED BY DHHS.
417	JULY PRODUCTS	5 GATEWAY CENTER STE 60	PITTSBURG	PA	15222	8669008322	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
418	GUARDIAN INSURANCE COMPANY	PO BOX 8007	APPLETON	WI	549128007	8006854542	CODE ASSIGNED BY SCHA
419	GEORGIA STATE HEALTH BENEFIT PLAN	PO BOX 38151	ATLANTA	GA	30334	8006266402	
420	CUNA MUTUAL INSURANCE GROUP	PO BOX 391	MADISON	WI	53701	6082385851	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
421	UNITED FOOD & COMMERICAL WORKER HEALTH&WELFARE	911 RIDGEBROOK RD.	SPARKS	MD	211529451	8006382972	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
432	M-PLAN CARDINAL HEALTH	PO BOX 357	LINTHICUM	MD	210900357	8006752605	CODE ASSIGNED BY SCHA
433	COMPANION LIFE	PO BOX 100102	COLUMBIA	SC	29202	8037880500	
434	PIEDMONT HEALTH ALLIANCE	116 BONHAM CT.	ANDERSON	SC	29621	8643759661	
435	SEABURY AND SMITH COMPANY, INC.	PO BOX 2545	NASHVILLE	TN	37219	8005822498	
436	DAVIS-GARVIN AGENCY	#1 FERNANDINA CT.	COLUMBIA	SC	29212	8037320060	
437	NEW ERA LIFE INSURANCE CO	PO BOX 4884	HOUSTON	TX	772104884	2813687200	
438	MAMSI LIFE AND HEALTH INSURANCE CO	PO BOX 993	FREDERICK	MD	21705	8002576458	
439	UNION SECURITY INSURANCE CO	PO BOX 981602	EL PASO	TX	79998	8004446254	USE 386 ASSURANT HEALTH
440	HEALTHNET	PO BOX 14702	LEXINGTON	KY	40512	8006417761	
441	FEDERAL MOGUL HEALTHCARE	PO BOX 1999	DETROIT	MI	48235	8005220041	
442	GE LIFE & ANNUITY ASSURANCE CO.	PO BOX 6700	LYNCHBURG	VA	24505	8002530856	
443	COVENTRY HEALTHCARE OF KANSAS	PO BOX 7109	LONDON	KY	39026	8667858077	CODE ASSIGNED BY SCHA
444	NATIONAL DISASTER MEDICAL SYSTEM						
445	CAROLINA CARE PLAN/MEDICAL MUTUAL INS. CO. OF OHIO	PO BOX 6018	CLEVELAND	OH	441011018	8003153143	ALSO KNOWN AS SUPERMED ANOTHER PHONE # 800-232-3143
446	EMPLOYEE BENEFIT SERVICES	PO BOX 9888	SAVANNAH	GA	314120088	8035778051	USE CODE 345 EMPLOYEE BENEFIT SERVICES
447	HEALTH NET	PO BOX 14700	LEXINGTON	KY	405125225	9004387886	MEDICARE ADVANTAGE PLAN
448	ASSURANT HEALTH INSURANCE	PO BOX 42033	HAZELWOOD	MD	63042	8005537654	CODE ASSIGNED BY SCHA
449	UNITED SERVICE ASSO. FOR HEALTHCARE	PO BOX 6080-288	MISSION VAIEJO	CA	926906080	8008721187	CODE ASSIGNED BY SCHA
450	DESERET SECURE	PO BOX 45530	SALT LAKE CITY	UT	841450530	8772200110	MEDICARE ADVANTAGE PLAN
451	ASSURECARE RISK MANAGEMENT	340 QUADRANGLE BLVD.	BOLINGBROOK	IL	60440	8007597422	
452	CIGNA INTERNATIONAL EXPATRIATE BENEFITS	PO BOX 15050	WILMINGTON	DE	19850	8004412668	
453	BLUE CROSS ANTHEM MEDICARE ADVANTAGE	2100 CORPORATE CENTER	NEWBURY PARK	CA	913201431	8006762583	MEDICARE ADVANTAGE PLAN
454	INTERNATIONAL UNION OF OPERATING ENGINEERS	166 WEST KELLY ST.	METUCHEN	NJ	08840	9085486662	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
455	ALASKA TEAMSTER TRUST	520 E 34TH AVE., STE. 107	ANCHORAGE	AK	995034116	8004784450	CODE ASSIGNED BY SCHA
456	FIRST HEALTH (A COVENTRY HEALTH CARE CO)	PO BOX 21680	EAGAN	MN	551210680	8664775465	
457	COMMERICAL TRAVELERS	70 GENESSE ST.	UTICA	NY	13502	8007563702	CODE ASSIGNED BY SCHA
458	ASSOCIATION BENEFIT PLAN (MEDICARE)	PO BOX 668587	CHARLOTTE	NC	282668587	8006340069	CODE ASSIGNED BY SCHA
459	GLASS MOTORS & PLASTIC (GMPA)	5245 BIG PINE WAY, SE 33907	FORT MYERS	FL	33907	8139366242	
460	MORRIS ASSOCIATES	PO BOX 50440	INDIANAPOLIS	IN	462500440	3175549000	
461	EVERCARE	PO BOX 31350	SALT LAKE CITY	UT	841310350	8888668298	MEDICARE ADVANTAGE PLAN
462	1ST MEDICAL NETWORK	PO BOX 724317	ATLANTA	GA	31139	8889806676	CODE ASSIGNED BY SCHA
463	TIM BAR CORP	PO BOX 449	HANOVER	PA	17331	7176324727	
464	INTERNATIONAL MEDICAL GROUP	407 N. FULTON ST.	INDIANAPOLIS	IN	46202	8006284664	
465	INTER CARE BENEFIT SYSTEMS	PO BOX 3559	ENGLEWOOD	CO	801553559	3037705710	
466	VALUE RX	PO BOX 421150	PLYMOUTH	MN	554420150	8009554879	USE CODE 333 EXPRESS SCRIPTS
467	FIRSERV HEALTH	PO BOX 182173	COLUMBUS	OH	432182173	8008482664	USE CODE 139
468	PHOENIX HEALTHCARE	PO BOX 150809	ARLINGTON	TX	76015	8003976241	
469	AMERICAN ASSOCIATION OF RETIRED PERSONS (AARP)	PO BOX 740819	ATLANTA	GA	30374	8005235880	
470	YODER BROTHERS	1001 LEBANON RD.	PENDLETON	SC	29670	8646468331	
471	CAREMARK	PO BOX 52195	PHOENIX	AZ	850722195	8003030187	
472	NATIONAL HEALTH CARE HEALTH BENEFITS PLAN (NHC)	PO BOX 1398	MURFREESBORO	TN	371331398	6158902020	
473	INTERNATIONAL MISSION BOARD (IMB)	PO BOX 6767	RICHMOND	VA	232300767	8042191585	CODE ASSIGNED BY SCHA
474	DIVERSIFIED PHARMACEUTICAL	PO BOX 169052	DULUTH	MN	55816	8002338065	USE CODE 333 EXPRESS SCRIPTS
475	BENEFIT ASSISTANCE CORP.	PO BOX 950	HURRICANE	WV	25526	3045621913	
476	CENTRAL STATES, SOUTHEAST & SOUTHWEST	PO BOX 5116	DES PLAINES	IL	60017	8003235000	
477	MEGA LIFE AND HEALTH INSURANCE COMPANY	PO BOX 981606	EL PASO	TX	79998	8005272845	
478	SMITH ADMINISTRATORS	PO BOX 163289	FORT WORTH	TX	76161	8008672582	
479	PRIMEXTRA	PO BOX 1088	TWINSBURG	OH	44087	8004334893	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
480	COVENTRY HEALTH CARE OF THE CAROLINAS	PO BOX 7715	LONDON	KY	40742	8008891947	COVENTRY HEALTH CARE IS PARENT CO. OF SOUTHERN HEALTH AND WELLPATH
481	BENOVATION	3481 CENTRAL PARKWAY, STE. 200	CINCINNATI	OH	45223	8006816912	CODE ASSIGNED BY SCHA
482	COVENTRY HEALTHCARE OF GEORGIA	PO BOX 7711	LONDON	KY	40742	8667321017	
483	COOPERATIVE BENEFITS ADMINISTRATORS	PO BOX 6249	LINCOLN	NE	68506	4024839250	
484	INTEGRITY BENEFITS NETWORK	PO BOX 4537	MARIETTA	GA	30061	7704281604	
485	PROVIDENT HEALTH PLAN	PO BOX 3125	PORTLAND	OR	972083125	8006283912	CODE ASSIGNED BY SCHA
486	PREFERRED CARE	PO BOX 22920	ROCHESTER	NY	146922920	8009993920	MEDICARE ADVANTAGE PLAN
487	PIEDMONT INS COMPANY	PO BOX 979	MARION	SC	29571	8434235541	
488	AMERICAN BENEFITS MANAGEMENT	8310 PORT JACKSON AVE. NORTHWEST	NORTH CANTON	OH	44720	3309665500	
489	SAVRX	PO BOX 8	FREEMONT	NE	68026	8003506714	
490	SHEET METAL LOCAL 20	PO BOX 42489	INDIANAPOLIS	IN	43242	8002482141	CODE ASSIGNED BY SCHA
491	VISION SERVICE PLAN	PO BOX 997100	SACRAMENTO	CA	958997100	8006227444	
492	LT11-LIFETRAC NETWORK	111100 WAYZATA BLVD.	MINNEAPOLIS	MN	55305		CODE ASSIGNED BY SCHA
493	UNITED TEACHERS ASSOCIATION	PO BOX 30010	AUSTIN	TX	787553010	8668808824	
494	AVESIS PHARMACY NETWORK	3724 N 3RD ST., STE. 300	PHOENIX	AZ	85012	6022413400	
495	NATIONAL PRESCRIPTION ADMINISTRATORS	PO BOX 1981	EAST HANOVER	NJ	079361981	8005226727	BOUGHT OUT BY EXPRESS SCRIPTS CC333
496	AMERICAN VETERINARIAN MEDICINE ASSN.	PO BOX 909720	CHICAGO	IL	606049720	8006216360	
497	TEXAS INTERNATIONAL	PO BOX 11007	WINSTON-SALEM	NC	27116	8663074711	
498	CAROLINA BENEFIT ADMINISTRATORS	PO BOX 3257	SPARTANBURG	SC	29304	8645736937	
499	EMPLOYEE BENEFIT CONSULTANTS	PO BOX 928	FINDLAY	OH	45839	8005587798	
500	DELTA DENTAL	PO BOX 1809	ALPHARETTA	GA	30023	8005212651	
501	UNION FIDELITY INSURANCE COMPANY	4850 ST. RD.	TREVOSE	PA	19049-	8005236599	
502	HIP HEALTH PLAN	PO BOX 2803	NEW YORK	NY	101162803	8004478255	MEDICARE ADVANTAGE PLAN
503	AMERICAN SPECIAL RISK MANAGEMENT	509 SOUTH LENOLA RD., BLDG. TWO	MOORESTOWN	NJ	08057	8003597475	
504	M CARE	PO BOX 130799	ANN ARBOR	MI	481130779	2156578920	CODE IN OPEN STATUS BY SCHA
505	ASSOCIATED ADMINISTRATORS	PO BOX 27806	BALTIMORE	MD	212857806	8006382972	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
506	EMPLOYEE BENEFIT PLAN ADMINISTRATORS	PO BOX 2000	EXETER	NH	03833	8002587298	
507	CENTRAL STATES HEALTH & LIFE CO. OF OMAHA	PO BOX 34350	OMAHA	NE	68134	4023971111	
508	GROUP HEALTH, INC. /EMBLEM HEALTH COMPANY	PO BOX 3000	NEW YORK	NY	101163000	2125014444	
509	EQUITABLE LIFE AND CASUALTY	PO BOX 2460	SALT LAKE CITY	UT	84110	8003525150	
510	EQUITABLE PLAN SERVICES	PO BOX 720460	OKLAHOMA	OK	73172	8007492631	
511	CIGNA BEHAVIORAL HEALTH	PO BOX 188022	CHATTANOOGA	TN	37422	8003364091	
512	ST11-STRATEGIC HEALTH	9501 NE 2ND AVE.	MIAMI SHORES	FL	33138		CODE ASSIGNED BY SCHA
513	VALUE OPTIONS	PO BOX 1850	HICKSVILLE	NY	118021850	8002880882	
514	JLT SERVICES (TPA FOR NY LIFE)	PO BOX 1511	LATHAM	NY	12110	8007933773	NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
515	LIFE OF THE SOUTH INSURANCE COMPANY	PO BOX 45237	JACKSONVILLE	FL	32232	8006616385	THIS CODE ASSIGNED BY SCHA NOT A MEDICAID REQUEST
516	DIRECT REIMBURSEMENT BENEFIT PLANS	1111 ALDERMAN DR., STE. 420	ALPHARETTA	GA	30202	7706645594	
517	UNIFORM MEDICAL PLAN	PO BOX 34850	SEATTLE	WA	98124	8007626004	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
518	NAT'L ASBESTOS WORKERS MED FUND	PO BOX 188004	CHATTANOOGA	TN	37422	8003863632	
519	HEALTHSOURE ADMINISTRATORS	PO BOX 382617	BIRMINGHAM	AL	35238	8778939294	
520	NEW JERSEY CARPENTERS	PO BOX 7818	EDISON	NJ	088180846	8006243096	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
521	ALLIANCE PPO, INC.	PO BOX 934	FREDERICK	MD	21705	8002350123	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
522	NATIONAL AUTOMATIC SPRINKLER INDUSTRY	800 CORPORATE DR.	LANDOVER	MD	20785	3015771700	
523	APA PARTNERS, INC.	PO BOX 1506	LATHAM	NY	121108006	8008333650	
524	HEALTHFIRST	PO BOX 130217	TYLER	TX	75713	8004778957	CODE ASSIGNED BY SCHA TPA
525	CONSECO MEDICAL INSURANCE CO.	PO BOX 1205	ROCKFORD	IL	61105	8009470319	USE CODE 282 WASHINGTON NATIONAL

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
526	AULTCARE	PO BOX 6910	CANTON	OH	44706	8003448858	
528	KAISER PERMANENTE	PO BOX 190849	ATLANTA	GA	31119	8006111811	MEDICARE ADVANTAGE PLAN
529	ANTHEM HEALTH	3575 KROGER BLVD., STE. 400	DULUTH	GA	30316	8008881966	
530	UNIVERSAL BENEFITS CORPORATION	PO BOX 97	SCRANTON	PA	185040097	8007470622	CODE ASSIGNED BY SCHA
531	MARY BLACK HEALTHNETWORK	1690 SKYLYN DR.,	SPARTANBURG	SC	29307	8645733535	
532	AMERICAN MEDICAL SECURITY	PO BOX 19032	GREEN BAY	WI	543079032	8002325432	
533	PHYSICIANS CARE NETWORK	PO BOX 101111	COLUMBIA	SC	292111111	8883239271	
534	PROVANTAGE PRESCRIPTION BENEFIT MANAGEMENT SERVICE	PO BOX 1662	WAUKEHA	WI	53187	2627844600	
535	CHP DIRECT/SUPERMED	PO BOX 94648	CLEVELAND	OH	441014648	8007731445	
536	CLAIMSWARE MANAGEMED	PO BOX 6125	GREENVILLE	SC	29606	8642348200	
537	KAISER PERMANENTE-OHIO REGION	PO BOX 5316-9774	CLEVELAND	OH	441010316	8006348816	CODE ASSIGNED BY SCHA
538	PENN GENERAL SERVICES	PO BOX 72077	ATLANTA	GA	303581535	8004441535	CODE ASSIGNED BY SCHA
539	MEDICAL MUTUAL INSURANCE OF OHIO	PO BOX 94648	CLEVELAND	OH	44101	8003621279	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
540	LIBERTY NATIONAL LIFE INSURANCE COMPANY	PO BOX 2612	BIRMINGHAM	AL	35202	2053252722	
541	CHILDRENS REHAB SERVICES	PO BOX 4217	SPARTANBURG	SC	293054217	8645962227	CODE ASSIGNED BY SCHA
542	THIRD PARTY ADMINISTRATORS/AMERICAN BENEFIT	1733 PARK ST.	NAPERVILLE	IL	60563	8006315917	
543	ACHA/CAREINGTON INTERNATIONAL CORP	PO BOX 2568	FRISCO	TX	75034	8002900523	CODE ASSIGNED BY SCHA
545	MOLINA HEALTHCARE OF OHIO	PO BOX 22712	LONG BEACH	CA	90801	8006424148	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
546	RISK MANAGEMENT SERVICES	PO BOX 6309	SYRACUSE	NY	13217	3154489000	
547	HARRINGTON HEALTH	PO BOX 30544	SALT LAKE CITY	UT	841300544	8777370769	
548	COMPBENEFITS INSURANCE CO.	PO BOX 804483	CHICAGO	IL	606804106	8005940977	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
549	WAL-MART STORES GROUP HEALTH PLAN	922 W. WALNUT STE. A	ROGERS	AR	72756 320	5016212929	USE CODE 401 BLUE CROSS BLUE SHIELD OF SC
550	EMPLOYEE SECURITY, INC.	7125 THOMAS EDISON DR., STE. 105	COLUMBIA	MD	21046	8006381134	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
551	COOPERATIVE MANAGED CARE SERVICES LLC	PO BOX 502530	INDIANAPOLIS	IN	46250	8668734516	CODE IN OPEN STATUS BY SCHA
552	CORESOURCE, INC.	PO BOX 2920	CLINTON	IA	52733	8003275462	
553	HEALTHSCOPE BENEFITS, INC..	PO BOX 99005	LUBBOCK	TX	79490	8883736102	
554	DIAMOND G EMPLOYEE BENEFIT TRUST	PO BOX 1298	GREENVILLE	TN	37744	4236396145	
555	PHILADELPHIA AMERICAN LIFE INSURANCE CO	PO BOX 4884	HOUSTON	TX	772104882	8005527879	CODE ASSIGNED BY SCHA
556	UNIFIED GROUP SERVICES	PO BOX 10	PENDLETON	IN	46064	7657781535	
557	AMERICORP INS. CO	PO BOX 3430	CARMEL	IN	46082	8666994186	
558	NATIONAL TRAVELERS LIFE INS. CO.	PO BOX 9197	DES MOINES	IA	50306	8002325818	INACTIVE 8/02
559	CAROLINA HOSPITAL SYSTEMS BENEFIT PLAN	PO BOX 100569	FLORENCE	SC	295010659	8436613875	
560	ALLEN MEDICAL CLAIMS ADMINISTRATORS	PO BOX 978	FT. VALLEY	GA	310300978	8008255406	
561	PHOENIX MUTUAL LIFE INSURANCE COMPANY	ONE AMERICAN ROW	HARTFORD	CT	06115	8004512513	THIS CARRIER PURCHASED BY CC864 GE GROUP ADMINISTRATORS
562	HEALTH CLAIMS SERVICES,INC.	PO BOX 9615	DEERFIELD BEACH	FL	33442	8002223560	
563	ADMINISTRATIVE SERVICE CONSULTANTS	3301 E ROYALTON RD. BLDG. D	BROADVIEW HEIGHTS	OH	44147		
564	MULTINATIONAL UNDERWRITERS	PO BOX 863	INDIANAPOLIS	IN	46206	8006052282	CODE ASSIGNED BY SCHA
565	UNITED BENEFITS	PO BOX 2480	DAYTONA BEACH	FL	321152480	8004344890	WAS POE & BROWN
566	UNIFIED GROUP SERVICES	PO BOX 10	PENDLETON	IN	46064	7657781535	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
567	EASTERN BENEFIT SYSTEMS	200 FREEWAY DR. E	EAST ORANGE	NJ	07018	8005240227	
568	SIMPLIFI	PO BOX 922043	HOUSTON	TX	772922043	8884465710	FORMERLY CBCA ADMINISTRATORS
569	MARYLAND PHYSICIANS CARE	PO BOX 61778	PHOENIX	AZ	85082	8009538854	CODE IN OPEN STATUS BY SCHA
570	SAMBA HEALTH BENEFIT PLAN	11301 OLD GEORGETOWN RD.	ROCKVILLE	MD	20852	8006386589	
571	CORESOURCE, INC.	PO BOX 8215	LITTLE ROCK	AR	722218215	8886049397	CODE IN OPEN STATUS BY SCHA
572	CATAMARAN	PO BOX 29044	HOT SPRINGS	AR	71093	8778398119	FORMERLY HEALTH TRANS
573	ST JOHN'S CLAIMS ADMINISTRATION	PO BOX 14409	SPRINGFIELD	MO	65814	8778757700	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
574	CITY OF AMARILLO GROUP HEALTH	PO BOX 15130	AMARILLO	TX	79105	8063784235	CODE IN OPEN STATUS BY SCHA
575	WISCONSIN ELECTRICAL EMPLOYEES	PO BOX 2430	BROOKFIELD	WI	53008	6082769111	CODE IN OPEN STATUS BY SCHA
576	SIOUX VALLEY HEALTH	PO BOX 91110	SIOUX FALLS	SD	57109	8007525863	
577	HEALTHMARKETS CARE ASSURED	PO BOX 69349	HARRISBURG	PA	17110	8772195460	CODE ASSIGNED BY SCHA
578	PROFESSIONAL ADMINISTRATORS, INC.	3751 MAGUIRE BLVD., STE. 100	ORLANDO	FL	32814	8007410521	
579	ANTHEM PRESCRIPTION MANAGEMENT	PO BOX 145433	CINCINNATI	OH	45250	8006620210	USE CARRIER A24
580	WORLD INSURANCE COMPANY	PO BOX 3160	OMAHA	NE	681030160	4024968000	
581	ALTA RX	PO BOX 30081	SALT LAKE CITY	UT	84130	8009985033	
582	USAA GENERAL INDEMNITY CO.	PO BOX 15506	SACRAMENTO	CA	958521506	8005318222	
583	ONE NATION BENEFIT ADMINISTRATORS	PO BOX 528	COLUMBUS	OH	43216	8008246796	NAME CHANGE WAS ANTHEM BENEFIT ADMINISTRATORS
584	UNITED HEALTH ONE	PO BOX 31374	SALT LAKE CITY	UT	841310374	8006578205	FORMALLY GOLDEN RULE
585	PLUMBERS & STEAMFITTERS WELFARE FUND	1024 MCKINLEY ST.	PEEKSILL	NY	10566	9147377220	
586	MCA ADMINISTRATORS (MANAGED CARE OF AMERICA)	MANOR OAK TWO, STE 605 1910 COCHRAN RD.	PITTSBURGH	PA	15220	4129220780	WAS DIVERSIFIED GROUP ADMINISTRATORS
587	FUTURE SCRIPTS	PO BOX 419019	KANSAS CITY	MO	64141	8886787012	
588	AUTOMATED BENEFIT SERVICES, INC.	PO BOX 321223	DETROIT	MI	482321223	8002751896	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
589	POLY AMERICA LP	2000 W MARSHALL DR.	GRAND PRAIRIE	TX	75051	8007855301	CODE IN OPEN STATUS BY SCHA
590	PHYSICIANS HEALTH SERVICES	PO BOX 981	BRIDGEPORT	CT	06601	8008484747	
591	OLD AMERICAN INSURANCE COMPANY	PO BOX 418573	KANSAS CITY	MO	64141	8167534900	
592	CONTEC	525 LOCUS GROVE RD.	SPARTANBURG	SC	29303	8645038333	CODE ASSIGNED BY SCHA
593	MUTUAL ASSURANCE ADMINISTRATORS, INC.	PO BOX 42096	OKLAHOMA CITY	OK	73123	8006489652	
594	NORWEST FINANCIAL	206 EIGHTH ST.	DES MOINES	IA	50309	5152432131	CODE ASSIGNED BY SCHA
595	AFLAC-AMERICAN FAMILY LIFE ASSO CO	1932 WYNNTON RD.	COLUMBUS	GA	31999	8009923522	
596	SECURE HORIZONS	PO BOX 659787	SAN ANTONIO	TX	782659787	8665798811	MEDICARE ADVANTAGE PLAN

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
597	MONARCH DIRECT	PO BOX 9004	SPRINGFIELD	MA	01101	8006289000	
598	WJB DORN VA MEDICAL CENTER	6439 GARNERS FERRY RD.	COLUMBIA	SC	292091639	8037764000	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
599	NATIONAL ELEVATOR INDUSTRY HEALTH BENEFITS	PO BOX 477	NEWTOWN SQUARE	PA	190730477	8005234702	
603	OTHER INDIGENT (HOSPITAL CHARITY)			SC			
604	CHAMPVA	PO BOX 469064	DENVER	CO	80246	3033317599	
606	VOCA.REHAB GENERAL						
607	WPS TRICARE FOR LIFE	PO BOX 7889	MADISON	WI	537077889	8667730404	
608	VOCATIONAL REHAB DISABILITY						
609	COMM FOR BLIND						
610	DHEC CANCER						
611	DHEC C. CHILDREN						
612	DHEC LOW RISK MATERNITY						
613	DHEC HIGH RISK MATERNITY						
614	TRICARE WEST	PO. BOX 202112	FLORENCE	SC	295022112	8004033950	INTERNET WWW.TRICARE-WEST.COM
615	DHEC STERILIZATION						
616	MEDICAID-OUT-OF-STATE						
617	MEDICARE RAILROAD (PGBA) PROFESSIONAL PART B	PO BOX 10066	AUGUSTA	GA	30999	8772887600	
618	MEDICARE PART A						
619	MEDICAID, SC						
620	MEDICARE PART B ONLY						
621	DEPT CORRECTIONS						
622	WORKMEN'S COMP						
623	CAROLINA MEDICARE PRIME HMO	201 EXECUTIVE CENTER DR.	COLUMBIA	SC	29210	8037507473	MEDICARE ADVANTAGE PLAN
624	OTHER SPONSOR						
625	DHEC MIGRANT HEALTH						
626	DHEC SICKLE CELL						
627	DHEC HEART						
628	DHEC HEMOPHILIA						

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
629	DHEC FAMILY PLANNING						
630	DHEC TB						
631	SHRINERS						
632	CRIME VICTIMS						
633	VETERANS ADMINISTRATION						
635	MUTUAL OF OMAHA	MUTUAL OF OMAHA PLAZA	OMAHA	NE	68175	4023427600	MEDICARE INTERMEDIARY PART A
636	MUTUAL OF OMAHA	MUTUAL OF OMAHA PLAZA	OMAHA	NE	68175		MEDICARE INTERMEDIARY PART B
637	SELECT HEALTH/FIRST CHOICE	PO BOX 7120	LONDON	KY	40742	8882762020	MEDICAID HMO
638	UNISON HEALTH PLAN HMO	250 BERRYHILL RD.	COLUMBIA	SC	29210	8037985852	MEDICAID HMO
639	HEALTHFIRST HMO	255 ENTERPRISE BLVD., STE. 20	GREENVILLE	SC	29615	8644551100	MEDICAID HMO
642	TRICARE FOR LIFE	PO BOX 7890	MADISON	WI	537077890	8667730404	
643	BCBS OF TENNESSEE	730 CHESTNUT ST.	CHATTANOOGA	TN	37402	8772966189	MEDICARE INTERMEDIARY
644	BCBS OF GEORGIA	PO BOX 9907	COLUMBUS	GA	31908	8004412273	MEDICARE INTERMEDIARY
645	STERLING MEDICARE CHOICE HMO	PO BOX 70	LINTHIEUM	MD	21900	6152445600	MEDICARE ADVANTAGE PLAN
646	CIGNA-MEDICARE	PO BOX 671	NASHVILLE	TN	37202	6152445600	MEDICARE INTERMEDIARY
648	HUMANA GOLD CHOICE (PFFS)	PO BOX 7060	CAMDEN	SC	29020	8775115000	MEDICARE ADVANTAGE PLAN
650	ABBEVILLE COUNTY						
651	AIKEN COUNTY						
652	ALLENDALE COUNTY						
653	ANDERSON COUNTY						
654	BAMBERG COUNTY						
655	BARNWELL COUNTY						
656	BEAUFORT COUNTY						
657	BERKELEY COUNTY						
658	CALHOUN COUNTY						
659	CHARLESTON COUNTY						
660	CHEROKEE COUNTY						
661	CHESTER COUNTY						

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
662	CHESTERFIELD COUNTY						
663	CLARENDON COUNTY						
664	COLLETON COUNTY						
665	DARLINGTON COUNTY						
666	DILLON COUNTY						
667	DORCHESTER COUNTY						
668	EDGEFIELD COUNTY						
669	FAIRFIELD COUNTY						
670	FLORENCE COUNTY						
671	GEORGETOWN COUNTY						
672	GREENVILLE COUNTY						
673	GREENWOOD COUNTY						
674	HAMPTON COUNTY						
675	HORRY COUNTY						
676	JASPER COUNTY						
677	KERSHAW COUNTY						
678	LANCASTER COUNTY						
679	LAURENS COUNTY						
680	LEE COUNTY						
681	LEXINGTON COUNTY						
682	MARION COUNTY						
683	MARLBORO COUNTY						
684	MCCORMICK COUNTY						
685	NEWBERRY COUNTY						
686	OCONEE COUNTY						
687	ORANGEBURG COUNTY						
688	PICKENS COUNTY						
689	RICHLAND COUNTY						
690	SALUDA COUNTY						
691	SPARTANBURG COUNTY						
692	SUMTER COUNTY						
693	UNION COUNTY						

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
694	WILLIAMSBURG COUNTY						
695	YORK COUNTY						
696	OUT-OF-STATE GA						
697	OUT-OF-STATE NC						
698	OUT-OF-STATE OTHER						
700							
701	UNI-CARE CHOICE HEALTH BENEFITS	PO BOX 51130	SPRINGFIELD	MA	01151	8002888630	
702	BOON CHAPMAN BENEFIT ADMINISTRATORS	PO BOX 9201	AUSTIN	TX	787669201	8002529653	CODE ASSIGNED BY SCHA
702DN	BOON CHAPMAN BENEFIT ADMINISTRATORS	PO BOX 9201	AUSTIN	TX	787669201	8002529653	DENTAL ONLY
703	TUCKER COMPANY & ADMINISTRATORS	9140 ARROW POINT BLVD. #200	CHARLOTTE	NC	282738102	7045259666	
704	UNITED FOOD & COMMERICAL WORKERS (UFCW)	1800 PHOENIX BLVD. STE. 310	ATLANTA	GA	30349	8002417701	
705	APS HEALTHCARE, INC.	PO BOX 1307	ROCKVILLE	MD	20849	8002218699	
706	PLUMBERS & PIPEFITTERS LOCAL NO. 421	PO BOX 840	MACON	GA	312020840	8887412673	
707	DILLON YARN MEDICAL BENEFITS	1019 TITAN RD.	DILLON	SC	29536	8437747353	
708	PERFORMAX	PO BOX 61505	KING OF PRUSSIA	PA	19406	8885547629	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
709	MERCER ADMINISTRATION	PO BOX 4546	IOWA CITY	IA	52244	8008687526	
710	21ST CENTURY HEALTH AND BENEFITS, INC.	PO BOX 5037	CHERRY HILL	NJ	08034	8003234890	
711	LABORERS DISTRICT COUNCIL OF GA AND SC	PO BOX 607	JONESBORO	GA	302370607	4044771888	
712	TDI MANAGED CARE SERVICES	620 EPSILON DR.	PITTSBURG	PA	15238	8005815300	CARRIER BOUGHT OUT BY PHARMACARE CC 740
713	HEALTH CARE CREDIT UNION ASSOC. HCCUA	PO BOX 260957	PLANT	TX	750260957	8663736366	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
714	STOWE ASSOCIATES	2872 WOODCOCK BLVD. #200	ATLANTA	GA	30341	8005337896	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
715	UNITED HEALTH & LIFE INSURANCE COMPANY	PO BOX 169050	DULUTH	MN	558168200	8005262414	USE CC113 UNITED HEALTHCARE
716	INDECS CORP	PO BOX 668	LYNDHURST	NJ	07071	8884463327	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
717	USA HEALTH CARE (MVP HEALTH CARE)	PO BOX 22920	ROCHESTER	NY	146922920	8009993920	CODE ASSIGNED BY SCHA
718	CIGNA PHARMACY SERVICES	PO BOX 188053	CHATTANOOGA	TN	374228053	8006225579	
719	FLORIDA HEALTH ALLIANCE	PO BOX 10269	JACKSONVILLE	FL	322470269	9043548335	
720	UNITED MINE WORKERS HEALTH & RETIREMENT FUND	ROUTE 2 BOX 218A	BIG STONE GAP	VA	24219	8006549763	
721	UNITED RESOURCE NETWORK	PO BOX 30758	SALT LAKE CITY	UT	84130	8778013507	CODE ASSIGNED BY SCHA
722	AMERICAN REPUBLIC INSURANCE COMPANY	PO BOX 21670	EAGAN	MN	55121	8002472190	
723	CAROLINA CONTINENTAL INSURANCE	PO BOX 427	COLUMBIA	SC	29202	8032566265	
724	MUTUAL MEDICAL PLANS	PO BOX 689	PEORIA	IL	61652	8004484689	CODE ASSIGNED BY SCHA
725	DIALYSIS CLINIC, INC.	203 FREEMONT AVE.	SPARTANBURG	SC	29303	8645852046	
726	INSURANCE SERVICE AND BENEFITS	3218 HIGHWAY 67 STE. 218	MESQUITE	TX	75150	8008783157	
727	GUARANTEE MUTUAL LIFE CO.	8801 INDIAN HILLS DR.	OMAHA	NE	68114	8004624660	
728	GENERAL PRESCRIPTION PROGRAMS, INC.	305 MADISON AVE. STE 1166B	NEW YORK	NY	10165	8003412234	
729	U.A. LOCAL 446 PLUMBERS AND PIPEFITTERS	PO BOX 191030	SACRAMENTO	CA	958191030	9164570821	CODE IN OPEN STATUS BY SCHA
730	GEORGIA HEALTHCARE PARTNERSHIP	PO BOX 16388	SAVANNAH	GA	314163088	8005666710	
731	ADOVA HEALTH	PO BOX 725549	ATLANTA	GA	31139	8664704959	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
732	HERTZ CLAIM MANAGEMENT	PO BOX 726	PARK RIDGE	NJ	07656	2013072177	
733	MOUNTAIN CLAIMS MANAGEMENT	PO BOX 1008	FRUITLAND	ID	83619	2084527979	CODE IN OPEN STATUS BY SCHA
734	STRATEGIC OUTBURSTING, INC.	PO BOX 241508	CHARLOTTE	NC	28224	8888367764	CODE NOT REQUESTED BY MEDICAID ASSIGNED BY SCHA
735	INTEGRITAS BENEFIT GROUP	PO BOX 1447	CORDOVA	TN	38088	9016858980	
736	SPECTERA	2811 LORD BALTIMORE DR.	BALTIMORE	MD	212442644	8006383120	
737	UNITED CONCORDIA	PO BOX 69451	HARRISBURG	PA	17106	8003320366	
738	FHA-TPA DIVISION	PO BOX 327810	FT. LAUDERDALE	FL	333329711	8037988698	CODE IN OPEN STATUS BY SCHA
739	BOLLINGER, INC.	PO BOX 727	SHORT HILLS	NJ	07078	8662670092	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
740	PHARMACARE	PO BOX 52188	PHOENIX	AZ	850722196	8002376184	AS OF 1/1/08 CO. MERGED WITH CAREMARK (471) ADD NEW POLICIES WITH 471
741	SPENCER & ASSOCIATES INS.	1 S. LIMESTONE ST., STE. 301	SPRINGFIELD	OH	45502	8667669016	CODE ASSIGNED BY SCHA
742	MIDA DENTAL PLAN	2000 TOWN CENTER, STE. 2200	SOUTHFIELD	MI	48075	8009376432	
743	EMPLOYEE PLANS, INC.	PO BOX 2362	FT. WAYNE	IN	468012362	2606257500	
744	SENIOR DIMENSIONS	PO BOX 15645	LAS VAGAS	NV	891145645	8009257455	
745	GROUP BENEFIT SERVICES	1312 BELLONE AVE.	LUTHERVILLE	MD	21093	8006386085	
746	MED-TAC CLAIMS	PO BOX 9110	NEWTON	MA	02160	8003479355	
747	PACIFICARE	PO BOX 6099	CYPRESS	CA	90630	8663169776	CODE ASSIGNED BY SCHA
748	HEALTH CARE SAVINGS, INC.	4530 PARK RD	CHARLOTTE	NC	28209		CODE ASSIGNED BY SCHA
749	GERBER LIFE INSURANCE COMPANY	PO BOX 2088	GRAND RAPIDS	MI	49501	8002533074	
750	BENEFIT ADMINISTRATIVE SERVICES	PO BOX 4509	ROCKFORD	IL	61110	8159699663	
751	POLARIS BENEFIT ADMINISTRATORS	PO BOX 2010	WESTERVILLE	OH	43086-	8002340225	
752	HYGEIA CORPORATION	15500 NEW BARN RD.	MIAMI LAKES	FL	33014	8005912650	CODE ASSIGNED BY SCHA
753	HEALTHNET	PO BOX 2226	AUGUSTA	GA	309032226	9009778221	
754	1199 SEIU NATIONAL BENEFIT FUND	PO BOX 1007	NEW YORK	NY	101081007	6464739200	
755	TOTAL BENEFIT SERVICES, INC.	PO BOX 30180	NEW ORLEANS	LA	70190		
756	INSURANCE MANAGEMENT ADMINISTRATORS (IMA)	PO BOX 71120	BOSSIER CITY	LA	711719944	8007429944	
757	J C PENNEY LIFE INSURANCE COMPANY	PO BOX 869090	PLANO	TX	750860909	9728816000	
758	HEALTHCHOICE	PO BOX 24870	OKLAHOMA	OK	731270870	8004892974	CODE ASSIGNED BY SCHA
759	MEDIPLUS	PO BOX 9126	DES MOINES	IA	50309	8002472192	AKA TROA
760	KEY BENEFIT ADMINISTRATORS	PO BOX 3253	MILWAUKEE	WO	53201	8003314757	
761	EMPLOYEE BENEFIT STRATEGIES	229 EAST MICHIGAN AVE., STE. 235	KALAMAZOO	MI	49007	8003257477	
762	ROYAL NEIGHBORS OF AMERICA	PO BOX 10850	CLEARWATER	FL	337578850	8778158857	CODE ASSIGNED BY SCHA
763	THE PROVIDENT	PO BOX 31499	TAMPA	FL	33631	8005257268	
764	CARE LINK HEALTH PLAN	PO BOX 7373	LONDON	KY	407427373	8003482922	
765	FREEDOM HEALTH	PO BOX 151348	TAMPA	FL	33684	8004012740	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
766	PALMER & CAY/CARSWELL, INC.	PO BOX 1286	SAVANNAH	GA	31402	9122346621	
767	HEALTHSCOPE BENEFITS	PO BOX 619055	DALLAS	TX	752619055	8006006212	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
768	WISCONSIN PHYSICIANS SERVICES	1717 WEST BROADWAY ST.	MADISON	WI	53708	8889154158	
769	FEDEX FREIGHTWAYS	PO BOX 840	HARRISON	AR	72602	8008744723	
770	PEOPLES BENEFIT LIFE INSURANCE	PO BOX 484	VALLEY FORGE	PA	19493	8005237900	
771	PACIFIC FIDELITY LIFE INSURANCE CO (P.F.L.)	PO BOX 982009	N RICHLAND HILLS	TX	761828009	8176566040	USE CODE 477 MEGA LIFE
772	BENEFIT SYSTEMS, INC.	PO BOX 6001	INDIANAPOLIS	IN	462066001	8008243216	
773	PHYSICIANS MUTUAL INSURANCE COMPANY	PO BOX 2018	OMAHA	NE	681032018	8002289100	DO NOT USE THIS CODE FOR MEDICARE ADVANTAGE PLANS OFFERED BY THIS CARRIER
774	MOLINA MEDICARE OPTIONS PLUS	PO BOX 22811	LONG BEACH	CA	90801	8006651328	MEDICARE ADVANTAGE PLAN
775	FIRST CHOICE BENEFITS MANAGEMENT	PO BOX 658	BELOIT	WI	535120658	8003035770	
776	AFID (ASSO. OF FRANCHISE AND INDEPENDENT DIST.)	1 S. LIMESTONE ST., STE. 301	SPRINGFIELD	OH	45502	8667669016	CODE IN OPEN STATUS BY SCHA
777	US HEALTH AND LIFE	PO BOX 37504	OAK PARK	MI	482370504	8002259674	THIS CODE NOT REQUESTED BY SCHA. ASSIGNED BY SCHA
778	AMERICAN CONTINENTAL INSURANCE CO	PO BOX 14770	LEXINGTON	KY	40512	8002644000	
779	WEB-TPA AMERICAN FIDELITY ASSURANCE CO	PO BOX 99906	GRAPEVINE	TX	760999706	8663932872	DORMANT 8/06
780	CORPORATE SYSTEMS ADMINISTRATION, INC.	PO BOX 4985	JOHNSON CITY	TN	376024985	8002752847	
781	MEDICAL CLAIMS MANAGEMENT CORP	PO BOX 25307	WINSTON-SALEM	NC	271145307	8003340609	
782	HOUSING BENEFIT PLAN	PO BOX 542077	DALLAS	TX	753542077	8009372036	
784	PACIFIC HEALTH ADMINISTRATORS	PO BOX 620123	ORLANDO	FL	328620123	8007766070	CODE ASSIGNED BY SCHA
785	THE HARVEST INSURANCE CO.	PO BOX 956003	LAKE MARY	FL	327950856	8002530856	CODE ASSIGNED BY SCHA
786	ACS BENEFIT SERVICES, INC.	PO BOX 2000	WINSTON-SALEM	NC	271022000	8008495370	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
787	PACIFICARE SENIOR SUPPLEMENT PLAN	PO BOX 6072	CYPRESS	CA	906300072	8008513802	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
788	TRANSAMERICA LIFE INSURANCE CO.	PO BOX 97	SCRANTON	PA	185040097	8008203372	CODE ASSIGNED BY SCHA
789	FIRST COMMUNITY HEALTH PLAN, INC.	PO BOX 382947	BIRMINGHAM	AL	35238	8007347826	CODE IN OPEN STATUS BY SCHA
790	MHNET BEHAVIORAL HEALTH	PO BOX 7802	LONDON	KY	40742	8007527242	
791	UNITEDHEALTH INTEGRATED SERVICES	PO BOX 30783	SALT LAKE CITY	UT	841300786	8665968447	
792	PIONEER LIFE INSURANCE COMPANY OF ILLINOIS	PO BOX 1250	ROCKFORD	IL	611051250	8159875000	USE CODE 282 WASHINGTON NATIONAL
793	HUMANA GOLD PLUS	PO BOX 14601	LEXINGTON	KY	405124601	8004574708	MEDICARE ADVANTAGE PLAN
794	UNITED FAMILY LIFE INSURANCE COMPANY	PO BOX 2204	ATLANTA	GA	30371	4046593300	
795	REGIONAL MEDICAL ADMINISTRATORS, INC.	PO BOX 4128	GLEN RAVEN	NC	272150901	3362267950	
796	LINECO	821 PARKVIEW BLVD.	LOMBARD	IL	601483230	8003237268	CODE ASSIGNED BY SCHA
797	TODAY'S OPTIONS UNIVERSAL AMERICAN	PO BOX 742528	HOUSTON	TX	77274	8664225009	MEDICARE ADVANTAGE PLAN
798	MEDCARE INTERNATIONAL	12480 WEST ATLANTIC BLVD., STE. 2	CORAL SPRINGS	FL	33071	9543455650	
799	GENWORTH FINANCIAL	PO BOX 8021	SAN RAFAEL	CA	949129974	8008764582	WAS GE FINANCIAL SERVICES
800	NEBCO (TENNECO)	PO BOX 97	SCRANTON	PA	185040097	8007177562	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
801	IMERICA LIFE AND HEALTH INS. CO	PO BOX 3287	ENGLEWOOD	CO	80155	8882738020	
802	CONSTITUTION LIFE INSURANCE CO	PO BOX 130	PENSACOLA	FL	325910130	8007896364	
803	FIRST CONTINENTAL LIFE INSURANCE	PO BOX 1911	CARMEL	IN	46032	8005381235	
804	PIEDMONT COMMUNITY HEALTHCARE, INC.	PO BOX 14408	CINCINNATI	OH	452500408	8004007247	
805	PENN TREATY NETWORK AMERICA (PTNA)	PO BOX 130	PENSACOLA	FL	325910130	8006357418	CODE ASSIGNED BY SCHA
806	NETWORK HEALTH PLAN	PO BOX 568	MENASHA	WI	54952	9207201300	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
807	OPTIMA HEALTH PLAN	PO BOX 5028	TROY	MI	460071199	8002291199	
808	NEW MARKET DIMENSION	PO BOX 1338	COCKEYVILLE	MD	21031	8005706745	
809	INTER VALLEY HEALTH PLAN	300 SOUTH PARK, PO BOX 6002	POMONA	CA	917696002	8002518191	CODE ASSIGNED BY SCHA
810	UNITED RESOURCE NETWORK	PO BOX 30758	SALT LAKE CITY	UT	84130	8778013507	CODE ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
811	SPARTANBURG REGIONAL HEALTHCARE SYSTEM	PO BOX 1000	LANCASTER	SC	29721		CODE ASSIGNED BY SCHA
812	UMR	PO BOX 30541	SALT LAKE CITY	UT	841300541	8008269781	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
813	CENTURY PLANNER	9201 WATSON RD., STE. 350	ST. LOUIS	MO	631261509	8007762453	
814	HEALTHCOMP ADMINISTRATORS	PO BOX 45018	FRESNO	CA	93718	8004427247	
815	BANKERS FIDELITY LIFE INSURANCE COMPANY	PO BOX 260040	PLANO	TX	75026	8664587499	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
816	ARCADIAN MEMBER CARE	PO BOX 4946	COVINA	CA	91723	8005738597	MEDICARE ADVANTAGE PLAN
817	PRIORITY HEALTH	PO BOX 232	GRAND RAPIDS	MI	49501	8004465674	
818	SEAFARERS HEALTH & BENEFIT PLAN (SHBP)	PO BOX 380	PINEY POINT	MD	20674	8002524674	
819	TRICARE OVERSEAS PROGRAM	PO BOX 7985	MADISON	WI	537077985	8009826257	CODE ASSIGNED BY SCHA 6/07/10
820	MMSI MAYO MANAGEMENT SERVICES	4001 41ST ST. WEST	ROCHESTER	NM	41154	8006356671	CODE ASSIGNED BY SCHA SEE CARRIER CODE 536
821	ODS HEALTH PLAN ADVANTAGE	PO BOX 4030	PORTLAND	OR	972084030	8773370650	
822	MEDICAL MUTUAL	PO BOX 6018	CLEVELAND	OH	44101	8002582873	CODE ASSIGNED BY SCHA
823	HEALTH ALLIANCE PLAN	PO BOX 02459	DETROIT	MI	48202	8004224641	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
824	ENVISION RX OPTIONS	2181 EAST AURORA RD., STE. 201	TWINSBURG	OH	44087	8003614542	
825	UNITED HEALTHCARE COMMUNITY PLAN	PO BOX 8207	KINGSTON	NY	12402	8006009007	MEDICARE ADVANTAGE PLAN
826	WILLSE & ASSOCIATES, INC.	PO BOX 1196	BALTIMORE	MD	21203	4105470454	
827	J. SMITH LANIER	PO BOX 72749	NEWNAN	GA	30271	8882954864	
828	NATIONAL PHARMACEUTICAL SERVICES	PO BOX 407	BOYSTOWN	NE	68017	8005465677	
829	ADMINISTRATIVE SOLUTIONS	PO BOX 2490	ALPHARETTA	GA	30023	6783390211	
830	CONTRACTORS EMPLOYEE BENEFIT ADM. (CEBA)	PO BOX 559017	AUSTIN	TX	78755	8002477724	
831	CORPORATE BENEFIT SOLUTIONS, INC.	PO BOX 8215	LITTLE ROCK	AR	72221	8886049397	
832	CAMERON AND ASSOCIATES	6100 LAKE FOREST DR.	ATLANTA	GA	30328	8003879919	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
833	MERCY HEALTH PLANS	PO BOX 4568	SPRINGFIELD	MO	658084568	8006472240	
834	DEFINITY HEALTH	PO BOX 9525	AMHERST	NY	14226	8663334648	BROUGHT OUT BY UNITED HEALTHCARE CARRIER 113
835	MANAGED PHARMACY BENEFITS	1100 NORTH LINDBERGH	ST. LOUIS	MO	63132	8006729540	THIS CARRIER BOUGHT OUT BY EXPRESS SCRIPTS.
836	HUMANA	PO BOX 14601	LEXINGTON	KY	40512	8005584444	
837	HEALTH ADMINISTRATION SERVICES	PO BOX 6724208	HOUSTON	TX	77267	8008655440	
838	SHESFIELD, OLSON & MCQUEEN	PO BOX 16608	ST. PAUL	MN	55116	8883308408	
839	CITIZENS SECURITY LIFE INS.	PO BOX 436149	LOUISVILLE	KY	402536149	5022442420	
840	AMERICAN, INCOME LIFE INSURANCE COMPANY	PO BOX 2608	WACO	TX	76797	8177723050	
841	WATKINS ASSOCIATED INDUSTRIES	PO BOX 1738	ATLANTA	GA	30301	8003333841	CODE ASSIGNED BY SCHA
842	GARDNER AND WHITE, INC.	PO BOX 40619	INDIANAPOLIS	IN	462400619	3172579131	
843	CORE MANAGEMENT RESOURCES GROUP	PO BOX 840	MACON	GA	31202	8887412673	
844	PRIME TIME HEALTH PLAN	PO BOX 6905	CANTON	OH	44706	8006177446	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
845	GEISINGER HEALTH PLAN GOLD	PO BOX 8200	DANVILLE	PA	178218200	8004989731	MEDICARE ADVANTAGE PLAN
846	SCRIPT CARE, INC.	6380 FOLSOM DR.	BEAUMONT	TX	77706	8008809988	
847	MAHONEY BENEFIT ADMINISTRATORS	PO BOX 7260	FORT LAUDERDALE	FL	33338	8002807093	
848	HERITAGE	PO BOX 1730	AUBURNDALE	FL	33823	8002822460	
849	E.O.S. HEALTH	PO BOX 27088	TEMPE	AZ	85285	8884568417	
850	ONENET PPO	PO BOX 934	FREDERICK	MD	217050934	8003423289	CODE ASSIGNED BY SCHA
852	BUILDERS MUTUAL INSURANCE CO	PO BOX 150006	RALEIGH	NC	276240006	8008094861	
853	COMPSYCH CORP.	PO BOX 8379	CHICAGO	IL	60680	8775955282	
854	BOYD CARE (BOYD BROTHERS TRANSPORTATION)	PO BOX 70	CLAYTON	AL	36016	3347751284	
855	UNIVERSITY HEALTH PLANS	PO BOX 830926 DEPT 003	BIRMINGHAM	AL	35283	8778780914	
856	TRANSAMERICA OCCIDENTAL LIFE	PO BOX 2101 TERMINAL ANNEX	LOS ANGELES	CA	90051	2137422111	
857	CORPORATE BENEFIT SERVICES, INC.	PO BOX 211778	EAGAN	MN	55121	7043730447	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
858	DENTAQUEST	PO BOX 2136	COLUMBIA	SC	29202	8003076553	NAIC 52040 MEDICAID DENTAL CLAIMS PROCESSOR
859	NEW ENGLAND GROUP TRUST	PO BOX 30466	TAMPA	FL	33630	8006541731	
860	MANAGED HEALTH NETWORK	PO BOX 209010	AUSTIN	TX	78720	8008352094	
861	SUPERIOR ESSEX	PO BOX 724907	ATLANTA	GA	31139	8772917920	
862	PERFORMAX	300 CORPORATE PARKWAY	AMHERST	NY	11226	8777776076	
863	INSURANCE ADMINISTRATION CORP.	PO BOX 39119	PHOENIX	AZ	85069	8008433106	
864	GE GROUP ADMINISTRATORS	PO BOX 150809	ARLINGTON	TX	76015	8882558961	
865	SECURIAN DENTAL PLANS	PO BOX 9385	MINNEAPOLIS	MN	554409385	8002349009	NAIC 93742
866	OLYMPIC HEALTH MANAGEMENT	PO BOX 5348	BELLINGHAM	WA	98227	3607349888	
867	BCBS OF NC	PO BOX 30087	DURHAM	NC	27702	9194897431	
868	KANSAS CITY LIFE	PO BOX 9040	AUSTIN	TX	78766	8008745254	
869	EMPLOYEE BENEFIT MANAGEMENT SERVICES	PO BOX 21367	BILLINGS	MT	59104	8007773575	
870	FOUNDATION HEALTH	PO BOX 453219	SUNRISE	FL	33345	8004415501	
871	UNITED BEHAVIORAL HEALTH	PO BOX 169053	DULUTH	MN	55816	8008776003	CODE ASSIGNED BY SCHA
872	UNITED HEALTHCARE PLAN OF RIVER VALLEY	3800 23RD AVE. #200	MOLINE	IL	61215	8002246602	CODE ASSIGNED BY SCHA THESE COMPANY BOUGHT OUT JOHN DEERE INS. CO. THIS WAS THE HMO FOR JOHN DEERE 6/29/07
873	MEDCO HEALTH	PO BOX 8190	MADISON	WI	537088190	8002217006	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY THE SCHA
874	HEALTH NET	PO BOX 14700	LEXINGTON	KY	40512	8887477823	THIS CODE NOT REQUESTED BY SCHA. ASSIGNED BY SCHA
875	AMERICAN SENTINEL	PO BOX 61140	HARRISBURG	PA	171061140	8006927338	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
876	HEALTHSOURCE OF NC, INC.	PO BOX 28087	RALEIGH	NC	27611	8008499000	USE CODE 134 CIGNA HEALTHCARE
877	PRE-EXISTING CONDITION INSURANCE PLAN (PCIP)	PO BOX 300	INDEPENDENCE	MO	640510300	8002207898	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
878	HRM CLAIM MANAGEMENT	PO BOX 4022	KALAMAZOO	MI	490034022	8002530966	
879	COVENTRY OF THE CAROLINAS	PO BOX 7102	LONDON	KY	40742	8662083610	FORMALLY WELLPATH
880	OPTIMUM HEALTH PARTNERS	PO BOX 2243	GREENVILLE	SC	29602	8642134992	
881	BEHAVIORAL HEALTH SYSTEMS	PO BOX 830724	BIRMINGHAM	AL	352830724	8002451150	
882	CONNECTICARE	PO BOX 4000	FARMINGTON	CT	06034	8772248230	CODE ASSIGNED BY SCHA
883	SELECT HEALTH OF SOUTH CAROLINA, INC.	7410 NORTHSIDE DR., STE. 208	CHARLESTON	SC	29420	8435691759	CODE IN OPEN STATUS BY SCHA
884	HEALTH FIRST HEALTH PLANS	PO BOX 565001	ROCKLEDGE	FL	329565001	8007167737	CODE IN OPEN STATUS BY SCHA
885	JOHN ALDEN INSURANCE COMPANY	PO BOX 020270	MIAMI	FL	33102	8003284316	
886	PLANNED ADMINISTRATORS, INC.	PO BOX 6927	COLUMBIA	SC	29260	8037540041	
887	CNIC HEALTH SOLUTIONS	PO BOX 3559	ENGLEWOOD	CO	80155	8004267453	
888	SOUTHEASTERN BENEFIT PLANS, INC.	335 ARCHDALE DR.	CHARLOTTE	NC	282174246	7045295400	
889	GROUP INSURANCE ADMINISTRATION, INC.	3350 PEACHTREE RD. NE STE. 1040	ATLANTA	GA	30326	8006210683	
890	PARTNERS NATIONAL HEALTH PLANS OF NORTH CAROLINA	PO BOX 17368	WINSTON-SALEM	NC	271167368	8009425695	
891	OPTIMUM CHOICE OF THE CAROLINAS, INC.	4 TAFT CT.	ROCKVILLE	MD	20850	8003438205	
892	INDEPENDENT HEALTH	PO BOX 9066	BUFFALO	NY	14231	8002471466	
893	KEYSTON HEALTH PLAN EAST	PO BOX 8339	PHILADELPHIA	PA	19101	8002273116	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
894	AMERIHEALTH MERCY HEALTH PLAN	PO BOX 7118	LONDON	KY	40742	8889917200	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
895	CONTINENTAL LIFE INS. OF TENNESSEE	PO BOX 1188	BRENTWOOD	TN	37024	8002644000	
896	OPTIMED HEALTH PLAN	4 TERRY DR., STE. 1	NEWTOWN	PA	18940	8004828770	
897	SOUTHERN BENEFIT ADM.	PO BOX 188006	CHATTANOOGA	TN	37422	8006784656	
898	ASSOCIATION & SOCIETY INS. CORP	PO BOX 2510	ROCKVILLE	MD	20847	8006382610	
899	AETNA HEALTH PLANS OF THE CAROLINAS, INC.	3 CENTERVIEW DR.	GREENSBORO	NC	27407	8004591466	HMO PLAN ONLY
900	KOHLER COMPANY	444 HIGHLAND DR.	KOHLER	WI	530441515	9204574441	
901	DENTAL CARE PLUS	100 CROWNE POINT PLACE	CINCINNATI	OH	45241	8003679466	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
902	BLUE CARE NETWORK OF MI	PO BOX 68710	GRAND RAPID	MI	49516	8006588878	CODE ASSIGNED BY SCHA. THIS IS THE HMO TO CC 504 WHICH IS THE POS
903	CAREPLUS HEALTH PLAN	PO BOX 31286	TAMPA	FL	336313286	8008674445	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
904	BEST CHOICE HEALTH PLAN	PO BOX 21128	FORT LAUDERDALE	FL	33335	8008674446	
905	GERBER LIFE MEDICARE SUPPLEMENT	PO BOX 2271	OMAHA	NE	68103	8776565425	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
906	GROUP HEALTH ADMINISTRATOR, INC.	PO BOX 6244	CHARLOTTE	NC	282071018	8002225790	
907	CELTIC LIFE INSURANCE CO.	PO BOX 46337	MADISON	WI	53744	8007662525	
909	PREFERRED HEALTH ALLIANCE CORP.	PO BOX 382048	BIRMINGHAM	AL	35238	8007228477	
910	AMERICAN ADMINISTRATIVE GROUP	PO BOX 5227	LISLE	IL	605325227	8003545112	WAS GALLAGER & BASSETT SERVICES
911	COMMUNITY HEALTH PARTNERS	PO BOX 5787	SPARTANBURG	SC	29304	8889628437	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
912	WELLS FARGO TPA-NC OFFICES	PO BOX 2857	FAYETTEVILLE	NC	28302	8003376288	
913	FLORIDA HOSPITAL HEALTHCARE SYSTEM	PO BOX 536847	ORLANDO	FL	328536847	8007414810	
914	NATIONAL TEACHERS ASSO LIFE INSURANCE CO.	PO BOX 2369	ADDISON	TX	75001	8886716771	
915	MANAGED HEALTH RESOURCES	PO BOX 30742	CHARLOTTE	NC	28208	7043555200	
916	MHEALTH	PO BOX 742567	HOUSTON	TX	77274	8886425040	
919	AMERICAN HEALTH GROUP, INC.	PO BOX 1500	MAUMEE	OH	43537	8008728276	
920	HEALTHSMART PREFERRED CARE	PO BOX 53010	LUBBOCK	TX	794533010	8064732500	
922	BLUE CHOICE HEALTHPLAN	PO BOX 6170	COLUMBIA	SC	292606170	8037868466	WAS COMPANION HEALTHCARE NAME CHANGE EFFECTIVE 7/1/05
923	UNITED HEALTHCARE COMMUNITY PLAN	PO BOX 6170	COLUMBIA	SC	292606170	8008682528	MEDICAID MCO PLAN
927	UNITED HEALTHCARE HERITAGE PLUS	UHC OF RIVER VALLEY PO BOX 5230	KINGSTON	NY	124025230	8002246602	
928	COOK INSURANCE	PO BOX 1029	BLOOMINGTON	IN	47402	8005932080	
929	NATIONAL HEALTH INSURANCE COMPANY	PO BOX 619999	DALLAS/FORT WORTH AIRPORT	TX	752619999	8002371900	
930	SENTRY LIFE INSURANCE COMPANY	PO BOX 8025	STEVENS POINT	WI	54481	8004267234	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
931	GOOD SAMARITAN PROGRAM	5151 WEST HWY 40	BEACHGROVE	IN	46140	3178942000	
932	MANHATTAN INSURANCE GROUP	PO BOX 925309	HOUSTON	TX	772925309	8006699030	CODE ASSIGNED BY SCHA. NOT REQUESTED BY MEDICAID
933	PREFERRED HEALTHCARE SYSTEMS	620 HOWARD AVE.	ALTOONA	PA	166014899		CODE ASSIGNED BY SCHA
934	ASSOCIATION & SOCIETY INS. CORP	PO BOX 2510	ROCKVILLE	MD	20847	8006382610	
936	KEY BENEFITS-TRANSCHOICE PLUS	PO BOX 3252	MILWAUKEE	WI	53201	8668676883	
937	MVP HEALTH CARE	PO BOX 2207	SCHENECTADY	NY	12301	8002295851	NAME CHANGE ONLY 4/09. WAS PREFERRED CARE
939	PREMIER HEALTH SYSTEMS	PO BOX 1640	COLUMBIA	SC	292021640	8032968999	CODE ASSIGNED BY SCHA
940	PRIVATE HEALTH CARE SYSTEMS (PHCS)	PO BOX 6090	DEPERE	WI	54115	6087793000	CODE ASSIGNED BY SCHA 6/18/07
941	FIDELITY SECURITY LIFE INSURANCE CO	419 E MAIN ST.	MIDDLETOWN	NY	10940	8008267531	THE CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
942	PRINCIPAL FINANCIAL GROUP	PO BOX 10357	DES MOINES	IA	503060357	8002474695	
943	LIBERTY MUTUAL LIFE INSURANCE	5 HUTCHINSON DR.	DANVERS	MA	01923	8889994767	CODE IN OPEN STATUS BY SCHA
945	CAROLINA ATLANTIC MEDICAL SERVICES ORGANIZATION	PO BOX 22528	CHARLESTON	SC	29413	8008100906	DORMANT 8/06
946	FIRST HEALTH	PO BOX 1377	THOMASVILLE	GA	31799	8668478235	
948	PHILADELPHIA AMERICAN LIFE INS. CO.	PO BOX 2465	HOUSTON	TX	77252	8005527879	
951	AMERICAN GROUP ADMINISTRATORS	101 CONVENTION CENTER DR., STE. 200	LAS VEGAS	NE	89109	8008424742	
952	STARK TRUSS CO., INC.	PO BOX 2080C	STOW	OH	44224	8004564002	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
953	USA HEALTHCARE ORGANIZATION	7301 N. 16TH ST., STE. 201	PHOENIX	AZ	85020	8008723860	CODE ASSIGNED BY SCHA
954	MULTIPLAN	115 5TH AVE.	NEW YORK	NY	100031004	8005463887	
955	DESIGN SAVERS PLAN	2814 SPRING RD., STE. 122	ATLANTA	GA	30339	8006165709	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
958	ITPE-NMU HEALTH AND WELFARE FUND	PO BOX 13817	SAVANNAH	GA	31416	9123527169	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
960	HEALTH EOS	PO BOX 6090	DER PERE	WI	541156090	8004355694	CODE ASSIGNED BY SCHA. NOT REQUESTED BY MEDICAID
961	MHN (MANAGED HEALTH NETWORK)	PO BOX 27018	LAS VEGAS	NV	89126	8004584642	CODE ASSIGNED BY SCHA
962	VICARE PLUS	PO BOX 1710	SUFFOLK	VA	23439	8779344403	
963	UNITED HEALTHCARE CLAIMS	PO BOX 29130	HOT SPRINGS	AR	71903	8882014111	
964	PHARMACEUTICAL CARE NETWORK	9343 TECH CENTER DR.	SACRAMENTO	CA	95826	8007770074	
965	PROFESSIONAL BENEFIT ADMINISTRATORS, INC. (PBA)	PO BOX 4687	OAKBROOK	IL	605223755	6306553755	
966	CAPITOL ADMINISTRATORS OF THE SOUTHEAST	PO BOX 188061	CHATTANOOGA	TN	37422	8886506566	
967	UNDERWRITERS SAFETY AND CLAIMS	PO BOX 23507	LOUISVILLE	KY	40223	8006781536	
968	AMERICAN BENEFIT ADMINISTRATIVE SERVICES	PO BOX 0928	BROOKFIELD	WI	53008	6304161111	
969	WHP HEALTH INITIATIVE	PO BOX 968022	SCHAUMBERG	IL	601968022	8002072568	
970	CONSOLIDATED WORKERS ASSOCIATION (CWA)	PO BOX 2647	CHINO HILLS	CA	91709	8009195514	CODE ASSIGNED BY SCHA
971	ATLANTA ADMINISTRATIONS	135 BEAVER ST.	WALTHAM	MA	02452	8005481256	
972	ASR CORP (ADMINISTRATION SYSTEM RESEARCH)	PO BOX 6392	GRAND RAPIDS	MI	49516	8009682449	
973	CAMBRIDGE INTEGRATED SERVICES GROUP, INC.	PO BOX 1687	GRAND RAPIDS	MI	49501	8007669780	USE CARRIER 171 AON
974	COMMERCE BENEFIT GROUP	PO BOX 900	ELYRIA	OH	44036	8002239941	
975	INFORMED RX	PO BOX 968022	SCHAUMBURG	IL	601968022	8006453332	WAS NATIONAL MEDICAL HEALTH CARD
976	PARAGON BENEFITS, INC.	PO BOX 12288	COLUMBUS	GA	31917	7062776710	
977	ZENITH ADMINISTRATION	26359	LAS VEGAS	NV	89126	8004265980	DORMANT 8/06
978	LEGGETT & PLATT	PO BOX 7687	HIGH POINT	NC	27264	8773112150	
979	MEDICAL REIMBURSEMENT OF AMERICA	113 SEABOARD LANE	FRANKLIN	TN	37067	6159633826	THIS CODE IS USED BY SCHA NOT AN ACTIVE MEDICAID CODE
980	BENEFIT SUPPORT, INC.	PO BOX 2977	GAINESVILLE	GA	30503	8007774782	
981	ARGUS HEALTH SYSTEMS	PO BOX 419019	KANSAS CITY	MO	64141	8005227487	
982	OFFICE OF GROUP BENEFITS STATE OF LOUISIANA	PO BOX 44036	BATON ROUGE	LA	708044036	8002728451	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
983	INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS	3901 E. WINSLOW AVE.	PHOENIX	AZ	85040	6022340497	
984	HOMELAND HEALTHCARE	PO BOX 3726	SEATTLE	WA	98124	8004934240	
985	BENESIGHT	PO BOX 340	PUEBLO	CO	81002	8003621116	
986	COMMONWEALTH BENEFIT ADMINISTRATORS	115 HANOVER ST.	ASHLAND	VA	23005	8005261677	
987	BANKERS FIDELITY LIFE INS CO	PO BOX 105652	ATLANTA	GA	30348	4042665500	
988	MID WEST NATIONAL LIFE INS. CO.	PO BOX 981606	EL PASO	TX	799981610	8007331110	
989	UNIVERA HEALTHCARE	PO BOX 23000	ROCHESTER	NY	14692	8772429464	
990	SOUTHERN GROUP ADMINISTRATORS, INC.	200 SOUTH MARSHALL ST.	WINSTON-SALEM	NC	27101	8003348159	
991	WEST PORT BENEFITS	PO BOX 66743	ST. LOUIS	MO	63166	8883065299	
992	CHESTERFIELD RESOURCES, INC.	PO BOX 1884	AKRON	OH	44309	8003210935	
993	MPI INTERNATIONAL, INC.	PO BOX 81913	ROCHESTER	MI	483081913	2488539010	
994	UNITED PROVIDER SERVICES	PO BOX 820277	FORT WORTH	TX	76182	8005198374	CARRIER BOUGHT OUT BY CC 740 PHARMACARE
995	MEDIMPACT	10680 TREENA ST., STOP 5	SAN DIEGO	CA	92131	8007882949	
996	J.F. MOLLOY & ASSO.	PO BOX 68947	INDIANAPOLIS	IN	46268	8003313287	SEE CARRIER 942 PRINCIPAL FINANCIAL GROUP
997	GENWORTH FINANCIAL	PO BOX 10821	CLEARWATER	FL	33757	8778259337	CODE IN OPEN STATUS BY SCHA
998	CANADA LIFE ASSURANCE CO.	6201 POWERS FERRY RD., STE. 100	ATLANTA	GA	30348	8003332542	
999	CIGNA HEALTHCARE OF SC/HEALTHSOURCE SC	PO BOX 190024	CHARLESTON	SC	294199024	8007203150	BOUGHT BY CIGNA HEALTHCARE CC 134
100DN	AETNA US HEALTHCARE	PO BOX 14094	LEXINGTON	KY	40512	8004517715	
100RX	AETNA PHARMACY	PO BOX 52444	PHOENIX	AZ	850722444	8002386279	
110RX	PROVIDENT/CAREMARK	PO BOX 686005	SAN ANTONIO	TX	78268	8008415550	USE CODE 280 CAREMARK
113DN	UNITED HEALTHCARE	PO BOX 30567	SALT LAKE CITY	UT	84130	8005215505	
134DN	CIGNA CONN GENERAL LIFE INSURANCE	PO BOX 188037	CHATTANOOGA	TN	37422	8002446224	DO NOT USE FOR MEDICARE. THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE
134RX	CIGNA CONN GENERAL LIFE INSURANCE	PO BOX 188053	CHATTANOOGA	TN	374228053	8006225579	USE CARRIER CODE 718

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
139DN	UMR	PO BOX 30541	SALT LAKE CITY	UT	84130	8008269781	WAS WAUSAU INS. CO.
139RX	WAUSAU INSURANCE COMPANY	PO BOX 8013	WAUSAU	WI	544028013	8008269781	
143DN	UMR	PO BOX 30541	SALT LAKE CITY	UT	841300541	8008269781	
153DN	KANAWHA LIFE INSURANCE COMPANY	PO BOX 6000	LANCASTER	SC	29721	8032862440	
160DN	UNICARE HEALTH AND LIFE INSURANCE	PO BOX 659444	SAN ANTONIO	TX	75265	8772179677	
201DN	HCH ADMINISTRATORS	PO BOX 1986	PEORIA	IL	61656	8003221516	
206DN	MED COST BENEFITS SERVICES	PO BOX 25987	WINSTON-SALEM	NC	27114	8007951023	
237DN	GUARDIAN LIFE INSURANCE CO. OF AMERICA	PO BOX 981572	EL PASO	TX	799981572	8005417846	
245RX	FIRST HEALTH	PO BOX 23070	TUCSON	AZ	85734	8005544954	
300DN	BENEFIT ADMINISTRATORS, INC.	PO BOX 6279	ERIE	PA	16512	8007772524	
302DN	GOVERNMENT EMPLOYEE HOSP. ASSOC. (GEHA)	PO BOX 21542	EAGAN	MN	55121	8774342336	DENTAL COVERAGE
308DN	GREAT WEST LIFE	PO BOX 188037	CHATTANOOGA	TN	37422	8776314227	
312DN	NATIONAL BENEFIT ADMINISTRATORS	PO BOX 690903	CHARLOTTE	NC	282277016	8004826736	
315DN	THOMAS COOPER AND COMPANY	PO BOX 63477	NORTH CHARLESTON	SC	29419	8437222115	
321DN	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	PO BOX 1358	GLEN BURNIE	MD	21060	8002222798	
345DN	EMPLOYEE BENEFIT SERVICES, INC.	PO BOX 1929	FORT MILL	SC	29716	8002421510	
370DN	DELTAHEALTH SYSTEMS	PO BOX 702500	WEST VALLEY	UT	84170	8774740605	
386DN	ASSURANT HEALTH	PO BOX 2940	CLINTON	IA	527332940	8004427742	DHHS INTERNAL RECOVERY CLAIMS BILLING MUST BE FAX TO: 414-224-0472
387DN	HEALTHGRAM	PO BOX 11088	CHARLOTTE	NC	28220	8004465439	DENTAL - HEALTHGRAM FORMERLY PRIMARY PHYSICIANS CARE
401DN	BLUE CROSS AND BLUE SHIELD OF SC	4101 PERCIVAL RD.	COLUMBIA	SC	29219	8037883860	THIS CODE USED ONLY FOR DENTAL CLAIMS WHERE BCBS IS THE INSURANCE CARRIER
415DN	WEYCO, INC.	PO BOX 30132	LANSING	MI	48909	5173497010	
445DN	CAROLINA CARE PLAN/MEDICAL MUTUAL INS. CO.	PO BOX 6018	CLEVELAND	OH	441011018	800315 314	DENTAL ONLY
476DN	CENTRAL STATES, SOUTHEAST & SOUTHWEST	PO BOX 5116	DES PLAINES	IL	60017	8003235000	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
536DN	CLAIMSWARE MANAGEMED	PO BOX 6125	GREENVILLE	SC	29606	8642348200	
552DN	CORESOURCE, INC.	PO BOX 2920	CLINTON	IA	52733	8003275462	
553DN	HEALTHSCOPE BENEFITS, INC.	PO BOX 99005	LUBBOCK	TX	79490	8009676831	
709DN	MARSH ADVANTAGEAMERICA	501 NORTH BROADWAY, STE. 500	ST. LOUIS	MO	63102	8008687526	FORMERLY BENEFIT PLAN SERVICES
751DN	POLARIS BENEFIT ADMINISTRATORS	PO BOX 1008	DELAWARE	OH	43015-	8002340225	
751RX	POLARIS BENEFIT ADMINISTRATORS	PO BOX 1008	DELAWARE	OH	43015-	8002340225	
766DN	PALMER & CAY/CARSWELL, INC.	PO BOX 1286	SAVANNAH	GA	31402	9122346621	
781DN	MEDICAL CLAIMS MANAGEMENT CORP	PO BOX 12995	CHARLOTTE	NC	282202995	8003340609	
836DN	HUMANA	PO BOX 14601	LEXINGTON	KY	40512	8005584444	
842DN	GARDNER AND WHITE, INC.	PO BOX 40619	INDIANAPOLIS	IN	462400619	3172579131	
857DN	CORPORATE BENEFIT SERVICES, INC.	PO BOX 12954	CHARLOTTE	NC	28220	7043730447	
879DN	DENEX DENTAL	111 ROCKVILLE PIKE STE. 700	ROCKVILLE	MD	20850	8666904908	DENEX DENTAL IS A PLAN UNDER WELLPATH SELECT/COVENTRY
885DN	JOHN ALDEN INSURANCE COMPANY	PO BOX 020270	MIAMI	FL	33102	8003284316	
886DN	PLANNED ADMINISTRATORS, INC.	PO BOX 6927	COLUMBIA	SC	29260	8037540041	
889DN	GROUP INSURANCE ADMINISTRATION, INC.	3350 PEACHTREE RD. NE STE. 1040	ATLANTA	GA	30326	8006210683	
897DN	SOUTHERN BENEFITS ADMINISTRATORS DENTAL	5305 VIRGINIA BEACH BLVD.	NORFOLK	VA	23502	7574618091	
909DN	PREFERRED HEALTH ALLIANCE CORP.	PO BOX 382048	BIRMINGHAM	AL	35238	2059691155	
937DN	MVP HEALTH CARE	PO BOX 763	SCHENECTADY	NY	12301	8004805640	
958DN	ITPE-NMU HEALTH AND WELFARE FUND	PO BOX 13817	SAVANNAH	GA	31416	9123527169	
A01	THRIVENT FINANCIAL FOR LUTHERANS	4341 N. BALLARD RD.	APPLETON	WI	54919	8008474836	
A02	ALTERNATIVE BENEFITS PLANS, INC.	2920 BRANDYWINE RD., STE. 106	ATLANTA	GA	30341	8002417319	
A03	STARMARK	PO BOX 2942	CLINTON	IA	52733	8005221246	THIS CARRIER HANDLES GROUPS WITH LESS THAN 50 EMPLOYEES. SEE CC212 FOR GROUPS OVER 50 EMPLOYEES.
A04	CONSULTEC PRESCRIPTION BENEFITS MANAGEMENT	9040 ROSWELL RD., STE. 700	ATLANTA	GA	303501853	8003654944	
A05	AMERICAN PUBLIC LIFE INSURANCE CO.	PO BOX 925	JACKSON	MS	39205	8002568606	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
A06	COLONIAL PENN FRANKLIN LIFE INSURANCE COMPANY	1818 MARKET ST.	PHILADELPHIA	PA	191811250	8005234000	THIS CARRIER PART OF CONSECO INSURANCE GROUP
A07	CONTINENTAL LIFE INSURANCE CO. OF SOUTH CAROLINA	PO BOX 6138	COLUMBIA	SC	29260	8037824947	
A08	INDEPENDENCE AMERICAN INS. CO. (IHC HEALTH SOLUTION)	PO BOX 21456	EAGON	MN	55121	8664290608	
A09	RX AMERICA	221 N CHARLES LINDBERG DR.	SALT LAKE CITY	UT	84116	8007708014	
A10	AMERISCRIPT	4301 DARROW RD., STE. 4200	STOW	OH	44224	8006816912	
A11	PREFERRED ADMINISTRATORS	15560 NORTH FLW BLVD.	SCOTTSDALE	AZ	85260	8772767198	
A12	MOUNTAIN CLAIMS MANAGEMENT	PO BOX 1008	FRUITLAND	ID	83616	8669527979	
A13	HOLDEN & COMPANY	PO BOX 10411	SAVANNAH	GA	31412	8004043344	
A14	EB RX	2045 MIDWAY DR.	TWINSBURG	OH	44087	8008007153	
A15	MANAGED PRESCRIPTIONS SERVICES (MPS)	ONE CITY CENTRE STE. 1100	ST. LOUIS	MO	631016922	8007596959	
A16	FCE BENEFIT ADMINISTRATOR	4615 WALZEM RD., STE. 300	SAN ANTONIO	TX	782181610	8008999355	
A17	NOVA HEALTHCARE ADMINISTRATORS	2680 GRAND ISLAND BLVD.	GRAND ISLAND	NY	140720308	8003333195	
A18	MSH MOBILITY BENEFITS	PO BOX 77	BEEBE PLAIN	VT	05823	8888421530	CODE ASSIGNED BY SCHA
A19	ISLAND GROUP ADMINISTRATION, INC.`	3 TOILSOME LANE	EAST HAMPTON	NY	11937	8009262306	CODE ASSIGNED BY SCHA
A20	PROFESSIONAL CLAIMS MANAGEMENT	PO BOX 35276	CANTON	OH	443155276	8003258424	
A20DN	PROFESSIONAL CLAIMS MANAGEMENT	PO BOX 35276	CANTON	OH	443155276	8003258424	
A21	PC HEALTH PLAN ADMINISTRATION	PO BOX 1377	THOMASVILLE	GA	31799	8884261937	CODE ASSIGNED BY SCHA
A22	PIEDMONT ADMINISTRATORS	PO BOX 25307	WINSTON-SALEM	NC	271145307	8008527040	
A23	SERV U PRESCRIPTION	PO BOX 26096-0096	MILWAUKEE	WI	53226	8007593203	
A24	WELLPOINT NEXT RX	PO BOX 2902	CLINTON	IA	527332902	8009627378	USE CARRIER 333 EXPRESS SCRIPTS
A25	BENESCRIPT	8300 E. MAPLEWOOD AVE.	GREENWOOD VILLAGE	CO	80111	8003453189	
A26	MARKEL SMART STM	PO BOX 15953	LUBBOCK	TX	79490	8002792290	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
A27	HEALTHCARE SUPPORT	25 COLUMBIA HEIGHTS	BROOKLYN HEIGHTS	NY	112012482	8005544022	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A28	SHENANDOAH LIFE INSURANCE CO	PO BOX 12847	ROANOKE	VA	24029	8008485433	
A29	MERITAN HEALTH	PO BOX 80884	INDIANAPOLIS	IN	46280	8006064841	
A30	RMSCO, INC.	PO BOX 678	LIVERPOOL	NY	130880678	8772047086	
A30DN	RMSCO, INC.	PO BOX 678	LIVERPOOL	NY	130880678	8772047086	
A31	UNITY HEALTH INSURANCE	PO BOX 610	SAUK CITY	WI	535831374	8003623308	
A32	MAGELLAN BEHAVIORAL HEALTH	PO BOX 1659	MARYLAND HEIGHTS	MO	63043	8003592422	
A33	ALLIANT HEALTH PLANS, INC.	PO BOX 21109	ROANOKE	VA	24108	8002834927	
A34	WOODS & GROOM	2549 17TH ST.	COLUMBUS	IN	47202	8003683429	DORMANT 8/06
A35	FABRI-KAL CORPORATION	PO DRAWER C	PIEDMONT	SC	29773	8642991720	CODE IN OPEN STATUS BY SCHA
A36	FIELDCREST CANNON (CANNON MILLS)	PO BOX 5000	EDEN	NC	272895000	8002223693	
A37	UNITED BEHAVIORAL/DENTAL SYSTEMS	PO BOX 30755	SALT LAKE CITY	UT	84130	8005575745	
A38	UNITED HEALTHCARE OF NC	PO BOX 2604	GREENSBORO	NC	274386304	8009991147	
A39	COMPLETE BENEFITS SOLUTIONS	6071 CARMEL RD., STE 305	CHARLOTTE	NC	28226	8662702316	
A40	STRATEGIC RESOURCE COMPANY	PO BOX 14079	LEXINGTON	KY	40512	8887729682	
A41	CLAIMS MANAGEMENT SERVICES	PO BOX 10888	GREEN BAY	WI	54307	8004727130	
A42	PRIMERICA LIFE INSURANCE COMPANY	3120 BRECKINRIDGE BLVD.	DULUTH	GA	30199	4043811000	
A43	PREMIER BENEFIT MANAGEMENT, INC.	7070-A KAIGHN AVE.	PENSAUKEN	NJ	08109		CODE ASSIGNED BY SCHA
A44	GLOBAL MEDICAL MANAGEMENT, INC.	7901 SW 36TH ST., STE. 100	DAVIE	FL	33328	9543706404	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A45	INTEQ GROUP	5445 LASIERRA DR., STE. 400	DALLAS	TX	75231	8009593953	
A46	STANDARD INSURANCE COMPANY	PO BOX 82622	LINCOLN	NE	68501	5033217000	
A47	STATESMAN NATIONAL LIFE INSURANCE COMPANY	3815 MONTROSE BLVD.	HOUSTON	TX	77006	7135266000	
A48	QUALMED OF OREGON	PO BOX 286	CLACKMAS	OR	970150286	8005685628	DORMANT 8/06
A49	ARIZONA FOUNDATION FOR MEDICAL CARE	PO BOX 2909	PHOENIX	AZ	850622909	6022318855	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
A50	FEDERAL EMPLOYEES COMPENSATION ACT	PO BOX 8300	LONDON	KY	407428300	8663358319	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A51	COAL MINE WORKERS COMP PROGRAM	PO BOX 8300	LONDON	KY	407428300	8663358319	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A52	NATIONWIDE SPECIALTY HEALTH CLAIMS	PO BOX 420	SPRINGFIELD	MA	01101	8005174791	
A53	LONGSHORE & HARBOR WORKERS COMP PROGRAM	PO BOX 8300	LONDON	KY	407428300	8663358319	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A54	CENTURY HEALTHCARE	PO BOX 2256	GRAPEVINE	TX	76099	8884441995	NEIC 30018
A55	AETNA LIFE AND CASUALTY	PO BOX 36890	LOUISVILLE	KY	40232	8004233289	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A56	VULCAN MATERIALS COMPANY	PO BOX 530187	BIRMINGHAM	AL	352530187	8642772371	DORMANT 8/06
A57	AMERICAN GROUP ADMINISTRATORS, INC.	101 CONVENTION CENTER DR., STE. 200	LAS VEGAS	NV	89109	8008424742	CODE ASSIGNED BY SCHA
A58	COMPREHENSIVE BENEFITS	PO BOX 8955	MELVILLE	NY	11747	8008283605	
A60							
A61	SUMMACARE HEALTH PLAN	PO BOX 3620	AKRON	OH	743893628	8009968701	
A62	AMERICAN MEDICAL AND LIFE INSURANCE (AMLI)	PO BOX 1353	CHICAGO	IL	60690	8882641512	
A63	CITIZENS INSURANCE	PO BOX 1627	ANDERSON	SC	29622	8643340090	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A64	NTCA (NAT'L TELECOMMUNICATIONS COOPERATIVE ASSO.)	ONE WEST PACK SQUARE STE 600	ASHEVILLE	NC	288013459	8282819000	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A65	DATARX	5920 ODELLE ST.	CUMMINGS	GA	30040	8778231273	
A66	PRAIRIE STATES ENTERPRISES, INC.	PO BOX 23	SHEBOYGAN	WI	530820023	8008157020	
A67	HEALTHSCOPE BENEFITS	PO BOX 99005	LUBBOCK	TX	794906831	8009676831	
A68	HOLLINGSWORTH SACO LOWELL CORP.	PO DRAWER 2327	GREENVILLE	SC	29602	8648593211	DORMANT 8/06
A69	KAISER FOUNDATION HEALTH PLAN OF SOUTHERN CA	PO BOX 7004	DOWNEY	CA	902427004	8003310420	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A70	NATIONAL EMPLOYEE BENEFIT ADMINISTRATORS	1920 N. FLORIDA MANGO RD	WEST PALM BEACH	FL	33409	8008225899	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
A71	CAROLINA BEHAVIORAL HEALTH ALLIANCE	PO BOX 571137	WINSTON-SALEM	NC	271571137	8004757900	
A72	BABB, INC.	850 RIDGE AVE.	PITTSBURGH	PA	15212	8002456102	
A73	CLAIMS TECHNOLOGY, INC.	100 COURT AVE., STE. 306	DES MOINES	IA	50309	8002458813	
A74	FIRST CAROLINA CARE, INC.	PO BOX 381686	BIRMINGHAM	AL	35238	8008113298	
A75	HEALTH COST SOLUTIONS	PO BOX 1439	HENDERSONVILLE	TN	37077	8882295020	WAS LIFECARE CENTERS OF AMERICA
A76	TOWER LIFE INS. CO.	310 S. MARY ST.	SAN ANTONIO	TX	78205	8006606077	
A77	SISCO	PO BOX 389	DUDUQUE	IA	52004	8004574725	
A78	HIGHWAY TO HEALTH (HTH)	PO BOX 968	HORSHAM	PA	19044	8883502002	THIS CODE ASSIGNED BY SCHA. NOT REQUESTED BY MEDICAID
A79	HEALTH SPECIAL RISK	4001 N. JOSEY LANE	CARROLLTON	TX	75007	9724926474	
A80	TOTAL SCRIPT	10901 WEST 120TH AVE. STE 110	BROOMFIELD	CO	80021	8007522211	
A81	BENESYS	PO BOX 90082	LUBBOCK	TX	79402	3372341789	
A82	UNITED HEALTHCARE INDEMNITY	PO BOX 740801	ATLANTA	GA	303740801	8008488406	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A83	GROUP RESOURCES, INC.	PO BOX 100043	DULUTH	GA	300969343	7706238383	
A84	HCC LIFE INSURANCE COMPANY	PO BOX 2005	FARMINGTON HILLS	MI	48333	8664004102	
A85	QUALCHOICE	PO BOX 25610	LITTLE ROCK	AR	722219914	8002357111	
A86	BENEFIT MANAGEMENT CO	PO BOX 269000	WESTON	FL	333269000	8002629175	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A87	SOUTHEAST COMMUNITY CARE (ARCADIAN HEALTH)	PO BOX 4946	COVINA	CA	91723	8005738597	
A88	WINDSOR STERLING	PO BOX 269003	PLANO	TX	750269003	8888588551	
A89	SPECIAL INSURANCE SERVICES (SIS)	PO BOX 250349	PLANO	TX	750250349	8007676811	CODE ASSIGNED BY SCHA
A90	EMPLOYEE BENEFIT CLAIMS, INC.	9501 WEST DEVON	ROSEMONT	IL	60018	3126963660	
A91	STATES GENERAL LIFE INS. CO	115 WEST 7TH ST., STE. 1200	FORT WORTH	TX	761027012	8007828375	
A92	PROVIDENT AMERICAN LIFE & HEALTH INS.	PO BOX 29158	SHAWNEE MISSION	KS	66201915	8007535133	
A93	AMERICAN COLLEGE OF SURGEONS	PO BOX 2522	FORT WORTH	TX	761132522	8004331672	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
A94	FORETHOUGHT LIFE INSURANCE COMPANY	PO BOX 981721	EL PASO	TX	79998	8774925870	
A95	REYNOLDS & REYNOLDS	PO BOX 1272	DAYTON	OH	45401	8007363539	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A96	HAMRICKS, INC.	742 PEACHOID RD.	GAFFNEY	SC	29340	8644877505	
A98	MERITAIN HEALTH	PO BOX 853921	RICHARDSON	TX	75085	8007654224	
A99	CHEROKEE INSURANCE	PO BOX 853925	RICHARDSON	TX	750853925	8002010450	
B01	HEALTH PARTNERS	PO BOX 1289	MINNEAPOLIS	MN	554401289	8889222313	
B01DN	HEALTH PARTNERS DENTAL	PO BOX 1172	MINNEAPOLIS	MN	55440	8889222313	
B02	LIFE INSURANCE CO. OF ALABAMA	PO BOX 349	GADSDEN	AL	35902	8002262371	
B03	CHESAPEAKE LIFE INS. CO.	PO BOX 809025	DALLAS	TX	753809025	8887563534	
B04	CARITEN HEALTHCARE	PO BOX 22987	KNOXVILLE	TN	37933	8002840042	CODE IN OPEN STATUS BY SCHA
B05	FOCUS HEALTHCARE MANAGEMENT, INC.	720 COOL SPRINGS BLVD.	FRANKLIN	TN	37067	6157784000	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B06	SOUTHCARE HEALTHCARE PREFERRED	1100 CIRCLE 75 PARKWAY, STE. 1400	ATLANTA	GA	30339	8004702004	
B07	MAGNACARE	PO BOX 1001	GARDEN CITY	NY	11530	8666246259	
B08	AMFIRST INSURANCE CO	PO BOX 16708	JACKSON	MS	39236	8888882519	
B09	DEARBORN NATIONAL	PO BOX 23060	BELLEVILLE	IL	62223	8003484512	
B10	PILGRIM HEALTH & LIFE INSURANCE	PO BOX 897	ATLANTA	GA	30303	4046592100	CODE IN OPEN STATUS BY SCHA
B11	CBCA ADMINISTRATORS, INC.	PO BOX 1339	MINNEAPOLIS	MN	55440	8008243882	
B12	JOHN HANCOCK LIFE AND HEALTH INSURANCE	JOHN HANCOCK B5-03 200 BERKELEY ST.	BOSTON	MA	02116	8003777311	
B13	WEB TPA	PO BOX 99906	GRAPEVINE	TX	760999706	8007582851	
B13DN	WEB TPA	PO BOX 99906	GRAPEVINE	TX	76099	8007582851	
B14	A.C.S. CONSULTING SERVICES, INC.	PO BOX 2000	WINSTON-SALEM	NC	271022000	3367592013	
B14DN	A.C.S. CONSULTING SERVICES, INC.	PO BOX 2000	WINSTON-SALEM	NC	271022000	3367592013	DENTAL ONLY
B15	HILLCREST BENEFIT ADMINISTRATORS	PO BOX 1516	MT. DORA	FL	32756	8007439264	
B16	MAGELLAN RX	11013 W BROAD ST., STE. 500	GLEN ALLEN	VA	23060	8006594112	
B17	ULTRA BENEFITS	PO BOX 763	WESTBORO	MA	01581	8668587223	
B18	LUMENOS	PO BOX 69309	HARRISBURG	PA	17106	8774957223	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
B19	RENAISSANCE DENTAL	PO BOX 17250	INDIANAPOLIS	IN	46217	8883589484	
B20	FMH BENEFIT SERVICES, INC.	PO BOX 25946	OVERLAND PARK	KS	66225	8009909058	
B21	PIONEER HEALTH	PO BOX 6600	HOLYOKE	MA	01041	8004234586	
B22	COVENTRY HEALTHCARE OF VIRGINIA	PO BOX 7704	LONDON	KY	40742	8006274872	
B23	LINCOLN FINANCIAL GROUP	PO BOX 614008	ORLANDO	FL	32861	8004232765	
B24	EMBLEM HEALTH CARE CO.	PO BOX 3000	NEW YORK	NY	10116	2125014444	
B25	HEALTH AND WELFARE FUND LOCAL 218	PO BOX 115027	ATLANTA	GA	30310	4047555665	
B26	IMSCO HEALTH PLAN	PO BOX 697	BUCKEYSTOWN	MD	217170697	8009442833	IMSCO - INTERNATIONAL MANAGEMENT SERVICE CO.
B27	HEALTH FIRST (PPO)	PO BOX 17709	GREENVILLE	SC	29606	8642893000	
B28	THE STANDARD	PO BOX 82622	LINCOLN	NE	68501	8005479515	
B29	PANAMERICAN BENEFIT SOLUTIONS	PO BOX 981644	EL PASO	TX	799981644	8006949888	WAS US NOW INSURANCE GROUP
B30	SOUTHERN BENEFITS, SOUTHEASTERN PIPE TRADERS	PO BOX 1449	GOODLETTSVILLE	TN	370701449	8008314914	
B31	GREAT AMERICAN LIFE INS. CO (GALIC)	PO BOX 559002	AUSTIN	TX	787553010	8008802745	
B32	MAXCARE	PO BOX 16430	OKLAHOMA CITY	OK	73113	8002597765	
B33	PHARMAVAIL DRUG COMPANY	3380 TRICKHUM RD., BLDG. 400, UNIT 100	WOODSTOCK	GA	30188	8009333734	
B34	ATLANTA LIFE INSURANCE COMPANY	100 AUBURN AVE., NE	ATLANTA	GA	30303	4046592100	
B35	PROCARE RX PBM	1267 PROFESSIONAL PARKWAY	GAINESVILLE	GA	30507	8006993542	
B36	COMMONWEALTH INDEMNITY PLAN	PO BOX 9016	ANDOVER	MA	01810	8004429033	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B37	BENEFIT ADMINISTRATORS	PO BOX 21308	COLUMBIA	SC	29221	8778400936	
B37DN	BENEFIT ADMINISTRATORS	PO BOX 1957	BEATTYVILLE	KY	41311	8003258424	
B38	MEDBEN	PO BOX 1009	NEWARK	OH	43058	8006868425	
B39	MEDICAL SAVINGS INSURANCE CO.	5835 WEST 74TH ST.	INDIANAPOLIS	IN	462781758	3173298222	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B40	TOTAL CLAIMS SOLUTION (TCS)	PO BOX 10888	GREEN BAY	WI	543070888	8003760110	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B41	VYTRA HEALTHCARE	PO BOX 9091	MELVILLE	NY	11747	8668089399	

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CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
B42	UMR	PO BOX 266	ONALASKA	WI	546568764	8002368672	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B43	AFFINITY HEALTH PLAN	PO BOX 981726	EL PASO	TX	799981726	8662475678	
B44	AMERICAN CHOICE HEALTH PLAN, LLC	PO BOX 922043	HOUSTON	TX	77292	8006334226	
B44DN	AMERICAN CHOICE HEALTH PLAN, LLC	PO BOX 922009	HOUSTON	TX	77292	8005989799	
B45	ATLANTICARE	PO BOX 613	HAMMONTON	NJ	08037	8883282287	
B46	TOTAL CLAIMS SOLUTION (TCS)	PO BOX 10888	GREEN BAY	WI	54307	8003760110	
B47	PHARMACY DATA MANAGEMENT, INC.	1170 E WESTERN RESERVE RD.	POLAND	OH	44514	8007740890	
B48	SELECT HEALTH	PO BOX 30192	SALT LAKE CITY	UT	84123	8005385038	
B49	FALLON COMMUNITY HEALTH PLAN	PO BOX 15121	WORCHESTER	MA	01615	8008685200	
B50	MEMBER HEALTH	PO BOX 391180	CLEVELAND	OH	44139	8888685854	
B51	INNOVIANT	PO BOX 8082	WAUSAU	WI	54402	8775592955	
B52	SOUTHERN PLANNED ADMINISTRATORS	PO BOX 218180	HOUSTON	TX	77218	2818291033	
B53	NATIONAL FOUNDATION LIFE INSURANCE COMPANY	110 WEST 7TH ST., STE. 300	FORT WORTH	TX	76102	8002219039	
B54	NGS AMERICAN, INC.	PO BOX 2310	MT. CLEMENS	MI	48046	8107797676	
B55	US SCRIPTS	2425 WEST SHAW AVE.	FRESNO	CA	93711	8004608988	
B56	MEDSAVE USA	3035 LAKELAND HILLS BLVD.	LAKELAND	FL	33805	8002263155	
B57	SOUTHERN FARM BUREAU LIFE INS. CO.	PO BOX 78	JACKSON	MS	39205	8004579611	
B58	AVMED HEALTH	PO BOX 569000	MIAMI	FL	332569000	8004528633	
B59	CASTIARX	701 EMERSON RD., STE. 301	CREVE COEUR	MO	63141	8665163121	
B60	STATE MUTUAL LIFE ASSURANCE COMPANY OF AMERICA	1100 31ST ST.	DOWNERS GROVE	IL	60515	8003233359	CODE IN OPEN STATUS BY SCHA
B61	AMERICAN BEHAVIORAL	3680 GRANDVIEW PARKWAY STE. 100	BIRMINGHAM	AL	35243	8009258327	
B62	LIBERTY DENTAL	PO BOX 26110	SANTA ANNA	CA	92799	8889020349	
B63	EASTERN LIFE AND HEALTH INSURANCE	PO BOX 10188	LANCASTER	PA	17605	8002330307	
B64	UNITED MEDICAL RESOURCES, INC.	PO BOX 30541	SALT LAKE CITY	UT	84130	5136193000	
B65	COMPASS ROSE HEALTH PLAN	PO BOX 141501	NASHVILLE	TN	37214	8775311159	
B66	KIRKE-VAN ORSDEL, INC.	PO BOX 9126	DES MOINES	IA	503069126	8002472192	USE CODE 759 MEDIPLUS PER SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
B67	NAVITUS HEALTH SOLUTIONS LLC	PO BOX 999	APPLETON	WI	549120999	8662682501	
B68	UPMC HEALTH BENEFITS, INC.	PO BOX 2999	PITTSBURGH	PA	15230	8773813764	
B69	AMERICAN INSURANCE ADMINISTRATORS	PO BOX 2348	COLUMBUS	OH	432162348	8009221245	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA.
B70	DECARE DENTAL	PO BOX 1348	MINNEAPOLIS	MN	55440	8005876857	
B71	CHCS SERVICES, INC.	PO BOX 12467	PENSACOLA	FL	325912457	8888031780	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B72	INTEGRITY NATIONAL LIFE INS.	PO BOX 32350	LOUISVILLE	KY	40232	5024261843	CODE ASSIGNED BY SCHA
B73	SOUTHERN CALIFORNIA PIPE TRADES TRUST FUND	501 SHATTO PLACE, 5TH FLOOR	LOS ANGELES	CA	90020	2133856161	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B74	STAR HRG	PO BOX 54150	PHOENIX	AZ	850784150	8002881474	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B75	HEALTH DESIGN PLUS	PO BOX 2584	HUDSON	OH	442362584	8008930777	
B76	INTERNATIONAL ASSO. BENEFITS	1747 PENNSYLVANIA AVE. NORTH WEST	WASHINGTON	DC	20006	8002751171	
B77	UNITED HEALTHCARE PLAN ADMINISTRATORS	PO BOX 121212	MARIETTA	GA	300670092	8005627079	USE CODE 985 BENESIGHT
B78	ARM GROUP (OMNICARE)	340 QUADRANGLE DR.	BOLINGBROOK	IL	60440	8009687222	
B79	FOX-EVERETT, INC.	PO BOX 6012	RIDGELAND	MI	39158	8774766327	
B80	INTEGRATED BEHAVIORAL HEALTH/IBH	PO BOX 30018	LAGUNA NIGUEL	CA	92607	8003951616	
B81	HM BENEFITS ADMINISTRATORS, INC.	PO BOX 535078	PITTSBURGH	PA	152535078	8002792624	
B82	AVANTE HEALTH	1111 E. HERNDON AVE., STE. 308	FRESNO	CA	93720	8664163617	
B83	STATE OF LOUISIANA EMPLOYEES	PO BOX 44036	BATON ROUGE	LA	70804	8002728451	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B84	HEALTH CARE CORPORATION	203 JANDERS RD.	CARY	IL	60013		CODE IN OPEN STATUS BY SCHA
B85	TUFTS HEALTHCARE	PO BOX 9185	WATERTOWN	MA	02471	8004238080	
B86	PREFERRED ONE ADMINISTRATIVE SERVICES	PO BOX 59212	MINNEAPOLIS	MN	55459	8009971750	
B87	HEALTH ALLIANCE	PO BOX 6003	URBANA	IL	616036003	8003227451	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
B88	GETTYSBURG HEALTH ADMINISTRATORS	PO BOX 1169	FREDERICK	MD	21702	8004974474	
B89	RXEDO	7800 DALLAS PARKWAY STE 460	PLANO	TX	75024	8888797336	
B90	FIRST CHOICE VIP CARE	PO BOX 307	LINTHICUM	MD	210900307	8005750418	THIS IS A MEDICARE ADVANTAGE PLAN.
B91	CHRISTIAN BROTHERS EMPLOYEE BENEFIT TRUST	1205 WINDHAM PARKWAY	ROMEOVILLE	IL	60446	8008070400	
B92	CARE SOURCE	ONE SOUTH MAIN	DAYTON	OH	45402	8004880134	
B93	UNIVERSITY HEALTH ALLIANCE	700 BISHOP ST., STE. 300	HONOLULU	HI	968134100	8005324000	
B94	THE CAPELLA GROUP	PO BOX 200368	ARLINGTON	TX	76006	8884113888	
B95	SINCLAIR HEALTH SERVICES	PO BOX 30827	SALT LAKE CITY	UT	84130	8888002230	
B96	ALTERNATIVE RISK MANAGEMENTS (ARM LTD)	814 N.W. HIGHWAY	ARLINGTON HEIGHTS	IL	60004	8003921770	
B97	NIPPON LIFE INSURANCE CO.	PO BOX 25951	SHAWNEE MISSION	KS	662255951	8003741835	
B98	AMERICAN PIONEER LIFE INSURANCE COMPANY	PO BOX 130	PENSACOLA	FL	32591	8005381053	
B99	GROUP & PENSION ADMINISTRATORS, INC.	PO BOX 749075	DALLAS	TX	75374	8662063224	
C01	TERMINIX SERVICE	PO BOX 2627	COLUMBIA	SC	29202	8037721783	CODE ASSIGNED BY SCHA
C02	FOUNDATION BENEFITS ADMINISTRATORS	6300 BRIDGEPOINT PKWAY, BLDG. 3 #400	AUSTIN	TX	78730	8883687910	
C03	TOTAL PLAN SERVICES, INC.	PO BOX 251369	PLANO	TX	75025	8009695238	
C04	CBA BLUE	PO BOX 9350	SOUTH BURLINGTON	VT	05407	8882229206	DENTAL ONLY
C05	STRATEGIC OUTSOURCING, INC. (SOI)	PO BOX 241508	CHARLOTTE	NC	28224	8888367764	
C06	MISSIONARY MEDICAL	PO BOX 45730	SALT LAKE CITY	UT	84145	8007771647	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C07	AMERIBEN SOLUTIONS	PO BOX 7186	BOISE	ID	83707	8007867930	
C08	BENECARD	PO BOX 2187	CLIFTON	NJ	07015	8007379528	
C09	HEALTH PLAN ADMINISTRATORS	PO BOX 2638	ROCKFORD	IL	61132	8156335800	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C10	ZAVATA	PO BOX 1208	AMERICUS	GA	31709	8008417735	WAS PARADIGM CARE PLAN
C11	MAESTRO HEALTH	P O BOX 1178	MATTHEWS	NC	28106	8002281803	
C11DN	MAESTRO HEALTH	P O BOX 1178	MATTHEWS	NC	28106	8002281813	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
C12	BENEFIT MANAGEMENT, INC.	PO BOX 1090	GREAT BEND	KS	66210	8002901368	
C13	CENTRAL RESERVE LIFE OF NORTH AMERICA INSURANCE CO	17800 ROYALTON RD.	STRONGSVILLE	OH	441365197	8003213997	
C14	COASTAL LUMBER CO	PO BOX 1576	WALTERBORO	SC	29488	8435382876	CODE IN OPEN STATUS BY SCHA
C15	ADVANCE PCS	PO BOX 52188	PHOENIX	AZ	850722196	4803914600	SEE CARRIER 471
C16	CONSOLIDATED BENEFITS, INC.	PO BOX 23686	COLUMBIA	SC	29224	8037365088	
C17	NATIONAL BENEFITS	110 GIBRALTAR RD.	HORSHAM	PA	19044	2154430404	
C18	EVOLUTIONS HEALTHCARE SYSTEMS	PO BOX 5001	NEW PORT RICHEY	FL	34656	8008814474	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C19	TAYLOR BENEFIT RESOURCES, INC.	PO BOX 6580	THOMASVILLE	GA	31758	8883525246	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C20	SCREEN ACTORS GUILD-PRODUCERS HEALTH PLAN	PO BOX 7830	BURBANK	CA	915107830	8007774013	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C22	BOSTON MUTUAL LIFE INSURANCE COMPANY	120 ROYALL ST.	CANTON	MA	02021	6178287000	
C23							
C24	ENCOMPASS HEALTH MANAGEMENT SYSTEM	6000 WEST TOWN PARKWAY STE 350	DES MOINES	IA	50266	8005113389	
C25	MEDICAL CLAIMS SERVICES	1 WALL ST., STE. 2A	RAVENSWOOD	WV	26164	8882250522	
C26	INTERACTIVE MEDICAL SYSTEMS, INC.	PO BOX 1349	WAKE FOREST	NC	27588	8004268739	
C27	SELECT BENEFIT ADMINISTRATORS	PO BOX 3245	MILWAUKEE	WI	53201	8004973699	
C27DN	SELECT BENEFIT ADMINISTRATORS	PO BOX 440	ASHLAND	WI	54806	8004973699	
C28	BENEFIT PLAN MANAGEMENT	PO BOX 536	ROCKLYN	MA	02370	8776427500	
C29	TRUE CHOICE USA	PO BOX 251369	PLANO	TX	75025	8002519665	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C30	KEENAN AND COMPANY	PO BOX 11431	TORRANCE	CA	90510	8006533626	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C31	CONSUMER HEALTH SOLUTIONS	PO BOX 3492	SPARTANBURG	SC	29304	8645739541	THE CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
C32	WELL FARGO INSURANCE	PO BOX 91608	LUBBOCK	TX	79490	8004354351	
C32DN	ASSURANT HEALTH	PO BOX 91608	LUBBOCK	TX	79490	8004354351	FORMALLY WELLS FARGO
C33	THE DESTINY HEALTH PLAN	PO BOX 4628	OAKBROOK	IL	60522	8668269345	
C34	GEOBLUE	933 FIRST AVENUE	KING OF PRUSSIA	PA	19406	8552823517	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C35	MUTUAL PROTECTIVE MEDICO LIFE INSURANCE COMPANIES	1515 S 75TH ST.	OMAHA	NE	68124	8002286080	SEE CODE C99
C36	NORTH AMERICAN INSURANCE COMPANY	PO BOX 44160	MADISON	WI	53744	6086621232	
C37	OLD SURETY LIFE INSURANCE CO	PO BOX 54407	OKLAHOMA CITY	OK	731541407	8002725466	
C38	STANDARD LIFE & ACCIDENT INSURANCE COMPANY	PO BOX 1800	GALVESTON	TX	775531800	8883501488	
C39	CONTINENTAL GENERAL INSURANCE COMPANY	PO BOX 247007	OMAHA	NE	681247007	4023973200	
C40	AVERA HEALTH PLANS	PO BOX 381506	BIRMINGHAM	AL	35238	8883222115	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C41	INTERNATIONAL BENEFITS ADMINISTRATORS, INC.	PO BOX 9306	GARDEN CITY	NY	11530	8004227617	
C41DN	INSUREX BENEFITS ADMINISTRATORS, INC.	PO BOX 41779	MEMPHIS	TN	381741799	9017256435	
C42	STANDARD CORPORATION	1400 MAIN ST., STE. 1300	COLUMBIA	SC	29201	8037716785	
C43	EMPLOYEE BENEFIT ADMINISTRATORS	PO BOX 5150	GREENVILLE	SC	29606	8642356474	
C44	S C MEDICAL ASSOCIATION-MEMBERS INSURANCE TRUST	PO BOX 6927	COLUMBIA	SC	29260	8037986207	
C45	TALL TREE ADMINISTRATORS	PO BOX 71747	SALT LAKE CITY	UT	841710747	8774534201	
C46	MEDCO HEALTH SOLUTIONS	PO BOX 2902	CLINTON	IA	527332902	8002727243	USE CARRIER 333 EXPRESS SCRIPTS
C47	KANAWHA BENEFIT SERVICES	PO BOX 50098	KNOXVILLE	TN	379500098	8008221274	
C47DN	KANAWHA BENEFIT SERVICES	PO BOX 50098	KNOXVILLE	TN	379500098	8008221274	
C48	SOUTHERN ADMINISTRATIVE SERVICES	PO BOX 8069	COLUMBUS	GA	31908	8004268803	
C49	ACS CONSULTING SERVICES, INC.	PO BOX 2000	WINSTON-SALEM	NC	27102	8008495370	WAS PENN WESTERN
C49DN	PENN WESTERN BENEFITS, INC.	PO BOX 2000	WINSTON-SALEM	NC	27102	8008465370	
C50	TENNESSEE BENEFIT ADMINISTRATORS	PO BOX 3257	SPARTANBURG	SC	29304		THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
C51	YALEHEALTH PLAN	PO BOX 208217	NEW HAVEN	CT	065208217	2034320250	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C52	TPA OF GEORGIA	4574 LAWRENCEVILLE HWY, STE. 201	LILBURN	GA	30047	7704517550	
C53							
C54	INTER-AMERICAS INS. CORP. (OOIDA)	PO BOX 9510	WICHITA	KS	672770510		THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C55	PLAN ADMINISTRATORS (MATURE AMERICAN)	734 15TH ST. NW, STE. 500	WASHINGTON	DC	20005	2023936600	
C56	COMPDENT	1930 BISHOP LANE STE. 132	LOUISVILLE	KY	40218	8006331262	
C57	WORLD TRAVEL PROTECTION	4600 WITMER INDUSTRIAL ESTATES #2	NIAGARA FALLS	NY	14305	8004564553	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C59	HUMANA CHOICE (PPO)	PO BOX 14605	LEXINGTON	KY	405784602	8004574708	MEDICARE ADVANTAGE PLAN
C60	INSTILL HEALTH SYSTEMS (FFS)	PO BOX 7061	CAMDEN	SC	290207845	8774467845	MEDICARE ADVANTAGE PLAN
C61	INSTILL HEALTH SYSTEMS (PPO)	PO BOX 7061	CAMDEN	SC	290207845	8774467845	MEDICARE ADVANTAGE PLAN
C62	BCBS OF SC MEDICARE BLUE PRIVATE (PFFS)	PO BOX 100133	COLUMBIA	SC	29202	8006053256	MEDICARE ADVANTAGE PLAN
C63	BCBS OF SC MEDICARE BLUE&MEDICARE BLUE PLUS (PPO)	PO BOX 100133	COLUMBIA	SC	29202	8006053256	MEDICARE ADVANTAGE PLAN
C64	BLUE CHOICE HEALTH PLAN (PPO)	PO BOX 6170	COLUMBIA	SC	29260	8772753256	MEDICARE ADVANTAGE (PPO)
C65	PRESBYTERIAN HEALTHCARE SERVICES	PO BOX 27489	ALBUQUERQUE	NM	87125	8003562219	
C66	CATERPILLAR, INC.	PO BOX 62920	COLORADO SPRINGS	CO	809622920	3094942363	
C67					-----		
C68	DENTAL BENEFIT PROVIDERS	PO BOX 389	ROCKVILLE	MD	20848	8004459090	
C69							
C70	AMERICAN RETIREMENT LIFE	PO BOX 30010	AUSTIN	TX	757553010	8664591755	REQUESTED BY THE SCHA
C71	JOHNS HOPKINS HEALTHCARE	6704 CURTIS CT.	GLEN BURNIE	MD	21060	8002612393	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
C72	ADVANCED INSURANCE ADMINISTRATION	125 MERRILL DR., STE. 2000	LITTLE ROCK	AR	72211	8882424800	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C73	UNION PACIFIC RAILROAD EMPLOYEES HEALTH	795 NORTH 400 WEST	SALT LAKE	UT	84103	8005470421	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C74	NATIONAL CLAIMS ADMINISTRATIVE SERVICES	PO BOX 981610	EL PASO	TX	799981610	7043643865	
C74DN	NATIONAL CLAIMS ADMINISTRATIVE SERVICES	PO BOX 220887	CHARLOTTE	NC	28222	7043643865	
C75	FLORIDA 1ST SERVICE ADMINISTRATORS, INC.	PO BOX 3607	WINTER HAVEN	FL	338853067	8002263155	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C76	WESTERN AND SOUTHERN GROUPS	PO BOX 5735	CINCINNATI	OH	45201	8004248622	
C77	CARPENTERS HOSPITALIZATION PLAN	3611 CHESTER AVE.	CLEVELAND	OH	44114	8004213959	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C78	KAISER PERMANENTE	PO BOX 370010	DENVER	CO	80237	4042612590	
C79	BENEFIT ADMINISTRATIVE SYSTEM, LTD	PO BOX 17475 JOVANNA DR., STE. 1B	HOMEWOOD	IL	60430	7087997400	
C80	ELDER HEALTH (MHN/HMC)	PO BOX 4433	BALTIMORE	MD	21223	8887768851	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C81	UNITED PAYORS & UNITED PROVIDERS	2273 RESEARCH BLVD.	ROCKVILLE	MD	20850	8002474144	
C82	AMERICAN STANDARD LIFE & ACCIDENT INS. CO.	PO DRAWER 3248, 224 NORTH INDEPENDENT	ENID	OK	73701	4052334000	CODE IN OPEN STATUS BY SCHA
C83	FREEDOM LIFE INSURANCE CO. OF AMERICA	PO BOX 1468	ARLINGTON	TX	76004	8669734647	
C84	CENTRAL UNITED & CHRISTIAN MUTUAL LIFE INS. CO.	2727 ALLEN PARKWAY	HOUSTON	TX	770192115	7135290045	
C85	LOYAL AMERICAN LIFE INSURANCE COMPANY	PO BOX 559004	AUSTIN	TX	78755	8006336752	
C86	NATIONAL STATES INSURANCE COMPANY	PO BOX 27321, 1830 CRAIG PARK CT.	ST. LOUIS	MO	63141	3148780101	
C87	SIHO INSURANCE SERVICES	PO BOX 1787	COLUMBUS	IN	47202	8008732022	
C88	ADVENTIST RISK MANAGEMENT	PO BOX 1928	GRAPEVINE	TX	76099	8006380589	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
C89	NEW SOURCES BENEFITS	PO BOX 6305	SPARTANBURG	SC	29304	8004761555	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C92	AMERICAN HEALTH CARE	3850 ATHERTON RD.	ROCKLIN	CA	95765	8008728276	
C92DN	AMERICAN HEALTH CARE	3001 DOUGLAS ST.	ROSEVILLE	CA	95661	8008728276	
C93	STUDENT ASSURANCE INSURANCE SERVICES	PO BOX 196	STILL WATER	MN	55085	8003282739	
C94	ERIN GROUP ADMINISTRATORS	PO BOX 7777	LANCASTER	PA	17604	8004333746	ANOTHER PHONE NUMBER 717-581-1300
C94DN	ERIN GROUP ADMINISTRATORS	PO BOX 7777	LANCASTER	PA	17604	8004333746	ANOTHER PHONE NUMBER 717-581-1300
C95	MIDWEST SECURITY	2700 MIDWEST DR.	ONALASKA	WI	54650	8002368672	
C96	MEDTRACK SERVICES	7101 COLLEGE BLVD., STE. 1000	OVERLAND PARK	KS	66210	8007714648	
C97	GEM GROUP	1200 THREE GATEWAY CENTER	PITTSBURGH	PA	15222	8002428923	
C98	MEDICAL BENEFIT ADM. OF MARYLAND, INC.	PO BOX 950	FORREST HILL	MA	60631	8885323467	
C99	MEDICO INSURANCE COMPANY	PO BOX 21660	EAGAN	MN	55121	8002286080	CARRIER WAS PREVIOUSLY C35.
CAS	CASUALTY CASE						
CO5							
CO9	EMPLOYEE BENEFITS TRUST	PO BOX 1431	WICHITA FALLS	TX	76307	8177617611	CODE ASSIGNED WITH LETTER O INSTEAD OF NUMERIC ZERO.
D01	INTERLINK HEALTH SERVICES	4950 NE BELNAP CT. #205	HILLSBORO	OR	97124	5036402000	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D02	INSURANCE ADMINISTRATOR OF AMERICA	PO BOX 5082	MT. LAUREL	NJ	08054	8009896739	
D03	PACIFIC SOURCE	PO BOX 7068	EUGENE	OR	97401	8006246052	
D04	LBA HEALTH PLANS, INC./PRIMARY SELECT	PO BOX 17098	OWINGS MILL	MD	211177098	8008158240	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D05	UPMC HEALTH BENEFITS, INC.	PO BOX 2999	PITTSBURGH	PA	15230	8773813764	MEDICARE ADVANTAGE PLAN
D06	SOUTHERN CALIFORNIA BAKERY & CONFECTIONARY	PO BOX 22041	COMMERCE	CA	90022	3237227171	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
D08	BIG LOTS ASSOCIATE BENEFIT PLAN	PO BOX 9071	DUBLIN	OH	430170971	8772542363	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D09	JM FAMILY ENTERPRISES	8019 BAYBERRY RD.	JACKSONVILLE	FL	32256	8008920059	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D10	SEVEN CORNERS, INC.	PO BOX 3430	CARMEL	IN	46082	8666994186	
D11	ADVANCED BENEFIT SOLUTIONS	PO BOX 71490	PHOENIX	AZ	85050	8884191094	CODE NOT REQUESTED BY MEDICAID ASSIGNED BY SCHA MEDICARE SUPPLEMENTAL PLAN
D12	SECUREHORIZONS DIRECT PFFS	PO BOX 12466	PENSACOLA	FL	325912466	8882024340	MEDICARE ADVANTAGE PLAN
D13	ARCADIAN	PO BOX 4946	COVINA	CA	91723	8007756490	CODE ORIGINALLY ASSIGNED AS MA IN ERROR USE CODE 816 FOR MA PLAN
D14	MEDICARE PLUS BLUE (BCBS OF MICHIGAN)	27000 ELEVEN MILE RD.	SOUTHFIELD	MI	48034	8002495103	MEDICARE ADVANTAGE PLAN
D15	SECURITYCHOICE ENHANCED PLUS	PO BOX 795180	SAN ANTONIO	TX	78279	8884458916	MEDICARE ADVANTAGE PLAN
D16	AETNA MEDICARE OPEN PLAN	PO BOX 14079	LEXINGTON	KY	405124079	8006240756	MEDICARE ADVANTAGE PLAN
D17	WELLCARE	PO BOX 795184	SAN ANTONIO	TX	78279	8662352770	MEDICARE ADVANTAGE PLAN
D18	COMMUNITY CARE SENIOR HEALTH PLAN	PO BOX 3249	TULSA	OK	741013249	8006428065	MEDICARE ADVANTAGE PLAN
D19	HEALTHFIRST 65 PLUS	PO BOX 5196	NEW YORK	NY	10274	8882601010	MEDICARE ADVANTAGE PLAN
D20	EXCELLUS MEDICARE BLUE CHOICE OPTIMUM	PO BOX 41915	ROCHESTER	NY	14604	8778839577	MEDICARE ADVANTAGE PLAN
D21	CARITEN SENIOR HEALTH	PO BOX 22885	KNOXVILLE	TN	37933	8656707790	MEDICARE ADVANTAGE PLAN
D22	SMART VALUE (BC OF GA) (PFFS)	PO BOX 3897	SCRANTON	PA	18505	8668659329	MEDICARE ADVANTAGE PLAN
D23	AMERICA'S HEALTH CHOICE MEDICAL PLANS,(HMO)	762 SOUTH US HWY. ONE PMB 224	VERO BEACH	FL	32962	8003089823	MEDICARE ADVANTAGE PLAN
D24	MOUNT CARMEL HEALTH PLAN (MCHP) MEDIGOLD (HMO)	PO BOX 6111	WESTERVILLE	OH	43086	8002403870	MEDICARE ADVANTAGE PLAN

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
D25	ELDER PLAN, INC. (HMO)	PO BOX 199100	BROOKLYN	NY	11219	7189218818	MEDICARE ADVANTAGE
D26	OXFORD MEDICARE ADVANTAGE (HMO)	PO BOX 7082	BRIDGEPORT	CT	06601	8002341228	MEDICARE ADVANTAGE PLAN
D27	SECURE HORIZONS PACIFICARE	PO BOX 25032	SANTA ANA	CA	927995032	7148253828	MEDICARE ADVANTAGE PLAN
D28	PYRAMID LIFE INSURANCE CO (PFFS)	PO BOX 958465	LAKE MARY	FL	327958465	4076281776	MEDICARE ADVANTAGE PLAN
D29	UNICARE LIFE & HEALTH INS. CO (PFFS)	233 S WACKER DR., STE. 3900	CHICAGO	IL	68606	3123247000	MEDICARE ADVANTAGE PLAN
D30	UNITED HEALTHCARE INS. CO (PPO)	PO BOX 150450	HARTFORD	CT	061150450	8607025000	MEDICARE ADVANTAGE PLAN
D31	LEON MEDICAL CENTER HEALTH PLAN	PO BOX 65-9006	MIAMI	FL	33265	3055595366	MEDICARE ADVANTAGE PLAN
D32	MEDICARE COMPLETE (UNITED HEALTH CARE)	PO BOX 659735	SAN ANTONIO	TX	782659735	8778423210	MEDICARE ADVANTAGE PLAN
D33	ADVANTRA FREEDOM	PO BOX 7154	LONDON	KY	407427154	8007135095	MEDICARE ADVANTAGE PLAN
D34	UNIVERSAL HEALTH CARE	PO BOX 3211	ST. PETERSBURG	FL	33731	8666904842	MEDICARE ADVANTAGE PLAN
D36	HOP/PSERS HEALTH ADMINISTRATION UNIT	PO BOX 2921	CLINTON	IA	52733	8007737725	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D37	WEST VIRGINIA LOCAL 152 HEALTH & WELFARE	5 HOT METAL ST., STE. 200	PITTSBURGH	PA	15203	8448517293	DENTAL ONLY
D38	AMERICAN INSURANCE ADMINISTRATORS	PO BOX 2348	COLUMBUS	OH	43216	8009221245	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D39	NEW YORK WELFARE FUND	101-49 WOODHAVEN BLVD.	OZONE PARK	NY	11416	7188455800	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D40	MINNESOTA POWER HEALTH PLANS	30 W SUPERIOR ST.	DULUTH	MN	55802	8888128800	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D41	BLUEGRASS FAMILY HEALTH	PO BOX 22738	LEXINGTON	KY	40522	8007872680	
D42	CARE IMPROVEMENT PLUS	PO BOX 4347	SCRANTON	PA	18505	8666862506	MEDICARE ADVANTAGE PLAN
D43	SOUTHEAST COMMUNITY CARE BY ARCADIAN HEALTH	PO BOX 4946	COVINA	CA	91723	8005738597	MEDICARE ADVANTAGE PLAN

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CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
D44	INDEPENDENT HEALTH	PO BOX 9066	BUFFALO	NY	14231	8666178585	MEDICARE ADVANTAGE PLAN
D45	HIGHMARK SECURITY BLUE	120 5TH AVE.	PITTSBURGH	PA	15222309	8005473627	MEDICARE ADVANTAGE PLAN
D46	GROUPHEALTH OPTIONS, INC.	PO BOX 34585	SEATTLE	WA	98124	8887674670	MEDICARE ADVANTAGE PLAN
D47	TOUCHSTONE HEALTH PSO	PO BOX 33519	INDIANAPOLIS	IN	462030519	8887770204	MEDICARE ADVANTAGE PLAN
D48	AMERICAN CONTINENTAL INSURANCE CO	PO BOX 2368	BRENTWOOD	TN	37024	6153371300	MEDICARE ADVANTAGE PLAN
D51	AMERIGROUP COMMUNITY CARE	PO BOX 61010	VIRGINIA BEACH	VA	234661010	8006004441	MEDICAID HMO
D52	WELLCARE OF GEORGIA	PO BOX 31224	TAMPA	FL	33531	8662311821	MEDICARE ADVANTAGE PLAN
D53	SIERRA OPTIMA PLUS CLAIMS	PO BOX 15645	LAS VEGAS	NV	891145645	8882742207	MEDICARE ADVANTAGE PLAN
D54	GATEWAY HEALTH PLAN MEDICARE ASSURED	PO BOX 11560	ALBANY	NY	122110655	8006855209	MEDICARE ADVANTAGE PLAN
D55	TOTAL CAROLINA CARE, INC.	1441 MAIN ST.	COLUMBIA	SC	29210	8664336031	MEDICAID HMO
D56	CITRUS HEALTH CARE, INC.	PO BOX 20547	TAMPA	FL	33622	8667691157	MEDICARE ADVANTAGE PLAN
D57	CIGNA MEDICARE ACCESS	PO BOX 22174	TEMPE	AZ	852852174	8005779410	MEDICARE ADVANTAGE PLAN
D58	BRAVO HEALTH MEDICARE ADVANTAGE	PO BOX 4433	BALTIMORE	MD	21223	8005561570	MEDICARE ADVANTAGE PLAN
D60	AMERIGROUP COMMUNITY CARE OF SC	PO BOX 31789	VIRGINIA BEACH	VA	234661789	8006004441	CODE ASSIGNED BY SCHA
D61	AMERICA'S 1ST CHOICE	PO BOX 210769	COLUMBIA	SC	29210	8663213947	MEDICARE ADVANTAGE PLAN
D62	SECURE HORIZONS DIRECT (UNITED HEALTHCARE)	PO BOX 31353	SALT LAKE CITY	UT	84131	8665798774	MEDICARE ADVANTAGE PLAN
D63	UNIVERA SENIOR CHOICE SECURE	PO BOX 23000	ROCHESTER	NY	15692	8006171114	MEDICARE ADVANTAGE PLAN
D64	EMPIRE HEALTHCHOICE ASSURANCE, INC.	PO BOX 100300 CLAIMS PROCESSING	COLUMBIA	SC	29204	8037888562	MEDICARE ADVANTAGE PLAN
D65	ANTHEM SENIOR ADVANTAGE	PO BOX 37690	LOUISVILLE	KY	402337180	8882909160	MEDICARE ADVANTAGE PLAN
D66	CHCCARES OF SOUTH CAROLINA	140 STONE RIDGE DR.	COLUMBIA	SC	29210	8668022474	MEDICAID HMO

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CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
D67	BLUE CROSS OF FLORIDA HEALTH OPTIONS	PO BOX 1798	JACKSONVILLE	FL	32231	8773522583	MEDICARE ADVANTAGE PLAN
D69	TOTAL CARE/HEALTHSPRING	PO BOX 20000	NASHVILLE	TN	372024070	8007437141	MEDICARE ADVANTAGE PLAN
D71	KEYSTONE 65	PO BOX 7799	PHILADELPHIA	PA	191017799	8002273116	MEDICARE ADVANTAGE PLAN
D74	DART MANAGEMENT CORP	PO BOX 318	MASON	MI	488540318	8002480457	
D75	WINDSOR MEDICARE EXTRA	PO BOX 269025	PLANO	TX	750269025	8662705223	MEDICARE ADVANTAGE PLAN
D79	EMPLOYEE HEALTH INSURANCE MANAGEMENT (EHIM)	26711 NORTHWESTERN HWY STE. 400	SOUTHFIELD	MI	48033	8003113446	
D81	HEARTLAND NATIONAL LIFE INSURANCE CO.	PO BOX 2878	SALT LAKE CITY	UT	84110	8008723860	REQUESTED BY THE SCHA
D82	SOLSTICE	PO BOX 14009	LEXINGTON	KY	40512	8777602247	
D85	US FIRE INSURANCE COMPANY	3195 LINWOOD RD., STE. 201	CINCINNATI	OH	45208	8005132981	
D87	LIFESTYLE HEALTHCARE	345 N. RIVERVIEW STE. 600	WICHITA	KS	67203	8668276607	FORMERLY MEDOVA HEALTHCARE
D94	AMERIGROUP COMMUNITY CARE	PO BOX 61010	VIRGINIA BEACH	VA	234661010	8006004441	MEDICAID HMO
D99	MEDICARE ADVANTAGE						MEDICARE ADVANTAGE PLAN GENERIC CODE
E102	PROTECTIVE LIFE INSURANCE	PO BOX 12687	BIRMINGHAM	AL	35202	2052687055	CANCER POLICY ONLY
E12	CAROLINA CRESCENT	1201 MAIN ST., STE. 970	COLUMBIA	SC	29201	8032516630	HEALTHY KIDS CONNECTION
E20	VRX PHARMACY SERVICES	PO BOX 9780	SALT LAKE CITY	UT	84109	8778799722	
E23	MAINE SENSE	PO BOX 1959	GRAY	ME	04039	8002908559	
E24	PBM PLUS	300 TECHNECENTER DR., STE. C	MILFORD	OH	45150	8002632178	
E29	BEST LIFE AND HEALTH INSURANCE CO.	PO BOX 890	MERIDIAN	ID	836800890	8004330088	
E30	BUSINESS ADMINISTRATORS AND CONSULTANTS, INC.	PO BOX 107	REYNOLDSBURG	OH	43068	8005212654	
E37	SELECT HEALTH	PO BOX 7120	LONDON	KY	40742	8882762020	HEALTHY KIDS CONNECTION
E38	UNISON HEALTH PLAN	250 BERRYHILL RD.	COLUMBIA	SC	29210	8037985852	HEALTHY KIDS CONNECTION
E41	MEDTRAK	7101 COLLEGE BLVD., STE. 1000	OVERLAND PARK	KS	66210	8007714648	
E42	TRUE RX	4 WILLIAMS BROTHERS DR.	WASHINGTON	IN	47501	8669214047	

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E43	THE HEALTH PLAN INSURANCE CO.	52160 NATIONAL RD. EAST	ST. CLAIRSVILLE	OH	43950	7406996273	
E44	ALTERNATIVE INSURANCE RESOURCE, INC.	PO BOX 680787	BIRMINGHAM	AL	352660787	8004514318	
E45	UNIFIED LIFE INSURANCE	PO BOX 25326	OVERLAND	KS	662255326	9136852233	
E46	TOLEDO FIREFIGHTERS HEALTH PLAN	PO BOX 5810	TROY	MI	480075810	4192555314	
E51	CHOICE BENEFITS	3801 OLD GREENWOOD RD.	FT. SMITH	AR	75278	8004516907	
E54	ALLEGIANCE BENEFIT PLAN MANAGEMENT	PO BOX 3018	MISSOULA	MT	598063018	8008771122	
E55	AG ADMINISTRATORS	PO BOX 979	VALLEY FORGE	PA	19482	8006348628	
E61	HEALTHEZ	PO BOX 398220	MINNEAPOLIS	MN	55439	8552809638	
E66	CHCCARE OF SOUTH CAROLINA	140 STONE RIDGE DR.	COLUMBIA	SC	29210	8668022474	
E73	TRISTAR BENEFIT ADMINISTRATORS	PO BOX 65887	WEST DES MOINES	IA	50265	8004564584	
E80	KANSAS INDEPENDENT PHARMACY (KPSC)	4125 SOUTH WEST GAGE CENTER DR., STE. 203	TOPEKA	KS	66604	8002793022	
E81	SELECT ADMINISTRATIVE SERVICES (SAS)	PO BOX 3209	GULFPORT	MS	39503	8008476621	
E82	SIMPLE BENEFIT PLANS	2810 PREMIER PARKWAY STE. 400	DULUTH	GA	30097	8002704158	
E87	BENEFIT ADMINISTRATIVE SYSTEMS	PO BOX 2920	MILWAUKEE	WI	53201	8005250582	
E89	BROADREACH MEDICAL RESOURCES	1350 BROADWAY #410	NEW YORK	NY	10018	8887182375	
E90	UNITED HEALTH (MEDICARE SOLUTIONS)	PO BOX 30436	SALT LAKE CITY	UT	84130	8778423210	MEDICARE ADVANTAGE
E91	SCOTT AND WHITE HEALTH PLAN	PO BOX 21800	EAGAN	MN	55121	8003217947	
E93	CUSTOM DESIGN BENEFITS	5589 CHEVIOT RD.	CINCINNATI	OH	45247	8005982929	
E95	TRUESCRIPTS	PO BOX 921	WASHINGTON	IN	47501	8442571955	RX
E96	MEDPARTNERS ADMINISTRATIVE	6920 POINT INVERNESS WAY	FORT WAYNE	IN	46804	8883129744	
E97	SIGNATURE CARE	PO BOX 5548	FORT WAYNE	IN	46895	8006664449	
E99	MAXORPLUS	320 SOUTH POLK ST., STE. 200	AMARILLO	TX	79101	8006870707	
E99RX	MAXORPLUS	320 SOUTH POLK ST., STE. 200	AMARILLO	TX	79101	8006870707	RX ONLY
F11	SOUTHERN SCRIPTS	PO BOX 2482	NATCHIPOCHES	LA	71457	8007109341	RX
F13	DENTEGRA	PO BOX 1850	ALPHARETTA	GA	300231850	8772804202	DENTAL
F14	MERIDIANRX	PO BOX 9306	GARDEN CITY	NY	48226	8553234580	RX

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F18	CARE CONNECT	PO BOX 830259	BIRMINGHAM	AL	352830259	8557067545	
F19	LIFEMAP	PO BOX 783	MILWAUKEE	WI	53201	8002841129	
F20	HEALTHPLEX	PO BOX 9255	UNIONDALE	NY	11553	8004680600	DENTAL
F21	TRUSTEED PLAN SERVICE	PO BOX 2950	TACOMA	WA	98401	2535645611	
F22	CONSOLIDATED HEALTH PLANS	2077 ROOSEVELT AVE.	SPRINGFIELD	MA	01104	8006337867	DENTAL
F23	WELLDYNE RX	PO BOX 90369	LAKELAND	FL	33804	8884792000	
F25	FIDELIO DENTAL INSURANCE COMPANY	2826 MT. CARMEL AV.	GLENSIDE	PA	19038	8002624949	DENTAL
F27	3PADMINISTRATORS	PO BOX 247	ONALASKA	WI	54650	6087793000	DENTAL ONLY
F28	CONTINENTAL BENEFITS	PO BOX 3610	BRANDON	FL	335093610	8553030837	
F29	BENEFIT COORDINATORS	PO BOX 210546	COLUMBIA	SC	29221	8037220110	
F29DN	BENEFIT COORDINATORS	PO BOX 210546	COLUMBIA	SC	29221	8037220110	DENTAL
F31	WILLIAM C. EARHART CO., INC.	PO BOX 97208	PORTLAND	OR	97208	8008460611	
F31DN	WILLIAM C. EARHART CO., INC.	PO BOX 4148	PORTLAND	OR	97208	8008460611	DENTAL ONLY
F32	DENTAL SELECT	PO BOX 851917	RICHARDSON	TX	75085	8014953000	DENTAL
F37	DISTRICT COUNCIL #37	125 BARCLAY ST.	NEW YORK	NY	10007	2158151600	DENTAL ONLY
F40	CITIZEN'S RX	1144 LAKE ST.	OAK PARK	IL	60301	8775327912	RX ONLY
F41	HEALTHCARE HIGHWAYS RX	5904 STONE CREEK DR.	THE COLONY	TX	75056	8446367506	RX ONLY
F42	PROACT	1126 US HIGHWAY 11	GOUVERNEUR	NY	13642	8662869885	RX ONLY
F43	TRICARE EAST	PO BOX 7981	MADISON	WI	537077981	8004445445	
F45	LIFETIME BENEFIT SOLUTIONS	PO BOX 780	LIVERPOOL	NY	13088	8772543132	
F45DN	LIFETIME BENEFIT SOLUTIONS	PO BOX 780	LIVERPOOL	NY	13088	8772543132	DENTAL ONLY
F46	HEALTH RESOURCES, INC.	PO BOX 659	EVANSVILLE	IN	47704	8007271444	
F46DN	HEALTH RESOURCES, INC.	PO BOX 659	EVANSVILLE	IN	47704	8007271444	DENTAL ONLY
F49	BLUE CROSS BLUE SHIELD OF WYOMING	PO BOX 2266	CHEYENNE	WY	82003	8004422376	
F49DN	BLUE CROSS BLUE SHIELD OF WYOMING	PO BOX 2266	CHEYENNE	WY	82003	8004422376	DENTAL ONLY
F50	FRINGE BENEFIT GROUP	PO BOX 21854	EAGAN	MN	55121	8772201862	ASSIGNED BY SC REVENUE AND FISCAL AFFAIRS OFFICE
F51	INSURANCE TPA	PO BOX 15953	LUBBOCK	TX	79490	8558489591	ASSIGNED BY SC REVENUE AND FISCAL AFFAIRS
F53	BOON GROUP	PO BOX 559017	AUSTIN	TX	78755	8664750056	ADDED BY SC REVENUE AND FISCAL AFFAIRS

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F54	ALLEGIANCE	PO BOX 3018	MISSOULA	MT	59806	8559992271	ADDED BY SC REVENUE AND FISCAL AFFAIRS
F55	COMMONWEALTH CARE ALLIANCE	PO BOX 2280	PORTSMOUTH	NH	14315	8666102273	ADDED BY SC REVENUE AND FISCAL AFFAIRS
F56	CAREFIRST BLUECHOICE MARYLAND	PO BOX 14116	LEXINGTON	KY	40512	8008425975	ADDED BY SC REVENUE AND FISCAL AFFAIRS
F57	AMBETTER PEACH STATE HEALTH PLAN	PO BOX 5010	FARMINGTON	MD	636405010	8776871180	ADDED BY SC REVENUE AND FISCAL AFFAIRS
F58	KAISER PERMANENTE MID ATLANTIC STATES	PO BOX 371860	DENVER	CO	802379998	8008104766	ADDED BY REVENUE AND FISCAL AFFAIRS
X01	BLUE CROSS & BLUE SHIELD OF MARYLAND, INC.	PO BOX 14115	LEXINGTON	KY	40512	8005244555	
X0A	BLUE CROSS OF GEORGIA/COLUMBUS, INC.	PO BOX 9907	COLUMBUS	GA	319089907	8004412273	POLICIES SHOULD BE ADDED WITH XOB. BCBS OF OF GA.
X0ARX	BLUE CROSS OF GEORGIA/COLUMBUS, INC.	PO BOX 9907	COLUMBUS	GA	319089907	8004412273	DO NOT USE FOR MEDICARE. THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE.
X0B	BLUE CROSS & BLUE SHIELD OF GEORGIA/ATLANTA, INC.	PO BOX 9907	COLUMBUS	GA	319086007	4048428000	FOR GEORGIA STATE EMPLOYEES USE CARRIER 419 GEORGIA STATE HEALTH BENEFIT PLAN
X0BDN	BCBS OF GEORGIA DENTAL	PO BOX 659444	SAN ANTONIO	TX	78265	4048428000	
X0C	BLUE CROSS & BLUE SHIELD OF NORTH CAROLINA	PO BOX 35	DURHAM	NC	27702	8002144844	
X0CDN	BLUE CROSS & BLUE SHIELD OF NORTH CAROLINA	PO BOX 2100	WINSTON-SALEM	NC	271022100	9194897431	
X0D	BLUE CROSS AND BLUE SHIELD OF FLORIDA	PO BOX 1798	JACKSONVILLE	FL	322310014	8007272227	
X0E	EMPIRE BLUE CROSS AND BLUE SHIELD	PO BOX 1407 CHURCH ST. STATION	NEW YORK	NY	10008	8003429816	
X0EDN	EMPIRE BCBS DENTAL	PO BOX 791	MINNEAPOLIS	MN	554400791	8007228879	
X0F	BLUE CROSS & BLUE SHIELD OF VIRGINIA	PO BOX 27401	RICHMOND	VA	23279	8009916061	
X0G							
X0H	BLUE CROSS & BLUE SHIELD UNITED OF WISCONSIN	PO BOX 2025	MILWAUKEE	WI	53201	4142246100	

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X0I	BLUE CROSS & BLUE SHIELD OF MARYLAND, INC.	PO BOX 9836	BALTIMORE	MD	21204	8005244555	USE CARRIER X01
X0J	PENNSYLVANIA BLUE SHIELD	PO BOX 890089	CAMP HILL	PA	17089	8006373493	
X0K	REGENCE BLUE CROSS BLUE SHIELD OF OREGON	PO BOX 1271	PORTLAND	OR	97207	5032255221	
X0KRS	REGENCE BCBS OF OREGON	PO BOX 12625 MAILSTOP S4P	SALEM OREGON	OR	97309	8884371508	RX PLAN ONLY MM CODE X0K
X0KRX	REGENCE BCBS OF OREGON	PO BOX 12625 MAILSTOP S4P	SALEM	OR	97309	8884371508	
X0L	BLUE CROSS & BLUE SHIELD OF DELAWARE, INC.	PO BOX 1991	WILMINGTON	DE	19899	3024210260	
X0M	BLUE CROSS OF MASSACHUSETTS, INC.	PO BOX 986020	BOSTON	MA	022986020	8002535210	
X0MDN	BCBS OF MASSACHUSETTS	PO BOX 986005	BOSTON	MA	02298	8002535210	DENTAL ONLY
X0N	BLUE CROSS AND BLUE SHIELD OF TEXAS	PO BOX 660044	DALLAS	TX	752660044	8004510287	
X0NDN	BLUE CROSS AND BLUE SHIELD OF TEXAS	PO BOX 660247	DALLAS	TX	75266	8004947218	
X0O	BLUE CROSS AND BLUE SHIELD OF ALABAMA	PO BOX 2294	BIRMINGHAM	AL	35201	8005176425	DO NOT USE FOR MEDICARE. THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE.
X0ODN	BLUE CROSS AND BLUE SHIELD OF ALABAMA	PO BOX 830389	BIRMINGHAM	AL	352830389	8005176425	
X0P	BLUE CROSS & BLUE SHIELD OF TENNESSEE	1 CAMERON HILL CIRCLE	CHATTANOOGA	TN	374020002	8004689736	
X0PDN	BLUE CROSS & BLUE SHIELD OF TENNESSEE	1 CAMERON HILL CIRCLE STE. 0002	CHATTANOOGA	TN	374020002	8005659140	
X0Q	BLUE CROSS & BLUE SHIELD OF MICHIGAN	PO BOX 312500	DETROIT	MI	48231	8004820898	
X0QDN	BLUE CROSS & BLUE SHIELD OF MICHIGAN	PO BOX 49	DETROIT	MI	48231	8888268152	
X0R	MEDICAL MUTUAL OF OHIO	PO BOX 6018	CLEVELAND	OH	44101	2166877000	
X0RDN	MEDICAL MUTUAL OF OHIO	PO BOX 981800	EL PASO	TX	79998	2166877000	
X0S	BLUE CROSS & BLUE SHIELD OF NEW JERSEY, INC.	PO BOX 1219	NEWARK	NJ	07101	8006241110	AKA HORIZON BCBS OF NEW JERSEY
X0SDN	BLUE CROSS & BLUE SHIELD OF NEW JERSEY, INC.	PO BOX 1311	MINNEAPOLIS	MN	55440	8003552583	AKA HORIZON BCBS OF NEW JERSEY
X0T	BLUE CROSS OF ILLINOIS	PO BOX 805107	CHICAGO	IL	60680	8006348644	
X0TDN	BLUE CROSS OF ILLINOIS	PO BOX 23059	BELLEVILLE	IL	62223	8668260914	
X0U	BLUE CROSS & BLUE SHIELD OF KENTUCKY, INC.	9901 LINN STATION RD.	LOUISVILLE	KY	40223	5024232011	

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X0V	BLUE SHIELD OF NORTHEASTERN NEW YORK	PO BOX 15013	ALBANY	NY	12212	5184534600	
X0W	BLUE CROSS OF CALIFORNIA	PO BOX 60007	LOS ANGELES	CA	90060	8006776669	
X0X	CENTRAL BENEFITS MUTUAL INSURANCE COMPANY	PO BOX 16526	COLUMBUS	OH	43216	6144645870	
X0Y	ANTHEM BLUE CROSS AND BLUE SHIELD	PO BOX 105187	ATLANTA	GA	30348	8005529159	
X0YDN	ANTHEM BLUE CROSS AND BLUE SHIELD	PO BOX 659444	SAN ANTONIO	TX	78265	8006224822	
X0YRX	ANTHEM BLUE CROSS AND BLUE SHIELD	PO BOX 37010	LOUISVILLE	KY	40233	8006224822	
X0Z	BLUE CROSS & BLUE SHIELD OF MISSISSIPPI, INC.	PO BOX 1043	JACKSON	MS	39215	6016644590	
X1A	BLUE CROSS BLUE SHIELD OF NEW MEXICO	PO BOX 27630	ALBUQUERQUE	NM	87125	8007113795	
X1D	BLUE CROSS /BLUE SHIELD OF NATIONAL CAPITAL AREA	550 12TH ST. SW	WASHINGTON	DC	20024	2024798000	
X1E	BLUE CROSS OF PUERTO RICO	PO BOX 366068	SAN JUAN	PR	009366068	8097599898	
X1F	BLUE CROSS & BLUE SHIELD OF RHODE ISLAND	500 EXCHANGE ST.	PROVIDENCE	RI	02903	4018317300	
X1FDN	BLUE CROSS BLUE SHIELD OF RHODE ISLAND	PO BOX 69427	HARRISBURG	PA	171069427	8008312400	DENTAL ONLY
X1G	INDEPENDENCE BLUE CROSS	PO BOX 211184	EAGAN	MN	551212594	8002752583	
X1H	BLUE CROSS & BLUE SHIELD OF CONNECTICUT, INC.	PO BOX 533	NORTH HAVEN	CT	06473	2032394961	
X1I	ARKANSAS BLUE CROSS AND BLUE SHIELD, INC.	PO BOX 2181	LITTLE ROCK	AR	72203	5013782010	
X1J	BLUE CROSS & BLUE SHIELD OF WESTERN NEW YORK, INC.	PO BOX 80	BUFFALO	NY	142400080	8008880757	
X1K	BLUE CROSS & BLUE SHIELD OF MEMPHIS	85 NORTH DANNY THOMAS BLVD.	MEMPHIS	TN	38103	9015293111	
X1L	BLUE CROSS & BLUE SHIELD OF LOUISIANA	PO BOX 98029	BATON ROUGE	LA	708989029	5042915370	
X1M	BLUE CROSS & BLUE SHIELD OF KANSAS	1133 SOUTHWEST TOPEKA BLVD.	TOPEKA	KS	66629	7852914180	
X1N	MEDICAL SERVICE CORPORATION OF EASTERN WASHINGTON	PO BOX 3048	SPOKANE	WA	99220	5095364900	
X1O	WELLMARK BLUE CROSS BLUE SHIELD OF IOWA	PO BOX 5023	SIOUX FALLS	SD	57104	5152454500	USE CARRIER CODE X2A
X1P	BLUE CROSS & BLUE SHIELD OF MINNESOTA	PO BOX 64338	ST. PAUL	MN	55164	8003822000	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
X1Q	BLUE CROSS & BLUE SHIELD OF MAINE	2 GANNETT DR.	SOUTH PORTLAND	ME	041066911	2077751550	
X1R	HIGHMARK BLUE CROSS BLUE SHIELD	PO BOX 890062	CAMPHILL	PA	170890062	4125447000	
X1S	COMMUNITY MUTUAL INSURANCE COMPANY	1351 WILLIAM HOWARD TAFT RD.	CINCINNATI	OH	45206	5132821016	CODE IN OPEN STATUS BY SCHA
X1T							
X1U	BLUE CROSS & BLUE SHIELD OF NEBRASKA	PO BOX 3248, MAIN PO STATION	OMAHA	NE	681800001	4023901820	
X1V	BLUE CROSS & BLUE SHIELD OF COLORADO	700 BROADWAY	DENVER	CO	80273	3038312131	
X1W	BLUE CROSS & BLUE SHIELD OF UTAH	PO BOX 30270	SALT LAKE CITY	UT	841300270	8013332100	
X1X	BLUE CROSS OF OHIO	PO BOX 956	TOLEDO	OH	43696	8003621279	
X1Y	BLUE SHIELD OF CALIFORNIA	PO BOX 272540	CHICO	CA	95927	8882351765	
X1YDN	BLUE SHIELD OF CALIFORNIA	PO BOX 272590	CHICO	CA	959272590	8887024171	
X1Z							
X20							
X21							
X25							
X2A	WELLMARK BLUE CROSS BLUE SHIELD OF IOWA	PO BOX 5023	SIOUX FALLS	SD	571175023	8005268995	
X2ADN	WELLMARK BLUE CROSS BLUE SHIELD OF IOWA	PO BOX 9354	DES MOINES	IA	503069354	8773330164	DENTAL
X2B	BLUE CROSS & BLUE SHIELD OF KANSAS CITY	PO BOX 419169	KANSAS CITY	MO	641416169	8008926048	
X2C							
X2D							
X2E							
X2F	EXCELLUS BLUECROSS BLUESHIELD	PO BOX 21146	EAGAN	MN	551210146	8007344069	TO VERIFY DENTAL COVERAGE CALL 1-800-724-1675
X2FDN	BLUE CROSS AND BLUE SHIELD OF THE ROCHESTER AREA	PO BOX 22999	ROCHESTER	NY	14692	7163253630	DENTAL
X2G	BLUE CROSS & BLUE SHIELD CENTRAL NEW YORK, INC.	PO BOX 4809	SYRACUSE	NY	132214809	3154483801	
X2H	BLUE CROSS & BLUE SHIELD OF UTICA-WATERTOWN, INC.	12 RHOADS DR., UTICA BUSINESS DISTRICT	UTICA	NY	13501	3157984238	
X2I							

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
X2J	BLUE CROSS & BLUE SHIELD OF NORTH DAKOTA	4510 13TH AVE. SW	FARGO	ND	581210001	8003682312	
X2K	CAPITAL BLUE CROSS	PO BOX 211457	EAGAN	MN	551213057	8009622242	
X2L	BLUE CROSS OF NORTHEASTERN PENNSYLVANIA	PO BOX 890179	CAMP HILL	PA	170890179	8008298599	
X2M	BLUE CROSS OF WASHINGTON AND ALASKA	PO BOX 91059	SEATTLE	WA	981119159	8007221471	
X2N							
X2O	BLUE CROSS & BLUE SHIELD OF WEST VIRGINIA, INC.	PO BOX 1353	CHARLESTON	WV	25325	3043477709	
X2P	MOUNTAIN STATE BLUE CROSS & BLUE SHIELD, INC.	PO BOX 1948	PARKERSBERG	WV	26102	3044247700	
X2Q							
X2R							
X2S	BLUE CROSS & BLUE SHIELD OF VERMONT	PO BOX 2365	SOUTH BURLINGTON	VT	54072365	054072365	
X2T	BLUE CROSS & BLUE SHIELD OF OKLAHOMA	PO BOX 3283	TULSA	OK	74102	9185603535	
X2U	BLUE CROSS & BLUE SHIELD OF MISSOURI	1831 CHESTNUT ST.	ST. LOUIS	MO	63103	3149234444	AKA ALLIANCE BLUE CROSS BLUE SHIELD
X2V	BLUE CROSS OF IDAHO HEALTH SERVICE, INC.	PO BOX 7408	BOISE	ID	83707	2083447411	
X2VDN	BLUE CROSS OF IDAHO HEALTH SERVICE	PO BOX 7408	BOISE	ID	83707	2083447411	DENTAL ONLY
X2X	BLUE CROSS BLUE SHIELD OF HAWAII	PO BOX 44500	HONOLULU	HI	96801	8007764672	
X2Y	BLUE CROSS BLUE SHIELD OF MONTANA	PO BOX 5004	GREAT FALLS	MT	59403	4067914000	
X3A	UNITED TEACHERS ASSO. INS. CO.	PO BOX 30010	AUSTIN	TX	78755	8008808824	
X3B	TPA EXCHANGE	PO BOX 4363	ST AUGUSTINE	FL	32085	8885022789	
XOKRX	REGENCE BCBS OF OREGON RX PLAN	PO BOX 12625 MAILSTOP S4P	SALEM	OR	97309	8884371508	RX PLAN ONLY MM PLAN IS X0K
XOV	BLUE CROSS OF NORTHEASTERN NEW YORK, INC.	PO BOX 15013	ALBANY	NY	12212	5184385500	
XYZ	OPTUM RX	PO BOX 29044	HOT SPRINGS	AR	71093	8007887871	FORMERLY PRESCRIPTION SOLUTIONS

APPENDIX 3 COPAYMENT SCHEDULE

The Copayment schedule reflects amounts the beneficiary is expected to pay to the provider at the time services are received. The current amounts are effective for dates of service on and after July 11, 2011 per Medicaid bulletin dated July 8, 2011, unless otherwise noted.

Service	Procedure Code/ Frequency	Amount
Physician Office Visits (Physician/Nurse Practitioner)	90791-90792 92002-92014 99201-99205 99212-99215 99241-99245	$3.30
*Durable Medical Equipment and Supplies	Services per day	$3.40
Optometrist	92002-92014 99201-99205 99212-99215 99241-99245	$3.30
Chiropractor	98940 98941 98942	$1.15
Podiatrist	99201-99205 99212-99215 99241-99245	$1.15
Home Health	S9128 S9129 S9131 T1021 T1028 T1030 T1031	$3.30
Federally Qualified Health Center (FQHC)	T1015	$3.30
Rural Health Clinic (RHC)	T1015	$3.30
Ambulatory Surgical Center	Services per day	$3.30
Dental	Services per day	$3.40

APPENDIX 3 COPAYMENT SCHEDULE

Service	Procedure Code/ Frequency	Amount
Pharmacy (The prescription copayment will apply to ages 19 and above only.)	Per prescription/refill	$3.40
Note: Effective for dates of service on and after July 1, 2015, the copayment will be $0 for certain medications for the treatment of diabetes, behavioral health disorders and smoking cessation products. Refer to the Pharmacy Co-Payment Waiver Medicaid bulletin dated May 26, 2015.		
Inpatient Hospital	Per admission	$25.00
Outpatient Hospital **(non-emergency)**	Per claim	$3.40

*__Note__: Durable Medical Equipment that is under a rent to purchase payment plan will have the $3.40 copayment split evenly among the 10-month rental payment schedule.

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MANAGED CARE

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MANAGED CARE SUPPLEMENT

MANAGED CARE OVERVIEW

Managed Care is a health care delivery model implemented by the South Carolina Department of Health and Human Services (SCDHHS) to establish a medical home for all Medicaid Managed Care eligible members. The goals of a medical home include:

- Provide accessible, comprehensive, family-centered coordinated care
- Manage the member's health care, perform primary and preventive care services, and arrange for any additional needed care
- Provide members access to a "live voice" 24 hours a day, 7 days a week, to ensure access to appropriate care
- Provide member education about preventive and primary health care, utilization of the medical home, and the appropriate use of the emergency room

Enrolling in a managed care plan does not limit benefits. Benefits offered under fee for service (FFS) Medicaid, as well as additional or enhanced benefits are provided by all Managed Care Organizations (MCOs). These additional benefits vary from MCO to MCO according to the contracted terms and conditions between SCDHHS and the managed care entity. Members and providers should contact the MCO with questions concerning additional benefits.

Examples of additional benefits include:

- 24-hour nurse advice line
- Care coordination
- Health management programs (asthma, diabetes, pregnancy, etc.)
- Unlimited office visits
- Waving Co-pays on some services

The Managed Care Division administers the program for Medicaid-eligible members by contracting with Managed Care Organizations (MCOs) to offer health care services. An MCO must receive a Certificate of Authority from the SC Department of Insurance and must be licensed as a domestic insurer by the State to render Medicaid managed care services. MCO model contracts are approved by the Centers for Medicare and Medicaid Services (CMS) and the South Carolina Department of Health and Human Services (SCDHHS).

This Managed Care supplement is intended to provide an overview of the Managed Care program. Providers should review the Managed Care Policy and Procedure Guide and the Managed Care contract for detailed program-specific requirements. Both the guide and the contract are located on the SCDHHS Web site at www.scdhhs.gov within the Managed Care section.

The Exhibits section of this supplement provides contact information for MCOs currently participating in the Medicaid Managed Care program as MCOs are subject to change at any time. Providers are encouraged to visit the SCDHHS website (www.scdhhs.gov) for the most current

MANAGED CARE SUPPLEMENT

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listing of MCOs, the counties in which they are authorized to operate, and the number of managed care enrollees within a county.

SC MEDICAID MANAGED CARE CONTACT INFORMATION

For additional information, contact the Managed Care Division at the following address:

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

PROGRAM DESCRIPTION

Managed Care Organizations (MCOs)

A Managed Care Organization (MCO) is commonly referred to as an HMO (Health Maintenance Organization) in the private sector. MCOs are required to operate under a contract with SCDHHS to provide healthcare services to beneficiaries through a network of healthcare professionals, both primary and specialty care, as well as hospitals, pharmacies, etc. This network is developed by contracting with the various healthcare professionals. Providers wanting to contract with an MCO must be enrolled in South Carolina Medicaid with SCDHHS.

Primary care providers (PCP) must be accessible within a thirty (30) mile radius, while specialty care providers, to include hospitals, must be accessible within a fifty (50) mile radius. While MCOs will contract with providers within a specific county, enrolled members may seek treatment, or be referred to in-network providers in other counties.

MCOs are responsible for providing core services to Medicaid-eligible individuals as specified in their contract with SCDHHS. The health care providers within the MCO network are not required to accept FFS Medicaid as most claims are filed to and processed by the MCO.

Core Benefits

Managed Care Organizations are fully capitated plans that provide a core benefit package similar to the current FFS Medicaid plan. MCO plans are required to provide members with “medically necessary” care for all contracted services. While appropriate and necessary care must be provided, MCOs are not bound by the current variety of service settings. For example, a service may only be covered FFS when performed in an inpatient hospital setting, while the MCO may authorize the same service to be performed both in an inpatient and an outpatient hospital setting.

MCOs may offer SCDHHS-approved additional benefits. These are benefits that go beyond the core package. Additions, deletions, or modifications to additional benefits made by the MCO must be approved by SCDHHS. These benefits may include medical services which are currently non-covered by FFS and/or which are above current Medicaid limitations.

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Providers should refer to the **Core Benefits** section of the MCO Policy and Procedures Guide on the SCDHHS website (www.scdhhs.gov) for a detailed explanation of core benefits.

Services Outside of the Core Benefits

The South Carolina Healthy Connections (Medicaid) program continues to provide and/or reimburse certain FFS benefits. Providers rendering services that are not included in the MCO's benefits package, but are covered under FFS Medicaid receive payment in accordance with the current Medicaid fee schedule. These services are filed to SC Medicaid for processing and payment. MCOs are responsible for the member's continuity of care by ensuring appropriate referrals and linkages to the Medicaid FFS providers. For specifics concerning services outside of the core benefits, please see the Managed Care Policy and Procedures Guide on the SCDHHS website www.scdhhs.gov.

MCO Program Identification (ID) Card

Managed Care Organizations issue an identification card to beneficiaries within fourteen (14) calendar days of the selection of a primary care provider, or the date of receipt of the member's enrollment data from SCDHHS, whichever is later.

To ensure immediate access to services, the provider should verify eligibility and enrollment through the Medicaid provider web tool regardless of a member's ability to supply a SC Medicaid or MCO ID card. The MCO ID card must include at least the following information:

- The MCO name
- The 24-hour telephone number for the member to use in urgent or emergency situations and to obtain any additional information
- The name of the primary care physician
- The member's name and Medicaid ID number
- The MCO's plan expiration date (optional)
- The Member Services toll-free telephone number
- The MCO and SC Medicaid logos

Claims Filing

Providers should file claims with the MCO for members participating in a managed care program, unless the service rendered is not covered by the MCO and is, instead, paid on a FFS basis by SC Medicaid. Providers should contact the MCO for managed care billing requirements. Non-contracted providers should contact the MCO for billing and prior authorization requirements prior to rendering services to MCO enrolled members. An exception is services rendered in an emergency room. Even if the physician is not in-network with the MCO, the MCO cannot refuse to reimburse for covered emergency services. Specifics concerning emergency coverage can be found in the MCO contract and Managed Care Policy and Procedure Guide.

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Prior Authorizations and Referrals

Providers, both in and out of network, should contact the member's MCO for assistance with prior authorization (PA) requirements before administering services. Each MCO may have different prior authorization requirements and services requiring PA.PA requirements may also differ according to the terms of a provider's contract with an MCO.

Admission to a hospital through the emergency department **may** require authorization. Hospitals should always check with the beneficiary's MCO for their requirements. The physician component for inpatient services **always** requires prior authorization. Specialist referrals for follow-up care after a hospital discharge may also require prior authorization.

Medical Homes Networks (MHNs) - Medically Complex Children's Waiver

SCDHHS administers one MHN specifically for individuals that are enrolled in the Medically Complex Children's Waiver program. Medical Homes Networks (MHNs) are Primary Care Case Management (PCCM) programs that link beneficiaries with a primary care provider (PCP). An MHN is a group of physicians who have agreed to serve as PCCM providers for this specific population. They work in partnership with the member to provide and arrange for most of the beneficiary's health care needs, including authorizing services provided by other health care providers. They also partner with a Care Coordination Services Organization (CSO) to accept the responsibility for providing medical homes for members and managing their care. The CSO supports the physicians and enrolled beneficiaries by providing care coordination, disease management, and data management.

The outcome of this medical home is a healthier, better educated Medicaid member, and cost savings for South Carolina through a reduction of acute medical care and disease-related conditions. The MHN provides case managers, who assist in developing, implementing, and evaluating the predetermined care management strategies of the network.

MHN Program Identification (ID) Card - Medically Complex Children's Waiver

A separate identification card is not issued for members enrolled in this program. Beneficiaries enrolled in this MHN will have only one identification card, the one issued by SC Medicaid. This card does not contain the name or phone number of the assigned PCP. Such information can only be obtained by checking eligibility at the Medicaid provider web tool.

Core Benefits - Medically Complex Children's Waiver

Services provided under this MHN program are all paid on a FFS basis. As such, all claims are submitted to and processed by SCDHHS. Benefits offered in the MHN program mirror those offered in FFS Medicaid.

Prior Authorizations and Referrals - Medically Complex Children's Waiver

The PCP is contractually required to either provide medically necessary services or authorize another provider to treat the member via a referral. If a member has failed to establish a medical

MANAGED CARE SUPPLEMENT

MANAGED CARE OVERVIEW

record with the PCP, the CSO, in conjunction with the PCP, shall arrange for the prior authorization (PA) on any existing referral. For a list of services that do not require authorization, refer to the **Exempt Services** section later in this supplement.

In some cases, the PCP may choose to authorize a service retroactively. All authorizations and consultations, including services authorized retroactively, are at the discretion of the PCP. The process for referring a member to a specialist can be made by telephone or in writing. The referral should include the number of visits being authorized and the extent of the diagnostic evaluation.

A PCP may authorize multiple visits for a specific course of treatment or a particular diagnosis. This prevents a provider to whom the member was referred from having to obtain a referral number for each visit so long as the course of treatment or diagnosis has not changed. The provider simply files the claims referencing the same referral number. It is the PCP's responsibility to authorize additional referrals for any further diagnosis, evaluation, or treatment not identified in the scope of the original referral. If a specialist needs to refer the member to a second specialist for the same diagnosis, the beneficiary's PCP must be contacted for a referral number.

A referral number is not required for services provided in a hospital emergency department or for an admission to a hospital through the emergency department. However, the physician component for inpatient hospital services does require a referral number. The hospital should contact the PCP for a referral number within 48 hours of the member's admission. Specialist referrals for follow-up care after discharge from a hospital also require a referral from the PCP. In addition to the MHN's authorization, prior approval may be required by SCDHHS to verify medical necessity before rendering some services. Prior authorizations are for medical approval only. Obtaining a prior authorization does not guarantee payment or ensure the member's eligibility on the date of service. Claims submitted for reimbursement must include the PCP's referral number.

Specific services sponsored by state agencies require a referral from that agency's case manager. The state agency's case manager should coordinate with the PCP and the MHN Care Coordinator to ensure the continuity of care. These services include, but are not limited to, the following:

- Audiologist Services
- High/Moderate Management Group Homes Services
- Occupational Therapist Services
- Physical Therapist Services
- Psychologist Services
- Speech Therapist Services
- Therapeutic Foster Care Services

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Referrals for a Second Opinion - Medically Complex Children's Waiver

PCPs are required to refer a member for a second opinion at his or her request when surgery is recommended.

Referral Documentation - Medically Complex Children's Waiver

All referrals must be documented in the member's medical record. The CSO and the PCP shall review the monthly referral data to ensure that services rendered to the beneficiary were authorized and recorded accurately in the medical record. It is the PCP's responsibility to review the referral data for validity and accuracy, and to report inappropriate and/or unauthorized referrals to the CSO. The CSO is responsible for investigating these incidents and notifying SCDHHS if Medicaid fraud or abuse is suspected.

Exempt Services - Medically Complex Children's Waiver

Beneficiaries can obtain the following services from Medicaid providers without obtaining a prior authorization from their PCP:

- Ambulance Services
- Dental Services
- Dialysis/End Stage Renal Disease Services
- Emergency Room Services (billed by the hospital)
- Family Planning Services
- Home- and Community-Based Waiver Services
- Independent Laboratory and X-ray Services[1]
- Medical Transportation Services
- Nursing Home Services
- Obstetrician and Gynecologist Services
- Optician Services
- Optometrist Services
- Pharmacy Services
- State Agency Services[2]

[1] FQHCs/RHCs that provide laboratory and x-ray services under a separate provider number (not the FQHC/RHC number) must enter a prior authorization number on the claim form or the claim will be rejected.

[2] Agencies exempt from prior authorization are the Department of Mental Health, the Continuum of Care, the Department of Alcohol and Other Drug Abuse, the Department of Disabilities and Special Needs, the Department of Juvenile Justice, and the Department of Social Services.

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Some services still require a prescription or a physician's order. Physicians should refer to the appropriate Medicaid Provider Manual for more detailed information and/or requirements, or contact the SCDHHS Provider Service Center (PSC) by calling (888) 289-0709. Providers can also submit an online inquiry at https://scdhhs.gov/webform/contact-provider-representative and a provider support representative will respond to the request.

Primary Care Provider Requirements - Medically Complex Children's Waiver

The primary care provider is required to either provide services or authorize another provider to treat the member. The following Medicaid provider types may enroll as a primary care provider:

- Family Medicine
- General Practitioners
- Pediatricians
- Internal Medicine
- Obstetrics and Gynecology
- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)
- Nurse Practitioners

24-Hour Coverage Requirements - Medically Complex Children's Waiver

The MHN requires PCPs to provide access to medical advice and care for enrolled members 24 hours per day, 7 days per week. A qualified medical practitioner must provide medical advice, consultation, and/or authorization or referral for services when appropriate within one hour of the member's presentation or notification. PCPs must have at least one telephone line that is answered by office staff during regular office hours.

MANAGED CARE SUPPLEMENT

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MANAGED CARE SUPPLEMENT

MANAGED CARE ELIGIBILITY

Individuals must apply for SC Medicaid prior to enrollment in a Managed Care Organization.. If the applicant meets the established Medicaid eligibility requirements, he or she may be eligible for participation in the South Carolina Medicaid Managed Care program. Not all Medicaid members will be eligible to participate in the Managed Care program.

The following Medicaid members are **not eligible** to participate in a South Carolina Medicaid **Managed Care**:

- Dually eligible Members (Medicare and Medicaid)*
- Members age 65 or older*
- Residents of a nursing home*
- Participants in limited benefits programs such as Family Planning, Specified Low Income Beneficiaries, Emergency Service Only, etc.
- Home- and Community-Based Waiver participants*
- PACE participants
- Medically Complex Children's Waiver Program participants
- Hospice participants
- Members covered by an MCO/HMO through third-party coverage
- Members enrolled in another Medicaid managed care plan (Medical Home Network)

Providers should verify the member's eligibility through the Web Tool or a point-of-service (POS) terminal prior to delivering services.

*SCDHHS along with the Centers for Medicare and Medicaid Services (CMS) currently operate a dual demonstration grant, SC Healthy Connections PRIME, where Medicaid managed care enrollment of these membership groups are allowed. For more information regarding the SC Healthy Connections PRIME program please access the SCDHHS website https://scdhhs.gov/service/healthy-connections-prime.

MANAGED CARE SUPPLEMENT

MANAGED CARE ELIGIBILITY

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MANAGED CARE SUPPLEMENT

MANAGED CARE ENROLLMENT

OVERVIEW

All managed care enrollment and disenrollment activities are handled through one single point of contact, South Carolina Healthy Connections Choices (SCHCC). SCHCC is responsible for processing the enrollment and disenrollment of Medicaid-eligible members into a managed care plan. Members may enroll online, by telephone, by mail, or by fax. Managed Care eligible Medicaid members are encouraged to actively enroll with a managed care plan.

SCHCC may be reached by calling (877) 552-4642, or via the SCHCC website: www.SCchoices.com. SCHCC should be contacted for assistance with enrollment, as well as transferring to, or disenrolling from, an MCO regardless of how long a member has been enrolled in their current MCO.

Members who are eligible for managed care participation are made aware of their eligibility via an outreach or enrollment mailing from SCHCC.

An **enrollment packet** is mailed to members who are required to make a managed care plan choice. Failure to do so will result in managed care plan assignment by SCHCC.

An **outreach packet** is mailed to beneficiaries who are eligible, but not required, to participate in a managed care plan. Managed care participation is on a voluntary basis for this population. (See **Enrollment Counselor Services** later in this supplement.)

Outreach and assignment is based on the member's eligibility category and/or Special Program enrollment, member assignment to an MCO is done on a prospective basis.

If a Medicaid member enrolled in a MCO loses Medicaid eligibility, but regains it within sixty (60) days, he or she will be automatically reassigned to the same plan and will forego a new ninety (90) day choice period.

Members cannot enroll directly with the MCO. Members must contact SCHCC to enroll in a managed care plan, or to change or discontinue their enrollment. A member can only change or disenroll without cause within the first ninety (90) days of enrollment. If the member is approved to enroll in a managed care plan, or changes his or her plan, prior to SCDHHS' creation of the MCO member list which is done in the next to last week of each month, the member appears on the MCO's member listing in the next month. If the member is approved, and entered into the system in the last seven (7) to ten (10) days of the month, the member will appear on the plan's member listing for the following month.

ENROLLMENT PROCESS

Medicaid members receive a managed care enrollment packet or an outreach packet by mail within two days of first becoming eligible for Medicaid, or thirty (30) to sixty (60) days prior to their annual Medicaid eligibility review. Members enrolled in a MCO will also receive a reminder letter from their health plan prior to their annual Medicaid eligibility review date.

MANAGED CARE SUPPLEMENT

MANAGED CARE ENROLLMENT

Members are always encouraged to open, read, and respond to the enrollment packets to avoid automatic MCO assignment. While managed care enrollment is encouraged during the annual eligibility review, FFS Medicaid beneficiaries may contact SCHCC to enroll at any time. They do not need to wait to receive enrollment information. Members enrolled in a managed care plan at the time of their annual review will remain in their MCO unless they contact SCHCC during their open enrollment (Ninety (90) day choice period) to request a change.

When enrollment packets are mailed, members have at least thirty (30) days from the mail date to choose an MCO. If a member fails to act on the initial enrollment packet, outbound calls are placed in an effort to encourage plan selection. If, after the outreach efforts, a member still fails to respond, he or she will be assigned to a MCO.

The assignment process places members into MCOs available in the county where the member resides based on the following criteria:

- The MCO, if any, in which the beneficiary was previously enrolled
- The MCO, if any, in which family members are enrolled
- The MCO is selected by a Quality Weighted Automated Assignment Algorithm process if no health plan was identified

There are three easy ways for members to enroll:

- Call SCHCC at (877) 552-4642
- Mail or fax the completed enrollment form contained in the enrollment packet
- Online at www.SCchoices.com

A member is enrolled in a Managed Care plan for a period of 12 months. The beneficiary shall remain enrolled in the MCO unless one of the following occurs:

- The member becomes ineligible for Medicaid and/or Managed Care enrollment
- The member forwards a written request to transfer plans for cause
- The member initiates the transfer process during the annual re-enrollment period
- The member requests transfer within the first ninety (90) days of enrollment

Enrollment of Newborns

Babies born to Medicaid-eligible mothers are automatically deemed Medicaid eligible. As such, they are subject to being enrolled into a MCO. If, at the time of delivery, the mother is enrolled with an MCO, the baby will be automatically enrolled into the same MCO as the mother.

Babies automatically enrolled into the mother's MCO have a ninety (90) day choice period following birth during which a change to their health plan may be made. Following the ninety (90) day choice period, the newborn enters into his or her lock-in period and may not change MCOs for the first year of life without "just cause." The newborn's effective date of enrollment into a managed care plan is the first day of the month of birth.

MANAGED CARE SUPPLEMENT

MANAGED CARE ENROLLMENT

Providers should refer to the appropriate Medicaid provider manual for additional limitations when providing services to newborns.

Primary Care Provider Selection and Assignment

Upon enrolling into a MCO, all beneficiaries are "assigned" to a primary care provider (PCP). When the member is assigned to an MCO, the MCO is responsible for assigning the PCP. After assignment, members may elect to change their PCP. **There is no lock-in period with respect to changing PCPs.** Enrolled members may change their PCP at any time and as often as necessary.

MCO members must call their designated Member Services area with the MCO to change their PCP. The name of the designated PCP will appear on all MCO cards. Should an MCO member change his/her PCP, he/she will be issued a new card from the MCO reflecting the new PCP.

MANAGED CARE SUPPLEMENT

MANAGED CARE ENROLLMENT

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MANAGED CARE SUPPLEMENT

MANAGED CARE DISENROLLMENT PROCESS

OVERVIEW

Members not required to participate in managed care may request to disenroll and return to fee-for-service Medicaid. Members required to participate in managed care may only request to transfer to another MCO as fee-for-service Medicaid is no longer an option for the mandatory managed care population.

Disenrollment/transfer requests are processed through the enrollment broker, SCHCC. The member, the MCO or SCDHHS may initiate this process. During the 90 days following the date of initial enrollment with the MCO, beneficiaries may change plans without cause. Only one change may be requested during this period. Once a change has been requested, or the first ninety (90) days following the date of initial enrollment has expired, members move into their "lock-in" period. Requests to change MCOs during the lock-in period are processed only for "just cause." Please refer to the MCO Policy and Procedures Guide and contract for additional information concerning just cause disenrollments.

Transfer requests made during the lock-in period require the completion of a Health Plan Change form, which may only be obtained by contacting SCHCC. The form requires the member to provide information confirming his or her attempt to resolve any issues necessitating disenrollment. That information includes documenting the date and time of the call to the MCO to discuss his or her issues, as well as the person with whom the member spoke. Failure to provide all required information will result in denial of the disenrollment request as all such requests must be reviewed by the SCDHHS.

Upon review by SCDHHS, the managed care plan is notified of the request to disenroll so that a plan representative may follow up with the member in an effort to address the concerns raised in the request for disenrollment. MCOs are required to notify SCDHHS within ten (10) days of the follow-up results for all complaints or disenrollment requests forwarded to the plan. If just cause is not validated, disenrollment is denied and the member remains in the managed care plan. A member's request to transfer is honored if a decision has not been reached within sixty (60) days of the initial request. The final decision to accept the member's request is made by SCDHHS.

If the member believes he or she was disenrolled/transferred in error, it is the member's responsibility to contact SCHCC or the MCO for resolution. The member may be required to complete and submit a new enrollment form to SCHCC.

INVOLUNTARY BENEFICIARY DISENROLLMENT

A beneficiary may be involuntarily disenrolled from a MCO at any time deemed necessary by SCDHHS or the MCO, with SCDHHS approval.

The MCO's request for member disenrollment must be made in writing to SCHCC using all applicable form(s), and the request must state in detail the reason for the disenrollment. The request must also include documentation verifying any change in the member's status. SCDHHS determines if the MCO has shown good cause to disenroll the member and informs SCHCC of

MANAGED CARE SUPPLEMENT

MANAGED CARE DISENROLLMENT PROCESS

their decision. SCHCC notifies both the MCO and the member of the decision in writing. The MCO and the member have the right to appeal any adverse decision. Providers should always check the Medicaid eligibility status of members before rendering service on the Medicaid Provider Web Tool.

The MCO may not terminate a member's enrollment because of any adverse change in the member's health. An exception would be when the member's continued enrollment in the plan would seriously impair the plan's ability to furnish services to either this particular member or other members.

For additional information, please review the involuntary disenrollment guidelines used by SCDHHS and the Managed Care plans in the **Disenrollment Process** section in the MCO Policy and Procedures Guide and contract.

MANAGED CARE SUPPLEMENT

EXHIBITS

MANAGED CARE PLANS BY COUNTY

All MCOs currently contracted with SCDHHS operate statewide.

The **Exhibits** section provides the contact information and a card sample for each MCO currently operating in South Carolina.

CURRENT MEDICAID MEDICAL HOMES NETWORKS (MHNS) FOR THE MEDICALLY COMPLEX CHILDREN'S WAIVER

The following MHN participates with the Medically Complex Children's waiver and South Carolina Healthy Connections Medicaid. MHN beneficiaries should present their South Carolina Healthy Connections Medicaid Insurance card in order to receive health care services. No additional card is necessary.

South Carolina Solutions

3555 Harden St Ext. Ste. 300
Columbia, South Carolina 29203
(888) 827-1665
www.sc-solutions.org

CURRENT MEDICAID MANAGED CARE ORGANIZATIONS

South Carolina Healthy Connections Medicaid MCOs are required to issue a plan identification card to enrolled members. Members should present both the MCO-issued identification card and the Healthy Connections Medicaid card. MCO cards contain important information on the member (name, plan number), the MCO (toll-free contact numbers), and the PCP.

SAMPLE MEDICAID MCO CARDS

The following card samples are used by MCOs that are currently authorized to operate in South Carolina.

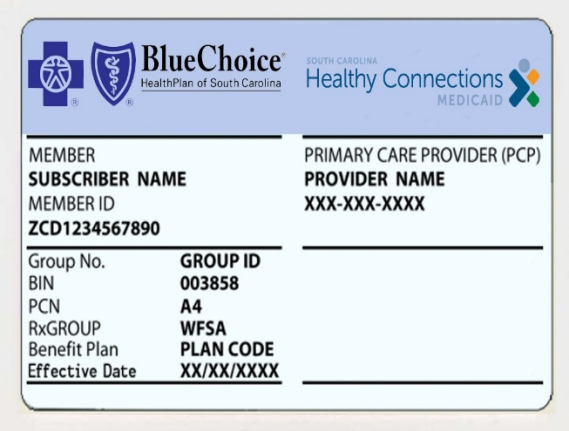
MANAGED CARE SUPPLEMENT

Absolute Total Care

Centene Corporation
(866) 433-6041
www.absolutetotalcare.com

Healthy Blue by BlueChoice

BlueChoice HealthPlan of South Carolina Medicaid
(866) 781-5094
www.bluechoicesc.com



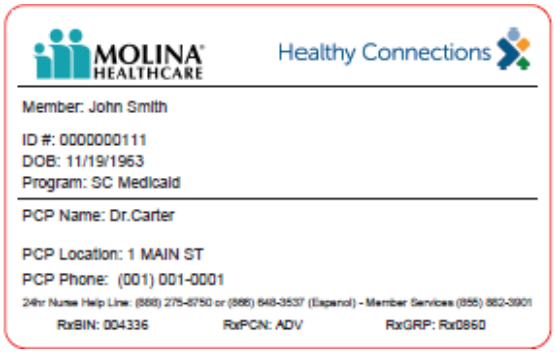
MANAGED CARE SUPPLEMENT

First Choice by Select Health

Select Health of South Carolina, Inc.
(888) 276-2020
www.selecthealthofsc.com

Molina Healthcare, Inc.

1-855-882-3901
www.molinahealthcare.com



MANAGED CARE SUPPLEMENT

WellCare of South Carolina, Inc.

(888) 588-9842
www.southcarolina.wellcare.com

PROVIDER MANUAL SUPPLEMENT

THIRD-PARTY LIABILITY

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PROVIDER MANUAL SUPPLEMENT

THIRD-PARTY LIABILITY

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THIRD-PARTY LIABILITY SUPPLEMENT

INTRODUCTION

"Third-party liability" (TPL) refers to the responsibility of parties other than Medicaid to pay for health insurance costs. Medicaid is always the payer of last resort, which means that Medicaid will not pay a claim for which someone else may be responsible until the party liable before Medicaid has been billed. For the most part, this means providers are responsible for billing third parties before billing Medicaid.

Third parties can include:

- Private health insurance
- Medicare
- Employment-related health insurance
- Medical support from non-custodial parents
- Long-term care insurance
- Other federal programs
- Court judgments or settlements from a liability insurer
- State workers' compensation
- First party probate-estate recoveries

Private health insurers and Medicare are the most common types of third party that providers are required to bill. For information on casualty cases and estate recovery, see Section 1 of your provider manual.

HEALTH INSURANCE RECORDS

Medicaid Insurance Verification Services (MIVS), Medicaid's TPL contractor, researches third-party insurance information. Sources of information include providers, eligibility offices, long-term care workers, private insurers, other government agencies, and beneficiaries themselves.

It can take up to 25 days for a new policy record to be added to a beneficiary's eligibility file and five days for corrections and updates of an existing record. New policy information and updates are added to the Medicaid Management Information System (MMIS) every working day.

ACCESS TO CARE

As a provider, your role in the TPL process begins as soon as you agree to treat a Medicaid-eligible patient. You should ask every patient and/or the patient's responsible party about other insurance coverage.

According to 42 CFR 447.20(b), **you cannot refuse to treat a Medicaid patient simply because he or she has other health insurance**. You and the patient should work together to decide whether you will consider the individual a Medicaid patient or a private-pay patient. If you accept the individual as a Medicaid patient, you are obligated to follow Medicaid's third-party liability guidelines and other policies. Remember, you agree to treat a patient as a Medicaid

patient for an entire spell of illness; you cannot change a beneficiary's status in the midst of a course of treatment.

When you first accept a Medicaid beneficiary, and at every service encounter thereafter, you will check to see whether the patient is eligible for Medicaid. At the same time, you will check for any other insurers you may need to bill. You should also perform a Medicaid eligibility check again when entering a claim, as eligibility and TPL information are constantly being updated.

South Carolina Healthy Connections (Medicaid) does not require you to obtain copies of other insurance cards from the beneficiary. You can obtain from South Carolina Healthy Connections (Medicaid) all the information you need to file with another insurer or to code TPL information on a Medicaid claim, including policy numbers, policy types, and contact information for the insurer, as long as Medicaid has that information on file.

Health Insurance Premium Payment Project

The Health Insurance Premium Payment (HIPP) project allows SCDHHS to pay private health insurance premiums for Medicaid beneficiaries who may be at risk of losing the private insurance coverage. SCDHHS will pay such premiums if the payment is deemed cost effective; see Section 1 of your provider manual for more information on qualifying situations. Maintaining good communication with your patients will help you identify candidates for referral to the HIPP program.

Eligibility Verification

- **Medicaid Card:** Possession of a Medicaid card means only that a beneficiary was eligible for Medicaid when the card was issued. You must use other eligibility resources for up-to-date eligibility and TPL information.
- **Point-of-Sale Devices and Eligibility Verification Vendors:** Check with your vendor to see how TPL information is reported.
- **Web Tool:** The Eligibility Verification function of the South Carolina Healthy Connections (Medicaid) Web-based Claims Submission Tool provides information about third-party coverage. See the Web Tool User Guide for instructions on checking eligibility.

REPORTING TPL INFORMATION TO MEDICAID

Providers are an important source of information from beneficiaries about third-party insurers. You can report this information to Medicaid in two ways: enter the information on claims submitted to Medicaid, or submit Health Insurance Information Referral Forms to Medicaid. When primary health insurance information appears on a claim form, the insurance information is passed to MIVS electronically for verification. This referral process is conducted weekly and contributes to timely additions and updates to the policy file.

THIRD-PARTY LIABILITY SUPPLEMENT

Health Insurance Information Referral Forms

The SCDHHS Health Insurance Information Referral Form is used to document third-party insurance coverage, policy changes, beneficiary coverage changes, carrier changes, and policy lapse information. You should fill out this form when you discover third-party coverage information that Medicaid does not know about, or when you have insurance documentation that indicates the TPL health insurance record needs an update.

A copy of the form is included in the Forms section of your provider manual, and samples appear at the end of this supplement. Send or fax the completed forms to:

South Carolina Healthy Connections
PO Box 101110
Columbia, SC 29211-9804
Fax: (803) 252-0870

COORDINATION OF BENEFITS

Health insurers adhere to "coordination of benefits" provisions to avoid duplicating payments. The health plan or payer obligated to pay a claim first is called the "primary" payer, the next is termed "secondary," and the third is called "tertiary." Together, the payers coordinate payments for services up to 100% of the covered charges at a rate consistent with the benefits.

Medicaid does not participate in coordination of benefits in the same way as other insurers. Medicaid is never primary, and it will only make payments up to the Medicaid allowable. However, you should understand how other companies coordinate payments.

COST AVOIDANCE VS. PAY & CHASE

South Carolina Healthy Connections (Medicaid) is required by the federal government to reject claims for which another party might be liable; this policy is known as "cost avoidance." Providers must report primary payments and denials to Medicaid to avoid rejected claims. The majority of services covered by Medicaid are subject to cost avoidance.

For certain services, Medicaid does not cost-avoid claims and will pursue recovery under a policy known as "Pay & Chase." Medicaid remains the payer of last resort in all cases; however, under Pay & Chase it temporarily behaves like a primary payer.

Services that fall under Pay & Chase are:

- Preventive pediatric services
- Dental EPSDT services
- Maternal health services
- Title IV – Child Support Enforcement insurance records
- Certain Department of Health and Environmental Control (DHEC) services under Title V

While providers of such services are encouraged to file with any liable third party before Medicaid, if they choose not to do so, SCDHHS will pay the claims and bill liable third parties directly through the Benefit Recovery program. More information on recovery appears later in

this supplement. If you choose to bill both a third party and Medicaid, you must enter the TPL filing information on your Medicaid claim as outlined in this supplement – rendering Pay & Chase-eligible services does not exempt you from the requirement to correctly code for TPL.

Resources Secondary to Medicaid

Certain programs funded only by the state of South Carolina (*i.e.*, without matching federal funds) should be billed secondary to Medicaid. The TPL claim processing subsystem does not reject claims for resources that may pay after Medicaid. These resources are:

- BabyNet
- Best Chance Network
- Black Lung
- Commission for the Blind
- Community Health
- Crime Victims Compensation Fund
- CRS (Children's Rehabilitative Services)
- Department of Corrections
- DHEC Cancer
- DHEC Family Planning (DHEC Maternal Child Health)
- DHEC Heart
- DHEC Hemophilia
- DHEC Migrant Health
- DHEC Sickle Cell
- DHEC TB
- Indian Health
- Other Indigent (hospital charity)
- Other Sponsor
- Ryan White Program
- State Aid Cancer Program
- Vaccine Injury Compensation
- Veterans Administration
- Vocational Rehabilitation Services

COPAYMENTS AND TPL

For certain services, Medicaid beneficiaries must make a Medicaid copayment. SCDHHS deducts this amount from what Medicaid pays the provider. Copayments are described in detail in Section 3 of your provider manual (if they apply to the services you provide).

Remember, as a Medicaid provider you have agreed to accept Medicaid's payment as payment in full. You can never balance bill a beneficiary receiving Medicaid-covered services for anything other than the Medicaid copayment. (You may, however, bill a beneficiary for services that Medicaid does not cover.)

When a beneficiary has Medicare or private insurance, he or she is still responsible for the Medicaid copayment. However, if the sum of the copayment and the Medicare/third-party payment would exceed the Medicaid-allowed amount, you must adjust or eliminate the copayment. In other words, though you may accept a primary insurance payment higher than what Medicaid would pay, the beneficiary's copayment cannot contribute to the excess revenue.

Medicaid beneficiaries with private insurance are **not** charged the copayment amount of the primary plan(s). When you accept a patient as a Medicaid patient, all Medicaid rules, including the Medicaid copayment rules, apply to that individual. These rules are federal law; they protect the Medicaid beneficiary by limiting his or her liability for payment for medical services.

THIRD-PARTY LIABILITY SUPPLEMENT

Medicaid determines payment in full and the patient's liability. Therefore, when you file a secondary claim with Medicaid, you can only apply the Medicaid copayment and cannot require the primary plan copayment as you would for a private pay patient.

DENIALS AND EOBS

When you bill a primary health insurer, you should obtain either a payment or a denial. You should also receive an Explanation of Benefits (EOB) that explains how the payment was calculated and any reasons for non-payment. Once you have received a reply from all potentially liable parties, if there are still charges that are not paid in full that might be covered by Medicaid, you may then bill Medicaid. This process is known as sequential billing.

Note that you must receive a *valid* denial before billing Medicaid. A request for more information or corrected information does not count as a valid denial.

POLICY TYPES

Each private policy listed in a patient's insurance record has an entry for "policy type," the most common of which is Health No Restrictions (HN). Another policy type you may encounter is HI, Health Indemnity; such policies pay per diem for hospital stays, surgeries, anesthesia, etc. HS, Health Supplemental, refers to policies that cover Medicare coinsurance and deductibles. Other policy types include Accident (HA) and Cancer (HC).

The policy type HN may be applied to a pharmacy carve-out, a mental health claim administrator, or a dental policy. The policy type does not provide specific information about the types of services covered, so you may have to take extra steps to determine whether to bill a particular carrier:

1. Ask the beneficiary. He or she should be able to tell you what kind of policy it is.
2. Look at the name of the carrier in the full list of carrier codes. The name may help you figure out the type of coverage (*e.g.*, ABC Dental Insurers).
3. Call SCDHHS Provider Service Center (PSC). Providers can also submit an online inquiry at http://scdhhs.gov/contact-us and a provider support representative will respond to you directly. He or she can look up more details of the plan in the TPL policy file.

TIMELY FILING REQUIREMENTS

Providers must file claims with Medicaid within a year of the date of service. If a claim is rejected, you must file a new claim within that year, and Void/Replacement adjustments must be made within that year as well – all activity related to the claim must occur within a year of the date of service in order for you to be paid.

Because of this timely filing requirement, you should bill third parties as soon as possible after service delivery. SCDHHS recommends that you file a claim with the primary insurer within 30 days of the date of service.

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Regardless of how long the third party takes to reply, providers must still meet Medicaid's timeliness requirements. Delays by other insurers are not a sufficient excuse for timeliness extensions.

Timely Filing	
Medicaid claims	One year
Medicare-primary claims to Medicaid	Two years or within six months from Medicare adjudication
Primary health insurance	30 days recommended

Late claim filing to the primary insurer and gaps in activity related to obtaining payment from a primary carrier are not reasonable practices. SCDHHS will not consider payment if a claim is not successfully adjudicated by the MMIS within the time frames above.

REASONABLE EFFORT

Providers occasionally encounter difficulties in obtaining documentation and payment from third parties and beneficiaries. For example, the third-party insurer may refuse to send a written denial or explanation of benefits, or a beneficiary may be missing or uncooperative. It is your responsibility as a provider to seek a solution to such problems.

"Reasonable effort" consists of taking logical, timely steps at each stage of the billing process. Such steps may include submitting new claims, making follow-up phone calls, and sending additional requested information. Many resources are available to help you pursue third-party payments. The PSC can work with you to explore these options.

Reasonable Effort and Insurance Companies

Below is a suggested process for filing to insurance companies. A flowchart based on this process can be found at the end of this supplement.

A. Send a claim to the insurance company.

If after **thirty days** you have received no response:

B. Call the company's customer service department to determine the status of the claim.

- **If the company has not received the claim:**
  1. Refile the claim. Stamp the claim as a repeat submission or send a cover note.
  2. Repeat follow-up steps as needed.
- **If the company has received the claim but considers the billing insufficient:**
  1. Supply all additional information requested by the company.
  2. Confirm that all requested information has been submitted.

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3. Allow thirty more days for the claim to be processed.
4. If there is no response within thirty days and all information has been supplied as requested, proceed as instructed below.

- **If the company has received the claim, considers the billing valid, and has not suspended the claim:**
  1. Make a note in your files.
  2. Follow up with a written request for a response.

C. If after two more weeks you have still received no response:

1. Write to the company citing this history of difficulties. Copy the South Carolina Department of Insurance Consumer Division on your letter.

Remember, difficulties with insurance companies do not exempt you from timely filing requirements. It is important that you file a claim as soon as possible after providing a service so that, should you encounter any difficulty, you have time to pursue the steps described above.

Once the Department of Insurance has resolved an issue (which usually takes about 90 days), you should have adequate information to bill Medicaid correctly. Following all the steps above should take no more than 180 days, well within the Medicaid timely filing limit of one year.

Reasonable Effort and Beneficiaries

Difficulties can arise when a beneficiary does not cooperate with an insurer's request for information. For example, U.S. military beneficiaries must report changes in their status and eligibility to the Defense Eligibility and Enrollment Reporting System (DEERS); a delay by a beneficiary may delay a provider's response from the insurer. An insurer may also need a beneficiary to send in subrogation forms related to a hospitalization.

It is in your interest to contact the beneficiary, whether by phone, certified letter, or otherwise. You may offer to help the beneficiary understand and fill out forms. Be sure to document all your attempts at contact and inform the insurer of such actions.

Occasionally insurers will pay a beneficiary instead of a provider. If you know an insurance payment will be made to a patient, you should consider having the patient sign an agreement indicating that the total payment will be turned over to the provider, and that failure to cooperate with the agreement will result in the beneficiary no longer being accepted as a Medicaid patient.

Reasonable Effort Documentation Form

In cases where you have made all reasonable efforts to resolve a situation, you can submit a Reasonable Effort Documentation form. The form must demonstrate that you have made sustained efforts to contact the insurance company or beneficiary. This document is used only as a last resort, when all other attempts at contact and payment collection have failed.

Attach the form to a claim filed as a denial. Attach copies of all documents that demonstrate your efforts (correspondence with the insurer and the Department of Insurance, notes from your files, etc.). If you are filing electronically, you must keep the Reasonable Effort Documentation form

and all supporting documentation on file. A blank Reasonable Effort Documentation form can be found in the Forms section of your provider manual, and examples appear at the end of this supplement.

REPORTING TPL INFORMATION ON CLAIMS

When you file a claim that includes TPL information, you will report up to five pieces of TPL information, depending on the type of claim:

For each insurer:

1. The carrier code
2. The insured's policy number
3. A payment amount or "0.00"

For the whole claim:

4. A denial indicator when at least one payer has not made payment
5. The total of all payments by other insurers

Carrier Codes

Medicaid, in conjunction with the South Carolina Hospital Association (SCHA), assigns every third-party insurer a unique three-digit alphanumeric code. Among the SCHA carrier codes are a few five-digit codes created by SCDHHS to satisfy carrier-specific claim filing requirements; these are identified by the suffix RX (pharmacy plans). SCHA carrier codes are used to identify insurers and other payers (including the Medicare Advantage plans) on dental, professional, and institutional claims. A complete list of carrier codes can be found in Appendix 2 of those provider manuals.

SCDHHS maintains an entirely separate list of five-digit carrier codes for pharmacy claims submission. Providers should visit http://southcarolina.fhsc.com or the SCDHHS Provider Information page at http://provider.scdhhs.gov/ to view the pharmacy carrier codes list.

With very few exceptions, the alphanumeric carrier codes assigned by the SCHA are three digits, alpha-numeric-alpha. However, if you file hard copy, you may want to indicate a zero as Ø to ensure it is keyed correctly.

If you cannot find a particular carrier or carrier code in your manual, please visit the SCDHHS Provider Information page at http://provider.scdhhs.gov/ to view the most current carrier codes list.

If you are billing a company for which you cannot find a code, you may use 199, the generic carrier code. MIVS will then call you to ask about the new insurer. You may prefer to submit a Health Insurance Information Referral Form to MIVS while you have the carrier information easily accessible, as MIVS may call you up to one month after the claim has been processed.

You may encounter the "CAS" carrier code when checking a beneficiary's eligibility. This code represents an open casualty case. Medicaid does not cost avoid claims with casualty coverage. You may decide to bill Medicaid directly and forgo participation in the case, or you may take

action with the liable party and not bill Medicaid. Timely filing requirements still apply even where there is a possible casualty settlement, so you must make your decision prior to the one-year Medicaid timely filing deadline.

Policy Numbers

Many insurance companies use Social Security numbers (SSNs) as policy numbers, but some are transitioning to policy numbers that do not rely on confidential information. You should use the number that appears on the beneficiary's health insurance card.

SCDHHS has begun adding these new policy numbers to beneficiary records. If one of your claims is rejected for failure to file to a private insurer (edit 150) and you have already filed to that insurer, there may be a policy number discrepancy; you should code the claim with the beneficiary's SSN. Edit codes and rejected claims are discussed in more detail below.

PHARMACY CLAIMS

TPL policies apply to all Medicaid services. Like other providers, pharmacists must bill all other potentially liable parties, including Medicare, before billing Medicaid. However, pharmacists' billing procedures differ from those of other providers. Pharmacists do not use the carrier codes assigned by the SCHA; South Carolina Healthy Connections (Medicaid) maintains separate carrier codes for pharmacy claims submission. Providers should visit the SCDHHS Provider Information page at http://provider.scdhhs.gov for pharmacy carrier codes. These unique codes may also be found at http://southcarolina.fhsc.com.

Pharmacists receive two-character NCPDP edit codes rather than South Carolina Healthy Connections (Medicaid) edit codes. Code 41 indicates that you need to file to a third-party payer, to include Medicare Parts B and D, if applicable.

Pharmacy services are generally cost-avoided; however, SCDHHS performs Pay & Chase billing for insurance resources that are Child Support Enforcement-ordered and in situations where the insurance company will not pay the Medicaid-assigned claim and instead makes payment to the subscriber. Pharmacists who file to primary plans but do not receive the insurance payment should report that fact to MIVS or SCDHHS so that Pay & Chase may be implemented instead of cost avoidance.

The point-of-sale contractor's Pharmacy Provider Manual contains complete instructions on how to submit TPL information on Medicaid claims.

NURSING FACILITY CLAIMS

Nursing facilities are required to follow Medicaid's TPL policies by billing other liable parties before billing Medicaid. The nursing facility claim form, the Turn Around Document, does not provide fields for coding TPL information. In order to have TPL payments calculated, you will report TPL payments and denials on a Health Insurance Information Referral Form and/or submit the insurance EOB with a new DHHS Form 181.

If you discover third-party coverage that Medicaid does not yet have on file, bill the third party and send a Health Insurance Information Referral Form to MIVS so that the insurance record

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may be put online. If Medicaid has already paid, you are responsible for refunding the insurance payment. Failure to report insurance that will likely be subsequently discovered may result in the claim being put into benefit recovery and recouped in a recovery cycle (see the section on recovery for more information).

To initiate Medicaid billing for a resident also covered by a third-party payer, submit a claim to Medicaid and receive a rejection (edit code 156 for commercial insurance) for having failed to file with the other liable third parties. This establishes your willingness to accept a resident as a Medicaid beneficiary. It also shows that you intend to adhere to Medicaid's timely filing requirements.

When you receive a rejected claim, attach all EOBs and submit a new DHHS Form 181 to the Medicaid Claims Control System (MCCS); they will route it to the Medicaid TPL department for processing. If you are subsequently paid by a third party, use Form 205 to refund part or all of your Medicaid payment. Mark "health insurance" as the reason for the refund, supply the insurance information, and attach a check for the amount being refunded.

Remember that claims in recovery have timely filing requirements. SCDHHS suggests that as soon as you receive a 156 edit and/or discover that a resident has third-party coverage, you check your records and bill the third party for previous claims for the current calendar year and for one year prior for which Medicaid should not have paid primary. If you wait for the next recovery cycle, you may run into timely filing deadlines. All previously paid claims that were not filed with the insurance company or third parties are subject to recovery by Medicaid.

Should MIVS mail you a letter of recovery, make sure you follow all procedures and timelines as required. The PSC will be able to assist you in completing all requirements from MIVS in order to avoid a take-back or to reverse a previous take-back.

If you have any other questions or concerns about third-party liability issues, call the PSC. Because nursing home billing cycles are often longer than those of other providers, it is essential that you contact SCDHHS early in the TPL billing process, before timely filing requirements become a concern.

The Nursing Facility Services Provider Manual contains complete billing instructions for nursing facilities. Please see also the following sections of this supplement: Eligibility Verification, Reporting TPL Information to Medicaid, Cost Avoidance vs. Pay & Chase, Timely Filing Requirements, and Reasonable Effort.

PROFESSIONAL, INSTITUTIONAL, AND DENTAL CLAIMS

The CMS-1500 and UB-04 claim forms have space to report two payers other than Medicaid. If there are three or more insurers, you will need to code your claim with the payers listed that pay primary and secondary. When your claim receives edit 151, you must submit a new claim and write in the carrier code, policy number, and amount paid in the third occurrences of fields 24, 25, and 26 of the CMS-1500, Claims submitted electronically will be processed automatically with up to ten primary payers.

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Professional Paper Claims

The CMS-1500 has two areas for entering other insurers: block 9 (fields 9a, 9c, and 9d) and block 11 (fields 11, 11b, and 11c). If there is only one primary insurer, you can use either block. If there are two insurers, use both blocks.

CMS-1500 TPL Fields

9a Other Insured's Policy or Group Number Enter the policy number.	**11 Insured's Policy Group or FECA Number** Enter the policy number.
9c Reserved for NUCC Use If the insurance has paid, indicate the amount paid in this field. If the insurance has denied payment, enter "0.00" in this field.	**11b Other Claim ID (Designated by NUCC)** If the insurance has paid, indicate the amount paid in this field. If the insurance has denied payment, enter "0.00" in this field.
9d Insurance Plan Name or Program Name Enter the three-character carrier code.	**11c Insurance Plan Name or Program Name** Enter the three-character carrier code.

10d Claim Codes (Designated by NUCC) Enter the appropriate TPL indicator for this claim.

The valid TPL indicators are:

- **1** Insurance denied
- **6** Crime victim
- **8** Uncooperative beneficiary

If either insurer denied payment, you will put the TPL indicator "1" in field 10d. "6" is used to alert SCDHHS to potential criminal proceedings and restitution. "8" is used in conjunction with the Reasonable Effort Documentation form to show that you have been unable to contact a beneficiary from whom you need information and/or payment.

29 Amount Paid Enter the total amount paid from all insurance sources. This amount is the sum of 9c and 11b.

Complete instructions for filling out CMS-1500 claim forms can be found in Section 3 of provider manuals for professional services. Sample CMS-1500s with TPL information appear at the end of this supplement.

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Institutional Paper Claims

Unlike other claim types, the UB claim form has a section for listing all parties being billed, **including Medicaid**. Medicaid's carrier code, 619, must be entered on all UB claims submitted to Medicaid.

Fields 50, 54, and 60 are the main fields for coding TPL information.

- Identify all other payers, with the primary payer on line A.
- For each payer other than Medicaid, enter the three-digit carrier code in field 50 and the corresponding payment in field 54.
- For denials, enter the carrier code in field 50 and "0.00" in field 54. Then, enter occurrence code 24 and the date of denial in item 31, 32, 33, or 34.
- You are not required to enter a provider number for payers other than Medicaid, though doing so will not affect your claim.
- Enter Medicaid (619) on line B or C. Leave field 54 of the Medicaid line blank; there will never be a prior payment.
- Enter the patient's 10-digit Medicaid ID number on the lettered line (A, B, or C) that corresponds to the Medicaid line in fields 50 – 54. Enter the other policy numbers on the same lettered line as the code and payment for that carrier.

UB-04 TPL Fields

	50 PAYER	51 PROVIDER NO	54 PRIOR PAYMENTS
A	618/620 (Medicare carrier code)		$33.01
B	401 (BCBS carrier code)		$255.39
C	619 (Medicaid carrier code)		

60 CERT.-SSN-HIC.-ID NO.
ABQ1111222
123456789-1212
1234567890

If one claim spans multiple claim forms, fields 50, 51, and 54 must be completed in exactly the same way on each page of the claim.

Complete instructions for filling out UB claim forms can be found in the Hospital Services and Psychiatric Hospital Services provider manuals, and a sample UB-04 with TPL information appears at the end of this supplement.

Dental Paper Claims

For samples and complete instructions for filling out the ADA and CMS-1500 claim forms, refer to the DentaQuest Dental Office Reference Manual (ORM) at http://www.DentaQuest.com

THIRD-PARTY LIABILITY SUPPLEMENT

Web-Submitted Claims

The Web Tool User Guide contains instructions for entering TPL information for all claim types except Dental using the Web Tool. The basic steps are the same as for paper claims.

REJECTED CLAIMS

If you file a claim to Medicaid for which you should have first billed a third-party insurer, your claim will be rejected unless 1) the policy has not yet been uploaded to the MMIS, or 2) the service is in Pay & Chase. The Eligibility section on the Web Tool will supply information you need to file with the third-party payer.

Insurance Edits

There are six edit codes indicating that a claim has not been filed to other insurers:

- 150: TPL coverage verified/filing not indicated on claim
- 151: Multiple insurance policies/not all filed – call TPL
- 155: Possible, not positive, insurance match/other errors
- 156: TPL verified/filing not indicated on claim
- 157: TPL coverage; no amount other sources on claim
- 953: Buy-in indicated – possible Medicare payer

If you receive one of these edit codes and have not filed a claim with all third parties listed under the Eligibility section on the Web Tool, you must do so. **Whenever you receive one of these edits, your subsequent attempts to obtain Medicaid payment must have at least one TPL carrier code and policy number even when there is no primary payment.** If a policy has lapsed by the time a claim is processed, SCDHHS will be unable to correctly identify the claim as TPL-related unless you enter the TPL information on a new claim.

The insurance carrier code, the policy number, and the name of the policyholder are all listed under the Eligibility section on the Web Tool, while the carrier's address and telephone number may be found in Appendix 2 of your provider manual or on the SCDHHS Web site. Because of timely filing requirements, you should file with the primary insurer as soon as possible.

If you have already filed a claim with all third parties listed on the Web Tool, check to see that all the information you entered is correct. Compare the carrier code and policy number you entered on the rejected claim and submit a new claim. You must re-enter all TPL information when filing a new claim.

Other TPL-related edit codes include:

165: TPL balance due/patient responsibility must be present and numeric

316: Third party code invalid

317: Invalid injury code

390: TPL payment amount not numeric

400: TPL carrier and policy number must both be present

THIRD-PARTY LIABILITY SUPPLEMENT

401: Amount in other sources, but no TPL carrier code

555: TPL payment is greater than payment due from Medicaid

557: Carrier payments must equal payments from other sources

565: Third-party payment, but no third-party ID

690: Amount from other sources more than Medicaid amount

732: Payer ID number not on file

733: Insurance information coded, but payment or denial indicator missing

953: Buy-in indicated on CIS – possible Medicare

Resolution instructions for these edit codes can be found in Appendix 1 of your provider manual.

CLAIM ADJUSTMENTS AND REFUNDS

If you are paid by a third-party insurer after you have been paid by Medicaid, you should initiate a claim adjustment if you wish to refund the original paid claim in full. You must use the Void/Replacement rather than the Void Only option. Unless there is a replacement claim, new TPL information will not be available to MIVS for investigation and addition to the policy file in the MMIS.

If the refund is for an amount less than the original Medicaid payment, contact MIVS for a manual TPL debit or send a refund check for the appropriate amount. Complete instructions for filing adjustments are in Section 3 of your provider manual, and sample Adjustment Form 130s appear at the end of this supplement. Please remember that hospital providers, pharmacists, and nursing facilities do not use the Form 130.

If you submit a refund to SCDHHS and subsequently discover that it was in error, SCDHHS must receive your credit adjustment request within 90 days of the refund.

Remember: you should not send a check when you make a claim-level adjustment. However, if you need to send a reimbursement check for any reason, fill out the Form for Medicaid Refunds (Form 205 – see the Forms section of your provider manual) and send it with the check to the following address:

South Carolina Healthy Connections
Cash Receipts
PO Box 8355
Columbia, SC 29202

RECOVERY

"Recovery" refers to all situations where Medicaid or the provider pursues third parties who are liable for claims that Medicaid has already paid. Recovery categories include Retro Medicare, Retro Health, and Pay & Chase.

MIVS is responsible for mailing recovery invoices and posting benefit recovery responses. If you have questions about recovery, please contact them directly. See the contact list at the end of the supplement.

THIRD-PARTY LIABILITY SUPPLEMENT

Retro Medicare

SCDHHS invoices institutional and professional medical providers at the beginning of each month for retroactive Medicare coverage (Retro Medicare). You will receive a letter indicating that your account will be debited. The letter identifies Medicare-eligible beneficiaries, claim control numbers, and dates of service, as well as the check date of the automated adjustment and an "own reference number" to identify the debit(s).

You are expected to file the affected claims to Medicare within 30 days of the invoice. After filing to Medicare, you have the option of filing a claim to Medicaid for consideration of an additional payment toward the coinsurance and deductible. Requests for reconsideration of the debit must be received within 90 days of the debit.

If Medicare has denied, you may submit a claim to Medicaid. Provider adjustments will not be submitted for payment in order to eliminate the possibility of duplicate payments. Certain claims for patients with Medicare Part B only, when it is impossible to file them within the one-year timely filing limit, may be an exception.

Despite the extended timely filing deadlines for Medicare-primary claims (six months from Medicare payment or two years from the date of service), you may encounter difficulties with timely filing when Medicare does not make a payment and a claim is in Retro Medicare. If a claim sent to Medicaid is denied with edit 510 for being more than one year after the date of service or six months after the Medicare remittance date, mail, or fax the rejected claim, with supporting documentation to MIVS. If the patient is Part B-only and a UB claim form has received edit 510, the rejected claim, with supporting documentation, should be forwarded or faxed to MIVS. If MIVS determines that the late filing is valid, they will make a credit adjustment.

Claims pulled into Retro Medicare, when filed within 30 days should meet Medicare one year timely filing rule.

Please note that the computer logic also reviews the procedures on the claims and does not pull into recovery procedure codes that are not Medicare covered.

South Carolina Healthy Connections (Medicaid) is responsible for attempting to recover all claims that can be filed within timely filing limits.

Retro Health and Pay & Chase

SCDHHS invoices institutional providers each month for Retro Health and Pay & Chase claims. Providers are expected to file the claims to the primary medical plan within the month of the invoice and to respond to the recovery letter upon receiving the primary adjudication.

One month after the first recovery letter, providers are notified of any claims for which there has been no response. Three months after the first invoice, claims for which there was no response are automatically debited. Requests for reconsideration of the debit must be received within 90 days of the debit. SCDHHS will not reconsider requests after the nine-month cycle.

THIRD-PARTY LIABILITY SUPPLEMENT

Retro Health Example

January 2018	Initial invoice
February 2018	Second letter
March 2018	Notification: Automated debit on last check date of the month

You should submit claims promptly to the primary carriers to avoid receiving timely filing denials from the primary health plans for cost avoidance and for recovery. If you fail to meet timely filing requirements and thus fail to meet a primary carrier's deadline, this is not an acceptable denial; however, when an insurer's timely filing deadline for a date of service is within approximately six weeks of an invoice in Retro Health or possibly before the Medicaid invoice, SCDHHS will accept the insurer's denial and stop a subsequent debit of the Medicaid paid claim from your account.

Insurers occasionally recoup payments made to providers who have put the insurance payment on a Medicaid secondary claim or who have refunded the Medicaid primary payment under Retro Health or Pay & Chase. When the provider submits proof of return of the primary payment, SCDHHS will consider reinstating payment by manual adjustment when the request is received within 90 days of the primary plan request to the provider.

CONCLUSION

Medicaid's ability to fund health care for low-income people relies in part on the success of its cost avoidance measures. For providers, third-party liability responsibilities can be summarized as follows:

- Bill all other liable parties before billing Medicaid.
- Make reasonable, good-faith efforts to get responses from insurers and beneficiaries.
- Code TPL information correctly on claims.

THIRD-PARTY LIABILITY SUPPLEMENT

TPL RESOURCES

The PSC is your first source for questions about third-party liability. Listed below are some other resources.

Dental Claims: Provider questions about third party liability should be directed to the DentaQuest Call Center at 1-888-307-6553 or via e-mail at denclaims@dentaquest.com.

SCDHHS Web site: http://www.scdhhs.gov

- Carrier codes
- Provider manuals
- Edit codes and resolutions

Provider Enrollment and Education Web site: http://MedicaideLearning.com

- Web Tool User Guide and Addenda

Medicaid Insurance Verification Services

South Carolina Healthy Connections
PO Box 101110
Columbia, SC 29211-9804
Email: MIVS@BCBSSC.com

Main Number	1-888-289-0709 option 5
Other Health Insurance	1-888-289-0709, option 5, option 1 803-252-0870 Fax
Fund Recovery	1-888-289-0709, option 5, option 1 803-462-2582 Fax
General Correspondence	1-888-289-0709, option 5, option 1 803-462-2583 Fax

Casualty, Estate Recovery, and HIPP Correspondence

South Carolina Healthy Connections
PO Box 100127
Columbia, SC 29202-3127

Casualty	1-888-289-0709, option 5, option 2 803-462-2579 Fax
Estate Recovery	1-888-289-0709, option 5, option 3 803-462-2579 Fax

THIRD-PARTY LIABILITY SUPPLEMENT

Health Insurance Premium Payment Project (HIPP)	1-888-289-0709, option 5, option 4 803-462-2580 Fax
Special Needs Trust	1-888-289-0709, option 5, option 5 803-462-2579 Fax

South Carolina Department of Insurance

300 Arbor Lake Drive, Suite 1200
PO Box 100105
Columbia, SC 29223
http://www.doi.sc.gov/

THIRD-PARTY LIABILITY SUPPLEMENT

SAMPLE FORMS

Form
Health Insurance Information Referral Form: Carrier change
Health Insurance Information Referral Form: Coverage ended
Reasonable Effort Documentation Form: Failure to respond – beneficiary
Reasonable Effort Documentation Form: Failure to respond – insurer
Reasonable Effort Flowchart
Adjustment Form 130: Primary insurer paid after the appeal process
Adjustment Form 130: Primary insurer payment received after Medicaid payment
UB-04: Medicare paid; private insurer denied
CMS-1500: Two private insurers; one paid, one denied
CMS-1500: Medicare and private insurer paid

THIRD-PARTY LIABILITY SUPPLEMENT

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID HEALTH INSURANCE INFORMATION REFERRAL FORM

Provider or Department Name: Acme Dental Clinic Provider ID or NPI: 1234560000

Contact Person: Richard Roe Phone #: 803-555-5555 Date: 03/01/10

I ADD INSURANCE FOR A MEDICAID BENEFICIARY WITH NO INSURANCE IN THE MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) – ALLOW 25 DAYS

Beneficiary Name: Jim Smith Date Referral Completed: 02/29/2010

Medicaid ID#: 222222222 Policy Number: AZ99999999999

Insurance Company Name: OmniCorp Insurers Group Number: 390-OP-777777

Insured's Name: N/A Insured SSN: 777-77-0000

Employer's Name/Address: Retired

II CHANGES TO AN INSURANCE RECORD THAT IS IN THE MMIS – MIVS SHALL WORK WITHIN 5 DAYS

_____ a. beneficiary has never been covered by the policy – close insurance.

__X__ b. beneficiary coverage ended - terminate coverage (date) 12/31/2009

_____ c. subscriber coverage lapsed - terminate coverage (date) _____

_____ d. subscriber changed plans under employer - new carrier is _____

- new policy number is _____

_____ e. beneficiary to add to insurance already in MMIS for subscriber or other family member.

(name) _____

ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.

Submit this information to Medicaid Insurance Verification Services (MIVS).

Fax: 803-252-0870 **or** **Mail:** Post Office Box 101110, Columbia, SC 29211-9804

III NEW POLICY NUMBERS FOR INSURANCE IN THE MMIS WITH THE SUBSCRIBER SSN

(SCDHHS is collecting new unique policy numbers and plans to replace existing insurance records through MMIS online modification as computer resources are available.)

Medicaid Beneficiary ID: _____ SSN: _____

Carrier Name/Code: _____ New Unique Policy Number: _____

Submit this information to South Carolina Department of Health and Human Services (SCDHHS).

Fax: 803-255-8225 **or** **Mail:** Post Office Box 8206, Attention TPL, Columbia, SC 29202-8206

DHHS 931 – Updated January 2008

THIRD-PARTY LIABILITY SUPPLEMENT

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID HEALTH INSURANCE INFORMATION REFERRAL FORM

Provider or Department Name: Acme Dental Clinic Provider ID or NPI: 1234560000

Contact Person: Richard Roe Phone #: 803-555-5555 Date: 03/01/2010

I ADD INSURANCE FOR A MEDICAID BENEFICIARY WITH NO INSURANCE IN THE MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) – ALLOW 25 DAYS

Beneficiary Name: John Doe Date Referral Completed: 02/28/2010

Medicaid ID#: 9999999999 Policy Number: DH123456

Insurance Company Name: National Dental Insurance Group Number: QWE1234

Insured's Name: Jane Doe Insured SSN: 123-45-6789

Employer's Name/Address: South Carolina State Library, 1500 Senate Street, Columbia, SC 29201

II CHANGES TO AN INSURANCE RECORD THAT IS IN THE MMIS – MIVS SHALL WORK WITHIN 5 DAYS

____ a. beneficiary has never been covered by the policy – close insurance.

____ b. beneficiary coverage ended - terminate coverage (date) _____

____ c. subscriber coverage lapsed - terminate coverage (date) _____

__X__ d. subscriber changed plans under employer - new carrier is GloboChem

- new policy number is A1111111110

____ e. beneficiary to add to insurance already in MMIS for subscriber or other family member.

(name) _____

ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.

Submit this information to Medicaid Insurance Verification Services (MIVS).

Fax: 803-252-0870 **or** **Mail:** Post Office Box 101110, Columbia, SC 29211-9804

III NEW POLICY NUMBERS FOR INSURANCE IN THE MMIS WITH THE SUBSCRIBER SSN

(SCDHHS is collecting new unique policy numbers and plans to replace existing insurance records through MMIS online modification as computer resources are available.)

Medicaid Beneficiary ID: _____ SSN: _____

Carrier Name/Code: _____ New Unique Policy Number: _____

Submit this information to South Carolina Department of Health and Human Services (SCDHHS).

Fax: 803-255-8225 **or** **Mail:** Post Office Box 8206, Attention TPL, Columbia, SC 29202-8206

DHHS 931 – Updated January 2008

THIRD-PARTY LIABILITY SUPPLEMENT

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
REASONABLE EFFORT DOCUMENTATION

PROVIDER Acme Orthopedic **DOS** 01/01/10

NPI or MEDICAID PROVIDER ID 1234567890

MEDICAID BENEFICIARY NAME Jane Doe

MEDICAID BENEFICIARY ID# 1111111111

INSURANCE COMPANY NAME Jones Health Insurance

POLICYHOLDER Jane Doe

POLICY NUMBER 987654321J

ORIGINAL DATE FILED TO INSURANCE COMPANY 01/15/10

DATE OF FOLLOW UP ACTIVITY 02/16/10

RESULT:
Called insurer to check claim status. Insurer needs bene to fill out subrogation forms

FURTHER ACTION TAKEN:

Called beneficiary on 02/16/10, 02/18/10, and 02/28/10. No answer and no answering machine. No other contact info on file w/ Medicaid or insurer.

DATE OF SECOND FOLLOW UP 03/05/10

RESULT:

Sent certified letter offering to help bene fill out forms. Bene refused letter. Called insurer 8/10/08; they will not act without forms.

I HAVE EXHAUSTED ALL OPTIONS FOR OBTAINING A PAYMENT OR SUFFICIENT RESPONSE FROM THE PRIMARY INSURER.

Mary Orthopod 03/12/10

(SIGNATURE AND DATE)

ATTACH A COPY OF FORM TO A NEW CLAIM AND FORWARD TO YOUR MEDICAID CLAIMS PROCESSING POST OFFICE BOX.

Revised 04/2014

THIRD-PARTY LIABILITY SUPPLEMENT

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
REASONABLE EFFORT DOCUMENTATION

PROVIDER Dr. Betty Smith **DOS** 03/05/10

NPI or MEDICAID PROVIDER ID 1231231230

MEDICAID BENEFICIARY NAME John Jones

MEDICAID BENEFICIARY ID# 9999999999

INSURANCE COMPANY NAME Global Health

POLICYHOLDER John Jones

POLICY NUMBER 8888888888

ORIGINAL DATE FILED TO INSURANCE COMPANY 03/07/10

DATE OF FOLLOW UP ACTIVITY 04/06/10

RESULT:
Called insurer. They received claim and have not suspended it. Sent follow-up letter requesting a response on 04/10/10.

FURTHER ACTION TAKEN:

04/27/10: No response from insurer. Called again; they could not find claim. Resubmitted on 04/29/10.

DATE OF SECOND FOLLOW UP 05/30/10

RESULT:

Called insurer; no action on claim. Notified Dept. of Insurance 05/31/10. Case is still open; Dept. of Ins. advised that we file with Medicaid now, as decision may take some time.

I HAVE EXHAUSTED ALL OPTIONS FOR OBTAINING A PAYMENT OR SUFFICIENT RESPONSE FROM THE PRIMARY INSURER.

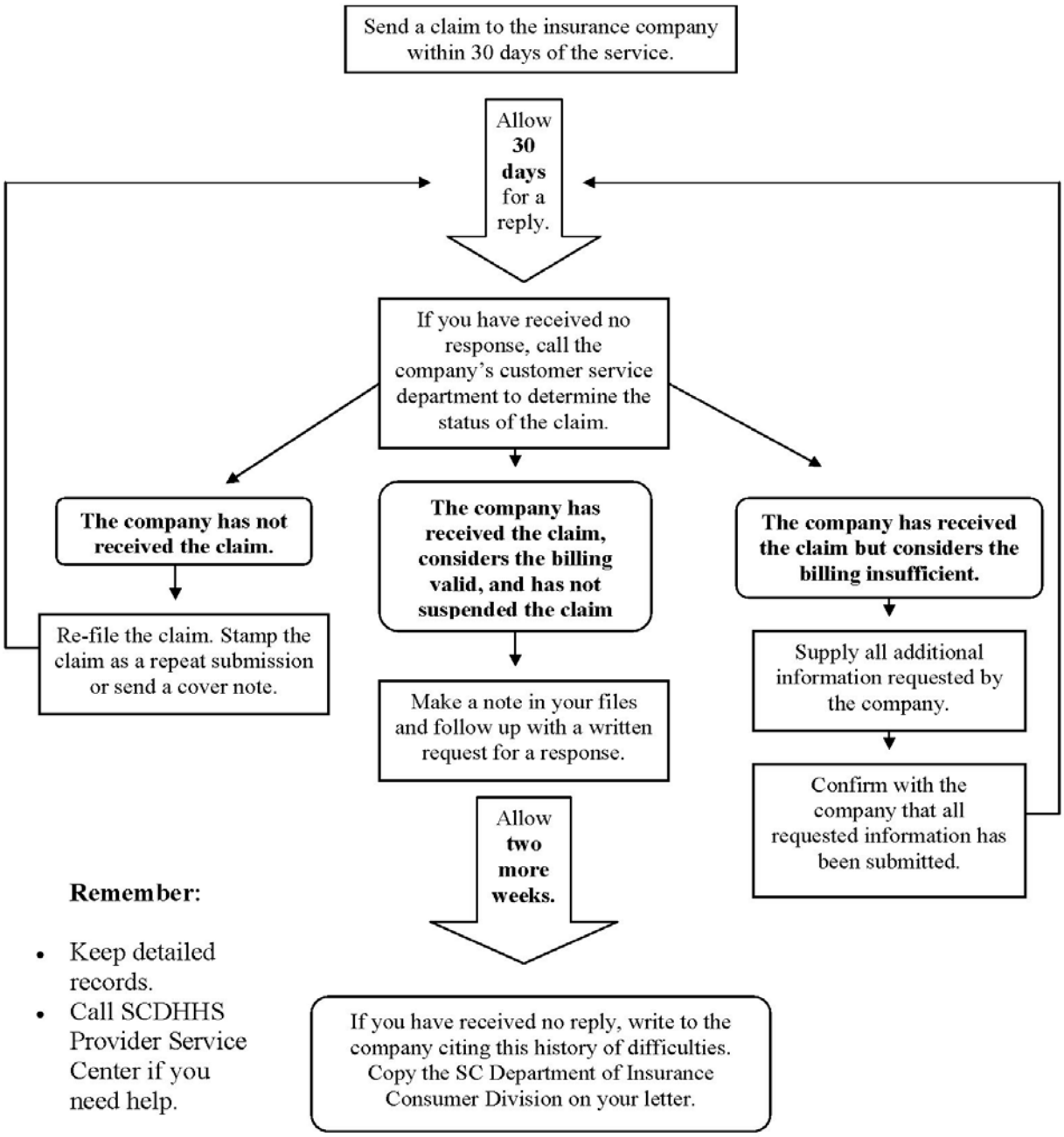
Betty Smith 06/03/10
(SIGNATURE AND DATE)

ATTACH A COPY OF THE FORM TO A NEW CLAIM AND FORWARD TO YOUR MEDICAID CLAIMS PROCESSING POST OFFICE BOX.

Revised 04/2014

THIRD-PARTY LIABILITY SUPPLEMENT

How to Obtain a Response from Insurance Company
A Suggested Third-Party Filing Process



Remember:

- Keep detailed records.
- Call SCDHHS Provider Service Center if you need help.

THIRD-PARTY LIABILITY SUPPLEMENT

South Carolina Department of Health and Human Services - Claim Adjustment Form 130

Provider Name: (Please use black or blue ink when completing form)

Johnson DME Supply

Provider Address :

111 Oak Lane

Provider City , State, Zip:

Anywhere, SC 22222-2222

Total paid amount on the original claim:

$1244.00

Original CCN:

5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 A

Provider ID:

A B C 1 2 3

NPI:

1 2 3 4 5 6 7 8 9 0

Recipient ID:

2 2 2 2 2 2 2 2 2 2

Adjustment Type:

○ Void ● Void/Replace

Originator:

○ DHHS ○ MCCS ● Provider ○ MIVS

Reason For Adjustment: (Fill One Only)

- ● Insurance payment different than original claim
- ○ Keying errors
- ○ Incorrect recipient billed
- ○ Voluntary provider refund due to health insurance
- ○ Voluntary provider refund due to casualty
- ○ Voluntary provider refund due to Medicare
- ○ Medicaid paid twice - void only
- ○ Incorrect provider paid
- ○ Incorrect dates of service paid
- ○ Provider filing error
- ○ Medicare adjusted the claim
- ○ Other

For Agency Use Only

Analyst ID:

- ○ Hospital/Office Visit included in Surgical Package
- ○ Independent lab should be paid for service
- ○ Assistant surgeon paid as primary surgeon
- ○ Multiple surgery claims submitted for the same DOS
- ○ MMIS claims processing error
- ○ Rate change
- ○ Web Tool error
- ○ Reference File error
- ○ MCCS processing error
- ○ Claim review by Appeals

Comments:

Primary insurer paid after the appeal process.

Signature: Jane Doe Date: 04/01/10

Phone: (555) 555-5555

DHHS Form 130 Revision date: 03-13-2007

THIRD-PARTY LIABILITY SUPPLEMENT

South Carolina Department of Health and Human Services - Claim Adjustment Form 130

Provider Name: (Please use black or blue ink when completing form)

Dr. Joe Jones

Provider Address :

123 Main Street

Provider City , State, Zip:

Somewhere, SC 22222-0000

Total paid amount on the original claim:

$230

Original CCN: 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 A

Provider ID:

NPI: 9 8 7 6 5 4 3 2 1 0

Recipient ID: 7 7 7 7 7 7 7 7 7 7

Adjustment Type:

○ Void ● Void/Replace

Originator:

○ DHHS ○ MCCS ● Provider ○ MIVS

Reason For Adjustment: (Fill One Only)

- ○ Insurance payment different than original claim
- ○ Keying errors
- ○ Incorrect recipient billed
- ● Voluntary provider refund due to health insurance
- ○ Voluntary provider refund due to casualty
- ○ Voluntary provider refund due to Medicare
- ○ Medicaid paid twice - void only
- ○ Incorrect provider paid
- ○ Incorrect dates of service paid
- ○ Provider filing error
- ○ Medicare adjusted the claim
- ○ Other

For Agency Use Only

Analyst ID:

- ○ Hospital/Office Visit included in Surgical Package
- ○ Independent lab should be paid for service
- ○ Assistant surgeon paid as primary surgeon
- ○ Multiple surgery claims submitted for the same DOS
- ○ MMIS claims processing error
- ○ Rate change
- ○ Web Tool error
- ○ Reference File error
- ○ MCCS processing error
- ○ Claim review by Appeals

Comments:

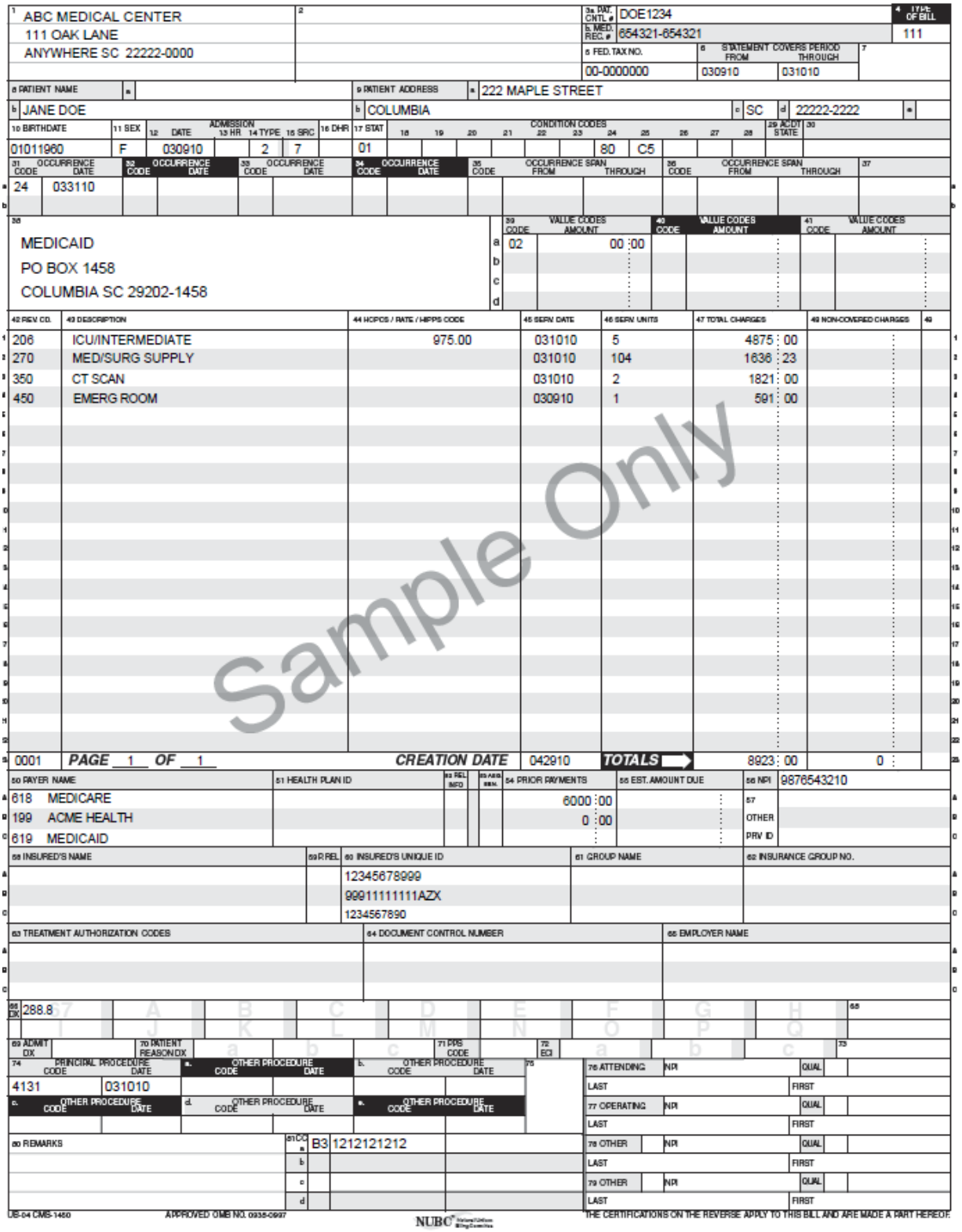
Primary insurance payment received after Medicaid payment.

Signature: *Mary Smith* Date: 04/01/10

Phone: (803) 555-5555

DHHS Form 130 Revision date: 03-13-2007

THIRD-PARTY LIABILITY SUPPLEMENT



1 ABC MEDICAL CENTER
111 OAK LANE
ANYWHERE SC 22222-0000

3a PAT. CNTL # DOE1234
b. MED. REC. # 654321-654321
4 TYPE OF BILL 111
5 FED. TAX NO. 00-0000000
6 STATEMENT COVERS PERIOD FROM 030910 THROUGH 031010

8 PATIENT NAME: JANE DOE
9 PATIENT ADDRESS: 222 MAPLE STREET
b COLUMBIA c SC d 22222-2222

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
01011960	F	030910		2	7		01							80	C5					

	31 OCCURRENCE CODE	31 OCCURRENCE DATE	32 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a	24	033110													
b															

38 MEDICAID
PO BOX 1458
COLUMBIA SC 29202-1458

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	02	00 00				
b						
c						
d						

	42 REV CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	206	ICU/INTERMEDIATE	975.00	031010	5	4875 00		
2	270	MED/SURG SUPPLY		031010	104	1636 23		
3	350	CT SCAN		031010	2	1821 00		
4	450	EMERG ROOM		030910	1	591 00		
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23	0001	PAGE 1 OF 1	CREATION DATE	042910	TOTALS	8923 00	0	

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	9876543210
A	618 MEDICARE				6000 00		57 OTHER	
B	199 ACME HEALTH				0 00		PRV ID	
C	619 MEDICAID							

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A			12345678999		
B			99911111111AZX		
C			1234567890		

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

	66 DX	67	A	B	C	D	E	F	G	H	68
	288.8	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
4131	031010					
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

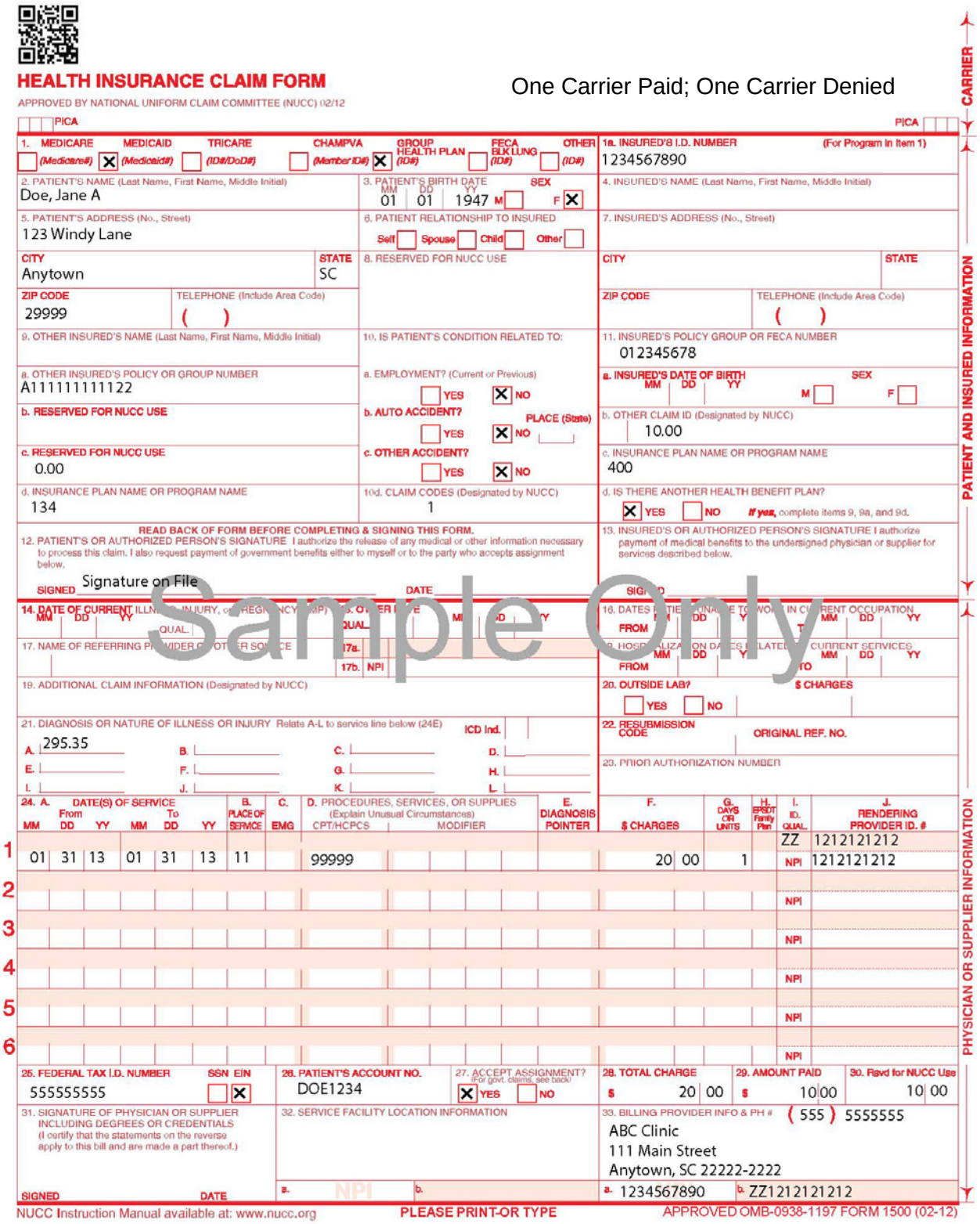
80 REMARKS

81CC		
a	B3	1212121212
b		
c		
d		

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

THIRD-PARTY LIABILITY SUPPLEMENT



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

One Carrier Paid; One Carrier Denied

CARRIER

PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) [X] | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN [X] (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, Jane A

3. PATIENT'S BIRTH DATE MM DD YY: 01 01 1947 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 123 Windy Lane

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown STATE: SC

8. RESERVED FOR NUCC USE

CITY: STATE:

ZIP CODE: 29999 TELEPHONE (Include Area Code): ( )

ZIP CODE: TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 012345678

a. OTHER INSURED'S POLICY OR GROUP NUMBER: A111111111122

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC): 10.00

c. RESERVED FOR NUCC USE: 0.00

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: 400

d. INSURANCE PLAN NAME OR PROGRAM NAME: 134

10d. CLAIM CODES (Designated by NUCC): 1

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on File DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. 295.35 B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01	31	13	01	31	13	11		99999			20 00	1		ZZ	1212121212
															NPI	1212121212
2															NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 555555555

26. PATIENT'S ACCOUNT NO.: DOE1234

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE $ 20 00

29. AMOUNT PAID $ 10 00

30. Rsvd for NUCC Use 10 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (555) 5555555

ABC Clinic
111 Main Street
Anytown, SC 22222-2222

a. 1234567890 b. ZZ1212121212

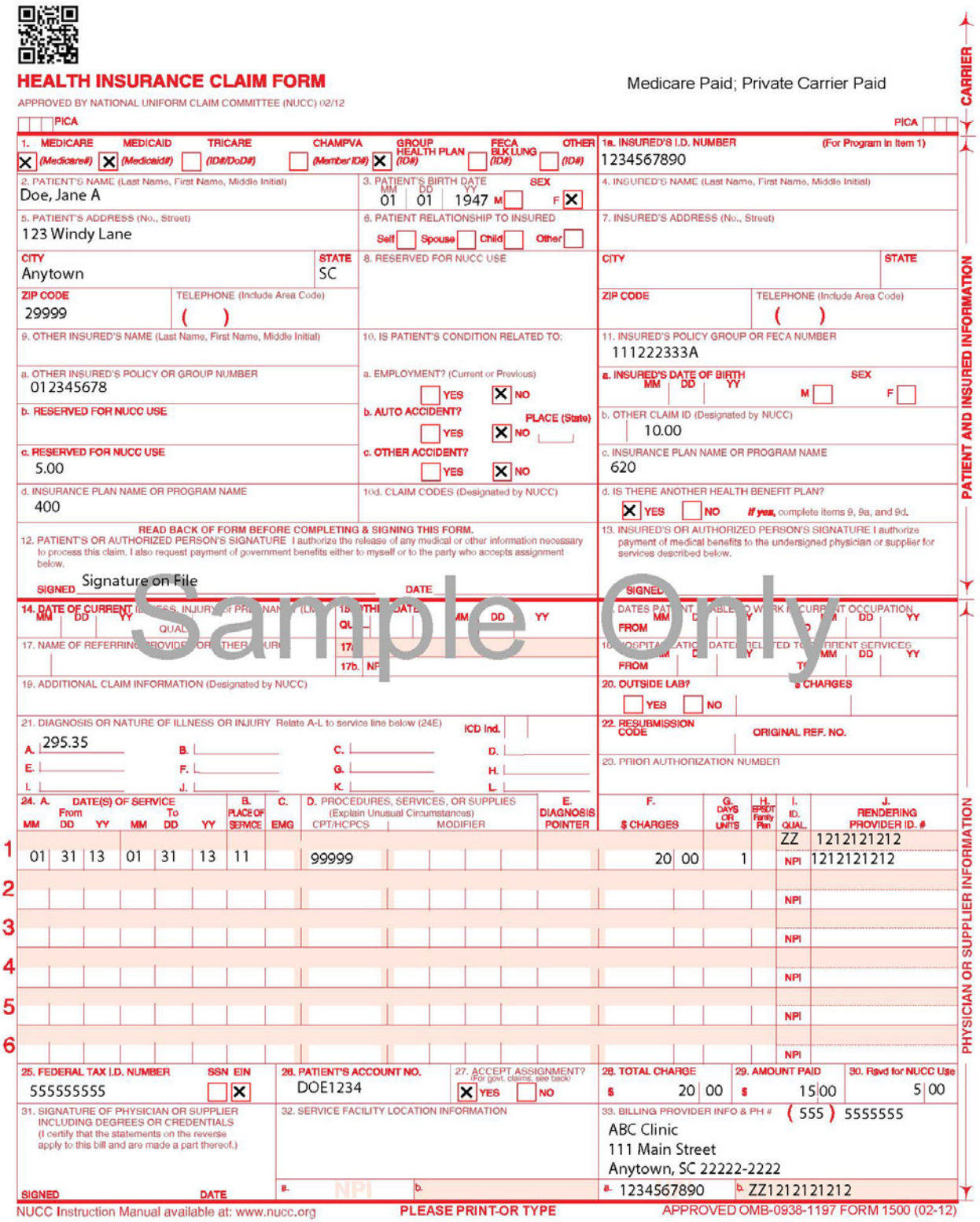
PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Sample Only

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT-OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

THIRD-PARTY LIABILITY SUPPLEMENT



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

Medicare Paid; Private Carrier Paid

PICA

1. MEDICARE [X] (Medicare#) MEDICAID [X] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [X] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, Jane A

3. PATIENT'S BIRTH DATE MM DD YY: 01 01 1947 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 123 Windy Lane

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Anytown STATE: SC

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE: 29999 TELEPHONE (Include Area Code): ( )

ZIP CODE TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 111222333A

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 012345678

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC): 10.00

c. RESERVED FOR NUCC USE: 5.00

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: 620

d. INSURANCE PLAN NAME OR PROGRAM NAME: 400

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on File DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. 295.35 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01	31	13	01	31	13	11		99999			20 00	1		ZZ	1212121212
															NPI	1212121212
2															NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER: 555555555 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: DOE1234

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE $ 20 00

29. AMOUNT PAID $ 15 00

30. Rsvd for NUCC Use 5 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (555) 5555555

ABC Clinic
111 Main Street
Anytown, SC 22222-2222

a. 1234567890 b. ZZ1212121212

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

Sample Only

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THIRD-PARTY LIABILITY SUPPLEMENT

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