Healthy Connections

PROVIDER MANUAL

Rehabilitative Behavioral Health Services

Established July 1, 2010
Updated April 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
Columbia, South Carolina 29202-8206
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MHRC

MEDICAID BULLETIN

TO: **Medicaid Rehabilitative Behavioral Health Services Providers**

SUBJECT: **Medicaid Policy Manual for Rehabilitative Behavioral Health Services**

The South Carolina Department of Health and Human Services is pleased to announce the new Medicaid Rehabilitative Behavioral Health Services Provider Manual. This manual is effective July 1, 2010, and is to be used for program information and requirements, billing procedures, and provider services guidelines. **Providers are urged to carefully review this manual.**

The 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 Rehabilitative Behavioral Health Services.

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 contains procedure codes, fee schedules, and other approval codes and modifiers.

Section 5, **Administrative Services,** contains contact information for SCDHHS state and county offices, contacts for claim form suppliers and vendors, and information about obtaining forms and manuals.

The Forms section includes forms and form samples referenced throughout the manual, as well as some generic forms.

The **appendices** include the following:

- Appendix 1: Edit Codes, CARCs & RARCs, and Resolutions
- Appendix 2: Carrier Codes
- Appendix 3: Schedule of Copayments

The **Third-Party Liability Supplement** explains third-party liability requirements and recommended practices. It includes sample forms and resources.

The **Managed Care Supplement** contains information on the managed care program, including pictures of the cards issued by the various managed care plans.

The most current version of the provider manual is maintained on the SCDHHS Web site at **www.scdhhs.gov**. [On the SCDHHS home page, click on the Provider Manuals link listed under the heading "Providers."] The Web site is updated on the first of every month to reflect any minor non-policy changes to provider manuals (for example, corrections to addresses, etc.).

Note: SCDHHS policy changes continue to be conveyed to providers as they occur via Medicaid bulletin; manuals are revised to reflect those changes as they occur. Providers with access to the Internet should check the SCDHHS Web site monthly to access information about any updates made to the provider manuals.

Should you wish to order a printed copy of the provider manual, please call South Carolina Medicaid Provider Outreach at (803) 264-9609. Charges for printed manuals are based on actual costs of printing and mailing.

To order a compact disk (CD) of the provider manual, please call the Provider Outreach number listed above. There is no charge for a provider manual CD. To access the files on the CD, 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 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 Family Services at 898-2564. Thank you for your continued support of the South Carolina Medicaid program.

/S/
Emma Forkner
Director

EF/mwcj

Enclosure

NOTE: **To receive Medicaid bulletins by e-mail, please register at http://bulletin@scdhhs.gov/**
To sign up for Electronic Funds Transfer of your Medicaid payment, please go to http://www.dhhs.state.sc.us/dhhsnew/hippa/index.asp and select "Electronic Funds Transfer (EFT) for instructions.

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APPENDICES

MANAGED CARE SUPPLEMENT

THIRD-PARTY LIABILITY SUPPLEMENT

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
04-01-19	1	35	Updated Prepayment Reviews
04-01-19	Appendix 1	56	Updated edit codes 906 and 907
03-01-19	Appendix 2	-	Updated carrier codes
12-01-18	Appendix 2	-	Updated carrier codes
11-01-18	Forms	-	Updated Claim Reconsideration Form
11-01-18	Appendix 1	55-56	Updated edit codes 906 and 907
10-01-18	Appendix 1	44, 55-56, 64-65	Updated edit codes 820, 906, 907, and 977
08-10-18	Change Control Record	1 2	• Added entries to 07-01-18 for Medicaid Rehabilitative Staff Qualifications and IPOC Components • Added entry to 03-01-18 for Utilization Management for Private Providers • Updated Forms section change descriptions for dates 01-01-18 and 03-01-18 • Updated Webpage change description for date 03-01-18
08-06-18	1	25	Updated Premium Payment Project
08-06-18	TPL Supplement	17-18	Updated TPL Resources
08-01-18	Appendix 2	-	Updated carrier codes
08-01-18	Managed Care Supplement	-	Updated entire section
07-01-18	2	23 35 59 126	• Updated Eligibility for Rehabilitative Services • Updated Medicaid Rehabilitative Staff Qualifications • Updated IPOC Components • Updated Service Documentation

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Date	Section	Page(s)	Change
07-01-18	3	34 34	• Updated Retro Health Insurance • Updated Retro Medicare
07-01-18	4	3	• Updated Crisis Management
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	23	Updated Eligibility for Rehabilitative Services
05-01-18	Forms	-	Updated Claim Reconsideration Form
05-01-18	Appendix 2	-	Updated carrier codes
04-01-18	2	73	• Updated Staff Qualifications
03-01-18	Change Control Record	11	• Moved entry dated 11-01-14 below entry dated 12-01-14 • Added Appendix 1 entry for date 12-01-14
03-01-18	2	48 130-131 136	• Corrected table header for Utilization Management for Private Providers • Updated Purpose, Peer Support Services (PSS) • Updated Peer Support Specialist
03-01-18	Forms		Updated the following forms to replace the SCDHHS letterhead: • Fax Cover Sheet for RBHS Exception • Request for Rehabilitative Behavioral Health Services Limit Exception • Rehabilitative Behavioral Health Services (RBHS) Referral Form • Community Integration Services Provider Credentialing Request • Therapeutic Childcare Center Credentialing Request

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Date	Section	Page(s)	Change
03-01-18	Webpage	-	Updated the following forms to replace the SCDHHS letterhead: • Fax Cover Sheet for RBHS Exception • Request for Rehabilitative Behavioral Health Services Limit Exception • Rehabilitative Behavioral Health Services (RBHS) Referral Form
02-01-18	Forms	-	Updated Health Insurance Information Referral Form (DHHS Form 931)
02-01-18	Appendix 2	-	Updated carrier codes
01-01-18	Forms	-	Updated the following forms to replace the SCDHHS letterhead: • Fax Cover Sheet for RBHS Exception • Request for Rehabilitative Behavioral Health Services Limit Exception • Rehabilitative Behavioral Health Services (RBHS) Referral Form • Community Integration Services Provider Credentialing Request • Therapeutic Childcare Center Credentialing Request
12-01-17	Forms	-	Updated Claim Reconsideration Form
11-01-17	Appendix 2	-	Updated carrier 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
08-01-17	5	4	Corrected formatting
08-01-17	Appendix 2	-	Updated carrier codes
07-01-17	Forms	-	Updated the following forms to replace the letterhead/logo:

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Date	Section	Page(s)	Change
			• Fax Cover Sheet for RBHS Exception • Request for Rehabilitative Behavioral Health Services Limit Exception • Rehabilitative Behavioral Health Services (RBHS) Referral Form • Community Integration Services Provider Credentialing Request • Therapeutic Childcare Center Credentialing Request
06-01-17	Forms	-	Updated Claim Reconsideration Form
06-01-17	Appendix 2	-	Updated carrier codes
05-01-17	Appendix 1	-	Updated Provider Service Center Hours of Operation
04-01-17	Forms	-	Updated the following forms to replace the letterhead/logo: • Fax Cover Sheet for RBHS Exception • Request for Rehabilitative Behavioral Health Services Limit Exception • Rehabilitative Behavioral Health Services (RBHS) Referral Form • Accreditation Crosswalk for Rehabilitative Behavioral Health Services • Accreditation for Rehabilitative Behavioral Health Services • Program Changes for Rehabilitative Behavioral Health Services • Voluntary Termination Notification for Rehabilitative Behavioral Health Services • Rehabilitative Behavioral Health Services (RBHS) Parent/Caregiver/Guardian Agreement to Participate in Community Support Service • Rehabilitative Behavioral Health Services (RBHS) Parent/Caregiver/Guardian Agreement to Participate in Community Support Service - Spanish • Community Integration Services Provider

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Date	Section	Page(s)	Change
			Credentialing Request • Therapeutic Childcare Center Credentialing Request
03-01-17	Forms	-	Updated Claim Reconsideration Form
02-01-17	Appendix 2	-	Updated carrier codes
01-01-17	4	2-3 8-9	• Updated Core Treatment and Psychotherapy Services • Updated Assessment, Psychotherapy, and Support Services
12-01-16	2	49	Updated Billable Code/Location of Service
12-01-16	3	7 8 16	• Updated Diagnostic Codes • Updated Place of Service Key • Updated CMS-1500 Instructions, field 24D
12-01-16	Forms	-	Updated Claim Reconsideration Form
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	7	• Updated Enrollment Application for Organizations
09-01-16	2	111 117	• Updated Behavior Modification (B-MOD), Service Documentation • Updated Family Support (FS) (0-21), Service Documentation
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

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Date	Section	Page(s)	Change
08-01-16	2	37 46	Updated Staff Monitoring/ Supervision Staff Updated Clinical Service Notes
08-01-16	4	8	Updated MCO Frequency Limits for procedure code 90837
08-01-16	Appendix 1	22, 23, 66	Updated edit codes 527, 532, and 965
07-01-16	2	3 12-20 25-48 51-54 64-77 81-93 96-112 113-158	Updated the following sections: • Rehabilitative Services • Provider Qualifications • Eligibility For Rehabilitative Services • Documentation Requirements • Billing Requirements • Core Rehabilitative Service Standards • Core Treatment – Psychotherapy and Counseling Services • Community Support Services
07-01-16	4	1-5	Updated the Procedure Codes Table
07-01-16	Forms	-	Updated the following documents/forms: • Accreditation Crosswalk • Rehabilitative Behavioral Health Services (RBHS) Parent/Caregiver/Guardian Agreement to Participate in Community Support Service • Rehabilitative Behavioral Health Services (RBHS) Referral Form • RBHS Limit Exception Request Form
07-01-16	Appendix 1	3, 65	Updated edit codes 062 and 974
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	2	27, 29	Updated Eligibility for Rehabilitative Services section.

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Date	Section	Page(s)	Change
05-01-16	Forms	-	Added the following forms: • Community Integration Services Provider Credentialing Request • Therapeutic Childcare Center Credentialing Request
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	13-14 27, 28 32, 33 34 36-40 47 78	Updated the following sections: • Maintenance of Staff Credentials • Documenting Medical Necessity for Community Support Services • Utilization Management for Private Providers • Service Limit Exception Process • Medicaid Rehabilitative Staff Qualifications • Documentation Requirements • Staff Qualifications
04-01-16	Forms	-	• Added Rehabilitative Behavioral Health Services (RBHS) Parent/Caregiver/Guardian Agreement to Participate in Community Support Service – Spanish
04-01-16	Managed Care Supplement	18-19	Replaced sample MCO cards
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 – 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

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Date	Section	Page(s)	Change
			• Appeals
02-01-16	2	25 31 38 113-114 119-120 127-128	Updated the following sections: • Documenting Medical Necessity for Community Support Services • Utilization Management For Private Providers • Medicaid Rehabilitative Staff Qualifications, Licensed Practical Nurse (LPN) • PRD, Same Day Service Restrictions (formerly Special Restrictions Related to Other Services) • B- Mod, Same Day Service Restrictions (formerly Special Restrictions Related to Other Services) • FS, Same Day Service Restrictions (formerly Special Restrictions Related to Other Services)
01-01-16	1	19	Updated to reflect Medicaid Bulletin dated December 9, 2015 - Charge Limits
01-01-16	2	23-46 47-52 57-59 62 72 72 71-84 85-100 101-132 133-180	• Updated the following sections: o Eligibility for Rehabilitative Services, Medical Necessity – entire section o Documentation Requirements – entire section o Non-Billable Medicaid Activities o IPOC Components o 90-Day Progress Summaries o Discharge/Transition Criteria o Core Rehabilitative Service Standards – entire section o Core Treatment – Psychotherapy and Counseling Services – entire section o Community Support Services – entire section o Substance Use Disorder Treatment Services
01-01-16	4	1-3 5-10	Updated the following sections: • Procedure Codes Table • DAODAS Only Procedure Codes
01-01-16	Forms	-	• Added Rehabilitative Behavioral Health Services (RBHS) Parent/Caregiver/Guardian

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Date	Section	Page(s)	Change
			Agreement to Participate in Community Support Service • Revised the Rehabilitative Behavioral Health Services (RBHS) Referral Form
01-01-16	Appendix 1	21	Added edit code 527
12-01-15	Cover	-	December 1, 2015 - Replaced manual cover
11-01-15	2	5-6 9 14-15 15 15-16 19 19 19-20 1-2 2-3 6-8 9 9-10 11-14 16-17 17-18 20 20-21 35	• Added the following sections: o Accreditation o Location/Zoning Requirements o Licensed Professionals o Training o Reporting Business Changes o Third-Party Liability o Maintenance of Fiscal and Medical Records o Quality Improvement and Monitoring • Updated the following sections: o Rehabilitative Services Overview o Rehabilitative Services o Enrollment Application for Organizations o Facility Qualifications (formerly Facility Requirements) o Business Requirements o Maintenance of Staff Credentials o Reporting Program Changes (formerly Reporting Changes) o Provider Termination (formerly Business Termination Guidelines) o Managed Care Organization o Quality Improvement Agent (QIO) Authorization o Medicaid Rehabilitative Staff Qualifications
11-01-15	Forms		Added the following forms: • Accreditation Crosswalk for Rehabilitative Behavioral Health Services • Accreditation for Rehabilitative Behavioral Health Services • Program Changes for Rehabilitative Behavioral Health Services

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Date	Section	Page(s)	Change
			• Voluntary Termination Notification for Rehabilitative Behavioral Health Services Deleted the following forms: • Sample Attestation Statement • Rehabilitative Services – Program Update
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	87	• Updated Admission Criteria for Children and Adolescents (ages 0-21)
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	2	 86,87 91 97	• Updated the following sections to reflect Medicaid Bulletin dated June 1, 2015 - ICD-10 Clinical Modification/ Procedure Coding System: o Eligibility for Rehabilitative Services o Admission Criteria for Children and Adolescents (ages 0-21) o Admission Criteria for Children and Adolescents (ages 0-21)
09-01-15	3	 6-7 14 22	• Updated the following sections to reflect Medicaid Bulletin dated June 1, 2015 — ICD-10 Clinical Modification/ Procedure Coding System: o Diagnostic Codes o CMS-1500 Claim From Completion Instructions, field 21 • Updated SC Medicaid Web-based Claims

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Date	Section	Page(s)	Change
			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	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
07-01-15	2	10	Corrected spelling for PRS services
07-01-15	Appendix 3	1-2	Updated Copayment Schedule
06-01-15	3	6-7	Updated Diagnostic Codes
05-01-15	2	10 13-37 38-58 60-71 73-86 91-111 118-159	Updated the following sections: • Provider Qualifications • Eligibility for Rehabilitative Services • Documentation Requirements • Core Rehabilitative Service Standards • Core Treatment – Psychotherapy and Counseling Services • Community Support Services • Substance Abuse Treatment Services
05-01-15	Forms		• Deleted Rehabilitative Behavioral Health Services (RBHS) Independent Third Party Attestation • Updated and renamed Request for Rehabilitative Behavioral Health Services Limit Exception • Added Rehabilitative Behavioral Health Services (RBHS) Referral Form
04-22-15	4	1-4	Updated Procedure Codes Table
04-01-15	Form		Updated the following forms: • Fax Cover Sheet for RBHS Exceptions • Request for RBHS Daily Service Limit Exception
03-19-15	4	1-11	Deleted effective date February 1, 2015 from table

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Date	Section	Page(s)	Change
			headings
03-13-15	3	13 25	• Updated CMS-1500 Claim Form Completion Instructions • Updated SC Medicaid Web-based Claims Submission Tool (Web Tool)
03-13-15	5	1	Updated Correspondence and Inquiries
03-01-15	2	 13-33 34-55 56-70 89-110	Updated the following sections: • Eligibility for Rehabilitative Services • Documentation Requirements • Core Rehabilitative Service Standards • Community Support Services
03-01-15	4	 1-4 5-9	Updated the following sections: • Procedure Codes Table • DAODAS Only Procedure Codes
03-01-15	Forms		Added the following forms: • Rehabilitative Behavioral Health Services (RBHS) Independent Third Party Attestation • Fax Cover Sheet for RBHS Exceptions • Request for RBHS Daily Service Limit Exception
03-01-15	Appendix 2		Updated carrier codes
02-01-15	2	 8 41 49-51	Updated the following sections: • Provider Qualifications • Documentation Requirements • Core Treatment – Psychotherapy and Counseling Services
02-01-15	4	1,2	Updated procedure codes table
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

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Date	Section	Page(s)	Change
12-01-14	2	10	Update the following sections: • Provider Qualifications • Core Treatment – Psychotherapy and Counseling Services
12-01-14	3	3-4 27-28	Added the following policies: • Copayment • Claim Reconsideration
12-01-14	4	5-10	Updated to reflect Medicaid Bulletin - Psychotherapy Frequency Limits in the Rehabilitative Behavioral Health Services (RBHS) manual in the Drug and Alcohol section
12-01-14	Forms		Added Claims 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	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
09-01-14	2	5-11 46-71 94-134	Updated the following sections • Provider Qualifications • Core Treatment – Psychotherapy and Counseling Services • Substance Abuse Treatment Services
09-01-14	4	1 5	• Updated procedure codes table • Updated DAODAS only procedure codes table
08-01-14	1	6	Updated to reflect Medicaid Bulletin dated July 22, 2014 – Coverage of New Screening Services for

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Date	Section	Page(s)	Change
			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	 1-2 3-11 13-30 31-49 52-71 78-89 109	Updated the following sections: • Rehabilitative Services Overview • Provider Qualifications • Eligibility for Rehabilitative Services • Documentation Requirements • Core Treatment-Psychotherapy and Counseling Services • Community Support Services • Substance Abuse Treatment Services
07-01-14	Forms	-	• Removed DHHS Form 254 • Removed Medical Necessity Statement for Rehabilitative Services
07-01-14	Appendix 1	15	Updated resolution for edit code 349, 369, 509
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
05-01-14	General Table of Contents	1	Removed DHHS county office listing
05-01-14	2	 3-9 24 37-45 48-64	Updated the following sections: • Provider Qualifications • Eligibility for Rehabilitative Services • Documentation Requirements • Core Rehabilitative Service Standards
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	Forms		Updated Rehabilitative Services – Program Update

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Date	Section	Page(s)	Change
			Form
05-01-14	Appendix 1	1, 2, 4, 45, 46, 62, 64, 92, 93	Updated the 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	3	1-41 7- 20 21 24-25	• 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	5	10	Updated Horry County address
04-01-14	Forms		• Updated Reasonable Effort Documentation and Duplicate Remittance Advice Request forms • Removed note on CMS-1500 (02/12) version claim form • Removed CMS-1500 (08/05) version claim form (s) • Removed Sample Edit Correction Form • Updated Sample Remittance Advice
04-01-14	Appendix 1	35	• Added edit code 527

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Date	Section	Page(s)	Change
		-	• 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	5 6-8 9-10 10-11 13-14 15-16 22-23 30-31	• Updated the following sections to reflect Medicaid Bulletin dated December 3, 2013 – Discontinuation of Edit Correction Form: 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)
02-01-14	Cover	-	January 1, 2014 - Replaced manual cover
02-01-14	5	9	Updated Florence County office telephone number
01-01-14	1	1, 2, 11 6, 23, 25 1-2 4 6 26 29-30 32 32	Updated to reflect the following bulletins: • Managed Care Organizational Changes dated November 15, 2013 • Discontinuation of Edit Correction Forms (ECFs) dated December 3, 2013 Updated the following sections: • Eligibility Determination • South Carolina Health Connections Medicaid card • South Carolina Web-based Claims Submissions Tool • Retroactive Eligibility • Program Integrity • Recovery Audit Contractor • Beneficiary Explanation of Medical Benefits Program

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
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	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
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
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
12-01-13	2	3-12 13-30 32-49 51-77 78-141	Updated the following sections: • Provider Qualifications Section • Eligibility for Rehabilitative Services • Documentation Requirements • Core Rehabilitative Standards • Community Support Services

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
12-01-13	4	32	Updated RBHS procedure codes tables
12-01-13	5	12	Updated Orangeburg mailing address zip codes
12-01-13	Forms	-	• Updated DHHS Form 254 • Updated Medical Necessity Statement for Rehabilitative Services
11-01-13	5	13	Updated York County mailing address
11-01-13	MC Supplement	18	Replaced BlueChoice MCO Medicaid card
10-01-13	5	12 13	• Updated Orangeburg office and mailing address • Updated York County office address
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	4	1-4 5-9	• Updated procedure codes table • Updated DAODAS only procedure codes table
09-01-13	5	8 10 13	• Updated Darlington County zip code • Updated Laurens County phone number • Updated York County office address
08-01-13	2	 1,2 3-10 11-25 27-43 45-53 55-68 69-85 87-108	Updated the following sections: • Rehabilitative Services Overview • Provider Qualifications • Eligibility for Rehabilitative Services • Documentation Requirements • Core Rehabilitative Service Standards • Core Treatment – Therapy and Counseling Services • Community Support Services • Substance Abuse Treatment
08-01-13	5	13	• Updated York County physical address

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Date	Section	Page(s)	Change
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	4	1 1-4 1-10	• Updated units of service language • Revised table header • Deleted MCO language in footer
07-01-13	5	8 11	• Updated Colleton County office telephone number • Deleted Newberry County PO Box address
07-01-13	Forms	-	Updated Rehabilitative Services – Provider Update Forms (formerly Rehabilitative Behavioral Health Services)
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
05-15-13	2	 1 3 11 31 54 70 87 107	Updated the following sections: • Rehabilitative Services Overview • Provider Qualifications • Eligibility for Rehabilitative Services • Documentation Requirements • Core Rehabilitative Service Standards • Core Treatment – Therapy and Counseling Services • Community Support Services Added Substance Abuse Treatment Services Section
05-15-13	4	1-4 6-11	• Updated Assessment, Therapy Service, and Support services procedure codes table • Updated DAODAS only procedure codes table
05-15-13	Forms	-	Added Rehabilitative Behavioral Health

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
			Services(RBHS) Program Update Form
05-01-13	3	6	Deleted Place of Service Code 21
04-01-13	1	6	Corrected the URL for MedicaideLearning.com
04-01-13	4	1-4 5-10	• Updated Assessment, Therapy Service, and Support services procedure codes table • Added DAODAS procedure codes table
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
03-01-13	2	7, 8	• Changed mental retardation to intellectual disabilities or related disabilities
03-01-13	4	1-4 5-10	• Updated Assessment, Therapy Service, and Support services procedure codes table • Added DAODAS procedure codes table
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)

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
02-01-13	Forms	-	Revised DHHS Form 254
02-01-13	4	-	• Updated RBHS procedure code table • Added new table for DAODAS only procedure codes
01-11-13	Forms	-	Corrected procedure code for Diagnostic Assessment without medical- initial on Form 254
01-04-13	Forms	-	Corrected procedure codes for Individual Psychotherapy on Form 254
01-01-13	2	39 41 42 43	Updated the following sections: • Diagnostic Assessment • Initial Assessment • Follow-up Assessment • Billing/Frequency Limits
01-01-13	4	1-8	Updated procedure code table
01-01-13	5	7 9	• Added Chester county Zip+4 code • Updated Greenville PO Box address
01-01-13	Forms	-	Updated Form 254
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	6 10-11 19, 34, 37	• 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

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		25-26	• Updated Electronic Funds Transfer (EFT)
12-01-12	5	Need page numbers	• Updated URL for provider information • Updated McCormick county office telephone number
12-01-12	Appendix 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
12-01-12	TPL Supplement	8, 9, 17	Updated web addresses for provider information and provider training
11-01-12	2	3-7 7 7 9 10 10 16	Updated the following sections: • Provider Qualifications (entire section) • Eligibility for Rehabilitative Services • Medical Necessity • Services Directly Provided by State Agencies • Referrals to Private Organizations • State Agency Referrals • Medicaid RBHS Staff Qualification for LISW-CP and SAP
11-01-12	5	1	Updated Allendale county office address
11-01-12	Appendix 2	-	Updated carrier code list
10-05-12	Forms	-	Updated Duplicate Remittance Advice Request Form
10-01-12	1	4	Replaced back of Healthy Connections Medicaid card
10-01-12	Appendix 1	-	Updated edit code information through document
08-01-12	1	2, 8, 9, 12, 13, 15, 25,	Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		34	
08-01-12	3	1, 26, 31, 34, 38 7, 19, 25	• 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 • Updated Duplicate Remittance Advice Request Form
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	5, 6, 10,17,	Updated program area contact information to reflect

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
	Supplement	24	Medicaid Bulletin dated June 29, 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
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 12	• Updated address for Marion County • Updated phone number for Newberry County
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	2	3 6 9	• Updated Private Organizations • Deleted Provisional Enrollment section • Updated Eligibility for Rehabilitative Services
02-01-12	3	22 24	• 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	3	- 25	• Updated hyperlinks throughout section • Updated EFT information
01-01-12	5	1	Deleted IVRS Information per “Retirement of Toll

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
			Free Eligibility Verification Line" bulletin released 11-18-11
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
11-01-11	1	24	Updated TPL contact information
11-01-11	3	39, 43, 44	Updated TPL contact information
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	Appendix 1	14, 29 47	• Added edit codes 334 and 584 • Updated edit code 845
09-01-11	1	19	Deleted information regarding National Correct Coding Initiative
09-01-11	5	13	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

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
08-01-11	Appendix 1	8	Updated edit codes 165 and 166
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	5	13	Deleted PO Box address for the Spartanburg County Office
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
06-01-11	5	5	Corrected Abbeville County PO Box Zip+4 Code
06-01-11	Forms	-	Removed Referral Request for Out of State Therapeutic Treatment Services form
05-01-11	1	8, 11	Added language prohibiting payment to institutions or entities located outside of the United States
05-01-11	Appendix 1	43	Updated edit code 796
04-01-11	2	3 5& 6	• Updated language for Private Organizations • Updated policy and Web sites for New Provider Enrollment for Private Organizations
04-01-11	5	6	Updated telephone number for Beaufort County
04-01-11	Forms	-	Updated Electronic Funds Transfer Form
04-01-11	Appendix 3	-	Updated copay amounts to reflect bulletin dated 3-16-11
03-01-11	1	7, 9	Updated to reflect Medicaid Bulletin dated February 9, 2011 – Provider Service Center

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
03-01-11	2	5, 6	Updated to reflect Medicaid Bulletin dated February 9, 2011 – Provider Service Center
03-01-11	3	20, 21, 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	- 67	Added SCDHHS Medicaid Provider Service Center (PSC) information at top of each page in header 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	2	-	Reformatted sections throughout document
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	 3-5 5-6 6-7 7 7 9 11 19 30 37	• Updated the following sections: o Private Organizations o New Provider Enrollment for Private Organizations o RBHS Enrollment Application o Provisional Enrollment o Reporting Changes o Closure of a RBHS Provider o Eligibility for Rehabilitative Services o Maintenance of Staff Credentials o Billable Code/Location of Service o Addendum IPOC

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Date	Section	Page(s)	Change
		40 55 12 12-13 14 15	o Progress Summaries o Special Restrictions • In the following sections, updated the medical necessity authorizing staff to include only the state referring LPHA: o Medical Necessity o Contents of the SCDHHS Medical Necessity Statement (MNS) o Referrals to Private Organizations o Referrals to Private Organizations, Medical Necessity o Diagnostic Assessment Services
01-01-11	3	21, 25, 26, 28 18, 34 25	• 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
01-01-11	5	13	Added toll-free telephone number for Saluda county
01-01-11	Forms	-	Added Duplicate Remittance Request 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

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Date	Section	Page(s)	Change
			• Updated the Retro Health and Pay & Chase section
12-01-10	Cover	-	Replaced "Medicaid Provider Manual" with "South Carolina Healthy Connections (Medicaid)"
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	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

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
10-01-10	Managed Care Supplement	-	• Removed all references to the SCHIP program to reflect Medicaid Bulletin dated August 19, 2010 – Changes to the Healthy Connections Kids (HCK) Program
		1	• Updated Managed Care Overview
		2	• Updated Managed Care Organizations and Core Benefits paragraphs
		3	• Updated MCO Program ID card paragraph
		4	• Updated MHN Program ID card paragraph
		5	• Updated Core Benefits
		6	• Updated Exempt Services
		13	• Updated Overview
		17	• Deleted "Medicaid Managed" from "Current Medicaid Managed Care Organizations" heading and following paragraph
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	Appendix 1	9	• Added edit code 225
		-	• Removed all references to the ADA Claim in the Resolution column
09-01-10	TPL Supplement	12	• Updated the Dental Paper Claims section to delete paper claims submission instructions and added the DentaQuest contact information
		13	• Updated the Web-Submitted Claims section with the exception to Dental claims
		18	• Updated the TPL Resources section to include the DentaQuest contact information for TPL questions
08-01-10	2		• Updated the following sections:
		2	o Rehabilitative Services Overview
		3, 4	o Private Organizations
		6	o New Provider Enrollment for Private Organizations
		7	o Private Organization Requirements

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		8 9 12 14 32 48	o Reporting Changes o Closure for a RBHS Provider o Contents of the SCDHHS Medical Necessity Statement (MNS) o Medical Necessity o Billable Code/Location of Service • Updated the Billing/Frequency Limits for Diagnostic Assessment Services Chart
08-01-10	3	7-8	Updated modifiers
08-01-10	4	1-8	Updated modifiers
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	Forms	-	Updated DHHS Form 254
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	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

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.

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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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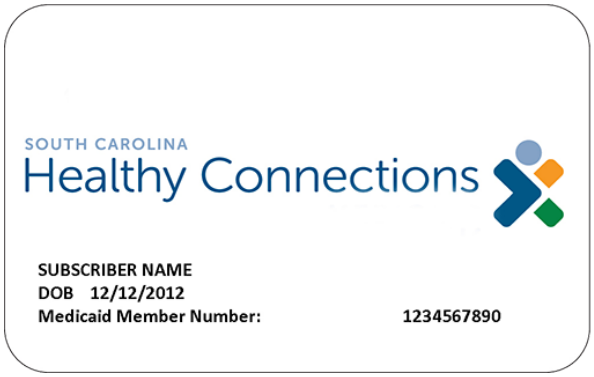
SOUTH CAROLINA MEDICAID PROGRAM



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

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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)

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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.

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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

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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.

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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,

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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

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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

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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.

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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

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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

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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

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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

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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.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

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.)

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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.

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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.

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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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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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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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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.

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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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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.

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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

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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

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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.

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APPEALS

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POLICIES AND PROCEDURES

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SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE SERVICES OVERVIEW

Effective July 1, 2010, the South Carolina State Medicaid Plan was amended to allow an array of behavioral health services under the Rehabilitative Services Option, 42 CFR 440.130(d). Rehabilitative Services are medical or remedial services that have been recommended by a physician or other Licensed Practitioner of the Healing Arts (LPHA) within the scope of their practice under South Carolina State Law and as further determined by the SCDHHS for maximum reduction of physical or mental disability and restoration of a beneficiary to their best possible functional level. This section describes these services, legal authorities, and the characteristics of the providers of services.

The purpose of this manual is to provide pertinent information to Rehabilitative Behavioral Health Services (RBHS) providers for successful participation in the South Carolina Medicaid Program. This manual provides a comprehensive overview of the program, standards, policies and procedures for Medicaid compliance. This provider manual only addresses the policy for state agencies and private organizations as service providers. All providers, unless otherwise specified, are required to meet all requirements as set forth in this policy manual for the delivery of services and all other applicable state and federal laws. Updates and revisions to this manual will be made by the South Carolina Department of Health and Human Services (SCDHHS) and will be made in writing to all providers.

SCDHHS encourages the use of “evidence-based” practices and “emerging best practices” that ensure thorough and appropriate screening, evaluation, diagnosis, and treatment planning, and fosters improvement in the delivery of behavioral health services to children and adults in the most effective and cost-efficient manner. Evidence-based practices are defined as interventions for which systematic empirical research has provided evidence of statistically significant effectiveness.

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE SERVICES OVERVIEW

Rehabilitative Services Overview (Cont'd.)

The National Registry of Evidence-based Programs and Practices (http://www.nrepp.samhsa.gov/) and other relevant specialty organizations publish lists of evidence-based practices that providers may reference.

Rehabilitative Behavioral Health Services are available to all Medicaid beneficiaries diagnosed with mental health and/or substance use disorder(s), as defined by the current edition of the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM)* or the *International Classification of Diseases (ICD)* who meet medical necessity criteria. 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 through the use of diagnostic and restorative services.

Eligible beneficiaries may receive Rehabilitative Behavioral Health Services from a variety of qualified Medicaid providers. Public agencies that contract with SCDHHS as qualified service providers may render these services directly to an eligible beneficiary.

REHABILITATIVE SERVICES

The following must be rendered in accordance with this policy:

- Behavioral Health Screening
- Diagnostic Assessment Services
- Psychological and Evaluation and Testing
- CALOCUS Assessment
- Individual Psychotherapy
- Group Psychotherapy
- Multiple Family Group Psychotherapy
- Family Psychotherapy
- Service Plan Development
- Crisis Management
- Medication Management
- Psychosocial Rehabilitation Services
- Behavior Modification

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE SERVICES OVERVIEW

REHABILITATIVE SERVICES (CONT'D.)

- Family Support
- Therapeutic Child Care
- Community Integration Services
- Peer Support Services (DMH and DAODAS providers only)
- Substance Abuse Treatment Services (DAODAS providers only)

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE SERVICES OVERVIEW

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SECTION 2 POLICIES AND PROCEDURES

PROVIDER QUALIFICATIONS

ACCREDITATION

All private RBHS providers must be accredited by one of the following accreditation organizations:

- Commission on Accreditation of Rehabilitation Facilities (CARF)
- Council on Accreditation (COA)
- The Joint Commission (TJC)

Effective November 1, 2015, all private RBHS providers must meet the following additional requirements to be considered fully accredited:

- Each service rendered by private RBHS providers must be accredited.
    - Please refer to the accreditation crosswalk located on the RBHS webpage at www.scdhhs.gov for further information concerning services and the above accreditation organizations.
- All locations owned and/or operated by private RBHS providers in South Carolina and/or the SC Medicaid Service Area (SCMSA) must be accredited.
- Accreditation for each service is a prerequisite for billing of that service. Any claims submitted for services that are not accredited are not payable and may result in termination.

Private RBHS providers enrolled prior to November 1, 2015 in the South Carolina Medicaid Program must maintain compliance with previous accreditation requirements and shall have until October 31, 2016 to provide evidence that the provider meets the above additional accreditation requirements. Providers must maintain, and be able to provide upon request, evidence of the accreditation certificate, the accreditation letter identifying the specific services that have been accredited, and the most recent accreditation survey report. Providers shall submit evidence of meeting additional requirements to the Division of Behavioral Health on the *Accreditation for Rehabilitative Behavioral Health Services* form, located

SECTION 2 POLICIES AND PROCEDURES

PROVIDER QUALIFICATIONS

ACCREDITATION (CONT'D.)

in the Forms section of the manual. The form can be submitted via the following options:

Email: behavioralhealth002@scdhhs.gov
Fax: (803) 255-8204

All enrolled private RBHS providers shall maintain accreditation status during the entire period of enrollment with SCDHHS. This includes, but is not limited to, periods of transition from one accreditation organization to another. Failure to maintain accreditation shall result in termination of enrollment.

Any denial, loss of, or any negative change in accreditation status must be reported to Division of Behavioral Health in writing via the *Program Changes for Rehabilitative Behavioral Health Services* form (located in the Forms section of the manual) within five (5) business days of receiving the notice from the accrediting organization. The written notification shall include information related, but not limited to:

- The provider's denial or loss of accreditation status;
- Any negative change in accreditation status;
- The steps and timeframes, if applicable, the accreditation organization is requiring from the providers to maintain accreditation.

Failure to notify SCDHHS of denial, loss of, or any negative change in accreditation status may result in termination of enrollment.

If at any time a provider loses accreditation, an automatic termination of enrollment shall occur. The applicant may not reapply for enrollment for one year from the effective date of the termination. Additionally, the applicant must be fully accredited at the time of application after the one year period.

ENROLLMENT APPLICATION FOR ORGANIZATIONS

To participate in the South Carolina Medicaid Program, applicants must meet, and shall maintain compliance with during enrollment, all applicable federal and state requirements, all requirements outlined in the SCDHHS Provider Enrollment manual, and this RBHS policy:

- Complete the SCDHHS online Enrollment Application and pay the required fee, if applicable

SECTION 2 POLICIES AND PROCEDURES

PROVIDER QUALIFICATIONS

ENROLLMENT APPLICATION FOR ORGANIZATIONS (CONT'D.)

- New applicants and all enrolled providers will be subject to pre-enrollment and post-enrollment site visits.

  At any time a provider changes locations within South Carolina or the SCMSA, a new site visit must be conducted before Medicaid services can commence at the new location.
- Evidence of current and valid accreditation must be submitted: A copy of the accreditation certificate, the accreditation letter identifying the specific services and sites that have been accredited, and the most recent accreditation survey report.
- LPHAs and/or medical staff must be licensed by the State where the service(s) is rendered to beneficiaries.
- The applicant must have a current business license or certificate of occupancy for each site located in South Carolina or the SCMSA. Business licenses and certificates of occupancy must be maintained the entire period of enrollment with SCDHHS.
  - If a county, or a municipality within a state, does not issue business licenses or certificates of occupancy, the provider must demonstrate evidence of the following documentation:
    - Articles of Incorporation and signature pages
    - Registration with the Secretary of State
  - A new business license and certificate of occupancy must be obtained any time a provider moves locations within South Carolina or the SCMSA.
- Office location(s) and the rendering of any service(s) must be located in South Carolina or within the SCMSA.
- Certificate of insurance indicating the provider maintains Commercial General Liability or Comprehensive Liability Insurance of at least $1,000,000/per occurrence, $3,000,000/general aggregate.

SECTION 2 POLICIES AND PROCEDURES

PROVIDER QUALIFICATIONS

ENROLLMENT APPLICATION FOR ORGANIZATIONS (CONT'D.)

- Proof of Worker's Compensation insurance, if provider employs five or more full time staff
- Accept the reimbursement rates established by Medicaid
- Have a computer, Internet access, dedicated land-line business phone number, and an email address to conduct business with SCDHHS

To request enrollment information, providers may contact SCDHHS Medicaid Provider Service Center (PSC) at 1-888-289-0709, submit an online inquiry at http://www.scdhhs.gov/contact-us, or access the online Medicaid enrollment application on the SCDHHS website. Once enrolled, providers are required to revalidate enrollment every three years.

It is the responsibility of all providers to continuously check the SCDHHS website for information, updates and changes, and provider manuals at https://www.scdhhs.gov/provider-manual-list/. Providers should also subscribe to SCDHHS Medicaid Bulletins and/or Provider Alerts.

When completing the application, providers **must select** "New Enrollment" and the following options:

Field	Option
Enrollment Type	Organization
Provider Type	Behavioral Health Services
Primary Specialty	Private Rehabilitative Health Services

Applications submitted to SCDHHS by private organizations with any options other than those specified in the table above will be denied.

Enrollment with SCDHHS does not provide a guarantee of referrals or a certain funding level. Failure to comply with Medicaid policy requirements may result in termination of Medicaid enrollment.

As a condition of participation in the South Carolina Medicaid Program, the provider must ensure that adequate and correct fiscal and medical records are kept to disclose the extent of services rendered and ensure that claims for funds are in accordance with all applicable laws, regulations, and policies.

SECTION 2 POLICIES AND PROCEDURES

PROVIDER QUALIFICATIONS

LOCATION/ZONING REQUIREMENTS

Providers must be housed in an office that is in a commercially zoned location.

A permanent sign must be affixed externally to the provider's office to identify the location of the provider.

Providers must continuously post office hours/hours of operation and emergency contact information for after-hours emergencies and support.

FACILITY QUALIFICATIONS

Residential Treatment providers must follow the guidelines set in the SCDHHS Provider Enrollment manual (*e.g.,* the business site must be located within South Carolina or the SCMSA, a 25 mile radius of the SC border) and be in compliance with Federal and State requirements (*e.g.,* if applicable, be licensed by the SC Department of Social Services). Residential facilities are limited to 16 or fewer beds in order to receive Medicaid reimbursement as Federal law prohibits Medicaid payment to institutions of Mental Disease as described in the Code of Federal Regulations, 42 CFR 435.1009.-101. All 16-bed residential substance abuse facilities must be licensed with the SC Department of Health and Environmental Control under the regulation of 61-93, the standards for Licensing Facilities that treat individuals for psychoactive substance abuse or dependence. Providers must maintain current licenses as a condition of enrollment.

BUSINESS REQUIREMENTS

Providers must meet the following requirements at all times:

- SCDHHS and USDHHS assume no responsibility with respect to accidents, illness or claims arising out of any activity performed by any State or private organization. The organization shall take necessary steps to insure or protect its recipient, itself and its personnel. The provider agrees to comply with all applicable local, staff, and federal occupational and safety acts, rules and regulations.
- Providers must have cost information available for review by SCDHHS upon request.
- All providers must demonstrate evidence of having the following required policies and procedures in place by January 1, 2016, and these shall be maintained during enrollment as a provider:

SECTION 2 POLICIES AND PROCEDURES

PROVIDER QUALIFICATIONS

BUSINESS REQUIREMENTS (CONT'D.)

- Confidentiality and protection of health information
- Record security and maintenance
- Record retention
- Use of electronic signatures if provider uses an Electronic Health Record (EHR) or Electronic Medical Record (EMR)
- Release of information
- Consent for treatment
- Beneficiary's rights and responsibilities
- Prohibition of abuse, neglect and exploitation of beneficiaries
- Code of ethics
- Freedom of choice
- Limited English proficiency
- Compliance program (including fraud, waste, and abuse)
- Admission and discharge of beneficiaries
- Conditions for termination of beneficiaries from services, including:
  - A list of reasons for termination;
  - Methods of averting the termination;
  - Education/Consultation with beneficiary and/or family about termination (*e.g.*, resources and options); and
  - Evidence beneficiary/family informed of termination.
- Personnel practices (including recruiting, hiring, and retention of staff as well as maintenance of personnel records)
- Use of volunteers and students/interns

- If the provider receives annual Medicaid payments of at least $5,000,000, the provider must comply with Section 6032 of the Deficit Reduction Act (DRA) of 2005, Employee Education about False Claims Recovery, and provide Federal False Claims Act education to its employees.

SECTION 2 POLICIES AND PROCEDURES

PROVIDER QUALIFICATIONS

MAINTENANCE OF STAFF CREDENTIALS

Providers shall ensure that all staff, including subcontractors, volunteers, students/interns, and other individuals under the authority of the provider who come into contact with beneficiaries are properly qualified, trained, and supervised. Providers must comply with all other applicable state and federal requirements.

The provider must have a designated full-time **Administrator** (CEO/Director) with clear authority over general administration and implementation of requirements established by the RBHS Medicaid policy, including responsibility to oversee the budget and accounting systems implemented by the provider, and have the authority to direct and prioritize work, regardless of where performed, and responsibility for the business operation of the entity. During times of absence (*e.g.*, medical leave, vacation, etc.), the provider must appoint, in writing, a qualified designee with administrative program experience.

The provider must have a designated full-time **Clinical Director** responsible for clinical supervision and implementation of clinical services rendered by the private provider. The Clinical Director must be available to staff by phone during all hours the provider is in operation for clinical consultation and emergency support. During times of absence (*e.g.*, medical leave, vacation, etc.), the provider must appoint, in writing, a qualified designee.

- Effective November 1, 2015 for private RBHS providers, all Clinical Directors must be South Carolina Licensed Practitioners of the Healing Arts. A master's level clinical professional who is serving as a Clinical Director without a South Carolina license on November 1, 2015, may continue to serve as Clinical Director until October 31, 2017, provided that he or she can demonstrate that he or she is making a bona fide effort to become a South Carolina LPHA. Minimum evidence of effort includes a copy of the supervision contract and application packet with the appropriate licensure board.

An organization must include, at minimum, an Administrator, a Clinical Director and two other professional or paraprofessional staff to provide direct services.

SECTION 2 POLICIES AND PROCEDURES

PROVIDER QUALIFICATIONS

MAINTENANCE OF STAFF CREDENTIALS (CONT'D.)

Providers must maintain documentation which verifies that all staff are properly qualified, screened, trained and supervised, including subcontractors, volunteers, students and/or interns and other individuals under the authority of the provider. Providers must maintain and make available upon request, appropriate records and documentation of such qualifications, trainings, and investigations. Failure of the provider to comply with this provision may result in the immediate termination of enrollment. SCDHHS may, upon good cause shown by the provider, and within the discretion of SCDHHS, allow the provider a reasonable amount of time to provide the documents requested.

Providers must maintain signature sheet(s) or electronic signature database(s) that identifies all individuals rendering services by name, signature, credentials, and initials.

The following required documents must be present in each personnel file, as applicable, prior to the start of employment and prior to rendering services to beneficiaries:

- A completed and signed employment application form (including criminal disclosure)
- A completed and signed job description that reflects the service(s) the person is responsible to render
- College, high school diploma, or GED transcripts with official raised seal from the education institution; copies are not acceptable.

  The degree must be from an accredited college or university listed in the U.S. Department of Education's Office of Post-secondary Education database at http://ope.ed.gov/accreditation/.
- Copies and primary source verification of all applicable professional licenses and certifications upon the start of employment and annually thereafter
- Letters or other documentation to verify previous employment or volunteer work that documents work experience with the population to be served as per the required Staff Qualifications later in this manual

SECTION 2 POLICIES AND PROCEDURES

PROVIDER QUALIFICATIONS

MAINTENANCE OF STAFF CREDENTIALS (CONT'D.)

- Evidence of criminal background checks completed prior to the start of employment, and annually thereafter
  - All criminal background checks must include information for each staff member with no less than a 10 year search. The criminal background check must include statewide (South Carolina) data, and any other state(s) the worker has resided in within the prior 10 years. In order for providers to make an offer of employment or retain current employees, the criminal background results shall not indicate any findings or criminal charges against the potential or current employee in the following categories:
  - Conviction for abuse, neglect, or exploitation of adults (as defined in the Omnibus Adult Protection Act, S.C. Code Ann. Title 43, Chapter 35) or of children (as defined in the Children's Code, S.C. Code Ann. Title 63, Chapter 7);
  - Felony conviction for any of the following, including guilty pleas and adjudicated pretrial diversions
    - crimes against persons, such as murder, rape, or assault, and other similar crimes
    - Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes
    - Any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct
    - Any felonies outlined in section 1128 of the Social Security Act

SECTION 2 POLICIES AND PROCEDURES

PROVIDER QUALIFICATIONS

MAINTENANCE OF STAFF CREDENTIALS (CONT'D.)

- Conviction of any kind concerning the misuse or abuse of any public assistance program (including, but not limited to, fraudulently obtaining benefits, engaging in fraudulent billing practices, and embezzling or otherwise misusing public assistance funds in any manner); and

- Evidence of exclusion checks from Medicare or Medicaid Programs completed prior to the start of employment and annually thereafter. The following sources shall be checked for all individuals:
  - South Carolina Excluded Providers list: https://www.scdhhs.gov/site-page/bureau-compliance-and-performance-review
  - Office of the Inspector General (OIG) provider exclusion database: https://exclusions.oig.hhs.gov/
  - Federal System for Award Management: https://www.sam.gov
- Evidence of state and national sex offender registries checks completed prior to the start of employment and annually thereafter

  Results of the sex offender registries checks should not indicate any findings or criminal charges against an individual.
- Evidence of child abuse registry checks completed prior to the start of employment and annually thereafter

  Results of the child abuse registry checks should not indicate any findings or criminal charges against an individual.
- Evidence of professional sanctions checks completed for licensed, certified, and unlicensed staff prior to the start of employment and annually thereafter

  Results of the professional sanctions checks should not indicate any substantiated findings of abuse or neglect against the individual. This includes:
  - All applicable state licensing/certification boards

SECTION 2 POLICIES AND PROCEDURES

PROVIDER QUALIFICATIONS

MAINTENANCE OF STAFF CREDENTIALS (CONT'D.)

- All applicable state Nurse Aide Registries or Health Care Personnel Registries. A list of state entities can be found in the NCSBN Directory of Nurse Aide Registries at: https://www.ncsbn.org/FINALNurseAide Registries 2014 2015 MC 11.4.14.pdf.

LICENSED PROFESSIONALS

All providers who enroll with South Carolina Medicaid to provide services in a category that require a professional license **must be licensed to practice in the State of South Carolina** and must not exceed their licensed scope of practice under state law.

When licensure is required for any service and the service is rendered outside of South Carolina, but within the SCMSA, the professional must be licensed in the respective state where the professional renders services to Medicaid beneficiaries. Professionals rendering services outside of South Carolina must not exceed the licensed scope of practice granted under that state's laws.

Providers who enroll as a physician or LPHA must be able to demonstrate evidence of experience working with the population(s) to be served.

Any services that are provided by staff who do not meet all of the staff qualification requirements in this manual are subject to recoupment. It is the provider's responsibility to ensure staff operates within the scope of practice as required by South Carolina State law.

TRAINING

Providers are responsible for ensuring that all staff are appropriately trained, including subcontractors, volunteers, students/interns, and other individuals under the authority of the provider. Providers are responsible for the development and provision of training to their staff when alternative training is not available. Individuals who are qualified based on documented professional behavioral health experience, training or certification, and/or licensure, to conduct such training shall carry out the instruction.

Specific training requirements are outlined later in this section.

Training records must indicate:

- The name of the training course;

SECTION 2 POLICIES AND PROCEDURES

PROVIDER QUALIFICATIONS

TRAINING (CONT'D.)

- The instructor's name and signature;
- The training agency or on-line training resource;
- The date(s) of the training;
- The hours of the training;
- Signed attestation for those in attendance (signatures must be legible);
- The outline and content of the training; and
- The completion of certification criteria, as applicable.

REPORTING BUSINESS CHANGES

SCDHHS requires a provider to 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 Provider Service Center (PSC) within thirty (30) days of the change. This updated information m*ust be submitted on the business letterhead* with an authorized signature. Updates can be submitted via fax or mail. The provider will not be able to make any updates over the telephone. Updates will be processed within ten (10) days of receipt. Please refer to the SCDHHS Provider Enrollment Manual for contact information.

REPORTING PROGRAM CHANGES

SCDHHS requires that a provider report programmatic change(s) to the Division of Behavioral Health. This updated information must be submitted on the *Program Changes for Rehabilitative Behavioral Health Services* form (located in the Forms section of the manual) within ten (10) days of the change. The provider will not be able to report any changes over the telephone. The form can be submitted via the following options:

Email: behavioralhealth002@scdhhs.gov
Fax: (803) 255-8204

The following program changes must be reported by the provider:

- Change in Administrator (CEO/Director)
- Change in Clinical Director
- Change in the number of RBHS staff resulting in less than two professional or paraprofessional staff available to provide services at any time

SECTION 2 POLICIES AND PROCEDURES

PROVIDER QUALIFICATIONS

REPORTING PROGRAM CHANGES (CONT'D.)

- Adverse events concerning staff licensure
- Any change in accreditation status as identified in the accreditation section of this manual including, but not limited to, all re-accreditation survey results
- Any change in facility license
- Other changes which affect compliance with Medicaid requirements

If the provider's and/or the Administrator's name(s) changes, the provider must submit a new Disclosure of Ownership and Control Interest Statement Form and an updated W-9 Form to the Provider Service Center (PSC). Refer to the SCDHHS website for the Disclosure Form. Questions concerning the W-9 form should be directed to Provider Service Center.

Providers planning to or currently operating a child/family care facility for Medicaid beneficiaries must ensure compliance with all state and federal mandates. Providers are encouraged to contact the South Carolina Department of Social Services (SCDSS) for information regarding registry and/or licensing requirements. Providers out of compliance are subject to termination.

Providers should reference the South Carolina Children's Code of Laws – Title 63 to ensure compliance with state licensing and child welfare regulations. Information can be located on the web at http://www.scchildcare.org.

PROVIDER TERMINATION

Providers may terminate enrollment upon providing SCDHHS with thirty (30) days written notice of termination. SCDHHS may terminate enrollment for good cause upon providing thirty (30) days written notice of termination. Notices of termination shall be sent by Certified Mail, Return Receipt Requested or nationally recognized overnight carrier, and be effective thirty (30) days after the date of receipt.

Providers shall adhere to all applicable federal and state laws, rules, and regulations, including but not limited to, the following requirements:

- If the provider voluntarily decides to (1) terminate the enrollment agreement as an RBHS provider, or (2) reduce the array of services offered/rendered to beneficiaries, the provider shall also notify the

SECTION 2 POLICIES AND PROCEDURES

PROVIDER QUALIFICATIONS

PROVIDER TERMINATION (CONT'D.)

Division of Behavioral Health via the *Voluntary Termination Notification for Rehabilitative Behavioral Health Services* form thirty (30) days prior to closing business or ending any discrete service. The form can be submitted via the following options:

Encrypted Email: behavioralhealth002@scdhhs.gov
Fax: (803) 255-8204

- The notification shall identify:
  - The effective date of the voluntary termination or reduction;
  - The rationale for the voluntary termination or reduction;
  - The service(s) to be voluntarily terminated (identify each service to be terminated and population(s) affected for each service to be terminated or reduced);
  - The number of beneficiaries affected by voluntary termination or reduction;
  - The plan for discharge or continuity of care for all beneficiaries affected;
  - The impact on staff;
  - The records management and security plan, including the location where the beneficiary and administrative records will be stored; and
  - Other entities notified of voluntary termination or reduction.
- The provider is obligated to notify beneficiaries of the effective termination date as soon as possible and shall assist all beneficiaries with discharge planning and continuity of care needs; evidence of these efforts shall be retained by the provider.

- If the provider is terminated involuntarily by Medicaid, or if the provider voluntarily terminates its relationship with Medicaid, the provider is responsible for all beneficiary and administrative records in the event of a post-payment review.

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PROVIDER QUALIFICATIONS

PROVIDER TERMINATION (CONT'D.)

- Prior to the closure, the provider will notify all beneficiaries and assist them with locating and transferring care to appropriate service providers.
- The provider is responsible for releasing records to any beneficiary who requests a copy of his or her records.
- The provider must also transfer records to the appropriate state agencies, if applicable.
- All fiscal and medical records shall be retained by the provider/owner for a period of five (5) years after last payment was made for services rendered. If any litigation, claim, audit, or other action involving the records has been initiated prior to the expiration of the five (5) years, 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 five (5) year period, whichever is later.

THIRD PARTY LIABILITY

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. All providers must pursue the availability of third-party payment sources.

Payment sources include, but are not limited to, Medicare, private health insurance, worker's compensation, and disability insurance. For additional information, please refer to Third-party Liability Supplement.

MAINTENANCE OF FISCAL AND MEDICAL RECORDS

Adequate and correct fiscal and medical records shall be kept by providers to disclose the extent of services rendered and to assure that claims for funds are in accordance with all applicable laws, regulations, and policies. All services rendered and claims submitted shall be in compliance with all applicable federal and state laws and regulations and in accordance with the South Carolina Plan for Medical Assistance, alerts, bulletins, SCDHHS policies, procedures, and Medicaid Provider Manuals.

SECTION 2 POLICIES AND PROCEDURES

PROVIDER QUALIFICATIONS

MAINTENANCE OF FISCAL AND MEDICAL RECORDS (CONT'D.)

All fiscal and medical records shall be retained for a period of five (5) years after last payment was made for services rendered. If any litigation, claim, audit, or other action involving the records has been initiated prior to the expiration of the five (5) years, 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 five (5) year period, whichever is later.

QUALITY IMPROVEMENT AND MONITORING

All providers should self-monitor adherence to applicable federal and state laws and regulations and in accordance with the South Carolina Plan for Medical Assistance, alerts, bulletins, SCDHHS policies, procedures, and Medicaid Provider Manuals. Any findings of non-compliance as a result of self-monitoring activities shall be communicated to and monetarily remitted to SCDHHS.

SCDHHS, or its designees, will conduct reviews to ensure that providers are in compliance with applicable laws, regulations, and policies. Other authoritative entities may conduct reviews of RBHS providers, including the State Auditor's Office, the South Carolina Attorney General's Office, United States Department of Health and Human Services, Government Accountability Office and/or their designees. Upon request, information must be furnished regarding any claim for payment to SCDHHS. All providers must grant access to SCDHHS, or its designees, to records for reviews and/or investigations for the purposes of reviewing, copying, and reproducing documents. Failure of the provider to comply with this provision may result in the immediate termination of enrollment.

MANAGED CARE ORGANIZATION

As of July 1, 2016, all RBHS services are covered under the managed care benefit package. If a beneficiary is enrolled with one of the state's contracted MCOs, all RBHS providers must receive prior approval and claim reimbursement directly from the member's MCO for services covered under the managed care service package. Please refer to the managed care policy and procedure manual at https://msp.scdhhs.gov/managedcare/site-page/mco-contract-pp for additional information regarding behavioral health and substance abuse services.

SECTION 2 POLICIES AND PROCEDURES

PROVIDER QUALIFICATIONS

MANAGED CARE ORGANIZATION (CONT'D.)

The policy herein does not cover services under a MCO. Providers are encouraged to visit the SCDHHS website at https://msp.scdhhs.gov/managedcare/ for additional information regarding MCO coverage.

QUALITY IMPROVEMENT AGENT (QIO) AUTHORIZATION

This section applies to RBHS providers required to obtain approval through the SCDHHS designated Quality Improvement Organization (QIO) (KEPRO). Providers must follow the prior authorization (PA) guidelines as outlined by SCDHHS before billing Medicaid. All services must be determined medically necessary as approved by the QIO.

The PA request form can be found on the QIO web portal at http://scdhhs.kepro.com. The PA request form must be submitted to the QIO with the required documentation. To receive reimbursement from Medicaid, all PA requests must be faxed to or submitted via the web portal to the QIO for approval. If PA requests are submitted via fax, a fax cover sheet must be included with the request along with supporting documentation such as SCDHHS forms and/or clinical documentation to the QIO.

The provider will be notified via a QIO approval letter if the PA request is approved. The provider must download the approved document(s) from the web portal and shall maintain letter(s) in the beneficiary's clinical record. The provider may contact the QIO for additional information as follows:

Customer Service: 1-855-326-5219
Fax: 1-855-300-0082
Provider Issues Email: atrezzoissues@KEPRO.com

Providers must ensure that all services are provided in accordance with all SCDHHS policy requirements. If SCDHHS or its designee determines that services were reimbursed when there was not a valid approval letter from the QIO in the beneficiary's file, the provider payments will be subject to recoupment.

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PROVIDER QUALIFICATIONS

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SECTION 2 POLICIES AND PROCEDURES

ELIGIBILITY FOR REHABILITATIVE SERVICES

The determination of eligibility for Rehabilitative Services should include a system-wide assessment and/or an intake process. This requires that specific information be gathered consistently regardless of the assessment tool being used. Medicaid-eligible beneficiaries may receive services when there is a confirmed psychiatric diagnosis from the current edition of the DSM or the ICD. This excludes irreversible dementias, intellectual disabilities or related disabilities, and developmental disorders unless they co-occur with a serious behavioral health disorder that meets current edition DSM criteria. Developmental disabilities should not be confused with behavioral health disorders. Persons with a developmental disability should be carefully assessed to determine if there are co-occurring behavioral problems and if those problems could be addressed with Rehabilitative Services. A determination should be made if the beneficiary is reasonably expected to improve in adaptive, social, and/or behavioral functioning from the delivery of services.

For dates of service on or after **September 30, 2015,** the use of V-codes is allowed under certain circumstances, but in general is considered temporary. Please see additional guidance regarding V-Codes and Medical Necessity for Child and Adolescent Community Support Services later in the manual.

For dates of service on or after **October 1, 2015,** the use of Z-codes is allowed but is considered temporary and may not be used for longer than six-month duration. Z-codes do not replace a psychiatric diagnosis from the current edition of the DSM or ICD. After six months, medical necessity must be established by a psychiatric diagnosis if continuation of services is needed. Z-codes may not be used for ages 7 and up for longer than six-month duration. The use of Z-codes is not time limited for children ages 0 to 6 of age. Clinical documentation justifying the need for continued RBHS must be maintained in the child's clinical record.

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MEDICAL NECESSITY

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 reasonably expected to relieve pain, improve and preserve health, or be essential to life. Services are not primarily for the benefit of the provider and/or for the convenience of the beneficiary/family, caretaker, or provider. Services and treatment shall be rendered in a cost effective and in the least restrictive setting required by the beneficiary's condition. Services and treatment shall be consistent with generally accepted professional standards of practice as determined by the Medicaid program, shall not be experimental or investigational in nature, and shall be substantiated by records including evidence of such medical necessity and quality.

All Medicaid beneficiaries must meet specific medical necessity criteria to be eligible for treatment services. An LPHA must certify that the beneficiary meets the medical necessity criteria for each service. Please refer to the "Documenting Medical Necessity" table for additional information. LPHAs authorized to confirm medical necessity can be found under "Licensed Practitioners of the Healing Arts (LPHAs)."

If the Medicaid recipient is in Fee for Service Medicaid, the following guidelines must be used to confirm medical necessity. If the Medicaid recipient is in one of the managed-care plans, SCDHHS allows for Managed Care Organizations (MCO's) to set prior authorization rules and guidance.

The determination of medically necessary treatment must be:

- Based on information provided by the beneficiary, the beneficiary's family, and/or collaterals who are familiar with the beneficiary
- Based on current clinical information. (If the diagnosis has not been reviewed in a 12 or more months, the diagnosis should be confirmed immediately.)
- Made by an LPHA enrolled in the SC Medicaid Program

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DOCUMENTING MEDICAL NECESSITY

As of July 1, 2016, medical necessity must be documented on a diagnostic assessment. For beneficiaries receiving services prior to July 1, 2016 whose medical necessity was documented via the IPOC, a diagnostic assessment must be completed to document medical necessity before the expiration of the IPOC.

The DA must be completed prior to any RBHS services being rendered. If a placement is necessary for Therapeutic Foster Care (TFC), the DA must be completed within 14 days of placement.

The diagnostic assessment must document the presence of a serious behavioral health disorder from the current edition of the DSM or the ICD, excluding irreversible dementias, intellectual disabilities or related disabilities and developmental disorders, unless they co-occur with a serious mental disorder that meets the current edition DSM criteria. The DA must clearly state recommendations for treatment, including services and the frequency for each service recommended.

Required elements of the diagnostic assessment can be referenced in the Diagnostic Assessment Service description located later in this manual.

The LPHA's name, professional title, signature and date must be listed on the document to confirm medical necessity.

The DA must be maintained in the Medicaid beneficiary's clinical record.

Medical Necessity must be confirmed within 365 calendar days, if the beneficiary needs continuing rehabilitative services.

If the beneficiary has not received services for 45 consecutive calendar days, medical necessity must be re-established by completing a follow-up assessment.

If SCDHHS or its designee determines that services were reimbursed when evidence of medical necessity, as outlined in this manual, was not documented and maintained in the beneficiary's record, payments to the provider shall be subject to recoupment.

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ELIGIBILITY FOR REHABILITATIVE SERVICES

Documenting Medical Necessity:

- Medical Necessity must be documented on a Diagnostic Assessment (DA) administered by an LPHA qualified to conduct this service in accordance with their respective licensing body. If the LPHA is an LMSW, a co-signature by an independently licensed LPHA is required of private providers.
- The DA must be completed prior to rendering any RBHS services, unless a therapeutic foster care placement is required.
- The LPHA's name, credentials, signature, and date of signature must be listed on the document to confirm medical necessity.
- The DA must document a serious mental health and/or substance use disorder or serious emotional disturbance from the current edition of the DSM or the ICD, excluding irreversible dementias, intellectual disabilities or related disabilities and developmental disorders, unless they co-occur with a serious mental disorder that meets the current edition DSM or the ICD criteria.
- The DA must clearly state recommendations for treatment, including services and the frequency for each service recommended. Additional required elements of the DA can be referenced in the Diagnostic Assessment Service description located later in this manual.
- Medical Necessity must be confirmed annually via a Diagnostic Assessment if there is clinical need for continued rehabilitative services.
- If the beneficiary has not received services for 45 consecutive calendar days, medical necessity must be re-established by completing a follow-up assessment.
- The DA must be maintained in the Medicaid beneficiary's clinical record.

REFERRAL PROCESS FOR RBHS

Referrals may be made among and between private providers enrolled in the SC Medicaid Program and State agencies.

Medicaid beneficiaries and/or families may also self-refer for services.

Referrals (provider to provider or self-referred) can be done via phone, email, fax, and hard copy mail.

Note: Providers must comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191.

Who Can Confirm Medical Necessity-Licensed Practitioners of the Healing Arts (LPHAs)

Licensed Practitioners of the Healing Arts (LPHAs) must be enrolled in the SC Medicaid Program. The following professionals are considered to be licensed at the **independent** level in South Carolina and can establish and/or confirm medical necessity:

- Licensed Physician
- Licensed Psychiatrist
- Licensed Psychologists
- Licensed Psycho-Educational Specialist

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Who Can Confirm Medical Necessity-Licensed Practitioners of the Healing Arts (LPHAs) (Cont'd.)

- Licensed Advanced Practice Registered Nurse
- Licensed Independent Social Worker-Clinical Practice
- Licensed Physician Assistant
- Licensed Professional Counselor
- Licensed Marriage and Family Therapist

When medical necessity for services is required to be established and/or confirmed by an independently licensed LPHA, the professional **must** be licensed at the independent level in each respective state where the professional renders services to Medicaid beneficiaries outside of South Carolina, but within the SC Medicaid Service Area.

A Licensed Master Social Worker is considered a Licensed Practitioner of the Healing Arts (LPHA) in South Carolina, and can establish and/or confirm medical necessity under a State Agency.

For private providers, a Licensed Master Social Worker must have the DA co-signed by an independently Licensed Practitioner of the Healing Arts.

LPHAs must be licensed in the state where they render services to the beneficiary.

Out-of-State LPHAs Confirming Medical Necessity

Out-of-state LPHAs must be enrolled in the SC Medicaid Program. The professional must be licensed at the independent level in each respective state where the professional renders services within the SC Medicaid Service Area. The following professionals can establish and/or confirm medical necessity within the state listed:

North Carolina	Georgia
• Medical Doctor (MD) • Doctor of Osteopathic Medicine (DO) • Nurse Practitioner (NP) • Family Nurse Practitioner (FNP) • Psychologist • Physician's Assistant (PA) • Physician's Assistant- Certified (PA-C) • Licensed Professional Counselor (LPC)	• Medical Doctor (MD) • Doctor of Osteopathic Medicine (DO) • Advanced Practice Registered Nurse- Nurse Practitioner (APRN-NP) • Advanced Practice Registered Nurse- Clinical Nurse Specialist (APRN-CNS) • Advanced Practice Registered Nurse- Clinical Nurse Specialist/Psychiatric Mental Health

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• Licensed Marriage and Family Therapist (LMFT) • Licensed Clinical Social Worker (LCSW)	(APRN- CNS-PMH) • Psychologist • Physician's Assistant (PA) • Licensed Professional Counselor (LPC) • Licensed Marriage and Family Therapist (LMFT) • Licensed Clinical Social Worker (LCSW)

RETROACTIVE COVERAGE

For beneficiaries receiving retroactive coverage, all other Medicaid service and documentation requirements must be met in order to receive Medicaid reimbursement for retroactively covered periods.

UTILIZATION MANAGEMENT FOR PRIVATE PROVIDERS

The rendering of Rehabilitative Behavioral Health Services shall be based on the establishment of medical necessity, shall be directly related to the beneficiary's clinical needs, and shall be expected to achieve the specific goals specified in the beneficiary's Individual Plan of Care (IPOC).

All RBHS providers shall ensure (1) that only the authorized units of services are provided and submitted to SCDHHS for reimbursement and (2) that all services are provided in accordance with all SC Medicaid Program policy requirements.

Prior authorization is required for all RBHS Community Support Services rendered by private providers.

Community Support Services rendered by private RBHS providers to child and adolescent beneficiaries must be prior authorized by the QIO, with the exception of beneficiaries in foster care. Services for these beneficiaries must be prior authorized by the South Carolina Department of Social Services.

REFERRAL SOURCE: STATE AGENCY	
Initial Prior Authorization	**Continued Service Prior Authorization**
For the initial authorization period, Medicaid may cover up to 90 days for child and adolescent beneficiaries, and up to 180 days for adult beneficiaries, based on the medical necessity documented on: • the Rehabilitative Behavioral Health Services Referral Form, • the QIO prior authorization request form, and	For the continued service authorization period, Medicaid may cover up to 90 days for child and adolescent beneficiaries, and up to 180 days for adult beneficiaries, based on the medical necessity documented on: • the most recent 90-day progress summary, • A current IPOC, • the QIO prior authorization request form,

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REFERRAL SOURCE: STATE AGENCY	
Initial Prior Authorization	**Continued Service Prior Authorization**
• supporting documentation, as applicable.	• Parent/Caregiver/Guardian Agreement to Participate in Community Support Services form, and • supporting documentation, as applicable. • *Note, if beneficiary needs continued services after 365 days, an updated diagnostic assessment is required to be submitted to the QIO.
REFERRAL SOURCE: SELF OR OTHER ENTITY--DOCUMENTATION FOR PRIOR AUTHORIZATION	
Initial Prior Authorization	**Continued Service Authorization**
For the initial medical prior authorization period, Medicaid may cover up to 90 days for child and adolescent beneficiaries, and up to 180 days for adult beneficiaries. Initial authorizations are required annually, and must be based on the following information: • the QIO prior authorization request form, • the Diagnostic Assessment (DA), • For beneficiaries 0-21, the age-appropriate assessment tool: o Parenting Stress Index (PSI) (birth to 1.5 years), or o The Child Behavior Check List (1.5 -5 years), or o CALOCUS administered by a qualified clinical professional with a CALOCUS-SCDHHS provider certification (ages 6-21) • For beneficiaries 15 years of age and under: Parent/Caregiver/Guardian Agreement to Participate in Community Support Services form and • supporting documentation, as applicable.	For the continued service prior authorization period, Medicaid may cover up to 90 days for child and adolescent beneficiaries, and up to 180 days for adult beneficiaries, based on the medical necessity documented on: • the QIO prior authorization request form • the most recent 90-day progress summary, • a current IPOC, • For beneficiaries 15 years of age and under: Parent/Caregiver/Guardian Agreement to Participate in Community Support Services form, and • supporting documentation, as applicable. • *Note, if beneficiary needs continued services after 365 days, an updated diagnostic assessment is required to be submitted to the QIO.

UTILIZATION MANAGEMENT FOR PRIVATE PROVIDERS

Requests for each continued service prior authorized period must be submitted to the QIO, ten (10) business days prior to the expiration of the current authorization. The QIO will process and either approve or deny service authorization(s) within five (5) business days of receipt, pending complete submission of all required information.

When Community Support Service(s) are added to a

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UTILIZATION MANAGEMENT FOR PRIVATE PROVIDERS (CONT'D.)

current approved course of treatment, each discrete service must be prior authorized by the QIO. Medicaid may cover additional services based on the medical necessity documented on:

- the most recent Diagnostic Assessment (DA),
- the age-appropriate assessment tool, administered and scored by a qualified clinician:
  - Parenting Stress Index (PSI) (birth to 1.5 years), or
  - The Child Behavior Check List (1.5 -5 years), or
  - CALOCUS administered by a qualified clinical professional with a CALOCUS-SCDHHS provider certification (ages 6-21),
- the QIO prior authorization request form,
- the Parent/Caregiver/Guardian Agreement to Participate in Community Support Services (for child beneficiaries),
- the IPOC,
- the most recent 90-day progress summary.

Should a beneficiary's treatment needs change with respect to the type of and/or frequency of each Community Support Service, the private provider must receive confirmation from the referring state agency to change the service type and/or frequency. Evidence of the state agency's confirmation of such changes may be included in a letter or email correspondence. This evidence shall be maintained in the beneficiary's clinical record.

FEE-FOR-SERVICE SERVICE LIMIT EXCEPTION PROCESS

There may be clinical exceptions to the service limits when the number of units or encounters allowed may not be sufficient to meet to the complex and intensive needs of a beneficiary. On these occasions, requests for frequencies beyond the service limits may be submitted directly to the South Carolina Department of Health and Human Services (SCDHHS) for approval. The table below identifies the required documentation for these requests.

Required Documentation for Requests
• Most recent Diagnostic Assessment • IPOC

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- The most recent Service Plan Development (SPD) note
- All CSNs for all services rendered to beneficiary during the previous 90-days of request, including PMA and SPD notes
- Parent/Caregiver/Guardian Agreement to Participate in Community Support Services form, as applicable
- QIO approval letter
- Fax Cover Sheet for RBHS Exceptions (if applicable)
- RBHS Exception Request Form

FEE-FOR-SERVICE SERVICE LIMIT EXCEPTION PROCESS (CONT'D.)

Requests must be complete and submitted in accordance with the defined sets of documentation requirements noted above. Requests that do not meet all of the requirements will not be processed.

Requests can be submitted to SCDHHS via the following methods:

- Fax: "Attn: RBHS Exceptions" to 803-255-8204
  - A fax cover sheet must be included with the fax
- **Encrypted** email to behavioralhealth002@scdhhs.gov

SCDHHS will either approve or deny, or request additional information within 10 business days of receipt of the request. The provider will be notified in writing if additional information is required. Additionally, should the request be denied, the provider will be notified in writing. The denial letter will explain how the provider may appeal the decision.

STAFF QUALIFICATIONS

All providers of Rehabilitative Behavioral Health Services must fulfill the requirements for South Carolina licensure/certification and appropriate standards of conduct by means of evaluation, education, examination, and disciplinary action regarding the laws and standards of their profession as promulgated by the South Carolina Code of Laws and established and enforced by the South Carolina Department of Labor Licensing and Regulation. Professionals, who have received appropriate education, experience, have passed prerequisite examinations as required by the applicable state laws and licensing/certification board and additional requirements as may be further established by SCDHHS, may qualify to provide Rehabilitative Behavioral Health Services. **The presence of licensure/certification means the established licensing board in accordance with SC Code of Laws,**

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STAFF QUALIFICATIONS (CONT'D.)

or the state in which the individual is practicing, has granted the authorization to practice in the state. Licensed professionals must maintain a current license and/or certification from the appropriate authority to practice in the State of South Carolina, or the state in which licensed clinical professionals render services, and must be operating within their scope of practice.

Medicaid Rehabilitative Staff Qualifications

Title of Professional	Level of Education/Degree/or Experience Required	License or Certification Required	State or Licensure Law	Services Able to Provide
PROFESSIONALS				
Psychiatrist	Doctor of medicine or osteopathy and has completed a residency in psychiatry	Licensed by SC Board of Medical Examiners	40-47-5 et seq.	All Services, except PSS
Physician	Doctor of medicine or osteopathy	Licensed by SC Board of Medical Examiners	40-47-5 et seq.	All Services, except PSS, PT
Psychologist	Doctoral degree in psychology	Licensed by SC Board of Psychology Examiners	40-55-20 et seq.	All Services except PSS
Physician Assistant (PA)	Completion of an educational program for physician assistants approved by the Commission on Accredited Allied Health Education Programs	Licensed by SC Board of Medical Examiners	40-47-905 et seq.	All Services, except PSS, PT
Pharmacist	Doctor of Pharmacy degree from an accredited school, college, or department of pharmacy as determined by the Board, or has received the Foreign Pharmacy Graduate Equivalency Certification issued by the National Association of Boards of Pharmacy (NABP)	Licensed by SC Board of Pharmacy	40-43-10 et seq.	MM
Advanced Practice Registered Nurse (APRN)	Doctoral, post-nursing master's certificate, or a minimum of a master's degree that includes advanced education composed of didactic and supervised clinical practice in a specific area of advanced practice registered nursing	Licensed by SC Board of Nursing; must achieve and maintain national certification, as recognized by the board, in an advanced practice registered nursing specialty	40-33-10 et seq.	All Services, except PSS, PT
Licensed Psycho-Educational Specialist	Master's degree plus 30 hours of psychopathology class, successfully complete the ETS School Psychology exam (PRAXIS), and be licensed	Licensed by SC Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists and Psycho-Educational Specialists	40-75-510 et seq.	B-Mod, BHS, CM, DA, FS, FP, GP, IP, MFGP, PRS, SPD, SAC,ST, PTR, ADA, ADS,CIS, TCC

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Title of Professional	Level of Education/Degree/or Experience Required	License or Certification Required	State or Licensure Law	Services Able to Provide
PROFESSIONALS				
Licensed Independent Social Worker – Clinical Practice (LISW-CP)	Master's or doctoral degree from a Board-approved social work program	Licensed by SC Board of Social Work Examiners	40-63-5 et seq.	B-Mod, BHS, CM, DA, FS, FP, GP, IP, MFGP, PRS, SPD, SAC,ST, PTR, ADA, ADS, CIS, TCC
Licensed Masters Social Worker (LMSW)	Master's or a 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	Licensed by SC Board of Social Work Examiners	40-63-5 et seq.	B-Mod, BHS, CM, DA**, FS, FP*, GP*, IP*, MFGP*, PRS, SPD, SAC, ST, PTR, ADA, ADS, CIS, TCC
Licensed Marriage and Family Therapist (LMFT)	A minimum of 48 graduate semester hours or 72 quarter hours in marriage and family psychotherapy along with an earned master's degree, specialist's degree, or doctoral degree. Each course must be a minimum of at least a 3 semester hour graduate level course with a minimum of 45 classroom hours or 4.5 quarter hours; one course cannot be used to satisfy two different categories.	Licensed by SC Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists and Psycho-Educational Specialists	40-75-5 et seq.	B-Mod, BHS, CM, DA, FS, FP, GP, IP, MFGP, PRS, SPD, SAC, ST, PTR, ADA, ADS, CIS, TCC
Licensed Professional Counselor (LPC)	A minimum of 48 graduate semester hours during a master's degree or higher degree program and have been awarded a graduate degree as provided in the regulations. All coursework, including any additional core coursework, must be taken at a college or university accredited by the Commission on the Colleges of the Southern Association of Colleges and Schools, one of its transferring regional associations, the Association of Theological Schools in the United States and Canada, or a post-degree program accredited by the Commission on Accreditation for Marriage and Family therapy Education or a regionally accredited institution of higher learning subsequent to receiving the graduate degree.	Licensed by SC Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists and Psycho-Educational Specialists	40-75-5 et seq.	B-Mod, BHS, CM, DA, FS, FP, GP, IP, MFGP, PRS, SPD, SAC,ST, PTR, ADA, ADS, CIS, TCC

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Title of Professional	Level of Education/Degree/or Experience Required	License or Certification Required	State or Licensure Law	Services Able to Provide
PROFESSIONALS				
Behavior Analyst	Must possess at least a master's degree, have 225 classroom hours of specific graduate-level coursework, meet experience requirements, and pass the Behavior Analysis Certification Examination	Behavior Analyst Certification Board	N/A	B-Mod, BHS, CM, DA** FS, FP*, GP*, IP*, MFGP*, PRS, SPD, SAC, ST, PTR, ADA, ADS, CIS, TCC
Certified Substance Abuse Professional	Master's degree in counseling, social work, family therapy, nursing, psychology, or other human services field, and/or 250 hours of approved training related to the core functions and certification as an addictions specialist	SC Association of Alcoholism and Drug Abuse Counselors Certification Commission and/or NAADAC Association for Addiction Professionals	40-75-300	B-Mod, BHS, CM, DA**, FS, FP*, GP*, IP*, MFGP*, PRS, SPD, SAC, ST, PTR, ADA, ADS, CIS, TCC
Clinical Chaplain	Master of Divinity from an accredited theological seminary and have two years of pastoral experience as a priest, minister, or rabbi and one year of clinical pastoral education that includes a provision for supervised clinical services and one year of experience working with the population to be served	Documentation of training and experience	40-75-290	B-Mod, BHS, CM, DA**, FS, FP*, GP*, IP*, MFGP*, PRS, SPD, SAC, ST, PTR, ADA, ADS, CIS, TCC
Qualified Mental Health Professional (QMHP)	Master's or doctoral degree from a program that is primarily psychological in nature (*e.g.*, counseling, guidance, or social science equivalent) from an accredited university or college and one year of experience working with the population to be served, working for a South Carolina State Agency		40-75-290	B-Mod, BHS, CM, DA, FS, FP, GP, IP, MFGP, PRS, SPD, SAC, ST, PTR, ADA, ADS, CIS, TCC
Mental Health Professional (MHP)	Master's or doctoral degree from a program that is primarily psychological in nature (*e.g.*, counseling, guidance, or social science equivalent) from an accredited university or college and one year of experience working with the population to be served		40-75-290	B-Mod, BHS, CM, DA**, FS, FP*, GP*, IP*, MFGP*, PRS, SPD, SAC, ST, PTR, ADA, ADS, CIS, TCC

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Title of Professional	Level of Education/Degree/or Experience Required	License or Certification Required	State or Licensure Law	Services Able to Provide
PROFESSIONALS				
Substance Abuse Professional (SAP)	Bachelor's degree in a health or human services related field and certification as a certified addiction counselor or in the process of becoming SCAADAC credentialed or be certified by SCAADAC	SC Association of Alcoholism and Drug Abuse Counselors Certification Commission	40-75-300 et seq.	B-Mod, BHS, CM, FS, PRS, SAC, ST, ADA, ADS, (Assist with developing the SPD), CIS, TCC
Licensed Bachelor of Social Work (LBSW)	Bachelor's degree in social work. (The practice of baccalaureate social work is a basic generalist practice that includes assessment, planning, intervention, evaluation, mediation, case management, information and referral, counseling, advocacy, supervision of employees, consultation, client education, research, community organization, and the development, implementation, and administration of policies, programs, and activities. Baccalaureate social workers are not qualified to diagnose and treat mental illness nor provide psychotherapy services. Baccalaureate social work is practiced only in organized settings such as social, medical, or governmental agencies and may not be practiced independently or privately.)	Licensed by SC Board of Social Work Examiners	40-63-5 et seq.	B-Mod, BHS, CM, FS, PRS, SAC, ST, ADA, ADS, SPD, CIS, TCC
Behavior Analyst	A board certified associate behavior analyst must have at least a bachelor's degree, have 135 classroom hours of specific coursework, meet experience requirements, and pass the Associate Behavior Analyst Certification Examination.	Behavior Analyst Certification Board	N/A	B-Mod, BHS, CM, FS, PRS, SAC, ST, ADA, ADS (Assist with developing the SPD), CIS, TCC
Licensed Registered Nurse (RN)	At a minimum, an associate's degree in nursing from a Board- approved nursing education program and one year of experience working with the population to be served	Licensed by SC Board of Nursing	40-33-10 et seq.	B-Mod, FS, MM, PRS, MA, ST, ADA, ADS, VI,CIS, TCC
Licensed Practical Nurse (LPN)	Completion of an accredited program of nursing approved by the Board of Nursing and one year of experience working with the population to be served, a high school diploma or GED equivalent	Licensed by SC Board of Nursing	40-33-10 et seq.	MM, MA, ADN, ADS, VI
PARAPROFESSIONALS				

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Title of Professional	Level of Education/Degree/or Experience Required	License or Certification Required	State or Licensure Law	Services Able to Provide
PROFESSIONALS				
Child Service Professional	Bachelor's degree from an accredited university or college in psychology, social work, early childhood education, child development or a related field or bachelor's degree in another filed and has a minimum of 45 documented training hours related to child development and children's mental health issues and treatment	None required	N/A	B-Mod, BHS, CM, FS, PRS, SAC, ST, ADA, ADS, (Assist with developing the SPD), TCC,CIS
PARAPROFESSIONALS (PRIVATE RBHS PROVIDERS DIRECTLY SERVING CHILDREN AND ADOLESCENTS IN THERAPEUTIC FOSTER CARE PLACEMENT)				
Child Service Professional	Bachelor's degree from an accredited university or college in psychology, social work, early childhood education, child development or a related field or bachelor's degree in another filed and has a minimum of 45 documented training hours related to child development and children's mental health issues and treatment	None required	N/A	B-Mod, BHS, CM, FS, PRS, SAC, ST, ADA, ADS, (Assist with developing the SPD),TCC, CIS
Mental Health Specialist	At a minimum, a high school diploma or GED equivalent and have three years of documented direct care experience working with the identified target population or completion of an approved 30 hour training and certification program		N/A	PRS, B-Mod, FS
PARAPROFESSIONALS (DAODAS ONLY)				
Substance Abuse Specialist	At a minimum, a high school diploma or GED equivalent and have three years of documented direct care experience working with the identified target population or completion of an approved training and certification program		N/A	PRS, B-Mod, FS, ST
Peer Support Specialist	High school diploma or GED equivalent peer support providers must successfully complete a pre-certification program that consists of 40 hours of training. The curriculum must include the following topics: recovery goal setting; wellness recovery plans and problem solving; person centered services; and advocacy. Additionally, peer support providers must complete a minimum of 20 hours of continuing education training annually, of which at least 12 hours must be face-to-face training.	Certification as a Peer Support Specialist	N/A	PSS

*Private service providers must be licensed at an independent level, or be under an *approved* supervision contract *if allowable* by their respective licensing board.

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**As of April 1, 2016, private service providers must be licensed practitioners of the healing arts in order to conduct a Diagnostic Assessment. LMSWs must have DA's cosigned by independent LPHAs.

SERVICE KEY					
Service	**Abbr.**	**Service**	**Abbr.**	**Service**	**Abbr.**
Alcohol and Drug Assessment *	ADA	Family Psychotherapy	FP	Psychosocial Rehabilitation Service	PRS
Alcohol and Drug Nursing Assessment*	ADN	Group Psychotherapy	GP	Psychological Testing and Evaluation	PTE
Alcohol and Drug Screening *	ADS	Individual Psychotherapy	IP	Psychological Testing & Reporting *	PTR
Behavior Modification	B-Mod	Vivitrol Injection*	VI	Service Plan Development	SPD
Behavioral Health Screening	BHS	Medication Administration *	MA	Skills Training and Development *	ST
Crisis Management	CM	Medication Management	MM	Alcohol and Drug Substance Abuse Counseling *	SAC
Diagnostic Assessment	DA	Medical Evaluation and Management*	E&M	Multiple Family Group Psychotherapy	MFGP
Family Support	FS	Peer Support Service **	PSS	Community Integration Services	CIS
Therapeutic Child Care	TCC				

***Service provided by DAODAS only.**

****Services provided only by DMH and DAODAS providers.**

STAFF QUALIFICATIONS (CONT'D.)

Please refer to the Core and Community Support Services sections for specific service requirements. Providers are subject to termination or denial of services if they are not in compliance with current policies and procedures.

STAFF MONITORING/ SUPERVISION STAFF

Rehabilitative Behavioral Health Services provided by licensed or certified professionals must follow supervision requirements as required by South Carolina State Law or the state law in which the individual is practicing, for each respective profession.

Services provided by any unlicensed/uncertified professionals must be clinically supervised by a master's level qualified clinical professional or an LPHA.

Services provided by master's level clinical professionals must be clinically supervised by an LPHA licensed to practice at the independent level.

Substance Abuse professionals who are in the process of becoming credentialed must be supervised by a certified substance abuse professional or an LPHA.

Licensed and/or master's level clinical professionals have the responsibility of planning and guiding the delivery of

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STAFF MONITORING/ SUPERVISION STAFF (CONT'D.)

services provided by unlicensed or uncertified professionals. These clinical professionals will evaluate and assess the beneficiary, as needed.

When services are provided by an unlicensed or uncertified professional, the state agency or private organization must ensure the following:

- The qualified licensed or master's level clinical professional who monitors the performance of the unlicensed professional must provide documented consultation, guidance, and education with respect to the clinical skills, competencies, and treatment provided, at least every 30 days.
- The supervising licensed or master's level clinical professional must maintain a log documenting supervision of the services provided by the unlicensed or uncertified professional to each beneficiary.
- Supervision may take place in either a group or individual setting. Supervision must include opportunities for discussion of the plan of care and the individual beneficiary's progress. Issues relevant to an individual beneficiary will be documented in a service note in the clinical record.
- Case supervision and consultation does not supplant training requirements. The frequency of supervision should be evaluated on a case-by-case basis.

TRAINING

Providers are expected to operate within current best practices to ensure competence and quality performance of staff. Training is essential to the development of a competent workforce capable of providing quality Rehabilitative Behavioral Health Services. Training provides the opportunity to respond to and strengthen the individual needs and skills of employees, subsequently strengthening and supporting the individual needs and skills of beneficiaries served. The following table outlines the training requirements for staff of RBHS:

Rehabilitative Behavioral Health Service Trainings			
Training:	**Orientation**	**Core Services**	**Community Support Services**
Timeframe to Complete:	Prior to rendering any services	Within first 60 days of hire	Within first 60 days of hire

SECTION 2 POLICIES AND PROCEDURES

ELIGIBILITY FOR REHABILITATIVE SERVICES

Rehabilitative Behavioral Health Service Trainings			
Minimum # of Hours Required	**20** total hours	**8** total hours	**8** hours minimum *plus* an additional **3** hours of "Service Specific Training" for each specific service to be rendered by individual staff (PRS, B-MOD, and FS)
Minimum # of Hours Required	**Topics/Areas that must be covered**	**Topics/Areas that must be covered**	**Topics/Areas that must be covered**
Required Material to be Covered	• Confidentiality/Protected Health Information* • Beneficiary Rights* • Prohibition of Abuse, Neglect, & Exploitation* • Overview of provider's Policy and Procedures • Ethics & Professional Conduct • Overview of Behavioral Health • Health & Safety/ Emergency Preparedness* • Workplace Violence • Cultural Competency/Diversity • Fraud, Waste, & Abuse • Overview of Service Documentation Expectations & Completion • Medicaid Billing *Additional information provided below	• Crisis Response and Intervention • IPOC Development • Person Centered Values, Principles, and Approaches • Assessments	• 8 hours minimum, covering the following topics: o Crisis Response and Intervention o IPOC Development o Person Centered Values, Principles, and Approaches o Childhood/Adolescent Development (if serving) • 3 hours minimum for each CSS Service Specific Training, covering the following topics: o Purpose and Service Description o Medical Necessity criteria for all populations served o Staff Qualifications o Staff-to-Beneficiary Ratio o Billing Frequency o Billable Place of Service o Non-Billable Medicaid Activities o Documentation Requirements
Minimum # of Hours Required	**Topics/Areas that must be covered**	**Topics/Areas that must be covered**	**Topics/Areas that must be covered**
			o Modalities o Interventions Example: Staff A renders both FS and B-Mod to beneficiaries. Staff A must have 3 hours of FS training and 3 hours of B-Mod training Interventions

Resources:

Confidentiality/Protected Health Information
Overview of Code of Federal Regulation, Title 45 CFR, Section 164.502 (45 CFR 164.502 - Uses and disclosures of protected health information: General rules) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Beneficiary Rights
Overview of the following (but not limited to):
- Title VI of the Civil Rights Act of 1964 that prohibits any discrimination due to race, color, or national origin (45 CFR Part 80)

SECTION 2 POLICIES AND PROCEDURES

ELIGIBILITY FOR REHABILITATIVE SERVICES

Rehabilitative Behavioral Health Service Trainings
- 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) - The Age Discrimination Act of 1975 that prohibits discrimination on the basis of age (45 CFR Parts 90 and 91) - Appeal - Freedom of Choice **Prohibition of Abuse, Neglect, & Exploitation** Focuses on mandated reporting, the provider's reporting policy, requirements for reporting abuse, neglect, exploitation, and disciplinary actions (internally and lawfully) which may be taken as a result of failure to report or follow policy and procedures. **Health & Safety/ Emergency Preparedness** Focuses on procedures detailing actions to be taken in the event or occurrence of a natural disaster (*e.g.*, tornado, hurricane, flood, earthquake, ice storm, snow storm, and etc.) and/or violent or other threatening situation (*e.g.*, explosion, gas leak, biochemical threats, acts of terrorism, and use of weapons, and etc.).

STAFF-TO-BENEFICIARY RATIO

Staff-to-beneficiary ratios are established for safety and therapeutic efficacy concerns. Ratios must be met and maintained at all times when services are rendered. Ratios must be maintained in accordance with the requirements of each individual service standard. Staff involved in the treatment delivery must have direct contact with beneficiaries. Staff present, but not involved in the treatment delivery, cannot be included in the ratio. Staff shall be in direct contact and involved with the beneficiary's activities during service delivery.

If at any time during the delivery of a service, the staff-to beneficiary ratio is not in accordance with the service standard, billing for beneficiaries in excess of the required ratio should be discontinued and subject to recoupment. **The ratio count applies to all participants receiving services from the provider regardless of whether or not the beneficiary is Medicaid eligible.**

Appropriately credentialed staff must be substituted or group sizes must be adjusted to meet the service standard requirements.

When services are provided in a group setting, the provider must maintain a list of beneficiaries and individuals present in the group and the staff person(s) responsible for service delivery. This documentation must be available upon request.

EMERGENCY SAFETY INTERVENTION (ESI)

The Emergency Safety Intervention (ESI) policy applies to any community-based provider that has policies

SECTION 2 POLICIES AND PROCEDURES

ELIGIBILITY FOR REHABILITATIVE SERVICES

EMERGENCY SAFETY INTERVENTION (ESI) (CONT'D.)

prohibiting the use of seclusion or restraints, but who may have an emergency situation requiring staff intervention. Providers must have a written policy and procedure for emergency situations and must ensure that direct care staff are prepared and trained in the event of an emergency.

If the provider intends to use restraint and/or seclusion, the provider is responsible for adhering to the following requirements:

- Providers must ensure that all staff involved in the direct care of a beneficiary successfully complete a training program from a certified trainer in the use of restraints and seclusion prior to ordering or participating in any form of restraint.
- Training should be aimed at minimizing the use of such measures, as well as ensuring the beneficiary's safety. For more information on selecting training models, go to the *Project Rest Manual of Recommended Practice*, available at http://www.frcdsn.org/rest.html.
- Providers must have a comprehensive written policy that governs the circumstances in which seclusion or restraints are being used that adheres to all state licensing laws and regulations (including all reporting requirements).

Failure to have these policies and staff training in place at the time services are rendered will result in termination from the Medicaid program and possible recovery of payments.

COORDINATION OF CARE

COORDINATION OF CARE

It is the responsibility of all service providers to coordinate care among all entities that render services to beneficiaries.

If a beneficiary is receiving treatment from multiple service providers, there should be evidence of care coordination in the beneficiary's clinical record. Coordination of care serves to promote continuity of care and ensure there is no duplication in services or billing. **Duplicated services cannot be reimbursed under Medicaid** and providers shall make every effort to contact other service providers involved in the current course of treatment for the beneficiary to ensure services are complimentary to one another and not duplicative in nature. In the event separate RBHS providers render

SECTION 2 POLICIES AND PROCEDURES

ELIGIBILITY FOR REHABILITATIVE SERVICES

COORDINATION OF CARE

COORDINATION OF CARE (CONT'D.)

services to the same beneficiary, coordination of care is essential to ensure the IPOCs are not in conflict with one another or the desired outcomes of the beneficiary.

PROVIDER CHOICE

Beneficiaries shall have free choice of any qualified enrolled Medicaid provider. The provider must assure that the provision of services will not restrict the beneficiary's freedom of choice and it is not in violation of section 1902(a)(23) of the Social Security Act.

OUT-OF-HOME PLACEMENT

In accordance with the Code of Federal Regulations, 42 CFR § 435.1009-1011, Rehabilitative Behavioral Health Services are not available for beneficiaries residing in an institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. An institution may deemed as an Institution for Mental Diseases (IMD) based on its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.

Inpatient Psychiatric Hospitals and Psychiatric Residential Treatment Facilities (PRTF) receive a per diem payment that is considered all-inclusive. Rehabilitative Behavioral Health Services provided to beneficiaries in these settings are not Medicaid reimbursable.

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

All Rehabilitative Behavioral Health Services (RBHS) providers shall maintain a clinical record for each Medicaid-eligible beneficiary that fully describes the extent of the treatment services provided. The clinical record must contain documentation sufficient to justify Medicaid participation, and should allow an individual not familiar with the beneficiary to evaluate the course of treatment. The absence of appropriate and complete records, as described below, may result in recoupment of payments by SCDHHS. An index as to how the clinical record is organized must be maintained and made available upon request.

Each provider shall have the responsibility of maintaining accurate, complete, and timely records and ensure the confidentiality of the beneficiary's clinical record.

The beneficiary's clinical record must include, at a minimum, the following:

- Comprehensive Diagnostic Assessment(s) and other assessments, as applicable
- Assessment tool(s), administered and scored by a qualified clinician, as applicable
    - Parenting Stress Index (PSI) (birth to 1.5 years), or
    - The Child Behavior Check List (1.5 -5 years), or
    - CALOCUS administered by a qualified clinical professional with a CALOCUS-SCDHHS provider certification (ages 6-21)

      (Exclusion to assessment tools: State agencies directly rendering RBHS and all providers directly rendering services to beneficiaries in foster care)
- Parent/Caregiver/Guardian Agreement to Participate in Community Support Services form, as applicable

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

DOCUMENTATION REQUIREMENTS (CONT'D.)

- Signed, credentialed or functional titled, and dated IPOCs — initial, reviews, and reformulations
- Behavior Modification Plan (BMP), as applicable
- Signed, credentialed or functional titled, and dated 90-day Progress Summaries
- Signed, credentialed or functional titled, and dated Clinical Service Notes (CSNs)
- RBHS Referral Form, as applicable
- QIO approval letter, as applicable
- Court orders, if applicable
- Copies of any evaluations and or tests, if applicable
- Signed releases, consents, and confidentiality assurances for treatment
- Physician's orders, laboratory results, lists of medications, and prescriptions (when performed or ordered)
- Copies of written reports (relevant to the beneficiary's treatment)
- Medicaid eligibility information, if applicable
- Other documents relevant to the care and treatment of the beneficiary

CONSENT TO EXAMINATIONS AND TREATMENT

A consent form, dated and signed by the beneficiary, parent, legal guardian, or primary caregiver (in cases of a minor), or legal representative, must be obtained at the onset of treatment from all beneficiaries and placed in the beneficiary's file from each treatment provider. If the beneficiary, parent, legal guardian, or legal representative cannot sign the consent form due to a crisis, and is accompanied by a next of kin or responsible party, that individual may sign the consent form. If the beneficiary is alone and unable to sign, a statement such as "beneficiary unable to sign and requires emergency treatment" must be noted on the consent form and must be signed by the LPHA and one other staff member. The beneficiary, parent, legal guardian, or legal representative should sign the consent form as soon as circumstances permit. A new consent form should be signed and dated each time a beneficiary is readmitted to the system after discharge.

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

CONSENT TO EXAMINATIONS AND TREATMENT (CONT'D.)

Consent forms are not necessary to conduct court ordered examinations. However, a copy of the court order must be kept in the clinical record.

CLINICAL SERVICE NOTES (CSNS)

The purpose of the Clinical Service Note (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.

Evidence of rendering services must be documented on CSNs. A CSN is required for each contact or service, for each date of service, for each beneficiary (if service was rendered in a group setting), and must be written and signed by the qualified staff who provided the service. Each CSN must support both the type of service billed and the number of units billed. Every CSN must be individualized to reflect treatment/service and interventions with a specific beneficiary, for each date of service, for each service rendered to the beneficiary and/or family. The content of CSNs shall not be duplicated, be it among the records of beneficiaries served by the provider and/or among dates of service for any one beneficiary served by the provider. If CSNs are not completed and maintained in accordance with the requirements in this manual, payments to the provider shall be subject to recoupment.

The CSN must include the following information:

- The beneficiary's name and Medicaid ID
- The date of service
- The name of the rehabilitative service (or its approved abbreviation) and the corresponding procedure code
- The number of units of service rendered
- The date of service in a month, day, and year format
- Document the start time and end time for each service delivered (Exclusion: Clubhouse program CSNs and foster parent CSNs are not required to reflect start and stop times)

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

CLINICAL SERVICE NOTES (CSNS) (CONT'D.)

- Location where the service was rendered (Refer to the Billable Code/Location of Service section for additional information.)
- The manner in which the service was delivered: individual or group; if the service is provided in a group setting, the number of participants must be identified on the CSN
- Be typed and/or handwritten – documentation must be legible
- Be kept in chronological order
- Abbreviations must be decipherable – if abbreviations are used, the provider must maintain a list of abbreviations and their meanings and the list must be made available to SCDHHS upon request
- Reference individuals by full name, title and agency or provider affiliation at least once in each note, as applicable
- Identification of other beneficiaries by name shall not be included
- Be signed, credentialed or functional titled, and signature dated (month/date/year) by the qualified staff who provided the service. The signature verifies that the services were provided in accordance with these standards.
- Billing modifiers must match the credentials of the individual rendering the service.
- Be completed and placed in the beneficiary's record immediately following the delivery of the service, but no later than five business days from the date of rendering the service

Providers must maintain adequate documentation to (1) support the number of units or encounters billed and to (2) support the each service billed.

Each CSN must address the following items to provide a pertinent clinical description and to ensure that the rehabilitative service conforms to the service description and authenticates the charges:

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

CLINICAL SERVICE NOTES (CSNS) (CONT'D.)

- The **focus** and/or reason for the session or interventions which should be related to treatment objective(s) and/or goal(a) on the IPOC, unless there is an unexpected event that needs to be addressed
- The detailed summary of the **interventions** (*e.g.,* action steps, tools used, techniques utilized, etc.) and involvement of qualified staff with the beneficiary and/or family during each contact or session/meeting (only time spent rendering the intervention or treatment can be billed – see the Non-Billable Medicaid Activities section of the manual for additional information)
- The individualized **response** of the beneficiary and/or beneficiary's family, as applicable, to the interventions and/or treatment rendered at each contact or session/meeting.
- The general **progress** of the beneficiary to include observations of their conditions/ mental status. Progress should reflect detailed individualized information about the beneficiary over the course of treatment and shall not reflect general categories of progress or general statements of progress in treatment (*e.g.,* Phrases such as "Moderate" or "Not making progress" without providing detailed information to support the identification of these will not meet this standard).
- The future **plan** for working with the beneficiary and the beneficiary's family, as applicable. This should reflect the plan of action for the next and foreseeable future sessions/meetings with the beneficiary (*e.g.,* Statements such as "Will continue to meet with person as per IPOC" will not meet this standard).

SERVICE UNIT CONTACT TIME

SCDHHS has adopted the Medicare 8 Minute Rule for services. This means that when indicated by any discrete RBHS service, a provider may not bill for a service of less than eight minutes. The actual minutes billed by any one provider in a day shall not exceed the daily unit limits. If any RBHS 15-minute service is performed for seven minutes or less on any day, the service is not reimbursable.

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

SERVICE UNIT CONTACT TIME (CONT'D.)

The expectation is that a provider's direct beneficiary contact time for each unit will average 15 minutes in length. If a provider has a consistent practice of billing less than 15 minutes for a unit, these situations will be highlighted for review.

Units	Time
1	Equal to 8 minutes but less than 23 minutes
2	Greater than/equal to 23 minutes, but less than 38 minutes
3	Greater than/equal to 38 minutes, but less than 53 minutes
4	Greater than/equal to 53 minutes, but less than 68 minutes
5	Greater than/equal to 68 minutes, but less than 83 minutes
6	Greater than/equal to 83 minutes, but less than 98 minutes
7	Greater than/equal to 98 minutes, but less than 113 minutes
8	Greater than/equal to 113 minutes, but less than 128 minutes
9	Greater than/equal to 128 minutes, but less than 143 minutes
10	Greater than/equal to 143 minutes, but less than 158 minutes
11	Greater than/equal to 158 minutes, but less than 173 minutes
12	Greater than/equal to 173 minutes, but less than 188 minutes
13	Greater than/equal to 188 minutes, but less than 203 minutes
14	Greater than/equal to 203 minutes, but less than 218 minutes
15	Greater than/equal to 218 minutes, but less than 233 minutes
16	Greater than/equal to 233 minutes, but less than 248 minutes

AVAILABILITY OF CLINICAL DOCUMENTATION

CSNs and other service documentation should be completed and placed in the clinical record immediately following the delivery of a service, but no later than five business days from the date of service. Any documentation completed and placed in the clinical records for any billed activity after this deadline shall be subject to recoupment.

Services must be documented in the clinical record and the documentation must justify the amount of reimbursement claimed to Medicaid.

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

BILLABLE CODE/LOCATION OF SERVICE

See the "Billable Place of Service" heading for each service under "Program Services" in this section. The following list provides the codes most commonly used:

03 — School

11 — Clinician or Doctor's Office

12 — Home

19 — Off Campus Hospital

22 — Outpatient Hospital

23 — Emergency Room

53 — Community Mental Health Center

55 — Substance Abuse Residential Facility

57 — Non-Residential Substance Abuse Facility

99 — Other Unlisted Facility (excluding recreational settings)

ABBREVIATIONS AND SYMBOLS

Service providers shall maintain a list of abbreviations and symbols used in clinical documentation, which leaves no doubt as to the meaning of the documentation. An abbreviation key must be maintained to support the use of abbreviations and symbols in entries. Providers must furnish the list and abbreviation key upon request of SCDHHS and/or its designee.

LEGIBILITY

All clinical documentation must be filed in chronological order. All clinical records must be current, consistently organized, and meet documentation requirements. Records must be arranged in a logical order so they can be easily and clearly reviewed, copied, and audited.

Original legible signature and credentials (*e.g.*, RN, LPC, etc.), or functional title (if not licensed or in possession of a degree from a higher institution of learning [*e.g.*, Child Service Professional]), of the person rendering the service must be present in all clinical documentation. Photocopied signatures, stamped signatures, or signatures of anyone other than the person rendering the service or co-signature, when required, are not acceptable. (See Section 1 of this manual for the use of electronic signatures and/or exceptions.)

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

ERROR CORRECTION

Clinical records are legal documents. Staff should be extremely cautious in making alterations to the records. In the event that errors are made, staff must 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. If an explanation is necessary to explain the corrections, they must be entered in a separate CSN.

LATE ENTRIES

Late entries (entries to provide additional documentation to supplement entries previously written) may be necessary at times to handle omissions in documentation. Late entries should rarely be used, and then only to correct a genuine error of omission or to add new information that was not discovered until a later time. When late entries are made, adhere to the following guidelines:

- Identify the new entry as a "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, documentation shall be completed within 10 business days of the date of service.

RECORD RETENTION

Clinical records shall be retained for a period of five years. If any litigation, claim, or other actions involving the records have been initiated prior to the expiration of the five-year period, the records shall be retained until completion of the action and resolution of all issues that arise from it or until the end of the five-year period, whichever is later. In the event of an entity's closure, providers must notify SCDHHS regarding medical records.

Clinical records must be arranged in a logical order to

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

RECORD RETENTION (CONT'D.)

facilitate the review, copy, and audit of the clinical information and course of treatment. Clinical records will be kept confidential in conformance with the Health Insurance Portability and Accountability Act (HIPAA) regulations and safeguarded as outlined in Section 1 of this manual. Questions regarding access to protected information should be referred to the PSC. Provider can also submit an online inquiry at http://www.scdhhs.gov/contact-us to request additional information.

All Protected Health Information (PHI) stored on portable devices must be encrypted. Portable devices include all transportable devices that perform computing or data storage manipulation or transmission including, but not limit to, diskettes, CDs, DVDs, USB flash drives, laptops, PDAs, Blackberries, cell phones, portable audio/video devices (such as iPods, MP3 and MP4 players), and personal organizers.

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

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SECTION 2 POLICIES AND PROCEDURES

BILLING REQUIREMENTS

NON-BILLABLE MEDICAID ACTIVITIES

The following is a list of activities that are not Medicaid-reimbursable under the Rehabilitative Behavioral Health Services policy. Professional judgment should be exercised in distinguishing between billable and non-billable activities. The following list is not an exhaustive list, but serves as a guide to identify activities that may not be billed as RBHS include:

- Transportation and/or travel time
- Transportation of beneficiaries
- Any activities to attempt contact with beneficiaries (*e.g.,* attempted phone calls, home visits, and face-to-face contacts, etc.)
- "Outreach" activities in which an agency or a provider attempts to contact potential Medicaid recipient
- Record audits or chart reviews
- Review of clinical record to become familiar with a beneficiary's case
- Staff meetings, trainings and supervision
- Activities provided by anyone other than a person who meets the qualifications to render a service
- Completion of any specially requested information regarding beneficiaries from the state office or from other agencies for administrative purposes
- Any social or recreational activities, or the supervision of such activities (*e.g.,* playing basketball, watching movies, etc.)
- Life Coaching
- Mentoring beneficiaries
- Documentation of service notes
- Unstructured client time (Periods of inactivity, free, and unstructured time may be necessary for a client, but is not part of a billable service.)

SECTION 2 POLICIES AND PROCEDURES

BILLING REQUIREMENTS

NON-BILLABLE MEDICAID ACTIVITIES (CONT'D.)

- Educational services provided by the public school system such as homebound instruction, special education or defined educational courses (*e.g.*, GED, Adult Development), or tutorial services in relation to a defined education course
- Education interventions that do not include individual process interactions
- Services provided to teach academic subjects or as a substitute for educational personnel (*e.g.*, a teacher, teacher's aide, an academic tutor, etc.)
- Shadowing beneficiary in the classroom
- Assisting beneficiary with homework or other educational assignments
- Any child care services or other services provided as a substitute for the parent or other primary care taker responsible for the beneficiary
- When prior authorization is required, dates of services not covered in the range of the QIO approval letter
- Services not identified on the IPOC (excluding those not required to be listed on the IPOC per policy)
- Services provided to children, spouse, parents or siblings of the beneficiary under treatment, or others in the beneficiary's life, to address problems not directly related to the beneficiary's issues and not listed on the beneficiary's IPOC
- Any art, movement, dance or drama therapies
- Filing, mailing, and faxing of any reports to other entities or individuals on behalf of the beneficiary
- Medicaid eligibility determinations and re-determinations
- Medicaid intake processing
- Completion of and monitoring of prior authorization requests for Medicaid services
- Required Medicaid utilization review
- Early and Periodic Screening Diagnostic and Treatment (EPSDT) administration

SECTION 2 POLICIES AND PROCEDURES

BILLING REQUIREMENTS

NON-BILLABLE MEDICAID ACTIVITIES (CONT'D.)

- Participation in job interviews
- The on-site instruction of specific employment tasks
- Staff supervision of actual employment services
- Assisting beneficiary in obtaining job placements
- Assisting clients in filling out applications (*i.e.*, job, disability, etc.)
- Assisting clients in performing the job or performing jobs for clients
- Drawing client's blood and/or urine specimen, and/or taking the specimen(s) to the lab
- Visiting beneficiaries while in another mental health service program, unless for a special treatment activity
- Retrieving medications for a beneficiary served by an RBHS provider and/or handing out prescriptions or medications
- Scheduling appointments with the physician or any other clinicians within same provider
- **S**taffing between clinicians in the same clinical unit within the RBHS provider for the purpose of supervision
- Waiting for and/or with a beneficiary in waiting rooms
- Respite care

COMPONENTS OF THE INDIVIDUAL PLAN OF CARE (IPOC)

Definition

The individual plan of care (IPOC) is an individualized comprehensive plan of care to improve the beneficiary's condition. The IPOC is developed in collaboration with the beneficiary, which may include an interdisciplinary team of the following: significant other(s), parent, guardian, primary caregiver, other state agencies and staff, or service providers. Multiple staff or members of an interdisciplinary team may participate in the process of developing,

SECTION 2 POLICIES AND PROCEDURES

BILLING REQUIREMENTS

Definition (Cont'd.)

preparing and/or reviewing the IPOC. While there may be certain treatment methodologies commonly utilized within a particular service, providers must ensure that services are tailored to the beneficiary's individual needs and the service delivery reflects knowledge of the particular treatment issues involved.

The assessment of the beneficiary is used to identify problems and needs, develop goals and objectives, and determine appropriate Rehabilitative Services and methods of intervention for the beneficiary. The IPOC outlines the service delivery needed to meet the identified needs and improve overall functioning.

The IPOC utilizes information gathered during the evaluation, screening and assessment process. The IPOC must be written to provide a beneficiary-centered and/or family-centered plan. The beneficiary must be given the opportunity to determine the direction of his or her IPOC. If family reunification or avoiding removal of the child from the home is a goal for the beneficiary, the family, legal guardian, legal representative, or primary caregiver must be encouraged to participate in the treatment planning process. Documentation of compliance with this requirement must be located in the beneficiary's record. If the family, legal guardian, legal representative, or primary caregiver is not involved in the treatment planning process, the reason must be documented in the beneficiary's clinical record. For adults, the family or a legal representative should be included as appropriate.

For beneficiaries receiving retroactive coverage, all other Medicaid service and documentation requirements must be met to receive Medicaid reimbursement for retroactively covered periods.

IPOC Documentation

Each provider is responsible for developing the IPOC. When the state agency refers for services and does not provide the IPOC, the private organization must develop the IPOC.

When state agencies refer beneficiaries to private RBHS providers for services, the private RBHS providers must adhere to the recommendations for services and specific frequencies set forth by the respective state agency.

IPOC documentation must meet all SCDHHS requirements

SECTION 2 POLICIES AND PROCEDURES

BILLING REQUIREMENTS

IPOC Documentation (Cont'd.)

and the following components listed below. If these components are also listed on the assessment, the assessment must be attached to the IPOC. It is important for overall health care and wellness issues to be addressed.

IPOC Components

The IPOC must include the following components:

Beneficiary Identification: Name and Medicaid ID number.

Presenting Problem(s): Statements that outline the beneficiary's specific needs that require treatment services. Statements that validate the need for treatment services based on medical necessity.

Psychiatric Diagnosis(es): The primary diagnosis that is the basis for the treatment planned, as well as the code and description according to the current edition of the DSM or the ICD.

For individuals who have more than one diagnosis regarding mental health, substance use and/or medical conditions, all diagnoses should be recorded.

Goals and Objectives: The IPOC should include a list of specific short-and long-term goals and objectives addressing the expected outcome of treatment. Goals and objectives should reflect input from the beneficiary and beneficiary's family, as applicable, and should be written so that they are observable, measurable, individualized (specific to the beneficiary's problems and/or needs) and realistic.

Goals are global statements that should reflect positive resolution to the beneficiary's identified needs and should include outcome measure(s) or expectation(s).

Objectives (short-term goals) are similar to and directly related to specified goals, but are highly specific and reflect small attainable steps to achieve goals.

The beneficiary's culture, community, support systems, environmental factors, and developmental and intellectual factors should be considered in the formulation of objectives.

Specific interventions: A list of specific therapeutic interventions (actions, activities, methods, etc.) used to meet the stated goals and objectives must be included. The identification of modalities to be used (*e.g.,* CBT, DBT,

SECTION 2 POLICIES AND PROCEDURES

BILLING REQUIREMENTS

IPOC Components (Cont'd.)

Motivational Interviewing, Psychoeducation, etc.) should be included as part of the interventions.

Specific services: All services to be rendered to beneficiaries and/or families must be identified on the IPOC (*e.g.*, Individual Therapy, Group Therapy, Family Therapy, Family Support, etc.)

Frequency of Services: The frequency must be listed on the IPOC for each service. Each service should be listed by its name or approved abbreviation with an individualized and specific planned frequency. The frequency must be appropriate to the needs of the beneficiary and beneficiary's family, as applicable, and shall not exceed medical necessity.

- Example: PRS frequency should be identified as the following:
  - PRS - 3 hours per day/2 days per week or PRS - 12 units per day/2 days per week
  - Should not be listed as PRS - Up to 20 hours a week.

Criteria for Achievement: Outline how success for each goal and objective will be demonstrated. Criteria must be reasonable, attainable, and measurable, must include target dates and must indicate a desired outcome to the treatment process.

Target Dates: A timeline for completion that is individualized to the beneficiary and their goals and objectives. Target dates should reflect projected incremental change over the course of a year, and should not uniformly reflect the annual expiration date of the IPOC.

Contact Information: Emergency contacts, including phone numbers, must be listed.

Discharge Plan: The IPOC must include a plan of action for discharge. This plan must include the anticipated date of discharge from services, beneficiary's and/or family's expected gains to be achieved through participation in treatment and services, and anticipated aftercare needed (if applicable).

SECTION 2 POLICIES AND PROCEDURES

BILLING REQUIREMENTS

IPOC Components (Cont'd.)

Beneficiary Signature: The beneficiary and guardian must sign the IPOC indicating they have been involved in the planning process and have been offered a copy of the IPOC. If the beneficiary does not sign the plan of care or if it is not considered appropriate for the beneficiary to sign the plan of care, the reason must be documented on the IPOC.

Authorized Signature(s): An LPHA, master's level staff or LBSW, the beneficiary, the clinician and/or interdisciplinary team which may include: significant other(s), parent, guardian, or primary caregiver, other state agencies, staff, or service providers must sign and date a signature sheet or the IPOC which identifies who is present during the IPOC meeting. If a separate signature sheet is completed, it must be kept with the IPOC.

The IPOC must be signed, titled and signature dated by the LPHA, master's level qualified clinical professional or LBSW. The IPOC must be filed in the beneficiary's clinical record with any supporting documentation such as the diagnostic assessment.

Services Not Required on the IPOC

The following services are **not** required to be listed on the IPOC:

- Diagnostic Assessment
- Crisis Management
- Service Plan Development
- Behavioral Health Screening

IPOC – CORE TREATMENT AND COMMUNITY SUPPORT SERVICES
DURATION • The initial IPOC must be completed, signed, titled, and signature dated by the LPHA or master's level qualified clinical professional within 30 calendar days of the Diagnostic Assessment. • Core Treatment Services may be rendered prior to the completion of the IPOC, provided the services are medically necessary. • If the IPOC is not completed and signed within 30 days, services rendered are not Medicaid reimbursable. **ADDENDUM** • When services are added or frequencies of services are changed in an existing IPOC, the addendum must include the signature and title of the clinician who formulated the addendum and the date it was formulated. All service changes must meet medical necessity criteria for each discrete service to be added. • The IPOC must be signed and dated by the reviewing LPHA or master's level qualified clinical professional to confirm changes.

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BILLING REQUIREMENTS

IPOC – CORE TREATMENT AND COMMUNITY SUPPORT SERVICES

- When space is unavailable on the current IPOC, a separate sheet must be added and labeled as "Addendum IPOC" and the addendum must accompany the existing IPOC.
- If changes and updates are made to the original IPOC, an updated copy must be provided to the beneficiary and other involved parties within 10 business days.

REFORMULATION

- The maximum duration of the IPOC is 365 calendar days from the date of the signature of the LPHA, or master's level qualified clinical professional on the IPOC.
- Prior to termination or expiration of the treatment period, the LPHA or master's level qualified clinical professional must review the IPOC with the beneficiary and evaluate the beneficiary's progress with respect to each of the beneficiary's treatment goals and objectives. Multiple staff members of an interdisciplinary team may participate in the process of developing, preparing and/or reviewing the IPOC.
- The signature of the LPHA or master's level qualified clinical professional responsible for the treatment is required.
- The IPOC must include the date of reformulation, the signature and title of the LPHA or master's level qualified professional authorizing services and the signature date.
- There should be evidence in the clinical record regarding the involvement of the beneficiary and the beneficiary's family, if applicable, in the reformulation of the IPOC.
- Copies of the reformulated IPOC must be distributed to all involved participants within 10 business days.

SERVICE PLAN DEVELOPMENT (SPD) OF THE IPOC

Purpose

The purpose of this service is to allow the interdisciplinary team the opportunity to discuss and or review the beneficiary's needs in collaboration and develop a plan of care. The interdisciplinary team will establish the beneficiary's goals, objectives and identify appropriate treatment or services needed by the beneficiary to meet those goals. Service Plan Development (SPD) assists beneficiaries and their families in planning, developing and choosing needed services.

Service Description

Service Plan Development is interaction between the beneficiary and a qualified clinical professional or a team of professionals to develop a plan of care based on the assessed needs, physical health, personal strengths, weaknesses, social history, support systems of the beneficiary and to establish treatment goals and treatment services to reach those goals.

The planning process should focus on the identification of the beneficiary's and his/or her family's needs, desired

SECTION 2 POLICIES AND PROCEDURES

BILLING REQUIREMENTS

Service Description (Cont'd.)

goals and objectives. The beneficiary and clinical professional(s) or interdisciplinary team should identify the skills and abilities of the beneficiary that can help achieve their goals, identify areas in which the beneficiary needs assistance, support, and decide how the team of professionals can help meet those needs.

An interdisciplinary team is typically composed of the beneficiary, his or her family and/or other individuals significant to the beneficiary, treatment providers and care coordinators.

An interdisciplinary team may be responsible for periodically reviewing progress made toward goals and modifying the IPOC as needed.

When there are multiple agencies or providers involved in serving the beneficiary, Service Plan Development should be conducted as a team process with the beneficiary. This treatment planning process requires meeting with at least one other health and human service agency or provider to develop an individualized, multi-agency service plan that describes corresponding needs of the beneficiary and identifies the primary or lead provider for accessing and/or coordinating needed service provision.

Multi-agency meetings may be face-to face or telephonic and only billable when the discussion focuses on planning and coordinating service provision for the identified beneficiary.

SPD-Interdisciplinary Team — Conference with Client/Family

The purpose of this service is to allow the physician, LPHA, master's level staff or LBSW to review with other entities or support teams. In addition, this service will provide the interdisciplinary team the opportunity to discuss issues that are relevant to the needs of the beneficiary with the beneficiary or family member being present. Effective service planning should include representation from all systems of support in which the beneficiary is engaged.

When the IPOC has been developed, a qualified clinical professional must review the IPOC with the beneficiary and/or family member or legal representation. The beneficiary must sign the IPOC. If the beneficiary cannot sign the IPOC, the reason must be documented on the IPOC.

SECTION 2 POLICIES AND PROCEDURES

BILLING REQUIREMENTS

SPD-Interdisciplinary Team — Conference with Client/Family (Cont'd.)

The physician, LPHA, master's level qualified clinical professional, or LBSW must sign the final document.

SPD-Interdisciplinary Team — Conference without Client/Family

The purpose of this service is to allow the physician, LPHA, master's level staff or LBSW to review with other entities or support teams. In addition, this service will provide the interdisciplinary team the opportunity to discuss issues that are relevant to the needs of the beneficiary without the beneficiary or family member being present. The components of the interdisciplinary team conference must be followed for this service.

Effective service planning should include representation from all systems of support in which the beneficiary is engaged.

When the IPOC has been developed, a qualified clinical professional must review the IPOC with the beneficiary and/or family member or legal representation. The beneficiary must sign the IPOC. If the beneficiary cannot sign the IPOC, the reason must be documented on the IPOC. The physician, LPHA, master's level qualified clinical professional, or LBSW must sign the final document.

Service Plan Development by Non-Physicians

The purpose of this service is to allow an LPHA master's level qualified clinical professional, or LBSW to review, with other entities or support teams, the issues that are relevant to the needs of the beneficiary with the beneficiary or family member.

Effective service planning should include representation from all systems of support in which the beneficiary is engaged

When the IPOC has been developed, a qualified clinical professional must review the IPOC with the beneficiary and/or family member or legal representation. The beneficiary must sign the IPOC. If the beneficiary cannot sign the IPOC, the reason must be documented on the IPOC.

The LPHA master's level qualified clinical professional, or LBSW must sign the final document.

SECTION 2 POLICIES AND PROCEDURES

BILLING REQUIREMENTS

Service Documentation

Documentation should include the involvement of the clinical professional and/or team of professionals in the following:

- All individuals present for the service planning
- The development, staffing, review and monitoring of the plan of care
- Discharge criteria and/or achievement of goals
- Confirmation of medical necessity and recommendations for services, including frequencies of services
- Establishment of one or more diagnoses, including co-occurring substance use disorder, if present

The IPOC must include the date it was completed, the signature and title of the physician, LPHA, or master's level qualified clinical professional, or LBSW signing the IPOC to authorize services. Refer back to the IPOC section to ensure all components are listed on the IPOC.

While attendance of multiple provider representatives may be necessary, only one professional that is actively involved in the planning process from each provider office may receive reimbursement. The provider representative must have documentation of the invitation to the IPOC meeting in the clinical record.

Medical Necessity Criteria

Beneficiaries eligible for these services must have a diagnosis of a mental illness and/or substance use disorder. The results of the assessment and/or screening tool must support the need for services.

Staff Qualifications

SPD is provided by, or under the supervision of, qualified professionals as specified under the "Staff Qualifications" section and in accordance with the South Carolina State Law.

Staff-to-Beneficiary Ratio

SPD requires at least one professional for each beneficiary.

SPD-Interdisciplinary Team-Conference requires participation from at least one other health and human service agency or provider involved with the beneficiary.

Participants are actively involved in the development, revision, coordination and implementation of the SPD.

SECTION 2 POLICIES AND PROCEDURES

BILLING REQUIREMENTS

Billing Frequency

SPD-Interdisciplinary Team Conference with and without client/family present is billed as an encounter.

SPD by a non-physician is billed in a 15-minute unit.

Special Restrictions Related to Other Services

State agencies that refer SPD to qualified providers may designate and authorize the provider to develop the plan of care. Providers should ensure that other health and human service agencies or providers involved with the beneficiary receive a copy of the IPOC.

SPD codes 99366, 99367, and H0032 cannot be billed on the same date of service. Assessment codes cannot be billed on the same date of service as 99366 and 99367. The assessment must be completed prior to the development of the IPOC.

DAODAS providers should continue to only utilize H0032 for IPOC development for Medicaid Fee for Service Providers and those members enrolled directly with a managed care organization. The LBSW is not authorized to sign the IPOC.

90-DAY PROGRESS SUMMARIES

The 90-day Progress Summary is a periodic evaluation and review of a beneficiary's progress toward the achievement of goals and objectives, overall response to treatment services, the appropriateness of services rendered, and the need for the beneficiary's continued participation in the treatment.

The progress summary shall be completed at least every 90 calendar days from the signature date on the initial IPOC, and every 90 days thereafter.

The progress summary must be completed and signed by the LPHA, or other qualified clinical professional. The progress summary must be clearly documented on the IPOC or on a separate sheet attached to the IPOC.

It is the responsibility of the current treatment provider to complete the 90-day Progress Summary. If a beneficiary is transferred to a new provider during the 90-day period, the discharging provider must submit clinical documentation, including a discharge summary, to the receiving provider to ensure a continuity of care.

The LPHA, or other qualified clinical professional will review and document the following:

SECTION 2 POLICIES AND PROCEDURES

BILLING REQUIREMENTS

90-DAY PROGRESS SUMMARIES (CONT'D.)

- The beneficiary's name and Medicaid ID number
- The beneficiary's progress toward treatment goals and objectives
- The appropriateness and frequency of the services provided
- The need for continued treatment
- Recommendations for continued services or discharge of services as outlined in the success criteria for each objective

DISCHARGE/TRANSITION CRITERIA

Beneficiaries should be considered for discharge from treatment or transferred to another level when they meet any of the following criteria:

- The beneficiary's level of functioning has significantly improved
- The beneficiary has made limited or no progress with respect to the goals outlined in the IPOC.
- Achieved the goals as outlined in the IPOC or reached maximum benefit
- Developed the skills and resources needed to transition to a lower level of care
- The beneficiary requested to be discharge from treatment (and is not imminently dangerous to self or others)
- The beneficiary requires a higher level of care (e.g. more intensive outpatient treatment, PRTF, or inpatient treatment)
- The beneficiary displays the inability to actively participate in the program or no longer is working or participating toward their goals
- The beneficiary should be re-evaluated for services before discharge from that particular service or level of care.

Discharge summary must include:

- Date of discharge from program
- Each RBHS service(s) the beneficiary received
- Start and End date of each service
- Presenting concerns/condition and diagnosis(es) at

SECTION 2 POLICIES AND PROCEDURES

BILLING REQUIREMENTS

DISCHARGE/TRANSITION CRITERIA (CONT'D.)

time of admission

- Description of the progress, or lack of progress, in achieving planned goals and objectives in the IPOC
- Rationale for discharge from service(s)
- Summary of the beneficiary's status/presentation at last contact
- Recommendations for possible services and supports needed after discharge for continuity of care (*e.g.*, medical care, personal care, self-help groups, peer connections, etc.)
- Medications prescribed or administered, if applicable
- Attempts to contact beneficiary/family, if discharge is unplanned

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SECTION 2 POLICIES AND PROCEDURES

CORE REHABILITATIVE SERVICE STANDARDS

SCREENING SERVICES

Behavioral Health Screening (BHS)

Purpose

The purpose of this service is to provide early identification of mental health and/or substance use disorder(s) to facilitate appropriate referral for a focused assessment and/or treatment. Behavioral Health Screening (BHS) is designed to identify behavioral health issues and/or the risk of development of behavioral health problems and/or substance abuse.

Service Description

This service requires completion of a brief questionnaire to examine the nature and context of the problem and identify patterns of behavior. Screenings are conducted using a standardized or SCDHHS-approved tool, through interviews or self-report. Some of the common tools used for screenings are:

GAIN — Global Appraisal of Individual Needs — Short Screener

DAST — Drug Abuse Screening Test

ECBI — Eyberg Child Behavior Inventory

SESBI— Sutter Eyberg Student Behavior Inventory

CIDI — Composite International Diagnostic Interview

Screenings should be scored utilizing the tool's scoring methodology and referrals made based on the interpretation of the results.

Screenings should focus on patterns of behavior and associated factors such as legal problems, mental health status, educational functioning, and living situation.

The beneficiary's awareness of the problem, feelings about his or her behavior, mental health or substance use and motivation for changing behaviors may also be integral parts of the screen.

SECTION 2 POLICIES AND PROCEDURES

CORE REHABILITATIVE SERVICE STANDARDS

Service Description (Cont'd.)

Prior to conducting the screening, attempts should be made to determine whether another screening had been conducted in the last 90 days. If a recent screening has been conducted, efforts should be made to access the record. A screening may be repeated as clinically appropriate or if a significant change in behavior or functioning has been noted.

Reimbursement for this service is only available for the interpretation and/or scoring of the screening tool and does not include time spent administering the tool.

Medical Necessity Criteria

All Medicaid-eligible beneficiaries who have been identified as having or at risk of a mental health and/or substance use disorder(s) are eligible for this service.

Staff Qualifications

BHS must be provided by qualified clinical professionals as defined in the "Staff Qualifications" section of this manual. Licensed clinical professionals must operate within their scope of practice, as allowed by state law.

Service Documentation

BHS results should be documented during the screening session with the beneficiary. The completed screening tool and written interpretation of the results must be filed in the beneficiary's clinical record within 10 working days from the date of service.

Services must be documented on a CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

Documentation must:

- Include the outcome of the screening
- Identify any referrals resulting from the screening
- Support the number of units billed

Staff-to-Beneficiary Ratio

BHS requires one qualified clinical professional for each beneficiary served. Beneficiaries in excess of the allowed ratio should not be present during the delivery of the service. The ratio count applies to all beneficiaries receiving services by a provider, regardless of whether or not the beneficiary is Medicaid eligible.

Billing Frequency

BHS is billed in 15-minute units for a maximum of two units per day. See Section 4 of this manual for additional information regarding procedure codes and frequencies.

SECTION 2 POLICIES AND PROCEDURES

CORE REHABILITATIVE SERVICE STANDARDS

Billable Place of Service

Services must be administered in a setting that is convenient for the both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

Excluded settings include acute care hospitals and recreational settings (a place primarily used for play and leisure activities, such as parks and community recreation centers).

Special Restrictions Related to Other Services

BHS shall not be billed on the same date of service as 90791 and/or H2000.

Diagnostic Assessment (DA) Services

Purpose

The purpose of this face-to-face assessment is to determine the need for RBHS, to establish or confirm a diagnosis (diagnoses), to assist in the development of an individualized plan of care based upon the beneficiary's strengths and needs, and/or to assess progress in treatment and confirm the need for continued treatment. This assessment includes a comprehensive bio-psychosocial interview and review of relevant psychological, medical, and educational records.

Assessments must be completed face-to-face with the beneficiary and include an evaluation of the beneficiary for the presence of a mental illness and/or substance use disorder.

If information obtained during the assessment results in a diagnosis, the assessment must identify the beneficiary's current symptoms or disorder via the current edition of the DSM or the ICD.

As a best practice, diagnoses should be updated as the condition of the beneficiary changes.

The assessment is used to determine the beneficiary's mental status, social functioning, and to identify any physical or medical conditions.

Assessments include clinical interviews with the beneficiary, family members or guardians as appropriate, review of the presenting problems, symptoms and functional deficits, strengths, medical and educational

SECTION 2 POLICIES AND PROCEDURES

CORE REHABILITATIVE SERVICE STANDARDS

Purpose (Cont'd.)

records and history, including past psychological assessment report and records. Initial assessments must include a clinical summary that identifies recommendations for and the prioritization of mental health and/or other needed services.

Once the initial assessment has been completed and services are deemed to be medically necessary, the development of the individual plan of care should be next.

Service Description

Psychiatric Diagnostic Assessment without Medical Services (Comprehensive Diagnostic Assessment) identify the beneficiary's needs, concerns, strengths and deficits and allows the beneficiary and his or her family to make informed decisions about the treatment. The assessment must include a comprehensive bio-psychosocial interview and review of relevant psychological, medical, and educational records to obtain information necessary to establish or support a diagnosis. It also serves to drive the development or revision of the treatment plan and development of discharge criteria.

The following components must be included in the Psychiatric Diagnostic Assessment without Medical Services (Comprehensive Diagnostic Assessment) include:

- Beneficiary's name and Medicaid ID number
- Date of the assessment
- Beneficiary's demographic information
  - Age
  - Date of birth (DOB)
  - Phone Number
  - Address
  - Relationship/Marital Status
  - Preferred Language
- Beneficiary's cultural identification, including gender expression, sexual orientation, culture and practices, spiritual beliefs, etc.
- Presenting complaint, source of distress, areas of need, including urgent needs (e.g., suicide risk, personal safety, and/or risk to others)
- Risk factors and protective factors, including steps taken to address identified current risks (e.g., detailed safety plan)

SECTION 2 POLICIES AND PROCEDURES

CORE REHABILITATIVE SERVICE STANDARDS

Service Description (Cont'd.)

- Mental/Behavioral health history of beneficiary, including previous diagnoses, treatment (including medication), hospitalizations
- Psychological history including previous psychological assessment/ testing measures, reports, etc.
- Substance use history including previous diagnoses, treatment (including medication), hospitalizations
- Exposure to physical abuse, sexual assault, antisocial behavior or other traumatic events
- Physical health history, including current health needs and potential high-risk conditions
- Medical history and medications, including history of past and current medications
- Family history, including relationships with family members, and involvement of individuals in treatment and services, family psychiatric and substance use history
- Mental status
- Functional assessment(s) (with age-appropriate expectations)
- Education and employment history
- Housing/living situation
- Diagnosis(es) of a serious behavioral health disorder (description and code must be identified for each) from the current edition of the DSM or the ICD, excluding irreversible dementias, intellectual disabilities or related disabilities and developmental disorders, unless they co-occur with a serious mental disorder that meets the current edition DSM criteria
- Initial start date of Rehabilitative Behavioral Health Services
- Planned service type and frequency of each recommended rehabilitative service
- Referrals for external services, support, or treatment

SECTION 2 POLICIES AND PROCEDURES

CORE REHABILITATIVE SERVICE STANDARDS

Service Description (Cont'd.)

Psychiatric Diagnostic Assessment with Medical Services includes the components listed above as well as the medical components listed below.

Additional components of a Psychiatric Diagnostic Assessment with Medical Services include:

- Medical history and medications
- Assess the appropriateness of initiating or continuing the use of medications, including medications treating concurrent substance use disorders
- Diagnose, treat, and monitor chronic and acute health problems
- This may include completing annual physicals and other health maintenance care activities such as ordering, performing, and interpreting diagnostic studies such as lab work and x-rays.

Mental Health Comprehensive Assessment - Follow-up

A Mental Health Comprehensive Assessment – Follow-up occurs after an initial assessment to re-evaluate the status of the beneficiary, identify any significant changes in behavior and/or condition, and to monitor and ensure appropriateness of treatment. Follow up assessments may also be rendered to assess the beneficiary's progress, response to treatment, the need for continued treatment and establish medical necessity for new or additional services to be added to the course of treatment.

When significant changes occur in behaviors and/or conditions, changes must be documented separately on the CSN and comply with the service documentation requirements. The course of treatment and documentation in the IPOC must reflect these changes.

Mental Health Comprehensive Assessments must be conducted face-to-face with the beneficiary.

Medical Necessity Criteria

All Medicaid-eligible beneficiaries who have been identified as having or at risk of mental health and/or substance use disorder(s) are eligible for this service.

SECTION 2 POLICIES AND PROCEDURES

CORE REHABILITATIVE SERVICE STANDARDS

Staff Qualifications

Diagnostic Assessment Services must be provided by qualified clinical professionals as defined in the "Staff Qualifications" section of this manual. Licensed clinical professionals must operate within their scope of practice, as allowed by state law.

When the assessment is completed by state agencies, the assessment must be conducted by a qualified clinical professional operating within one's scope of practice. The professional must be specifically trained to render and review the assessment tool to make a clinically appropriate referral.

When the assessment is completed by private RBHS providers, the assessment must be conducted by an independently licensed LPHA operating within one's scope of practice. An LMSW may also complete the DA, which must be cosigned by the independently licensed LPHA. The provider must be specifically trained to render and review the assessment tool to make a clinically appropriate referral.

Service Documentation

The completed assessment tool and written interpretation of the results must be filed in the beneficiary's clinical record within 10 working days from the date of service.

Documentation must include the following components:

- Beneficiary's name and Medicaid ID number
- Date of the assessment
- Include the outcome of the assessment
- Identify any referrals resulting from the assessment
- The diagnostic code and the diagnosis

In addition to the assessment itself, the diagnostic assessment service must be documented on a CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

Staff-to-Beneficiary Ratio

All assessments require one qualified clinical professional for each beneficiary. Beneficiaries in excess of the allowed ratio should not be present during the delivery of the service. The ratio count applies to all beneficiaries receiving services by a provider, regardless of whether or not the beneficiary is Medicaid eligible.

SECTION 2 POLICIES AND PROCEDURES

CORE REHABILITATIVE SERVICE STANDARDS

Billing Frequency

The initial and follow-up diagnostic assessments are billed as an encounter. See Section 4 of this manual for additional information regarding procedure codes and frequencies.

The initial assessment may be rendered once every six months.

The follow-up assessment may be rendered up to twelve times in a year.

Billable Place of Service

Services must be administered in a setting that is convenient for the both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

Excluded settings include acute care hospitals, Inpatient Psychiatric Hospitals, Psychiatric Residential Treatment Facilities (PRTF), institutions of more than 16 beds, and recreational settings (a place primarily used for play and leisure activities, such as parks and community recreation centers).

Special Restrictions Related to Other Services

The assessment with medical cannot be rendered or billed on the same day as the assessment without medical.

The Mental Health Comprehensive follow-up assessment should only be utilized when documented behavioral changes have occurred and when the beneficiary needs to be re-assessed.

Efforts should be made to determine whether another diagnostic assessment has been conducted in the last 90 days and information should be updated as needed. If a diagnostic assessment has been conducted within the last 90 days, efforts should be made to access those records.

CALOCUS ASSESSMENT — PRTF AND COMMUNITY SUPPORT SERVICES

South Carolina Department of Health and Human Services requires the use of the Child and Adolescent Level of Care Utilization System (CALOCUS) as the standardized pre-admission criteria for all beneficiaries being considered for placement in a psychiatric residential treatment facility (PRTF) and/or RBHS Community Support Services. **The assessment must be a face-to-face assessment with the beneficiary.**

The Child and Adolescent Level of Care Utilization System (CALOCUS) links a clinical assessment with

SECTION 2 POLICIES AND PROCEDURES

CORE REHABILITATIVE SERVICE STANDARDS

CALOCUS ASSESSMENT — PRTF AND COMMUNITY SUPPORT SERVICES (CONT'D.)

standardized criteria that describes the level of intensity of services needed for a beneficiary. The CALOCUS rating can be done for any beneficiary in any setting, regardless of the diagnosis or service agency with which the beneficiary is involved.

CALOCUS must be administered by a Licensed Practitioner of the Healing Arts that has successfully completed training on CALOCUS and passed a competency test with prior written approval from SCDHHS. Master's level clinical staff with three years of experience working with beneficiaries and families that have successfully completed training on CALOCUS and passed a competency test may be eligible to administer CALOCUS, with prior written approval from SCDHHS.

CALOCUS training and certification will be offered by SCDHHS. All training information will be posted on the Medicaid provider Web site at: https://training.scdhhs.gov/moodle/login/index.php.

The CALOCUS tool considers four distinct types of potential co-morbid areas: psychiatric, substance use, developmental and medical.

CALOCUS ranges from Level 1 to Level 6 where the frequency, intensity, location and duration of treatment are correlated to the severity of the child or adolescent's condition.

The level of care system can be viewed as a continuum ranging from medical maintenance or minimal treatment in a minimally restrictive environment to a PRTF, a more restrictive treatment environment.

The child or adolescent is evaluated and rated in the following six dimensions:

- Risk of Harm
- Functional Status
- Co-Morbidity
- Recovery
- Resiliency and Treatment History
- Treatment Acceptance and Engagement

Treatment and/or services are recommended based on the composite score of the dimensions and the corresponding

SECTION 2 POLICIES AND PROCEDURES

CORE REHABILITATIVE SERVICE STANDARDS

CALOCUS ASSESSMENT — PRTF AND COMMUNITY SUPPORT SERVICES (CONT'D.)

level of care. Services may include a community mental health system, a private therapist, an interagency community-based system of care, or other providers of mental, psychiatric or behavioral health services. It is always preferable to keep children in their communities, when this is an option, and clinical professionals should determine if enhanced community services could be provided to support the child and his or her family as an alternative to placement.

The levels of care are:

Level 1 – Recovery Maintenance and Health Management

Level 2 – Outpatient Services

Level 3 – Intensive Outpatient Services

Level 4 – Intensive Integrated Service without 24-Hour Psychiatric Monitoring

Level 5 – Non-secure 24-Hour Services with Psychiatric Monitoring

Level 6 – Secure 24-Hour Services with Psychiatric

When CALOCUS score indicates a Level 4, 5, or 6, PRTF placement is not required. Other community resources at a higher frequency and/or intensity of services, based on the needs of the individual, should be considered.

For more detailed information regarding the CALOCUS screening and process, refer to the Psychiatric Hospital Manual.

Staff-to-Beneficiary Ratio

CALOCUS assessment requires one qualified clinical professional for each beneficiary served.

Billing Frequency

The CALOCUS assessments are billed as an encounter. One encounter can be reimbursed every six months. See Section 4 of this manual for additional information regarding procedure codes and frequencies.

Billable Place of Service

CALOCUS assessments must be administered in a setting that is convenient for the both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

SECTION 2 POLICIES AND PROCEDURES

CORE REHABILITATIVE SERVICE STANDARDS

Billable Place of Service (Cont'd.)

Excluded settings include Psychiatric Residential Treatment Facilities (unless prior approved for retro-eligibility) and recreational settings (a place primarily used for play and leisure activities, such as parks and community recreation centers).

Service Documentation

Assessments must be documented in a manner which addresses all of the necessary components and clearly establishes medical necessity. When submitting a claim for the CALOCUS assessment, documentation of the scoring instrument and supporting clinical documentation is required.

In addition to the CALOCUS form itself, the service must be documented on a CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

PSYCHOLOGICAL TESTING AND EVALUATION (PTE)

Psychological Testing and Evaluation services involve the use of formal testing procedures using reliable and valid instruments to measure the areas of intellectual, cognitive, adaptive, emotional and behavioral functioning, along with personality styles, interpersonal skills and psychopathology (*e.g.*, MMPI, Rorschach, and WAIS). Testing and evaluation must involve face-to-face interaction between a licensed psychologist and the beneficiary for the purpose of evaluating the beneficiary's intellectual, emotional, and behavioral status. Tests must be standardized and validated measures recognized by the scientific and professional community as a national standard for professional practice, and may include measures of intellectual and cognitive abilities, neuropsychological status, attitudes, motivations, and/or personality characteristics, as well as use of other non-experimental methods of evaluation.

Psychological testing and evaluation may be used for the purpose of diagnostic clarification, as in the case of establishing a DSM diagnosis or a differential diagnosis, once a thorough comprehensive assessment/initial clinical interview has been conducted and testing is deemed necessary for further clinical understanding or treatment planning.

Prior to administering a battery of tests it is important for the evaluating psychologist to review relevant clinical information from the most recent Diagnostic Assessment

SECTION 2 POLICIES AND PROCEDURES

CORE REHABILITATIVE SERVICE STANDARDS

PSYCHOLOGICAL TESTING AND EVALUATION (PTE) (CONT'D.)

and/or medical, psychiatric, and educational evaluations. The psychologist must consider historical clinical information, identify specific referral questions to be addressed by the evaluation, and determine that the clinical questions cannot be addressed through a Diagnostic Interview with a skilled clinician.

When necessary or appropriate, consultation shall only include telephone or face-to-face contact by a psychologist to the family, school, or another health care provider to interpret or explain the results of psychological testing and/or evaluations related to the care and treatment of the beneficiary. The psychologist is expected to render an opinion and/or advice. The psychologist must document the recommended course of action.

Medical Necessity Criteria

All Medicaid-eligible beneficiaries who have been identified as having or at risk of a mental health and/or substance use disorder(s) are eligible for this service, provided that there is a clear, documented reason that the testing is needed (*e.g.,* differential diagnosis, atypical symptomatology, prior/current mental health treatment is ineffective). Information should be provided in the documentation to explain why a Diagnostic Assessment was inconclusive and why testing is needed to clarify the diagnosis.

Staff Qualifications

Psychological Testing and Evaluation must be provided by qualified Clinical Psychologists operating within their scope of practice, as allowed by state law and who have been specifically trained to provide and review the assessment tool and make a clinically appropriate referral.

When the administration and interpretation of psychological tests is required to aid in the determination of diagnoses and the level of impairment, a psychologist must provide the diagnosis.

Service Documentation

Services must be documented on a CSN with a start time and end time. The CSN must include the purpose of the test, the results of the Psychological testing and evaluation and/or make reference to the completed test. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

SECTION 2 POLICIES AND PROCEDURES

CORE REHABILITATIVE SERVICE STANDARDS

Service Documentation (Cont'd.)

The completed test and written interpretation of the results must be filed in the beneficiary's clinical record within 10 working days from the date the service was completed.

Documentation must include:

- Beneficiary's name and Medicaid ID number
- Name of the tests that were conducted (*e.g.,* Minnesota Multiphasic Personality Inventory [MMPI]).
- Test results and interpretation
- Identify any recommendations or referrals based on test results
- The diagnoses code and the diagnosis
- Documentation must support the number of units billed

Staff-to-Beneficiary Ratio

Psychological Testing and Evaluation Services require one professional for each beneficiary.

Billing Frequency

Psychological Testing and Evaluation is billed as a 60 minute unit with a limit of ten units billed within a week and a limit of 20 units billed per year. See Section 4 of this manual for additional information regarding procedure codes and frequencies.

Billable Place of Service

Services must be administered in a setting that is convenient for the both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

Excluded settings include acute care hospitals, Inpatient Psychiatric Hospitals, Psychiatric Residential Treatment Facilities (PRTF), institutions of more than 16 beds, and recreational settings (a place primarily used for play and leisure activities, such as parks and community recreation centers).

Special Restrictions Related to Other Services

The evaluating psychologist should inquire about and review any prior testing (*e.g.,* psycho-educational, psychological, developmental and/or neuropsychological) that may have been administered, and request copies for review prior to conducting a new battery. If prior testing

SECTION 2 POLICIES AND PROCEDURES

CORE REHABILITATIVE SERVICE STANDARDS

Special Restrictions Related to Other Services (Cont'd.)

cannot be reviewed, the provider should document their attempts to access the information and offer an explanation pertaining to the clear medical necessity for a new assessment. Attempts should be made to determine when tests were previously administered to ensure that test exposure is not a factor in the outcome of the evaluation. If an assessment has been conducted in the last 90 days, an assessment should be repeated only if a significant change in behavior or functioning has been noted. A repeated assessment must be added to the clinical records.

Delivery of this service should include contacts with family and/or guardians of children for the purpose of securing pertinent information necessary to complete an evaluation of the beneficiary.

The Diagnostic Assessment must be completed before the Psychological testing and evaluation has been conducted.

The Psychological Testing and Evaluation and Diagnostic Assessment can be billed on the same day. The assessments must be billed separately.

Code	Assessment	Description	Modifier	Frequency
90791	Psychiatric Diagnostic Assessment without medical services - Initial (Comprehensive Diagnostic Assessment)	Licensed Psychologist Master's level staff	AH HO	1 encounter per 6 months
90792	Psychiatric Diagnostic Assessment with medical services - Initial	Specialty physician (Psychiatrist) Physician team member svc (PA) Nurse practitioner (APRN)	AF AM SA	1 encounter per 6 months
H2000	Child and Adolescent Level of Care Utilization System (CALOCUS)	Licensed Psychologist Master's level	AH HO	1 encounter per 6 months
96101	Psychological Testing and Evaluation	Licensed Psychologist	AH	1 unit = 60 minutes 10 units per week 20 units per year
H0031	Mental Health Comprehensive Assessment – Follow-up	Licensed Psychologist Master's level	AH HO	1 encounter per day 12 encounters per year

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — PSYCHOTHERAPY AND COUNSELING SERVICES

PSYCHOTHERAPY

Psychotherapy Services are provided within the context of the goals identified in the beneficiary's plan of care. An Assessment must be completed to determine the need for psychotherapy services. The nature of the beneficiary's needs and diagnosis including substance abuse, strengths, and resources, determine the extent of the issues addressed in treatment, the psychotherapeutic modalities used by the clinical professional and its duration.

Psychotherapy Services are based on an empirically valid body of knowledge about human behavior. Psychotherapy Services do not include educational interventions without therapeutic process interaction or any experimental therapy not generally recognized by the profession. These services do not include drug therapy or other physiological treatment methods.

Psychotherapy Services are planned face-to-face interventions intended to help the beneficiary achieve and maintain stability; improve their physical, mental, and emotional health; and cope with or gain control over the symptoms of their illness(es) and the effects of their disabilities. Psychotherapy Service should be used to assist beneficiaries with problem solving, achieving goals, and managing their lives by treating a variety of behavioral health issues. Psychotherapy Services may be provided in an individual, group, or family setting. The assessments, plans of care, and clinical service notes must justify, specify, and document the initiation, frequency, duration and progress of the therapeutic modality.

As of April 1, 2016, providers of core treatment who are not employed by governmental entities must possess a license to practice in psychology, social work, professional counseling, marriage and family therapy, or medicine. Providers who are pursuing their independent license during a supervised period of clinical practice may also render core treatment services, provided that they possess an approved supervision contract with the applicable licensing board.

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — PSYCHOTHERAPY AND COUNSELING SERVICES

PSYCHOTHERAPY (CONT'D.)

All licensed professionals must be in conformance with the relevant practice act(s). By submitting claims to SCDHHS for reimbursement, licensed professionals attest that they are in conformance with the relevant practice act(s) and associate regulations. Any services performed by licensed professionals, to include supervisory relationships, that do not comport with the relevant practice act(s) and regulations are subject to recoupment by the Department, and a referral made to the appropriate board at South Carolina Department of Labor, Licensing and Regulation (SCLLR).

Individual Psychotherapy (IP)

Purpose

The purpose of this face-to-face intervention is to assist the beneficiary in improving his or her emotional and behavioral functioning. The clinical professional assists the individual in identifying maladaptive behaviors and cognitions, identifying more adaptive alternatives, and learning to utilize those more adaptive behaviors and cognitions.

Service Description

IP is an interpersonal, relational intervention directed towards increasing an individual's sense of well-being and reducing subjective discomforting experience. IP may be psychotherapeutic and/or therapeutically supportive in nature.

IP involves planned therapeutic interventions that focus on the enhancement of a beneficiary's capacity to manage his or her emotions and behaviors through effective decision making, developing and acquiring coping skills, making better choices and decisions regarding co-occurring substance abuse, achievement of personal goals, and development of self-confidence and self-esteem.

Treatment should be designed to maximize strengths and to reduce problems and/or functional deficits that interfere with a beneficiary's personal, family, and/or community adjustment. Interventions should also be designed to achieve specific behavioral targets, such as improving medication adherence or reducing substance abuse.

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — PSYCHOTHERAPY AND COUNSELING SERVICES

Medical Necessity Criteria

Beneficiaries eligible for these services must have a diagnosis of a mental health and/or substance use disorder(s). The results of the assessment and/or screening tool must indicate a functioning level that would support the need for services and the behavior must interfere with the ability to function in at least two of these areas: daily living, personal relationships, work setting, school and recreational settings.

Staff Qualifications

IP must be provided by qualified clinical professionals as defined in the "Staff Qualifications" section of this manual. Licensed clinical professionals must operate within their scope of practice, as allowed by state law.

Staff-to-Beneficiary Ratio

IP requires one qualified clinical professional to one beneficiary served.

Service Documentation

IP must be listed on the IPOC with a specific planned frequency to meet the identified individualized needs of the beneficiary.

Services must be documented on a CSN with a start time and end time. The CSN must document how the psychotherapy session applied to the identified beneficiary's treatment goals. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

Billing Frequency

IP is billed as an encounter. There are three encounter ranges based on amount of time spent with the beneficiary. There can be one encounter per day with a limit of six encounters per month. Six sessions in any combination can be billed in a month. See Section 4 of this manual for additional information regarding procedure codes and frequencies.

Billable Place of Service

Services must be rendered in a setting that is convenient for the both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

Excluded settings include acute care hospitals, Inpatient Psychiatric Hospitals, Psychiatric Residential Treatment Facilities (PRTF), institutions of more than 16 beds, and recreational settings (a place primarily used for play and

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — PSYCHOTHERAPY AND COUNSELING SERVICES

Billable Place of Service (Cont'd.)

leisure activities, such as parks and community recreation centers).

Special Restrictions Related to Other Services

None.

Group Psychotherapy (GP)

Purpose

Group Psychotherapy (GP) is a method of treatment in which several beneficiaries with similar problems meet face-to-face in a group with a clinician. The focus of GP is to assist beneficiaries with solving, emotional difficulties and to encourage the personal development of beneficiaries in the group.

The group process allows members to offer each other support, share common experiences, identify strategies that have been successful for them, and to challenge each other's behaviors and cognitions. The therapist guides the group to ensure the process is productive for all members and focuses on identified therapeutic issues.

Service Description

GP involves a small therapeutic group that is designed to produce behavior change. The group must be a part of an active treatment plan and the goals of GP must match the overall treatment plan for the individual beneficiary. GP requires a relationship and interaction among group members and a stated common goal. The focus of the psychotherapy sessions must not be exclusively educational or supportive in nature. The intended outcome of such group oriented, psychotherapeutic services is the management, reduction, or resolution of the identified behavioral health and/or substance abuse problems, thereby allowing the beneficiary to function more independently and competently in daily life.

Beneficiaries who meet the following criteria may benefit from GP:

- Beneficiaries with interpersonal problems related to their diagnoses and functional impairments. Interaction with peers in a group setting will allow the beneficiary to develop and practice new skills and focus on the factors that impact the beneficiary's symptoms.

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — PSYCHOTHERAPY AND COUNSELING SERVICES

Service Description (Cont'd.)

- Beneficiaries with the same or similar needs that may gain insight by being in a group with others with shared experiences
- Beneficiaries who have a similar experiences
- Beneficiaries need to demonstrate a level of competency to function in a group.

Medical Necessity Criteria

Beneficiaries eligible for these services must have a diagnosis of a mental health and/or substance use disorder(s). The results of the assessment and/or screening tool must indicate a functioning level that would support the need for services and the behavior must interfere with the ability to function in at least two of these areas: daily living, personal relationships, work setting, school and recreational settings.

Staff Qualifications

GP must be provided by qualified clinical professionals as defined in the "Staff Qualifications" section of this manual. Licensed clinical professionals must operate within their scope of practice, as allowed by state law.

Service Documentation

GP must be listed on the IPOC with a specific planned frequency to meet the identified individualized needs of the beneficiary.

Services must be documented on a CSN with a start time and end time. The CSN must document how the psychotherapy session applied to the identified beneficiary's treatment goals. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

Staff-to-Beneficiary Ratio

GP requires one qualified clinical professional and no more than eight beneficiaries (1:8). Beneficiaries in excess of the allowed ratio should not be present during the delivery of the service. The ratio count applies to all beneficiaries receiving services by a provider, regardless of whether or not the beneficiary is Medicaid eligible.

Billing Frequency

GP is billed as an encounter. A session must last a minimum of an hour. More than one session can be billed per day, with a limit of eight sessions per month. See Section 4 of this manual for additional information regarding procedure codes and frequencies.

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — PSYCHOTHERAPY AND COUNSELING SERVICES

Billable Place of Service

Services must be rendered in a setting that is convenient for the both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

Excluded settings include acute care hospitals, Inpatient Psychiatric Hospitals, Psychiatric Residential Treatment Facilities (PRTF), institutions of more than 16 beds, and recreational settings (a place primarily used for play and leisure activities, such as parks and community recreation centers).

Special Restrictions Related to Other Services

None.

Multiple Family Group Psychotherapy (MFGP)

Purpose

Multiple Family Group Psychotherapy treatment will allow beneficiaries and families with similar issues to meet face-to-face in a group with a clinician. The group's focus is to assist the beneficiary and family members in resolving emotional difficulties, encourage personal development and ways to improve and manage their functioning skills.

The group process allows members to offer each other support, share common experiences, identify strategies that have been successful for them, and to challenge each other's behaviors and cognitions. The therapist guides the group to ensure that the process is productive for all members and focuses on identified therapeutic issues.

Service Description

MFGP involves a small therapeutic group that is designed to produce behavioral change. The beneficiary must be a part of an active treatment plan and the goals of MFGP must match the overall treatment plan for the individual beneficiary. MFGP requires a relationship and interaction among group members and a stated common goal.

MFGP is directed toward the restoration, enhancement, or prevention of the deterioration of role performance of families. The psychotherapy allows the therapist to address the needs of several families at the same time and

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — PSYCHOTHERAPY AND COUNSELING SERVICES

Service Description (Cont'd.)

mobilizes group support between families. The process provides commonality of the MFGP experience; including experiences with behavioral health and or co-occurring substance use disorders, and utilizes a complex blend of family interactions and therapeutic techniques, under the guidance of a therapist. The intended outcome of such family-oriented, psychotherapeutic services is the management, reduction, or resolution of the identified mental health problems, thereby allowing the beneficiary and family units to function more independently and competently in daily life.

Beneficiaries who meet the following criteria may benefit from MFGP:

- Beneficiaries with interpersonal problems related to their diagnoses and functional impairments. Interaction with peers in a group setting will allow the beneficiary to develop and practice new skills and focus on the factors that impact the beneficiary's symptoms.
- Beneficiaries with the same type of problem that may gain insight by being in a group with others
- Beneficiaries who have a similar experiences,
- Beneficiaries need to demonstrate a level of competency to function in a group.

Medical Necessity Criteria

Beneficiaries eligible for these services must have a diagnosis of mental health and/or substance use disorder(s). The results of the assessment and/or screening tool must indicate a functioning level that would support the need for services and the behavior must interfere with the ability to function in at least two of these areas: daily living, personal relationships, work setting, school and recreational settings.

Staff Qualifications

MFGP must be provided by qualified clinical professionals as defined in the "Staff Qualifications" section of this manual. Licensed clinical professionals must operate within their scope of practice, as allowed by state law.

Service Documentation

MFGP must be listed on the IPOC with a specific planned frequency to meet the identified individualized needs of the beneficiary.

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — PSYCHOTHERAPY AND COUNSELING SERVICES

Service Documentation (Cont'd.)

Services must be documented on a CSN with a start time and end time. The CSN must document how the psychotherapy session applied to the identified beneficiary's treatment goals. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

Staff-to-Beneficiary Ratio

MFGP requires one qualified clinical professional for a minimum of two family units served (a minimum of four individuals) and a maximum of up to eight individuals which includes the beneficiaries and their families. Beneficiaries in excess of the allowed ratio should not be present during the delivery of the service. The ratio count applies to all beneficiaries receiving services by a provider regardless of whether or not the beneficiary is Medicaid eligible.

Billing Frequency

MFGP is billed as an encounter. A session must last a minimum of an hour. More than one session can be billed per day, with a limit of eight sessions per month. See Section 4 of this manual for additional information regarding procedure codes and frequencies.

Billable Place of Service

Services must be rendered in a setting that is convenient for the both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

Excluded settings include acute care hospitals, Inpatient Psychiatric Hospitals, Psychiatric Residential Treatment Facilities (PRTF), institutions of more than 16 beds, and recreational settings (a place primarily used for play and leisure activities, such as parks and community recreation centers).

Special Restrictions Related to Other Services

None.

Family Psychotherapy (FP)

Purpose

The purpose of this face-to-face intervention is to address the interrelation of the beneficiary's functioning with the functioning of his or her family unit. The therapist assists family members in developing a greater understanding of

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — PSYCHOTHERAPY AND COUNSELING SERVICES

Purpose (Cont'd.)

the beneficiary's psychiatric and/or behavioral disorder and the appropriate treatment for this disorder, identifying maladaptive interaction patterns between family members and how they contribute to the beneficiary's impaired functioning, and identifying and developing competence in utilizing more adaptive patterns of interaction.

Service Description

Family Psychotherapy (FP) involves interventions with members of the beneficiary's family unit *(i.e.*, immediate or extended family or significant others) with or on behalf of a beneficiary to restore, enhance, or maintain the family unit.

FP may be rendered with or without the beneficiary to family members of 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.

FP tends to be short-term treatment, with a focus on resolving specific problems such as eating disorders, difficulties with school, or adjustments to bereavement or geographical relocation. Treatment should be focused on changing the family dynamics and attempting to reduce and manage conflict. The family's strengths should be used to help them handle their problems.

FP helps families and individuals within that family understand and improve the way they interact and communicate with each other (*i.e.*, transmission of attitudes problems and behaviors) and promote and encourage family support to help facilitate the beneficiary's improvement. The goal of FP is to get family members to recognize and address the problem by establishing roles that promote individuality and autonomy, while maintaining a sense of family cohesion.

Interventions include, but are not limited to, the identification and the resolution of conflicts arising in the family environment, including conflicts that may relate to substance use or abuse on the part of the beneficiary or family members, and the promotion of the family's understanding of the beneficiary's mental disorder, its dynamics, and treatment. Services may also include addressing ways in which the family can promote recovery

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — PSYCHOTHERAPY AND COUNSELING SERVICES

Service Description (Cont'd.)	for the beneficiary from mental illness and/or co-occurring substance use disorders.
Medical Necessity Criteria	Beneficiaries eligible for these services must have a diagnosis of a mental health and/or substance use disorder(s). The results of the assessment and/or screening tool must indicate a functioning level that would support the need for services and the behavior must interfere with the ability to function in at least two of these areas: daily living, personal relationships, work setting, school and recreational settings.
Staff Qualifications	FP must be provided by qualified clinical professionals as defined in the "Staff Qualifications" section of this manual. Licensed clinical professionals must operate within their scope of practice, as allowed by state law.
Service Documentation	FP must be listed on the IPOC with a specific planned frequency to meet the identified individualized needs of the beneficiary. Services must be documented on a CSN with a start time and end time. The CSN must document how the psychotherapy session applied to the identified beneficiary's treatment goals. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.
Staff-to-Beneficiary Ratio	FP is one professional to one individual beneficiary and their family unit per encounter. Only one individual beneficiary can be billed for any one session of family psychotherapy.
Billing Frequency	FP is billed as an encounter and can only be rendered once per day. A session must last a minimum of an hour. FP with the beneficiary can be rendered four sessions per month. FP without the beneficiary can be rendered four sessions per month. See Section 4 of this manual for additional information regarding procedure codes and frequencies.
Billable Place of Service	Services must be rendered in a setting that is convenient for the both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — PSYCHOTHERAPY AND COUNSELING SERVICES

Billable Place of Service (Cont'd.)

Excluded settings include acute care hospitals, Inpatient Psychiatric Hospitals, Psychiatric Residential Treatment Facilities (PRTF), institutions of more than 16 beds, and recreational settings (a place primarily used for play and leisure activities, such as parks and community recreation centers).

Special Restrictions Related to Other Services

When multiple members of a family are identified beneficiaries, reimbursement for FP shall be for only one of the beneficiaries present in the session, not all beneficiaries.

CRISIS MANAGEMENT (CM)

Purpose

The purpose of this face-to-face or telephonic short-term service is to assist a beneficiary who is experiencing urgent or emergent marked deterioration of functioning related to a specific precipitant in restoring his or her level of functioning. The goal of this service is to maintain the beneficiary in the least restrictive, clinically appropriate level of care.

Service Description

The clinician must assist the beneficiary in identifying the precipitating event, in identifying personal and/or community resources that he or she can rely on to cope with this crisis, and in developing specific strategies to be used to mitigate this crisis and prevent similar incidents.

A crisis can be defined as an event that places a beneficiary in a situation that was not planned or expected. Sometimes, these unexpected events can hinder the beneficiary's capacity to function. Clinical professionals should provide an objective frame of reference within which to consider the crisis, discuss possible alternatives, and promote healthy functioning. All activities must occur within the context of a potential or actual psychiatric crisis.

Crisis Management (CM) should therefore be immediate methods of intervention that can include stabilization of the person in crisis, counseling and advocacy, and information and referral, depending on the assessed needs of the individual. **CM is not a scheduled service**.

Face-to-face inventions require immediate response by a clinical professional and include:

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — PSYCHOTHERAPY AND COUNSELING SERVICES

Service Description (Cont'd.)

- A preliminary evaluation of the beneficiary's specific crisis
- Intervention and stabilization of the beneficiary
- Reduction of the immediate personal distress experienced by the beneficiary
- Development of an action plan that reduces the chance of future crises through the implementation of preventative strategies
- Referrals to appropriate resources
- Follow up with each beneficiary within 24 hours, when appropriate
- Telephonic interventions are provided either to the beneficiary or on behalf of the beneficiary to collect an adequate amount of information to provide appropriate and safe services, stabilize the beneficiary, and prevent a negative outcome.

An evaluation of the beneficiary should be conducted promptly to identify presenting concerns, issues since last stabilization (when applicable), current living situation, availability of supports, potential risk for harm to self or others, current medications and medication compliance, current use of alcohol or drugs, medical conditions, and when applicable, history of previous crises including response and results.

Individuals in crisis who require this service may be using substances during the crisis. Substance use should be recognized and addressed in an integrated fashion, as it may add to risk, increasing the need for engagement in care. This coordination must be documented in the individual's plan of care.

Medical Necessity Criteria

Beneficiaries eligible for these services must have a diagnosis of a mental health and/or substance use disorder(s); experience acute psychiatric symptoms; or experience psychological and/or emotional changes that result in increased personal distress. Services are also provided to beneficiaries who are, at risk for a higher level of care, such as hospitalization or other out-of-home placement.

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — PSYCHOTHERAPY AND COUNSELING SERVICES

Medical Necessity Criteria (Cont'd.)

Beneficiaries in crisis may be represented by a family member or other individuals who have extensive knowledge of the beneficiary's capabilities and functioning.

Staff Qualifications

CM must be provided by qualified clinical professionals as defined in the "Staff Qualifications" in this section. Licensed clinical professionals must operate within their scope of practice, as allowed by state law.

Bachelor's level staff providing this service must have documented intensive training in Crisis Management.

Service Documentation

CM is not required to be listed on the IPOC.

Services must be documented on a CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes. A CSN must be completed upon contact with the beneficiary and should include the following:

- Start time and stop time as well as the duration
- All participants during the service
- Summary of the crisis or the symptoms that indicate the beneficiary is in a crisis
- Content of the session, including safety risk assessment and safety planning
- Active participation and intervention of the staff
- Response of the beneficiary to the treatment
- Beneficiary's status at the end of the session
- A plan for what will be worked on with the beneficiary
- Resolution of the crisis

Staff-to-Beneficiary Ratio

CM requires at least one qualified clinical professional for each beneficiary.

Billing Frequency

CM is billed in 15-minute units. See Section 4 of this manual for additional information regarding procedure codes and frequencies.

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — PSYCHOTHERAPY AND COUNSELING SERVICES

Billable Place of Service

Services must be rendered in a setting that is convenient for the both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

Excluded settings include acute care hospitals, Inpatient Psychiatric Hospitals, Psychiatric Residential Treatment Facilities (PRTF), institutions of more than 16 beds, and recreational settings (a place primarily used for play and leisure activities, such as parks and community recreation centers).

Special Restrictions Related to Other Services

Services provided to children must include coordination with family or guardians and other systems of care as appropriate.

MEDICATION MANAGEMENT (MM)

Purpose

The purpose of this face-to-face service is to train and educate the beneficiary about his or her medication, to determine any physiological and/or psychological effects of medication(s) on the beneficiary, administer necessary medications, and to monitor the beneficiary's compliance with his or her medication regime.

Service Description

Medication Management (MM) is focused on topics such as possible side effects of medications, possible drug interactions, and the importance of compliance with medication. During assessments, attempts should be made to obtain necessary information regarding the beneficiary's health status and use of medications.

MM encompasses those processes through which medicines are selected, procured, delivered, prescribed, administered, and reviewed to optimize the contribution that medicines make to producing informed and desired outcomes of the beneficiary's care.

MM includes two or more of the following services:

- Management, which involves prescribing and then reviewing medications for their side effects
- Monitoring, which involves observing and encouraging people to take their medications as

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — PSYCHOTHERAPY AND COUNSELING SERVICES

Service Description (Cont'd.)

prescribed (frequently used with people with a poor compliance history)

- Administration, which is the actual giving of an oral medication by a licensed professional
- Training, which educates beneficiaries and their families on how to follow the medication regime and the importance of doing so
- Assess the need for beneficiaries to see the physician

MM may provide the following:

- Determine the overt physiological effects related to any medication(s)
- Determine psychological effects of medications
- Monitor beneficiaries' compliance to prescription directions
- Educate beneficiaries as to the dosage, type, benefits, actions, and potential adverse effects of the prescribed medications
- Educate beneficiaries about psychiatric medications and substance abuse in accordance with nationally accepted practice guidelines
- Monitor and evaluate the beneficiary's response to medication(s)
- Perform a medication review to identify, resolve, and prevent medication-related problems, including adverse drug events
- Document the care delivered and communicate essential information to the beneficiary and/or other service providers, if appropriate. When the service is provided to children, the service should include communication and coordination with the family and/or legal guardian.
- Provide verbal education and training designed to enhance the beneficiary understanding and appropriate use of the medications
- Provide information, support services, and resources designed to enhance beneficiary's adherence to medication regiment

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — PSYCHOTHERAPY AND COUNSELING SERVICES

Service Description (Cont'd.)

- Coordinate and integrate MM services within the broader health care management services being provided to the beneficiary

Medical Necessity Criteria

Beneficiaries eligible for these services must have a diagnosis of a mental illness and/or substance use disorder(s). The results of the assessment and/or screening tool must indicate a functioning level that would support the need for services. The beneficiary must be on medication prescribed by a physician or being educated on how to take their medication appropriately.

Staff Qualifications

MM services must be provided by qualified licensed clinical professionals operating within their scope of practice as allowed by state law.

Service Documentation

MM must be listed on the IPOC with a specific planned frequency to meet the identified individualized needs of the beneficiary.

MM must be documented on CSNs with start and stop times identified. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes. The following items must be recorded on CSNs:

- Medications the beneficiary is currently taking, or reference to the physician's order or other document in the medical record that lists all the medications prescribed to the beneficiary
- All benefits and side effects of new medications being prescribed or for medications that is potentially dangerous
- Any change in medications and/or doses and rationale for any change, if applicable
- Documentation of any medications being prescribed
- Follow-up instructions for the next visit

Staff-to-Beneficiary Ratio

MM requires at least one qualified licensed clinical professional for each beneficiary.

Billing Frequency

MM is billed in 15-minute units. See Section 4 of this manual for additional information regarding procedure codes and frequencies.

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — PSYCHOTHERAPY AND COUNSELING SERVICES

Billable Place of Service	Services must be rendered in a setting that is convenient for the both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality. Excluded settings include acute care hospitals, Inpatient Psychiatric Hospitals, Psychiatric Residential Treatment Facilities (PRTF), institutions of more than 16 beds, and recreational settings (a place primarily used for play and leisure activities, such as parks and community recreation centers).
Special Restrictions Related to Other Services	MM cannot be reimbursed with Individual Psychotherapy with the E&M codes when rendered to a beneficiary on the same day.

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — PSYCHOTHERAPY AND COUNSELING SERVICES

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SECTION 2 POLICIES AND PROCEDURES

COMMUNITY SUPPORT SERVICES

PSYCHOSOCIAL REHABILITATION SERVICES (PRS)

Purpose

The purpose of this face-to-face service is to enhance, restore and/or strengthen the skills needed to promote and sustain independence and stability within the beneficiary's living, learning, social, and work environments. PRS is a skill building service, not a form of psychotherapy or counseling. PRS is intended to be time-limited. The intensity and frequency of services offered should reflect the scope of impairment. Services are generally more intensive and frequent at the beginning of treatment and are expected to decrease as the beneficiary's skills develop. Services are based on medical necessity, shall be directly related to the beneficiary's diagnostic and clinical needs and are expected to achieve the specific rehabilitative goals specified in the beneficiary's IPOC.

PRS include activities that are necessary to achieve goals in the IPOC in the following areas:

- Independent living skills development related to increasing the beneficiary's ability to manage his or her illness, illness, to improve his or her quality of life, and to live as actively and independently in the community as possible
- Personal living skills development in the understanding and practice of daily and healthy living habits and self-care skills
- Interpersonal skills training that enhances the beneficiary's communication skills, ability to develop and maintain environmental supports, and ability to develop and maintain interpersonal relationships

Service Description

PRS is designed to improve the quality of life for beneficiaries by helping them assume responsibility over their lives, strengthen living skills, and develop environmental supports necessary to enable them to function as actively and independently in the community, as possible.

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY SUPPORT SERVICES

Service Description (Cont'd.)

PRS must be provided in a supportive community environment. Each beneficiary should be offered PRS in a manner that is strengths-based and person centered.

PRS must provide opportunities for the beneficiary to acquire and improve skills needed to function as adaptively and independently as possible in the community and facilitate the beneficiary's community integration.

Medical Necessity Criteria

Admission Criteria for Adults (age 22 and older)

A-G must be met to satisfy criteria for admission into PRS services.

A. The beneficiary has received a diagnostic assessment, and has been diagnosed with a serious and persistent mental illness (SPMI), which includes one of the following diagnoses: Bipolar Disorder, Major Depression, a diagnosis within the spectrum of psychotic disorders, and/or substance use disorder (SUD).

B. The beneficiary has a serious and persistent mental illness (SPMI) and/or substance use disorder (SUD) and the symptom-related problems interfere with the individual's functioning and living, working, and/or learning environment.

C. As a result of the SPMI or SUD, the beneficiary experiences moderate to severe functional impairment that interferes with three or more of the following areas: daily living, personal relationships, school/work settings, and/or recreational setting.

D. Traditional mental health services (e.g., individual/family/group therapy, medication management, etc.) alone are not clinically appropriate to prevent the beneficiary's condition from deteriorating. The level of care provided is determined by the clinician to be the least restrictive and that the benefits to receiving the treatment outweigh any potential harm.

E. Beneficiary meets three or more of the following criteria as documented on the Diagnostic Assessment:

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY SUPPORT SERVICES

Admission Criteria for Adults (age 22 and older) (Cont'd.)

- Is not functioning at a level that would be expected of typically developing individuals their age
- Is at risk of psychiatric hospitalization, homelessness, and/or isolation from social supports due to the beneficiary's SPMI and/or SUD
- Exhibits behaviors that require repeated interventions by the mental health, social services, and/or judicial system
- Experiences impaired ability to recognize personal and/or environmental dangers and/or significantly inappropriate social behavior

F. Beneficiary is expected to benefit from the intervention and identified needs would not be better met by any other formal or informal system or support.

G. The service is recommended by a Licensed Practitioner of the Healing Arts (LPHA) acting within the scope of his/her professional licensure.

Continued Service Criteria for Adults (age 22 and older)

A-E must be met to satisfy criteria for continued PRS services.

A. The beneficiary continues to meet the admission criteria.

B. There is documentation from the provider that the beneficiary is receiving the scope and intensity of services required to meet the program goals stated in the service description.

C. Beneficiary has shown improvement in functioning in at least two of the following areas: daily living, personal relationships, school/work settings, and/or recreational setting, and is expected to continue to benefit from PRS, which remains appropriate to meet the beneficiary's needs.

D. The beneficiary and others identified by the treatment plan process are active participants in the creation of the treatment plan and discharge plan, and are actively participating in treatment. The

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Continued Service Criteria for Adults (age 22 and older) (Cont'd.)

beneficiary's designated others and treatment team agrees on treatment goals, objectives and interventions.

E. The desired outcome or level of functioning has not been restored and/or sustained over the time frame outlined in the beneficiary's Individual Plan of Care (IPOC).

Admission Criteria for Children (age 0-21)

A-I must be met to satisfy criteria for admission into PRS services.

A. The beneficiary has received a diagnostic assessment, which includes a DSM diagnosis that requires and will respond to therapeutic interventions specific to the PRS service description.

B. The beneficiary has a serious and persistent mental illness (SPMI), serious emotional disturbance (SED) and/or substance use disorder (SUD), and the symptom-related problems interfere with the individual's functioning and living, working, and/or learning environment. (Children under the age of 7 may qualify for these services if they are diagnosed with an applicable Z-code, per the current DSM).

C. As a result of the SED, SPMI or SUD, the beneficiary experiences moderate to severe functional impairment that interferes with three or more of the following areas: daily living, personal relationships, school/work settings, and/or recreational setting.

D. Beneficiary meets three or more of the following criteria as documented on the diagnostic assessment:

- Is not functioning at a level that would be expected of typically developing individuals their age;
- Is deemed to be at risk of psychiatric hospitalization and/or out-of-home placement;
- In the last 90 days exhibited behavior that resulted in at least one intervention

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Admission Criteria for Children (age 0-21) (Cont'd.)

by crisis response, social services, or law enforcement;

- Experiences impaired ability to recognize personal or environmental dangers or significantly inappropriate social behavior.

E. The family/caregiver/guardian agrees to be an active participant, which involves participating in interventions to better understand and care for the beneficiary for the purpose of maintaining progress during and after treatment.

F. Traditional mental health services (e.g., individual/family/group therapy, medication management, etc.) alone are not clinically appropriate to prevent the beneficiary's condition from deteriorating. The level of care provided is determined by the clinician to be the least restrictive and that the benefits to receiving the treatment outweigh any potential harm.

G. The service is recommended by a Licensed Practitioner of the Healing Arts (LPHA) acting within the scope of his/her professional licensure.

H. Beneficiary is expected to benefit from the intervention and needs would not be better met by any other formal or informal system or support.

I. The score on the age-appropriate assessment tool, completed by the LPHA, indicates need for PRS *

- For beneficiaries from birth until 1.5 years, has scored in the 81st percentile or above on the Parenting Stress Index (PSI)
- For beneficiaries age 1.5-5 years, has scored in the borderline to clinical range (minimum T score of 65) on at least one syndrome scale and one DSM-Oriented scale on The Child Behavior Check List (CBCL)
- For beneficiaries 6-18 years, has been assigned a minimum CALOCUS composite score of 17

*Private Providers Only

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Continued Service Criteria for Children (ages 0-21)

A-E must be met to satisfy criteria for continued PRS services.

A. The beneficiary continues to meet the admission criteria.
B. There is documentation from the provider that the beneficiary is receiving the scope and intensity of services required to meet the program goals stated in the service description.
C. The beneficiary has shown improvement in functioning in at least two of the following areas: daily living, personal relationships, school/work settings, and/or recreational setting, and is expected to continue to benefit from PRS, which remains appropriate to meet the beneficiary's needs.
D. The family/caregiver/guardian, and others identified by the treatment plan process are actively participating in treatment. The beneficiary's designated others and treatment team agrees on treatment goals, objectives and interventions.
E. The desired outcome or level of functioning has not been restored or sustained over the time frame outlined in the beneficiary's Individual Plan of Care (IPOC).

Staff Qualifications

PRS must be provided by qualified clinical professionals and paraprofessionals as defined in the "Staff Qualifications" section. PRS services rendered by paraprofessionals must be under the supervision of qualified clinical professionals.

A Bachelor's Degree or above or a certified Substance Abuse Specialist (SAS) currently affiliated with DAODAS is required to render PRS.

Exclusions: Provider staff directly serving children in Therapeutic Foster Care (TFC) placement must have, at a minimum, a high school diploma or GED.

Service Documentation

PRS must be listed on the IPOC with a specific planned frequency to meet the identified individualized needs of the beneficiary.

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Service Documentation (Cont'd.)

The qualified staff providing the service is responsible for completing and signing the clinical service notes. The notes should clearly identify the specific goal(s) from the IPOC for which the delivery of PRS addresses. Services must be documented upon each contact with the beneficiary. Additionally, the clinical service notes and other documentation must meet all SCDHHS requirements.

Documentation must clearly reflect the specific need of the beneficiary and the therapeutic interventions and support rendered to address the need(s) of the beneficiary.

For beneficiaries age 0 through 15 years of age, the Parent/Caregiver/Guardian Agreement to Participate in Community Support Services form must be completed and maintained in the beneficiary's record. In the unlikely event that the beneficiary's family or caregiver is unable or unwilling to be an active participant, this must be clearly documented in the clinical record.

Staff-to-Beneficiary Ratio

PRS can be provided individually, face-to-face with one participant at a time.

PRS can be provided in small groups of no more than one staff to eight (1:8) adult participants and no more than one staff to eight (1:8) child and adolescent participants, regardless of the payer source of the participants in the group. Only staff who meet the staff qualification requirements for PRS are considered for the 1:8 ratio. For example: If a group consists of nine children, two staff must be present and actively rendering the service. If two staff are not present and actively rendering the service, the provider cannot be reimbursed for the service as the ratio exceeds 1:8.

Beneficiaries in excess of the allowed ratio should not be present during the delivery of the service. The ratio count applies to all beneficiaries receiving services by a provider regardless of whether or not the beneficiary is Medicaid eligible.

Billing Frequency

PRS is billed in 15-minute units. See Section 4 of this manual for additional information regarding procedure codes and frequencies.

Billable Place of Service

Services must be rendered in a setting that is convenient for the both the beneficiary and the professional that affords an

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Billable Place of Service (Cont'd.)

adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

PRS is not Medicaid reimbursable if it is provided in the following places of service: acute care hospitals, Inpatient Psychiatric Hospitals, Psychiatric Residential Treatment Facilities (PRTF), institutions and residential settings of any type of more than 16 beds, and recreational settings (a place primarily used for play and leisure activities, such as parks and community recreation centers).

Same Day Service Restrictions

Community Support Services (CSS) are defined as the following five services: Psychosocial Rehabilitation, Behavioral Modification, Community Integration Services, Therapeutic Child Care, and Family Support Services

SCDHHS will only reimburse for one RBHS Community Support Service (CSS) per day. For example, FS-Behavioral Modification will not be reimbursed on the same day as Psychosocial Rehabilitation Services or Family Support.

Exception: Individual (1:1) PRS may be provided on the same day as Community Integration Services.

Children in foster care, therapeutic foster care, and those served by the Continuum of Care are exempt from the same-day service restriction.

For services rendered to beneficiaries that are residing in a Community Residential Care Facility or Substance Abuse Facility, activities must be above and beyond structured activities required daily by the DHEC licensure requirements. This delineation must be clearly defined, documented, and accessible in the beneficiary record.

BEHAVIOR MODIFICATION (B-MOD)

Purpose

The service is provided to children and adolescents ages 0 to 21. The purpose of this face-to-face service is to provide the beneficiary with in vivo redirection and modeling of appropriate behaviors in order to enhance his or her functioning within the home or community. Shadowing (following and observation) a beneficiary in any setting is not reimbursable under Medicaid. Behavior Modification (B-Mod) is intended to be time-limited and the intensity of

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Purpose (Cont'd.)

services offered should reflect the scope of impairment. Services are generally more intensive and frequent at the beginning of treatment and are expected to decrease over time as the beneficiary's skills develop. Services are based upon a finding of medical necessity, shall be directly related to the beneficiary's diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals specified in the beneficiary's IPOC.

Service Description

The goal of B-Mod is to alter patterns of behavior that are inappropriate or undesirable of the child or the adolescent. B-Mod involves the utilization of regularly scheduled interventions designed to optimize emotional and behavioral functioning in the natural environment through the application of clinically planned techniques that promote the development of healthy coping skills, adaptive interactions with others, and appropriate responses to environmental stimuli.

B-Mod provides the beneficiary the opportunity to alter existing behaviors, acquire new behaviors, and function more effectively within his or her environment. Interventions are planned in such a way that they are constantly supporting, guiding, and reinforcing the beneficiary's ability to learn life skills.

B-Mod involves the identification of precipitating factors that cause a behavior to occur. New, more appropriate behaviors are identified, developed, and strengthened through modeling and shaping. Intervention strategies that require direct involvement with the beneficiary must be used to develop, shape, model, reinforce and strengthen the new behaviors.

B-Mod techniques allow professionals to build the desired behavior in steps and reward those behaviors that come progressively closer to the goal and allow the beneficiary the opportunity to observe the professional performing the desired behavior.

Successful delivery of B-Mod should result in the display of desirable behaviors that have been infrequently or never displayed by the beneficiary. These desirable responses must be reflected in progress notes and show increasing frequency for ongoing behavioral modification.

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Medical Necessity Criteria

Admission Criteria for Children and Adolescents (ages 0-21)

A-J must be met to satisfy criteria for admission into B-Mod services.

A. The beneficiary is under 22 years of age.

B. The beneficiary has received a diagnostic assessment, which includes a current DSM diagnosis that requires and will respond to therapeutic interventions and which documents the need for B-Mod.

C. The beneficiary has a serious and persistent mental illness (SPMI), serious emotional disturbance (SED) and/or substance use disorder (SUD), and must be engaging in one or more of the following behaviors: physical aggression, verbal aggression, object aggression, and/or self-injurious behavior that presents risk of harm to self or others (Children under the age of 7 may qualify for these services if they are diagnosed with an applicable Z-code, per the current DSM).

D. The beneficiary's behaviors interfere with three or more of the following areas: daily living, personal relationships, school/work settings, and/or recreational setting.

E. Beneficiary meets three or more of the following criteria as documented on the Diagnostic Assessment:

- Is not functioning at a level that would be expected of typically developing individuals their age
- Is deemed to be at risk of psychiatric hospitalization or out-of-home placement
- In the last 90 days exhibited behavior that resulted in at least one intervention by crisis response, social services, or law enforcement
- Experiences impaired ability to recognize personal and/or environmental dangers and/or significantly inappropriate social behavior

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Admission Criteria for Children and Adolescents (ages 0-21) (Cont'd).

F. The beneficiary's behavioral needs require interventions to decrease identified behaviors and to facilitate the beneficiary's success in his or her home and community.

G. The family or caregiver agrees to be an active participant, which involves participating in interventions to better understand the beneficiary's needs identified in the DA and IPOC, for the purpose of maintaining progress during and after treatment.

H. Beneficiary is expected to benefit from the intervention and needs would not be better met clinically by any other formal or informal system or support.

I. The service is recommended by a Licensed Practitioner of the Healing Arts (LPHA) acting within the scope of his/her professional licensure.

J. The score on the age-appropriate assessment tool, completed by the LPHA, indicates need for B-Mod*:

- For beneficiaries from birth until 1.5 years, has scored in the 81st percentile or above on the Parenting Stress Index (PSI)
- For beneficiaries age 1.5-5 years, has scored in the borderline to clinical range (minimum T score of 65) on at least one syndrome scale and one DSM-Oriented scale on The Child Behavior Check List (CBCL)
- For beneficiaries 6-18 years, has been assigned a minimum CALOCUS composite score of 17

*Private providers only

Continued Service Criteria for Children and Adolescents (ages 0-21)

A-E must be met to satisfy criteria for continued B-Mod services.

A. The beneficiary continues to meet the admission criteria.

B. There is documentation from the provider that the beneficiary is receiving the scope and intensity of services required to meet the program goals stated

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Continued Service Criteria for Children and Adolescents (ages 0-21)

in the beneficiary's IPOC. The progress summary must specifically capture progress on each goal listed on the IPOC.

C. The desired outcome or level of functioning has not been restored or sustained over the time frame outlined in the beneficiary's Individual Plan of Care (IPOC).

D. The beneficiary has shown improvement in functioning in at least two of the following areas: daily living, personal relationships, school/work settings, and/or recreational setting, and is expected to continue to benefit from B-Mod, which remains appropriate to meet the beneficiary's needs.

E. The beneficiary's IPOC and treatment process should be youth guided and family driven. The beneficiary, the beneficiary's designated others, and treatment team agree on treatment goals, objectives and interventions.

Service Documentation

The beneficiary's IPOC and treatment process must be youth guided and family driven. The beneficiary, the beneficiary's designated others, and treatment team agree on treatment goals, objectives and interventions.

B-Mod must be listed on the IPOC with a specific planned frequency to meet the identified individualized needs of the beneficiary.

In addition to the IPOC, a Behavior Modification Plan (BMP) must be included in the beneficiary's clinical record. See below for specific components of the BMP.

The qualified staff providing the service is responsible for completing and signing the clinical service notes. The notes must clearly identify the specific goal(s) from the IPOC for which the delivery of B-Mod addresses. Services must be documented upon each contact with the beneficiary. Additionally, the clinical service notes and other documentation must meet all SCDHHS requirements, outlined in Section 2 (Documentation Requirements) of this manual.

Documentation must clearly reflect the specific need of the beneficiary and the therapeutic interventions and support rendered to address the need(s) of the beneficiary.

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Service Documentation (Cont'd.)

For beneficiaries aged 0 through 15, the Parent/Caregiver/Guardian Agreement to Participate in Community Support Services form must be completed and maintained in the beneficiary's record.

Beneficiaries receiving B-Mod must have the Parent/Caregiver/Guardian Agreement form signed prior to the initiation of B-Mod services.

- For children who are in foster care, the Parent/Caregiver/Guardian Agreement must be signed by the foster parent. In the event the foster parent changes during the 90-day authorization period, the new foster parent must sign the Parent/Caregiver/Guardian Agreement for the next 90-day authorization cycle. In the event that there is a refusal or an inability to sign the agreement B-Mod services must not be provided.
- In addition to general documentation requirements, service documentation for B-Mod must identify the presence of the inappropriate and/or undesirable and detail how the behavior was redirected by qualified staff.

Behavior Modification Plan (BMP)

A Behavior Modification Plan (BMP) addresses the beneficiary's specific behavioral challenge(s). The BMP supports the beneficiary in learning and utilizing positive behavioral interventions, strategies and supports. The BMP should focus on understanding why the behavior occurred, then focus on teaching an alternative behavior that meets the beneficiary's need(s).

The BMP must remain current and therefore must be amended when a new intervention, strategy or support is warranted or if no progress is being made. The BMP must be revised as needed and must always be current.

The BMP must be developed by a team consisting of the beneficiary, family/caregiver and B-Mod provider. The BMP must be consistent with the beneficiary's goals outlined within the IPOC.

Components that must be included in BMP (including but not limited to):

- Name
- Medicaid Number

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Behavior Modification Plan (BMP) (Cont'd.)

- Date of BMP and/or date of revision
- Target Behavior(s):
  - An operational definition of each problem behavior to be decreased
  - An operational definition of each replacement behavior to be increased
  - A measurable objective for each problem behavior and replacement behavior
- Identify the desired behavioral change
- Intervention Strategies: includes specific interventions and strategies to be implemented in addressing the target behavior(s)/goal(s)
- Environmental Changes: includes any changes to the setting or environment necessary to effectively implement the strategies and interventions
- Timelines/Review Dates: includes segments of time during which specific portions of the BMP are to be addressed, as well as specific dates by which specific portions of the BMP are to be reviewed, with regard to progress
- Behavioral Crisis Plan: How will a behavioral crisis be handled?
- Monitoring Progress/Evaluation Methods: includes a description of how progress toward achieving desired outcomes will be monitored and evaluated, including timeframes and data collection
- Progress Review Date: the date the plan will be reviewed for effectiveness
- Names of participants in the creation of the BMP
- Signatures of persons who participated in the development of the plan (beneficiary, family/caregiver, and B-Mod staff)

Staff Qualifications

The specific behavior plan must be developed by an independent LPHA and conform to prevailing standards of practice based on peer-reviewed literature. B-Mod must be provided by qualified clinical professionals and paraprofessionals as defined in the "Staff Qualifications"

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Staff Qualifications (Cont'd.)

section. B-Mod services rendered by paraprofessionals must be under the supervision of qualified clinical staff. A Bachelor's Degree or above or a certified Substance Abuse Specialist (SAS) currently affiliated with DAODAS is required to render B-Mod.

- Exclusion: Provider staff directly serving children in Therapeutic Foster Care (TFC) placement must have, at a minimum, a high school diploma or GED.

Staff-to-Beneficiary Ratio

B-Mod is a 1:1 service. B-Mod must not be provided in group settings.

Billing Frequency

B-Mod is billed in 15-minute units. See Section 4 of this manual for additional information regarding procedure codes and frequencies.

Billable Place of Service

Services must be rendered in a setting that is convenient for the beneficiary, affords an adequate therapeutic environment and protects the beneficiary's rights to privacy and confidentiality.

B-Mod is not Medicaid reimbursable if it is provided in the following places of service: acute care hospitals, Inpatient Psychiatric Hospitals, Psychiatric Residential Treatment Facilities (PRTF), institutions and residential settings of any type of more than 16 beds, and recreational settings (a place primarily used for play and leisure activities, such as parks and community recreation centers).

Same Day Service Restrictions

Community Support Services (CSS) are defined as the following five services: Psychosocial Rehabilitation, Behavioral Modification, Family Support Services Community Integration Services, and Therapeutic Child Care.

SCDHHS will only reimburse for one RBHS Community Support Service (CSS) per day. For example, Behavioral Modification will not be reimbursed on the same day as Psychosocial Rehabilitation Services or Family Support.

Exceptions to any same day service restrictions are noted under the specific service.

Children in foster care, therapeutic foster care, and those served by the Continuum of Care are exempt from the same-day service restriction.

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FAMILY SUPPORT (FS) (0-21)

Purpose

The purpose of this face-to-face service is to enable the family or caregiver (parent, guardian, custodian or persons serving in a caregiver role) to serve as an engaged member of the beneficiary's treatment team and to develop and/or improve the ability of the family or caregiver(s) to appropriately care for the beneficiary. Family Support (FS) is intended to be time-limited and the intensity of services offered should reflect the scope of impairment. Services are generally more intensive and frequent at the beginning of treatment and are expected to decrease over time as the beneficiary's and family/caregiver's skills develop. Services are based upon a finding of medical necessity, must be directly related to the beneficiary's diagnostic and clinical needs, and are expected to achieve the rehabilitative goals specified in the beneficiary's IPOC.

Service Description

FS is intended to:

- Equip families with coping skills to independently manage challenges and crisis situations related to the beneficiary's behavioral health and/or substance use disorder
- Educate families/caregivers to advocate effectively for the beneficiary in their care
- Provide families/caregivers with information and skills necessary to allow them to be an integral and active part of the beneficiary's treatment team
- Model skills for the family/caregiver

Family Support (FS) is a service with the primary purpose of treating the beneficiary's behavioral health and/or substance use disorder.

FS does not include case management activities nor does it include respite care or child care services of any kind.

Medical Necessity Criteria

Admission Criteria

A-I must be met to satisfy criteria for admission into Family Support services.

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Admission Criteria (Cont'd.)

A. The beneficiary is under the age of 22.

B. The beneficiary has received a diagnostic assessment, which includes a current DSM diagnosis and specific clinical needs that will respond to therapeutic interventions and which documents the need for FS.

C. The beneficiary has a serious and persistent mental illness (SPMI), serious emotional disturbance (SED) and/or substance use disorder (SUD), and the symptom-related problems interfere with the individual's functioning, living, working, and/or learning environment. Children under the age of 7 may qualify for these services if they are diagnosed with an applicable Z-code, per the current DSM.

D. As a result of the SED, SPMI or SUD, the beneficiary experiences moderate to severe functional impairment that interferes with three or more of the following areas: daily living, personal relationships, school/work settings, and/or recreational setting.

E. Beneficiary meets three or more of the following criteria as documented on the Diagnostic Assessment:

- Is not functioning at a level that would be expected of typically developing individuals their age
- Is deemed to be at risk of psychiatric hospitalization and/or out-of-home placement
- In the last 90 days exhibited behavior that resulted in at least one intervention by crisis response, social services, or law enforcement
- Experiences impaired ability to recognize personal and/or environmental dangers and/or significantly inappropriate social behavior

F. Family/caregiver agrees to be an active participant in treatment; FS services should provide opportunities for the family/caregiver to acquire

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Admission Criteria (Cont'd.)

and improve skills needed to better understand and care for the needs of the beneficiary (e.g., managing crises, providing education about the beneficiary's diagnosis).

G. Beneficiary is expected to benefit from the intervention and needs would not be better met by any other formal or informal system or support.

H. The service is recommended by a Licensed Practitioner of the Healing Arts (LPHA) acting within the scope of his/her professional licensure.

I. The score on the age-appropriate assessment tool, completed by the LPHA, indicates need for FS*:

- For beneficiaries from birth until 1.5 years, has scored in the 81st percentile or above on the Parenting Stress Index (PSI)
- For beneficiaries age 1.5-5 years, has scored in the borderline to clinical range (minimum T score of 65) on at least one syndrome scale and one DSM-Oriented scale on The Child Behavior Check List (CBCL)
- For beneficiaries 6-18 years, has been assigned a minimum CALOCUS composite score of 17

*Private providers only

Continued Service Criteria

A-E must be met to satisfy criteria for continued FS services.

A. There is documentation from the provider that the beneficiary is receiving the scope and intensity of services required to meet the program goals specific to the treatment needs stated in the beneficiary's IPOC.

B. The desired outcome or level of functioning has not been restored or sustained over the time frame outlined in the beneficiary's Individual Plan of Care (IPOC).

C. The beneficiary has shown improvement in functioning in at least two of the following areas: daily living, personal relationships, school/work settings, and/or recreational setting, and is expected

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Continued Service Criteria (Cont'd.)

to continue to benefit from FS, which remains appropriate to meet the beneficiary's needs.

D. The beneficiary continues to meet the admission criteria.

E. The beneficiary's IPOC and treatment process should be youth guided and family driven. The beneficiary, the beneficiary's designated others, and treatment team agree on treatment goals, objectives and interventions.

Service Documentation

The qualified staff providing the service is responsible for completing and signing the clinical service notes. The notes should clearly identify the specific goals from the IPOC for which the delivery of FS addresses. Services must be documented upon each contact with the beneficiary and/or family/caregiver. Additionally, the clinical service notes and other documentation must meet all SCDHHS requirements, outlined in Section 2 (Documentation Requirements) of this manual.

Documentation must clearly reflect the specific need of the beneficiary and the therapeutic interventions and support rendered to address the needs of the beneficiary.

Beneficiaries aged 0 through 15 must have the Parent/Caregiver/Guardian Agreement form signed prior to the initiation of FS services.

For children who are in foster care, the Parent/Caregiver/Guardian Agreement must be signed by the foster parent. In the event the foster parent changes during the 90-day authorization period, the new foster parent must sign the Parent/Caregiver/Guardian Agreement for the next 90-day authorization cycle. In the event that there is a refusal or an inability to sign the agreement FS services must not be provided.

The beneficiary's IPOC and treatment process should be youth guided and family driven. The beneficiary, the beneficiary's designated others, and treatment team agree on treatment goals, objectives and interventions.

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Staff Qualifications

FS must be provided by qualified professionals as defined in the general Staff Qualifications section of this manual. Staff providing the service must have a Bachelor's Degree or above, or be a certified Substance Abuse Specialist (SAS) affiliated with DAODAS.

Exclusion: Provider staff directly serving children in Therapeutic Foster Care placement must have, at a minimum, a high school diploma or GED.

Staff-to-Beneficiary Ratio

FS requires one qualified staff for each family unit served. If more than one child in a family has met medical necessity for FS they must be served separately.

Billing Frequency

FS is billed in 15-minute units. See Section 4 of this manual for additional information regarding procedure codes and frequencies.

Billable Place of Service

Services must be rendered in a setting that is convenient for the beneficiary, affords an adequate therapeutic environment and protects the beneficiary's rights to privacy and confidentiality.

FS is not Medicaid reimbursable if it is provided in the following places of service: acute care hospitals, Inpatient Psychiatric Hospitals, Psychiatric Residential Treatment Facilities (PRTF), institutions and residential settings of any type of more than 16 beds, and recreational settings (a place primarily used for play and leisure activities, such as parks and community recreation centers).

Same Day Service Restrictions

Community Support Services (CSS) are defined as the following five services: Psychosocial Rehabilitation, Behavioral Modification, Family Support Services, Community Integration Services, and Therapeutic Child Care.

SCDHHS will only reimburse one RBHS Community Support Service (CSS) per day. For example, Behavioral Modification will not be reimbursed on the same day as Psychosocial Rehabilitation Services or Family Support.

Exceptions to any same day service restrictions are noted under the specific service.

Children in foster care, therapeutic foster care, and those served by the Continuum of Care are exempt from the same-day service restriction.

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Same Day Service Restrictions (Cont'd.)

Services provided on the behalf of the beneficiary must include coordination with family/caregiver and other systems of care as appropriate. FS must not be rendered with more than one family unit at a time.

Children in foster care, therapeutic foster care, and those served by the Continuum of Care are exempt from the same-day service restriction.

THERAPEUTIC CHILD CARE (TCC)

Purpose

The purpose of this face-to-face service is to assist children with severe emotional and/or behavioral disturbances, and to promote or enhance appropriate developmental functioning which fosters social, emotional, and self-regulatory behavioral competence. Services incorporate a combination of psychotherapy and skill building.

Provider Credentialing

In order to provide TCC enrolled RBHS providers must apply to become credentialed in TCC.

In order to apply for TCC, providers must meet the following requirements:

- Hold a DSS licensure or approval as a daycare facility
- At least one staff member must be credentialed in Trauma-Focused Cognitive Behavior Therapy (TF-CBT) or Parent-Child Interactive Therapy (PCIT)
- Are accredited by one of the following entities in at least one of the applicable standards:
  - Commission on Accreditation for Rehabilitation Facilities
    - CYS Manual: Counseling/Outpatient, Early Childhood Development, Intensive Family Based Services, Intensive Outpatient Treatment, and/or Community Transition
    - BH Manual: Intensive Family Based Services, and/or Outpatient Programs
  - Council on Accreditation

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Provider Credentialing (Cont'd.)

- Child and Family Development and Support Services (CFD), Day Treatment Services (DTX), Family Preservation and Stabilization Services (FPS), Outpatient Mental Health Services (MH), or Services for Mental Health and/or Substance Use Disorders (MHSU)

- The Joint Commission
  - BHC Day Treatment- Child/Youth Category and/or Mental Health- Child/Youth Category

Service Description

TCC is a child-focused, family-centered intervention which targets the relationship between the child and the parent (or primary caregiver). Grounded in attachment theory, services are relationship-based, developmentally appropriate, and trauma informed. Services must be evidence-based and include either Trauma Focused Cognitive-Behavioral Therapy (TF-CBT), or Parent-Child Interactive Therapy (PCIT). The TCC must have documentation of staff certification to provide the evidence-based treatment being utilized as well as a documented plan for fidelity monitoring.

TCC provides a continuum of individual, family, and group services that meet the needs of children with severe emotional and/or behavioral disturbances. The service is family-focused, with the intention of keeping the child in his or her home and community. The child and child's family are expected to develop behaviors and skill sets such that the child will not require intensive treatment in the future.

- TCC involves ongoing assessment, treatment activities, and therapeutic structure during program hours.
- Therapeutic group interventions are provided directly to the child through a combination of activities that foster social and emotional competence and self-control.
- Parallel work with the primary caregiver is an essential component of this service. A minimum of one hour per week must be spent with the primary

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Service Description (Cont'd.)

caregiver that includes parent-child interaction to encourage language and play, interpretation of child's behavior and reinforcement of a primary caregiver's appropriate actions and interactions.

As a result of TCC, it is expected that:

- The child will demonstrate an improved ability to initiate and respond to social interactions in a developmentally appropriate manner.
- The child will show a significant reduction in intense and disruptive problem behaviors that interfere with the child's ability to successfully participate in normal developmental experiences or present a danger to self and/or others.
- The child will develop age-appropriate behavioral competencies that will result in enhanced problem solving, coping strategies, self-control, and more successful interactions with other children and adults.
- The child will demonstrate an enhanced ability to meaningfully perform age-appropriate role functions and to learn from the home and educational environments.
- The child will show significant improvements in mood as evidenced by reductions in excessive irritability and/or sadness.
- The child will demonstrate a reduction in behaviors which previously made the child's behavior unmanageable in the home, school, and community.

As a result of TCC, it is expected that there will be an increase in the child's ability to be present, interact, and participate in various tasks for longer periods of time. Further, the child will demonstrate an increased capability to interact with adults in therapeutic and educational tasks, resulting in increased educational and emotional functioning. The improvements in mood will be accompanied by positive changes in self-worth and confidence.

It is expected that parents or primary caregivers of beneficiaries will:

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COMMUNITY SUPPORT SERVICES

Service Description (Cont'd.)

- Learn strategies for managing problem behaviors and interacting effectively with their children;
- Identify and reduce maladaptive patterns and stresses in the home that compound the child's behavioral and emotional challenges;
- Consistently and appropriately provide for the child's basic needs for health, safety, comfort, affection, and stimulation.

Medical Necessity Criteria

Admission Criteria

A-J must be met to satisfy criteria for admission into TCC Services.

A. The beneficiary must be under the age of 6.

B. The beneficiary has been diagnosed with a serious emotional disorder (SED), or an applicable Z-code diagnosis, per the current DSM.

C. The beneficiary requires and is expected to respond to therapeutic interventions specific to the TCC service description.

D. The beneficiary must be exhibiting moderate to severe behavioral problems that significantly impair the beneficiary's ability to function at an age-appropriate developmental level.

E. The family or caregiver agrees to be an active participant, which involves participating in interventions to better understand the beneficiary's needs identified in the DA and IPOC, for the purpose of maintaining progress during and after treatment.

F. Traditional mental health services (e.g., individual/family/group therapy, medication management, etc.) alone are not clinically appropriate to prevent the beneficiary's condition from deteriorating.

G. The level of care provided is determined by the clinician to be the least restrictive and that the benefits to receiving the treatment outweighs any potential harm.

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Admission Criteria (Cont'd.)

H. The beneficiary has a history of exclusion from one or more daycare or preschool due to behavioral problems and/or is at risk for abuse or neglect.

I. The beneficiary is expected to benefit from the interventions and needs would not be better met by any other formal or informal system or support.

J. The score on the age-appropriate assessment tool, completed by the LPHA, indicates need for TCC*:

- For beneficiaries from birth until 1.5 years, has scored in the 81st percentile or above on the Parenting Stress Index (PSI).
- For beneficiaries age 1.5-5 years, has scored in the borderline to clinical range (minimum T score of 65) on at least one syndrome scale and one DSM-Oriented scale on The Child Behavior Check List (CBCL).

Continued Service Criteria

A-E must be met to satisfy criteria for continued TCC services.

A. The beneficiary continues to meet the Admission Criteria.

B. There is documentation from the provider that the beneficiary is receiving the scope and intensity of services required to meet the program goals stated in the beneficiary's IPOC.

C. The beneficiary has shown improvement and is expected to continue to benefit from TCC, which remains appropriate to meet the beneficiary's needs.

D. The beneficiary and others identified by the treatment plan process are active participants in the creation of the treatment plan and discharge plan, and are actively participating in treatment. The beneficiary's designated others and treatment team agrees on treatment goals, objectives and interventions.

E. Desired outcome or level of functioning has not been restored or sustained over the timeframe outlined in the beneficiary's individual plan of care (IPOC).

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Service Documentation

TCC must be listed on the IPOC with a specific planned frequency to meet the identified individualized needs of the beneficiary. Services must be documented upon each contact with the beneficiary. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

Documentation must clearly reflect the specific needs of the beneficiary and the therapeutic interventions and support rendered to address the need(s) of the beneficiary. Additionally, there must be individual documentation completed for each encounter (e.g. group vs. individual).

The qualified staff providing the service is responsible for completing and signing the clinical service notes. The notes should clearly identify the specific goal(s) from the IPOC which the delivery of TCC addresses.

In addition to documentation for TCC, the Parent/Caregiver/Guardian Agreement to Participate in Community Support Services form must be completed and maintained in the beneficiary's record.

A calendar of scheduled program activities and hours will be posted and available. A clinical summary of the child's participation and parent or caregiver's involvement in the scheduled activities shall be included in the documentation of services received.

Staff Qualifications

TCC is provided by qualified staff as defined in the general Staff Qualifications section of this manual. TCC providers must be under the supervision of licensed clinical staff. In addition, at least one clinical staff member must be rostered to provide TF-CBT or PCIT. For the initial year of TCC provision, this requirement may be satisfied by a clinician receiving training and supervision in TF-CBT or PCIT as part of the rostering process.

Staff-To-Beneficiary Ratio

TCC can be provided individually, face-to-face with one participant at a time, or provided face-to-face with two to six participants in a small group.

TCC must be provided in small groups of no more than one staff to six (1:6) child participants (unless state daycare license requirements mandate a smaller ratio), regardless of the payer source of the participants in the group. Only staff who meet the staff qualification requirements for TCC are

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY SUPPORT SERVICES

Staff-To-Beneficiary Ratio (Cont'd.)

considered for the 1:6 ratio. For example: if a group consists of seven children, two staff must be present and actively rendering the service. If two staff are not present and actively rendering the service, the provider cannot be reimbursed for the service as the ratio exceeds 1:6.

Billing Frequency

TCC is billed as a 15-minute unit. See Section 4 of this manual for additional information regarding procedure codes and frequencies.

TCC Services must be rendered in a DSS licensed or approved daycare facility that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

Same-Day Service Exclusion

Only one RBHS Community Support Service (CSS) will be reimbursed on any date of service. A private RBHS provider, or multiple private RBHS providers, shall not be reimbursed for services when more than one CSS is provided to a beneficiary and/or family on the same date of service. Children in foster care, therapeutic foster care, and those served by the Continuum of Care are exempt from the same-day service restriction.

COMMUNITY INTEGRATION SERVICES (CIS)

Purpose

The purpose of this face-to-face service is to assist adult beneficiaries diagnosed with serious and persistent mental health disorder(s) or co-occurring mental health and substance use disorders achieve identified behavioral health treatment goals in an the environment of their choice.

Provider Credentialing

In order to apply for CIS, providers must meet the following requirements:

- Providers (entity and clinical director) must have three years of experience serving adults with serious and persistent mental illness or co-occurring substance use disorders in a structured setting
- CIS must be facility-based
- CIS program facility must be open for a minimum of five hours per day, at least five days a week

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COMMUNITY SUPPORT SERVICES

Provider Credentialing (Cont'd.)

- Are accredited in the following:
  - Commission on Accreditation for Rehabilitation Facilities
    - BH Manual: Community Integration
  - Council on Accreditation
    - Vocational Rehabilitation Services (VOC), Supported Community Living Services (SCL), Services for Substance Use Conditions (SA), Services for Mental Health and/or Substance Use Disorders (MHSU), Psychiatric Rehabilitation Services (PSR), Outpatient Mental Health Services (MH), Adult Day Services, Counseling, Support, and Education Services (CSE), and/or Day Treatment Services (DTX)
  - The Joint Commission
    - BHC Day Treatment- Adult, Mental Health-Adult, or Community Integration

Service Description

CIS programs are appropriate for adults with a serious and persistent mental illness or co-occurring serious and persistent mental illness and substance use disorders who wish to participate in a structured program with staff and peers and have identified behavioral health treatment goals that can be achieved in a supportive and structured environment.

CIS requires that a beneficiary be actively involved in the development and management of his/her overall rehabilitation, including planned goals, objectives and intervention activities included on the IPOC. The beneficiary who is meaningfully involved in CIS programs should be able to articulate his/her individual goals and objectives and to identify ways in which his/her current activities are intended to assist him/her in achieving those goals and objectives and further his/her own recovery.

There must be a collaborative and supportive relationship between the providers, beneficiary, and family (if family is involved) to work on IPOC goal achievement. The goals of the IPOC should address the following skills development, educational, and pre-vocational activities as necessary:

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COMMUNITY SUPPORT SERVICES

Service Description (Cont'd.)

- Community living competencies (e.g., self-care, cooking, money management, personal grooming, maintenance of living environment).
- Social and interpersonal competencies (e.g., conversational competency, developing and/or maintaining a positive self-image, regaining the ability to evaluate the motivation and feelings of others to establish and maintain positive relationships).
- Personal adjustment competencies (e.g., developing and enhancing personal abilities in handling life experiences and crises, including stress management, leisure time management, coping with symptoms of mental illness).
- Cognitive and adult role competencies (e.g., task-oriented activities to develop and maintain cognitive abilities, to maximize adult role functioning such as increased attention, improved concentration, better memory, enhancing the ability to learn and establishing the ability to develop empathy).
- Prevocational activities (e.g., development of positive work habits and participation in activities that would increase the beneficiary's purpose, confidence and re-engagement in meaningful activities and/or employment, time management; prioritizing tasks, taking direction from supervisors, importance of learning and following the policies/rules and procedures of the workplace, problem solving/conflict resolution in the workplace, communication and relationships with coworkers and supervisors, on-task behavior and task completion skills).

Providers are encouraged to utilize evidence-based best practice models that may include: the Boston University Psychosocial Rehabilitation approach, the Lieberman Model, the International Center for Clubhouse Development approach, the Fountain House model, or blended models/approaches in accordance with current psychosocial rehabilitation research. Practitioners providing this service are expected to maintain knowledge

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COMMUNITY SUPPORT SERVICES

Service Description (Cont'd.)

and skills regarding current research trends in best/evidence based models and practices for psychosocial rehabilitation.

The place of service for CIS must be open for a period of five or more hours per day at least five days per week. CIS maybe provided on weekends or in the evening.

Medical Necessity

Admission Service Criteria

A-H must be met to satisfy criteria for admission into CIS services.

A. The beneficiary is 18 years or older.

B. The beneficiary has been diagnosed with a serious and persistent mental illness (SPMI), which includes one of the following diagnoses: Bipolar Disorder, Major Depression, a diagnosis within the spectrum of psychotic disorders, or an SPMI with a co-occurring substance use disorder (SUD).

C. As a result of the SPMI or co-occurring SUD, the beneficiary has a moderate to severe functional impairment that limits role performance and/or skill deficits in three or more of the following areas: social, educational/vocational, daily living and/or self-maintenance, relative to the person's cultural environment.

D. Traditional mental health services (e.g. individual/family/group therapy, medication management, etc.) alone are not clinically appropriate to prevent the beneficiary's condition from deteriorating.

E. Beneficiary meets three or more of the following criteria as documented on the Diagnostic Assessment:

- Is not functioning at a level that would be expected of typically developing individuals their age
- Is at risk of psychiatric hospitalization, homelessness or isolation from social supports due to the beneficiary's SPMI or co-occurring disorders

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Admission Service Criteria (Cont'd.)

- Exhibits behaviors that require repeated interventions by the mental health, social services, or judicial systems
- Experiences impaired ability to recognize personal or environmental dangers or significantly inappropriate social behavior

F. Without the support of a CIS program, the beneficiary will be unable to function in the community.

G. The beneficiary is not at imminent risk of harm to self, others, and/or property.

H. The beneficiary is expected to benefit from the interventions and needs would not be better met by any other formal or informal system or support.

Continued Service Criteria

A-E must be met to satisfy criteria for continued CIS services.

A. The beneficiary continues to meet the Admission Criteria.

B. There is adequate documentation from the provider that the beneficiary is receiving the scope and intensity of services required to meet the program goals stated in the service description.

C. The beneficiary has shown improvement in at least two of the following areas: social, educational/vocational, daily living and/or self-maintenance, relative to the person's cultural environment.

D. The beneficiary is expected to continue to benefit from CIS, which remains appropriate to meet the beneficiary's needs.

E. Withdrawal of CIS may result in loss of rehabilitation gains or goals obtained by the beneficiary.

Service Documentation

CIS must be listed on the IPOC with a specific planned frequency to meet the identified individualized needs of the beneficiary. Services must be documented upon each contact with the beneficiary. Additionally, the documentation must meet all SCDHHS requirements for

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clinical service notes.

Service Documentation (Cont'd.)

Documentation must clearly reflect the specific need of the beneficiary and the therapeutic interventions and support rendered to address the need(s) of the beneficiary.

The qualified staff providing the service is responsible for completing and signing the clinical service notes. The notes should clearly identify the specific goal(s) from the IPOC for which the delivery of CIS addresses.

Staff-Qualifications

CIS must be provided by qualified clinical professionals and/or paraprofessionals as defined in the "Staff Qualifications" section. CIS services rendered by paraprofessionals must be under the supervision of qualified clinical professionals and/or LPHAs.

Staff-To-Beneficiary Ratio

Staff to beneficiary ratio of 1:8 or less must be maintained at all times in order to bill Medicaid for the service.

Billing Frequency

CIS is billed as a 15-minute unit. See Section 4 of this manual for additional information regarding procedure codes and frequencies.

Billable Place of Service

Services must be provided in an approved community-based facility that is open for operation at least 25 hours per week.

Same Day Service Restrictions

Community Support Services (CSS) are defined as the following five services: Psychosocial Rehabilitation, Behavioral Modification, Family Support Services Community Integration Services, and Therapeutic Child Care.

SCDHHS will only reimburse for one RBHS Community Support Service (CSS) per day. For example, -Behavioral Modification will not be reimbursed on the same day as Psychosocial Rehabilitation Services or Family Support.

Exception: CIS may be provided on the same as individual (1:1) PRS.

PEER SUPPORT SERVICES (PSS)

Purpose

The purpose of this service is to assist beneficiaries' recovery from mental health and/or substance abuse

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disorders by sharing similar lived experience and recovery.

Purpose (Cont'd.)

This service is person centered with a recovery focus and allows beneficiaries the opportunity to direct their own recovery and advocacy process. The service promotes skills for coping with and managing symptoms while utilizing natural resources and the preservation and enhancement of community living skills.

The qualified peer support specialist gives advice and guidance, provides insight, shares information on services and empowers the beneficiary to make healthy decisions. The unique relationship between the peer support specialist and the beneficiary fosters understanding and trust in beneficiaries who otherwise would be alienated from treatment. The beneficiary's plan of care determines the focus of Peer Support Services (PSS)

The peer support specialist will utilize their own experience and training to assist the beneficiary in understanding how to manage their illness in their daily lives by helping them to identify key resources, listening and encouraging beneficiaries to cope with barriers and work towards their goals. The peer support specialist will also provide ongoing support to keep beneficiaries engaged in proactive and continual follow up treatment.

The peer support specialist actively engages the beneficiary to lead and direct the design of the plan of care and empowers the beneficiary to achieve their specific individualized goals. Beneficiaries are empowered to make changes to enhance their lives and make decisions about the activities and services they receive. The peer support specialist guides the beneficiary through self-help and self-improvement activities that cultivate the beneficiary's ability to make informed independent choices and facilitates specific, realistic activities that lead to increased self-worth and improved self-concepts.

Service Description

Services are multi-faceted and emphasize the following:

- Personal safety
- Self-worth
- Introspection
- Choice

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Service Description (Cont'd.)

- Confidence
- Growth
- Connection
- Boundary setting
- Planning
- Self-advocacy
- Personal fulfillment
- The Helper Principle
- Crisis management
- Education
- Meaningful activity and work
- Effective communications skills

Due to the high prevalence of beneficiaries with mental health and/or substance use disorders and the value of peer support in promoting dual recovery, identifying individuals co-occurring disorders who require a dual treatment is a priority.

The availability of services is a vital part of PSS to reinforce and enhance the beneficiary's ability to cope and function in the community and develop natural supports. Services must be rendered face to- face. The beneficiary must be willing to participate in the service delivery. Services are structured or planned one-to-one or group activities that promote socialization, recovery, self-advocacy, and preservation.

PSS must be coordinated within the context of a comprehensive, individualized POC that includes specific individualized goals. Providers should use a person-centered planning process to help promote beneficiary ownership of the POC.

Such methods actively engage and empower the beneficiary and individuals selected by the beneficiary, in leading and directing the design of the service plan and, thereby, ensure that the plan reflects the needs and preferences of the beneficiary in achieving the specific, individualized goals that have measurable results and are specified in the service plan.

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Service Description (Cont'd.)

Service interventions include the following:

- Self-help activities that cultivate the beneficiary's ability to make informed and independent choices. Activities help the beneficiary develop a network for information and support from others who have been through similar experiences.
- Self-improvement includes planning and facilitating specific, realistic activities leading to increased self-worth and improved self-concepts.
- Assistance with substance use reduction or elimination provides support for self-help, self-improvement, skill development, and social networking to promote healthy choices, decisions, and skills regarding substance use disorders or mental illness and recovery.
- System advocacy assists beneficiaries in making telephone calls and composing letters about issues related to substance use disorders, or mental illness or recovery.
- Individual advocacy discusses concerns about medications or diagnoses with a physician or nurse at the beneficiary's requests. Further, it helps beneficiaries arrange the necessary treatment when requested, guiding them toward a proactive role in their own treatment.
- Crisis support assists beneficiaries with the development of a crisis plan. It teaches beneficiaries:
    - How to recognize the early signs of a relapse
    - How to request help to prevent a crisis
    - How to use a crisis plan
    - How to use less restrictive, hospital alternatives
    - How to divert from using the emergency room
    - How to make choices about alternative crisis support
    - Housing interventions instruct beneficiaries in learning how to maintain stable housing or

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learning how to change an inadequate housing situation.

Service Description (Cont'd.)

- Social network interventions assist beneficiaries with learning about the need to end unhealthy personal relationships, how to start a new relationship, and how to improve communication with family members.
- Education and/or employment interventions assist beneficiaries in obtaining information about going back to school or getting job training. Interventions give beneficiaries an opportunity to acquire knowledge about mainstreaming back into full-time or part-time work. Additionally, they are taught how to obtain reasonable accommodations under the Americans with Disabilities Acts (ADA).

Services Evaluation and Outcome Criteria

To the extent measurable, the service will be evaluated on the effectiveness of developing rehabilitative skills and diminishing the effects of mental illness, substance use, or co-occurring disorders. Particular attention will be given to measuring outcomes for individuals who identify as having concurrent mental illness and substance use disorders, as well as those who may have greater difficulties with access to the appropriate services.

PSS should be monitored and reviewed quarterly using the following measures:

- A client advisory group that consists of the peer support specialist, the clinical supervisor, and other clinical staff shall meet quarterly to discuss the services and provide guidance as needed.
- The focus group consists of the beneficiaries, clinical staff, and the peer support specialist. The group will meet to discuss comments from the suggestion box and any other issues.
- Service satisfaction surveys and system-wide surveys must provide outcome measures in the following areas for PSS:
  - **Satisfaction with Services** — Beneficiaries will rate their satisfaction of PSS as evidenced by a survey that measures their own perception of care. Service satisfaction surveys and system-wide surveys will be used to improve access to

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Services Evaluation and Outcome Criteria (Cont'd.)

treatment, and to improve the quality of treatment.

- **Access to Services** — Beneficiaries will rate the accessibility of the services and how much assistance the program provided. The survey should be given at the beginning of the service and at the end of the service. The survey will assist in providing a guide to help determine treatment intensity for mental health and/or substance use disorders.
- **Clinical Outcomes** — Beneficiaries receiving PSS will maintain or improve their functioning as evidenced by a combination of the beneficiary's self-report measure of outcome (*e.g.*, MHSIP); and a clinical measure, such as the Global Assessment of Functioning (GAF).

Medical Necessity Criteria

Admission Criteria

- Beneficiary has been diagnosed with a serious and persistent mental illness (SPMI), and/or a substance use disorder (SUD); AND
- Beneficiary meets **two or more** of the following criteria as a result of the mental illness:
  - Has had significant difficulty independently and consistently accessing behavioral health services (*e.g.*, relies on emergency department services, has had two or more inpatient admissions over the last year);
  - Is being released from incarceration, or being discharged from a hospital or facility-based program;
  - Has had severe functional impairment that interferes with activities of daily living, including hygiene, nutrition, finances, home maintenance, child care, or difficulties with other community service needs, such as housing, transportation, or legal issues;
  - Has experienced significant challenges meeting educational or employment goals;
  - Lives in unsafe or temporary housing;

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Admission Criteria (Cont'd.)

- Does not have sufficient family or other social support, or the supports that are in place are insufficient to help ameliorate or manage his or her condition

- Beneficiary is assessed to be at low risk of serious harm to self or others; AND
- Beneficiary has demonstrated a need for assistance with community living and the service is recommended by a Licensed Practitioner of the Healing Arts (LPHA) acting within the scope of his/her professional licensure; AND
- The service, including frequency of the service, is recommended as a result of the Diagnostic Assessment; AND
- Beneficiary has an Individual Plan of Care (IPOC) that addresses mental health concerns and any co-occurring general medical condition; AND
- The person is expected to benefit from the intervention and needs would not be better clinically met by any other formal or informal system or support.

Continued Service Criteria

- Beneficiary is eligible to continue this service if
  - The beneficiary continues to meet admission guidelines for this level of care; OR
  - The IPOC, current or revised, can be reasonably expected to improve the presenting mental illness, and objective behavioral indicator of improvement are documented in the beneficiary's progress notes; OR
  - Beneficiary is actively involved in the Peer Support process, and participating in interventions; OR
  - Beneficiary does not require a higher level of care, and no other intervention level would be appropriate; OR
  - Beneficiary is making some progress, but the interventions need to be modified so that greater gains can be achieved.

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Staff Qualifications

Peer Support Specialist

The peer support specialist must possess, at a minimum, a high school diploma or GED, and he or she must have successfully completed and passed a certification training program, and he or she must be 18 years of age or older.

The criteria for meeting the consumer of services qualification are:

- Have had a diagnosis of behavioral health or substance use disorder, as defined by the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders and received treatment for the disorder
- Self-identify as having had a behavioral health and/or substance use disorder
- Be in a recovery program

Peer support specialists must have the following experience:

- The ability to demonstrate recovery expertise including knowledge of approaches to support others in recovery and dual recovery, as well as the ability to demonstrate his or her own efforts at self-directed recovery
- One year of active participation in a local or a national mental health and/or substance use consumer movement, which is evidenced by previous volunteer service or work experience
- Peer support providers **must** successfully complete a precertification program that consists of:
    - Forty hours of training including recovery goal setting, wellness recovery plans and problem solving, person-centered services, and advocacy
    - A minimum of 20 hours of continuing education training annually, of which at least 12 hours must be face-to-face training. All trainings must be approved by SCDHHS or

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other authorized entity.

Supervision

Supervision must be provided by a master's level staff or higher or a bachelor's level staff with a CAC II certification.

The supervisor must be available to supervise the peer support specialist and ensure that he or she provides services in a safe, efficient manner in accordance with accepted standards of clinical practice and certification and/or training standards as approved by SCDHHS.

The supervisor is required to chair regularly scheduled staff meetings with the peer support specialists to discuss administrative and individual treatment issues. At a minimum, staff meetings shall occur monthly. Staff meetings are not separately billable under another clinical service, unless the staffing includes a physician consultation. The supervisor shall review services that address specific program content and assess the beneficiary's needs. Issues relevant to the individual beneficiary will be documented in a staff note and noted in the beneficiary's medical record.

The supervisor is also required to perform at least one evaluation of the beneficiary no later than six months after admission to the program. The evaluation shall be repeated annually to:

- Monitor the recovery process of the beneficiary
- Monitor the focus of the services provided
- Ensure that the beneficiary continues to meet the Peer Support criteria

The evaluation must be kept in the beneficiary's file and may be billed separately as a follow-up assessment.

Service Documentation

PSS must be documented in the IPOC with a planned frequency and should be documented upon contact with the beneficiary. The staff providing the service is responsible for completing and signing the documentation. Documentation should clearly identify the specific goals from the IPOC for which the delivery of this service addresses.

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Service Documentation (Cont'd.)

Billable services must be documented in units on the beneficiary's CSN. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

Providers shall submit an annual report to the SCDHHS program manager within 60 calendar days after the close of the state fiscal year. This report should include summaries of the service provision and the service evaluation and outcome criteria, and the number of beneficiaries participating in the service.

Staff-to-Beneficiary Ratio

PSS is provided one-to-one or in a group setting. When rendered in groups, PSS shall not exceed one professional per eight beneficiaries.

Billing Frequency

PSS is billed in 15-minute units with 16 units billed per day. Services must be documented on the CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

Billable Place of Service

The only excluded settings are acute care hospitals. PSS can be rendered in a community mental health center, substance abuse facility, or setting that is convenient for both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

As a group service, PSS may operate in the same building as other day services. However, with regard to staffing, content, and physical space; a clear distinction must exist between day services during the hours the PSS is in operation. PSS do not operate in isolation from the rest of the programs in the facility.

Special Restrictions Related to Other Services

PSS cannot be billed for Medicaid beneficiaries that reside in an acute care hospital facility.

PSS can only be provided by DMH and DAODAS.

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SUBSTANCE USE DISORDER TREATMENT SERVICES

PROGRAM DESCRIPTION

SCDHHS and the South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) have implemented a statewide system to coordinate alcohol and other drug (AOD) services that are critical to serving eligible Medicaid beneficiaries. AOD services are rendered by Alcohol and Drug Commission providers through outpatient and residential treatment programs.

SCDHHS has adopted the American Society of Addiction Medicine's Patient Placement Criteria (ASAM-PPC) for the Treatment of Substance-Related Disorders as the basis for the beneficiary's placement in the appropriate levels of care. This manual specifies the policies that SCDHHS requires providers to meet, in addition to the ASAM criteria

Beneficiaries must have a diagnosis of a substance use disorder or co-occurring substance use and mental health disorders from the most recent DSM or ICD manual and meet medical necessity requirements before being placed in an AOD outpatient or residential treatment program. Services must be authorized by a physician or Licensed Practitioner of the Healing Arts (LPHA).

Outpatient and residential services may require a physical examination to be completed within a specified time frame by a qualified health care professional.

Coordination of care must occur when a beneficiary is being served by multiple agencies and/or providers. Each provider is responsible for making the effort to identify, during the intake process, whether a beneficiary is already receiving treatment from another Medicaid provider. Other Medicaid providers involved in the treatment of the beneficiary must be notified of their need for AOD services. Medically necessary services should never be denied to a beneficiary because another provider has been identified as the service provider. Additionally, each provider should also notify other involved agencies or providers immediately if a beneficiary in an overlapping situation discontinues their services.

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SUBSTANCE USE DISORDER TREATMENT SERVICES

PROGRAM DESCRIPTION (CONT'D.)

Providers must ensure that staff responsible for the provision of services meets the appropriate licensing, credentialing, certification, or privileging standards required for each service or level of care.

DADOAS providers may render specific services listed in the "Core Rehabilitative," "Core Treatment," and "Community Support" sections above. In order to be reimbursed for these services, DAODAS providers must follow the guidelines under "DAODAS Only Procedure Codes" in Section 4 of this manual.

PROGRAM SERVICES

Services listed below are rendered only by DAODAS providers. See the criteria listed below for policy guidelines and Section 4 for frequency limitations and modifiers.

Alcohol and Drug Screening (ADS) and Brief Intervention Services

Purpose

The purpose of this service is to provide early identification of a substance use disorder or co-occurring substance use and mental health disorders and to facilitate appropriate referral for a focused assessment and/or treatment. Alcohol and Drug Screening (ADS) is designed to identify beneficiaries who are at risk of development of behavioral health and/or substance use problems.

Service Description

This service requires completion of a brief questionnaire to examine the nature and context of the problem and identify patterns of behavior. Screenings are conducted using a standardized or SCDHHS-approved tool, through interviews, or self-report. Some of the common tools used for screenings are:

GAIN — Global Appraisal of Individual Needs — Short Screener

DAST — Drug Abuse Screening Test

ECBI — Eyberg Child Behavior Inventory

SESBI — Sutter Eyberg Student Behavior Inventory

CIDI — Composite International Diagnostic Interview

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SUBSTANCE USE DISORDER TREATMENT SERVICES

Service Description (Cont'd.)

Screenings should be scored utilizing the tool's scoring methodology and referrals made based on the interpretation of the results**.**

Screenings should focus on patterns of behavioral health and/or substance use disorder and associated factors such as legal problems, mental health status, educational functioning, and living situation.

The beneficiary's awareness of the problem, feelings about his or her mental illness and/or substance use disorder and motivation for changing behaviors may also be integral parts of the screening.

Prior to conducting the screening, attempts should be made to determine whether another screening had been conducted in the last 30 days. If a recent screening has been conducted, efforts should be made to access the record. A screening may be repeated as clinically appropriate or if a significant change in behavior or functioning has been noted.

Medical Necessity Criteria

All Medicaid-eligible beneficiaries who have been identified as having or at risk of a substance use disorder or co-occurring substance use and mental health disorders are eligible for this service.

Staff Qualifications

ADS may be provided by qualified clinical professionals who have been specifically trained to review the screening tool and make a clinically appropriate referral. Please refer to "Staff Qualifications" for a list of qualified clinical professionals authorized to render ADS.

Service Documentation

Services must be documented on the CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes ADS results should be documented during or immediately following the screening session with the beneficiary. The completed screening tool and written interpretation of the results must be filed in the beneficiary's clinical record within 10 working days from the date of service.

Documentation must contain the following:

- The outcome of the screening
- Identify any referrals resulting from the screening
- Support the number of units billed

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SUBSTANCE USE DISORDER TREATMENT SERVICES

Staff-to-Beneficiary Ratio

ADS require one staff member for each beneficiary. Beneficiaries in excess of the allowed ratio should not be present during the delivery of the service. The ratio count applies to all beneficiaries receiving services by a provider, regardless of whether or not the beneficiary is Medicaid eligible.

Billing Frequency

ADS is billed as an encounter. Twelve (12) encounters are allowed in a year. Only one encounter code is allowed per day.

Billable Place of Service

The only exclude settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or setting that is convenient for both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

Special Restrictions in Relationship to Other Services

An AOD initial assessment without a physical examination cannot be billed on the same date of services as an AOD structured screening and brief intervention service.

Alcohol and Drug Assessment (ADA)

Purpose

The purpose of this face-to-face assessment is to determine the need for rehabilitative services by establishing medical necessity, to establish and/or confirm a diagnosis, and to provide the basis for the development of an effective course of treatment. The Initial Assessment may include, but is not limited to, psychological assessment/testing to determine accurate diagnoses or to determine differential diagnoses.

Initial assessments must be conducted face-to-face with the beneficiary and include an evaluation of the beneficiary for the presence of a behavioral health or substance use disorder.

Service Description

The information obtained during the assessment must lead to a diagnosis that identifies the beneficiary's current symptoms or disorder by using the current edition of the DSM or ICD.

Diagnoses should be updated as the condition of the beneficiary changes. Information relating to a diagnosis

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Service Description (Cont'd.)

that has not been reviewed in a 12-month or more periods should be confirmed immediately.

The assessment is used to determine the beneficiary's mental status, social functioning, and to identify any physical or medical conditions.

Assessments include clinical interviews with the beneficiary, family members or guardians as appropriate, review of the presenting problems, symptoms and functional deficits, strengths, medical and educational records and history, including past psychological assessment report and records.

Once the assessment has been completed and services are deemed to be medically necessary; the development of the individual plan of care should be next.

The assessment services identify the beneficiary's needs, concerns, strengths and deficits and allow the beneficiary and his or her family to make informed decisions about the treatment. Patient condition, characteristics, or situational factors may require services described as being with interactive complexity. The assessment includes a bio-psychosocial assessment to gather information that establishes or supports a diagnosis, provides the basis for the development or modification of the treatment plan, and development of discharge criteria.

Components of the diagnostic assessment service include:

- Beneficiary demographic information
- Presenting complaint or source of distress
- Medical history and medications
- Family history
- Psychological and/or psychiatric treatment history including previous psychological assessment/ testing measures, reports, etc.
- Substance use history for beneficiary and family
- Mental status
- Functional assessment (with age-appropriate expectations)
- Exposure to physical abuse, sexual abuse, anti-social behavior, or other traumatic events

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Service Description (Cont'd.)

- A psychiatric diagnosis from the current edition of the DSM or the ICD, excluding irreversible dementias, intellectual disabilities or related disabilities, and developmental disorders, unless they co-occur with a serious mental disorder that meets the current edition DSM criteria
- The specific rehabilitative service(s) recommended
- Identification of the beneficiary's problems

Follow-up Assessment

A follow-up assessment occurs after an initial assessment to re-evaluate the status of the beneficiary, identify any changes in behavior and/or condition, and to monitor and ensure appropriateness of the treatment. Follow-up assessments may also be rendered to assess the beneficiary's progress, response to treatment, and the need for continued treatment and establish medical necessity.

When significant changes occur in behaviors and/or conditions, changes must be documented separately on the CSN and comply with the service documentation requirements. The course of treatment and documentation in the IPOC must reflect these changes.

Medical Necessity Criteria

All Medicaid-eligible beneficiaries who have been identified as having or at risk of a substance use disorder or co-occurring substance use and mental health disorders.

Staff Qualifications

The assessment must be provided by qualified clinical professionals as defined in the "Staff Qualifications" section of this manual, who have been specifically trained to provide and review the assessment tool and make a clinically appropriate referral.

Service Documentation

Services must be documented on the CSN with a start time and end time Additionally; the documentation must meet all SCDHHS requirements for clinical service notes. The completed assessment tool and written interpretation of the results must be filed in the beneficiary's clinical record within 10 working days from the date of service.

The documentation must include the outcome of the assessment, identify any referrals resulting from the assessment and support the number of units billed.

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Service Documentation (Cont'd.)

Documentation must include components of the assessment and the following:

- Beneficiary's name and Medicaid ID number
- Include the outcome of the assessment
- Identify any referrals resulting from the assessment
- The diagnose code and diagnoses
- Documentation must support the number of units billed

Staff-to-Beneficiary Ratio

The initial and follow-up assessments require one staff member for each beneficiary. Beneficiaries in excess of the allowed ratio should not be present during the delivery of the service. The ratio count applies to all beneficiaries receiving services by a provider, regardless of whether or not the beneficiary is Medicaid eligible.

Billing Frequency

The initial and follow-up assessments are billed as an encounter. A session should last a minimum of 60 minutes. One encounter is allowed every six months and coordination care should occur between providers. Services must be documented on the CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

Billable Place of Service

The only exclude settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or setting that is convenient for both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

Special Restriction in Relationship to Other Services

Assessment with medical cannot be rendered or billed on the same day as the Assessment without medical. Efforts should be made to determine whether another diagnostic assessment has been conducted in the last 90 days and information should be updated as needed. If a diagnostic assessment has been conducted within the last 90 days, efforts should be made to access those records. Services are rendered by the staff listed in Section 4 of this manual.

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SUBSTANCE USE DISORDER TREATMENT SERVICES

Alcohol and Drug/Substance Abuse Counseling (SAC)

Purpose

The purpose of this face-to-face intervention is to assist beneficiaries in their recovery process. Alcohol and Drug/Substance Abuse Counseling (SAC) is focused on exploring and identifying the consequences of continued substance abuse, identifying triggers for substance abuse, and developing alternative coping strategies.

This service provides reinforcement of the beneficiary's ability to function within the confines of society without having to rely on addictive substances. SAC addresses goals identified in the plan of care that involves the beneficiary relearning basic coping strategies, understanding related psychological problems that trigger addictive behavior, and encouraging the beneficiary to recognize opportunities to change their behavior and how to achieve their goals.

Service Description

SAC requires face-to-face and goal-oriented interactions between a beneficiary and a clinical professional. The interactions provide the beneficiary with the skills and supports needed to reduce the use of substances, obtain abstinence, and successfully manage their illness. This service supports the beneficiary in achieving and maintaining improved ability to function in his or her daily living.

The goal of SAC is to aid beneficiaries in recovery from substance use disorders. SAC serves to educate beneficiaries about substance abuse and cultivate the skills needed to attain and sustain progress on identified goals; such as skills needed to manage anger or to cope with the urge to use substances by altering thoughts and actions that lead to substance abuse.

Interventions should focus on helping the beneficiary to develop the motivation to change substance-abusing behaviors and pursue life goals. Interventions should also focus on improving communication and conflict resolution skills and developing healthy boundaries.

SAC allows the clinical professional to listen to, interpret, and respond to the beneficiary's expression of physical,

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Service Description (Cont'd.)

emotional, and/or cognitive problems and help them to develop the skills and supports needed to live a satisfying life without substance abuse. SAC explores issues coexisting with and contributing to substance use or abuse, such as, delinquent behavior and/or mental health concerns (*e.g.*, depression, anger, anxiety, interpersonal conflicts, poor self-esteem, and anger management).

Substance Abuse Group - Counseling

Groups serve as a forum to share information about managing day-to-day without using illicit substances and may address major developmental issues that contribute to addiction, interfere with recovery, or contribute to relapse.

A qualified clinical professional may meet with the beneficiary and one or more family members to identify and address substance abuse issues in a family setting. SAC should actively involve members of the beneficiary's immediate family, extended family, or significant others as determined appropriate. In a group setting, SAC allows the clinical professional to meet the needs of several beneficiaries at the same time and mobilize group support.

Medical Necessity Criteria

Beneficiaries eligible for this service must have a diagnosis of a substance use disorder or co-occurring substance use and mental health disorders. The results of the screening and/or assessment tool must indicate a functioning level that would support the need for services and the behavior must interfere with the ability of the beneficiary to function in at least two of these areas: daily living, personal relationships, work setting, school and recreational settings.

Staff Qualifications

SAC services must be provided by a qualified clinical professional or under the supervision of a qualified clinical professional as defined in the "Staff Qualifications" section.

Service Documentation

Documentation must indicate how the counseling session applies to the identified beneficiary's treatment goals. Services must be documented on the CSN with a start time and end time. Documentation must be signed off by a BA staff with CAC II or higher credentialed staff. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

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SUBSTANCE USE DISORDER TREATMENT SERVICES

Staff-to-Beneficiary Ratio

SAC requires at least one professional for each beneficiary or group of up to 16 beneficiaries. Beneficiaries in excess of the allowed ratio should not be present during the delivery of the service. The ratio count applies to all beneficiaries receiving services by a provider, regardless of whether or not the beneficiary is Medicaid eligible.

Billing Frequency

Individual counseling is billed in a 15-minute unit. Group counseling is billed as an encounter. A group session should last at a minimum of 60 minutes. If the session last longer than 60 minutes, this time is not billable. Only one encounter code is allowed per day.

Billable Place of Service

The only exclude settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or setting that is convenient for both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

Special Restrictions in Relationship to Other Services

None.

Skills Training (ST) and Development Services for Children

Purpose

The purpose of this service is to provide Skills Training and Development to children, with the primary target population of beneficiaries 0 to 6 years of age. The service is intended to restore functioning that the beneficiary either had or would have achieved if normal development had not been impaired by risk factors of substance use disorder, or co-occurring substance use and mental health disorders. This face-to-face service provides activities that will restore or enhance targeted behaviors and improve the child's ability to function in his or her living, learning, and social environments. Skills Training and Development is a form of skills building support. It is not a form of psychotherapy or counseling. Interventions are planned in such a way that they are constantly supporting, guiding, and reinforcing the beneficiary's ability to learn and utilize needed life skills.

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SUBSTANCE USE DISORDER TREATMENT SERVICES

Service Description

Skills Training and Development is a means to affect behavioral changes to reduce the risk of or actual impaired performance in school, family and social relationships, work opportunities, recreational opportunities, etc. Services involve regularly scheduled interventions designed to optimize emotional and behavioral functioning in the natural environment through the application of clinically planned activities that promote the development of healthy coping skills, adaptive interactions with others, and appropriate responses to environmental stimuli.

Through interaction with appropriately trained and qualified staff, activities will focus on skill deficits and provide the beneficiary the opportunity to alter existing behaviors, acquire new behaviors, and function more effectively within his or her environment.

This service includes activities identified during the assessment and is necessary to achieve the goals in the plan of care.

Skills Training and Development interactions include the following:

- Skills activities designed to promote age-appropriate behavior and to improve the beneficiary's functioning within the home or social environments
- Basic living skills development designed to help the beneficiary learn and practice daily, healthy living habits, and age-appropriate self-care skills
- Interpersonal skills training designed for age-appropriate and normal development of the beneficiary to improve communication, problem solving, and self-management

Successful delivery of Skills Training and Development should result in the display of age-appropriate and desirable behavior that has been infrequent or never displayed.

Skills Training include services provided in a small group based on the assessed needs and level of functioning of the beneficiary.

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SUBSTANCE USE DISORDER TREATMENT SERVICES

Medical Necessity Criteria

Beneficiaries 0 to 6 years of age who have been identified as having or are at risk of a substance use disorder and/or co-occurring substance use disorder and mental illness are eligible for this service. The results of the screening and/or assessment tool must indicate a functioning level that supports the need for services and the behavior must interfere with the ability to function in at least two of these areas: daily living, personal relationships, work setting, school and recreational settings.

Staff Qualifications

Skills Training and Development services are provided by qualified staff, under the supervision, of qualified clinical staff as defined in the "Staff Qualifications" section. Effective July 1, 2015, staff providing the service must have a Bachelor's Degree or above, or be a certified Substance Abuse Specialist (SAS) affiliated with DAODAS.

Service Documentation

The CSN must document how Skills Training and Development applies to the beneficiary's treatment goals. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes. The service must be listed on the IPOC with a planned frequency and should be documented upon contact with the beneficiary or immediately afterwards.

The physician, LPHA, or other qualified clinical professional is responsible for developing the IPOC that includes strategies for eliminating and managing behaviors.

The staff providing the service is responsible for completing and signing the documentation. Documentation must be signed off by a BA staff with CAC II or higher credential staff.

In addition to general documentation requirements, the documentation of this service must include the inappropriate or undesirable behavior of the beneficiary and how the behavior was redirected.

Staff-to-Beneficiary Ratio

Skills Training and Development is provided face-to-face with the beneficiary. The service can be rendered in groups of one staff to 12 beneficiaries, as appropriate, based on the needs of the beneficiary. The ratio count applies to all beneficiaries receiving services by a provider, regardless of whether or not the individual is Medicaid eligible.

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SUBSTANCE USE DISORDER TREATMENT SERVICES

Billing Frequency

Skills Training and Development is billed in a 15-minute unit.

Billable Place of Service

The only exclude settings are acute care hospitals Services can be rendered in a community mental health center, substance abuse facility, or setting that is convenient for both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

Special Restrictions in Relationship to Other Services

Services provided to children must include coordination with family or guardians and other systems of care, as appropriate.

Psychological Testing and Reporting (PTR)

Purpose

Psychological Testing and Reporting services include psycho-diagnostic assessment of emotionality, intellectual abilities, personality, and psychopathology (*e.g.*, MMPI, and WAIS).

Testing and evaluation must involve face-to-face interaction between a master's level qualified health care professional and the beneficiary for evaluating the beneficiary's intellectual, emotional, and behavioral status. Testing may include measures of intellectual and cognitive abilities, neuropsychological status, attitudes, emotions, motivations, and personality characteristics, as well as use of other non-experimental methods of evaluation.

Psychological Testing and Reporting may be used for the purpose of psycho-diagnostic clarification, as in the case of establishing a DSM diagnosis or a differential diagnosis, once a thorough comprehensive assessment/initial clinical interview has been conducted and testing is deemed necessary for further clinical understanding or treatment planning.

All psychological assessment/testing by the assessor must include a specific referral question(s) that can be reasonably answered by the proposed psychological assessment/testing tools to be administered. All requests for psychological assessment/testing must clearly establish the benefits of the psychological assessment/testing,

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Purpose (Cont'd.)

including, but not limited to, how the psychological assessment/testing will inform treatment.

Service Description

When necessary or appropriate, a consultation shall only include telephone or face-to-face contact by a qualified clinical professional to the family, school, or another health care provider to interpret or explain the results of psychological testing and/or evaluations related to the care and treatment of the beneficiary.

The psychologist is expected to review the report and render the diagnoses. The psychologist must document the recommended course of action.

Medical Necessity Criteria

All beneficiaries who have been identified as having or are at risk of a diagnosis of a substance use disorder or co-occurring substance use and mental health disorders.

Staff Qualifications

Psychological Testing and Reporting must be provided by a qualified clinical professional operating within their scope of practice, as allowed by state law, and who is specifically trained to provide and review the assessment tool and make a clinically appropriate referral.

When the administration and interpretation of psychological tests are required to aid in the determination of diagnoses and the level of impairment, a psychologist must provide the diagnoses.

Service Documentation

The documentation must include the purpose of the test; the results of Psychological test and/or refer to the completed test.

The completed test and written interpretation of the results must be filed in the beneficiary's clinical record within 10 working days from the date the service was completed.

Documentation must include the following:

- Beneficiary's name and Medicaid ID number
- Include the outcome of the test
- Identify any referrals resulting from the test
- The diagnoses code and the diagnose

Documentation must support the number of units billed.

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Staff-to-Beneficiary Ratio

Psychological Testing and Reporting requires one professional for each beneficiary. Beneficiaries in excess of the allowed ratio should not be present during the delivery of the service. The ratio count applies to all beneficiaries receiving services by a provider, regardless of whether or not the beneficiary is Medicaid eligible.

Billing Frequency

Psychological Testing and Reporting is billed as a 60-minute unit with a limit of ten units billed within a week and a limit of 20 units billed per year. Services must be documented on the CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

Billable Place of Service

The only excluded settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or setting that is convenient for both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

Special Restrictions in Relationship to Other Services

Efforts should be made to determine whether another psychological testing has been conducted within the last 90 days and information should be updated as needed. If an assessment has been conducted within the last 90 days, efforts should be made to access those records. An assessment should be repeated only if a significant change in the behavior or functioning of the beneficiary has been noted.

This service cannot be utilized when a determination of the appropriateness of initiating or continuing the use of psychotropic medication is required.

Delivery of this service should include contacts with the family and/or guardians to secure pertinent information necessary to complete an evaluation of the beneficiary.

The Diagnostic Assessment must be completed before the Psychological Testing and Reporting has been conducted.

Psychological Testing and Reporting and Diagnostic assessment may be billed on the same day. Assessments must be billed separately and provide different outcomes.

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SUBSTANCE USE DISORDER TREATMENT SERVICES

MEDICAL SERVICES

Evaluation and Management of Medical Services (E&M)

The purpose of the service is to make medical decisions for treatment and/or referral for services after a medical assessment. The service is delivered face to face, which includes time spent performing an examination to obtain the beneficiary's medical history.

Physical Examination

A physical examination is a face-to-face interaction between a qualified medical health care professional and the beneficiary. The professional must assess the beneficiary's status and provide diagnostic evaluation and screening. The physical examination is one mechanism used to provide referrals for AOD rehabilitative services. The physical examination may include a tuberculosis test, as deemed necessary by the health care professional.

The examination may also be used to determine the following:

- Medical necessity for initiating AOD rehabilitative services
- The need for specialized medical assessment
- The need for a referral to other health care providers

Physical examinations must include the following:

- A brief medical history of the beneficiary to include hospital admissions and surgeries; allergies; present medication information about shared needles, sexual activity, sexual orientation; and history of hepatitis, cirrhosis, or liver diseases
- A history of the beneficiary's and their family's involvement with alcohol and/or other drugs
- An assessment of the beneficiary's nutritional status
- An examination including, but not limited to, vital signs; inspection of the ears, nose, mouth, teeth and gums; inspection of the skin for recent or old needle marks and tracking; and abscesses or scarring from healed abscesses

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Physical Examination (Cont'd.)

- A general assessment of the beneficiary's cardiovascular system, respiratory system, gastrointestinal system, and neurological status
- A screening for anemia (A hematocrit or hemoglobin test may be used when the physician has access to the equipment.)

Evaluation for New Patients

A new patient is one who has not received any professional services from the health care professional or another qualified health care professional of the exact same specialty and sub-specialty who belongs to the same group practice, within the past three years.

The evaluation of a new patient requires the following three components:

- A detailed history
- A detailed examination
- A medical decision

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem and includes the beneficiary's and/or their family. The encounter should last at least 30 minutes.

Evaluation for Established Patients

An established patient is one who has received professional services from a qualified health professional or another qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

The evaluation of an established patient requires two of the three key components below:

- An expanded problem focused history
- An expanded problem focused examination
- A medical decision making of low complexity

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem and includes the beneficiary and/or their family. The encounter should last at least 15 minutes.

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SUBSTANCE USE DISORDER TREATMENT SERVICES

Medical Necessity Criteria	All beneficiaries who have been identified as having or are at risk of a diagnosis of a substance use disorder or co-occurring substance use and mental health disorders.
Staff Qualifications	Services are provided by qualified professionals operating within their scope of practice, as allowed by state law. Qualified health care professionals include physicians, physician assistants (PA) and advanced practical registered nurse (APRN) practitioners. A physician must be available in the event of an emergency.
Service Documentation	The appropriate medical documentation must appear in the beneficiary'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. Services must be documented on the CSN and signed by a qualified professional within the appropriate time frame for the beneficiary's level of care. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.
Staff-to-Beneficiary Ratio	Services require at least one professional for each beneficiary.
Billing Frequency	Services are billed as an encounter. Only one encounter code is allowed per day.
Billable Place of Service	The only excluded settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or setting where the beneficiary and the professional will have an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.
Special Restrictions in Relationship to Other Services	New Patient (99203) and Established Patient (99213) services are allowed one per day per service. When a beneficiary receives a medical evaluation and management (E/M) service on the same day as a psychotherapy service by the same medical professional, providers must document both the E/M and psychotherapy

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Special Restrictions in Relationship to Other Services (Cont'd.)

codes. The difference in the services must be significant and documented separately on the CSN.

Only one EM encounter is allowed per day when the Individual Psychotherapy codes (90833 and 90836) are used.

A nurse is responsible for assisting in monitoring the beneficiary's medical treatment and medication administration.

Alcohol and Drug Assessment Nursing Services (ADN)

Service Description

Alcohol and Drug Assessment Nursing Services (AND) are provided as a face-to-face interaction between a qualified health care professional and the beneficiary.

Services may be rendered to beneficiaries as a discrete service. This service is also included in the bundled service packages.

Components of the service include, but are not limited to, the following:

- Providing medical assessment(s)
- Assessing and/or monitoring the beneficiary's physical status
- Assessing and/or monitoring the beneficiary's response to treatment
- Providing medication management
- Assessing the need for referrals to other health care systems
- Monitoring the beneficiary's mental behaviors
- Verifying the beneficiary's medications, which may have been prescribed as oral or injection
- Assessing the need for the beneficiary to see the physician
- Monitoring for overt side effects related to any medication
- Monitoring for psychological effects of the medications

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Service Description (Cont'd.)	• Monitoring for interactions of psychiatric medications, prescribe medications, and substance abuse
Medical Necessity Criteria	All Medicaid-eligible beneficiaries who have been identified as having or at risk of a substance use disorder or co-occurring substance use and mental health disorders.
Staff Qualifications	Services must be provided by qualified health care professionals operating within their scope of practice, as allowed by state law.
Service Documentation	The appropriate medical documentation must appear in the beneficiary's medical record to justify medical necessity for the level of service reimbursed, including the illness, history, physical findings, diagnosis, and prescribed treatment. Services must be documented on the CSN or nursing progress form and signed by a qualified health care professional within the appropriate time frame for the beneficiary's level of care. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes. A nursing discharge form must be completed when the beneficiary moves to another level of service.
Staff-to-Beneficiary Ratio	Services require at least one qualified nursing professional for each beneficiary.
Billing Frequency	When billed as a discrete service, Alcohol and Drug Nursing Services are billed in a 15-minute unit.
Billable Place of Service	The only excluded settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or a setting where the beneficiary and the professional will have an adequate therapeutic environment that protects the beneficiary's rights to privacy and confidentiality.
Special Restrictions in Relationship to Other Services	Nursing Services may be billed when providing discrete services, IOP, or Day treatment/Partial Hospital services.

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SUBSTANCE USE DISORDER TREATMENT SERVICES

Medication Administration (MA)

Purpose

The purpose of this service is to allow a heath care professional to administer an injection to the beneficiary. The medical record must substantiate the medical necessity for this treatment.

Service Description

Medication Administration is rendered in response to a physician, PA, or APRN order. The order must be documented on a Physician Medical Order (PMO) form. The qualified health care professional must ensure the form is properly completed and included in the medical record to confirm the initial and any subsequent contacts with the beneficiary.

Medical Necessity Criteria

Beneficiaries eligible for this service must have a diagnosis of a substance use disorder or co-occurring substance use and mental health disorders. Providers must have a prescription or medical order from a qualified health care professional to administer the prescription drug Vivitrol.

Staff Qualifications

Services must be provided by qualified health care professionals operating within their scope of practice, as allowed by state law.

Service Documentation

Medication Administration must be listed in the plan of care and PMO and be documented on a CSN as the service to be rendered.

The provider of the service must include the following items on the CSN in order to provide a relevant clinical description, ensure the service conforms to the service description, and authenticate the charges:

- A list of the beneficiary's current prescribed medications and over-the-counter medications
- **Note:** Providers can reference a PMO or other documentation in the medical record that lists all the medications prescribed to the beneficiary.
- The quantity and strength of the dosage given
- The injection route (I.M., I.D., I.V.)
- The injection site

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Service Documentation (Cont'd.)

- The side effects or adverse reactions of medications
- All benefits of the medications being prescribed
- Any change in medications and/or doses and the rationale for any change, if applicable
- Follow-up instructions for the next visit

Staff-to-Beneficiary Ratio

Medication Administration requires at least one qualified health care professional for each beneficiary.

Billing Frequency

Medication Administration is billed as an encounter and must be billed with the injection code. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

Billable Place of Service

The only excluded settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or setting where the beneficiary and the professional will have an adequate therapeutic environment that protects the beneficiary's rights to privacy and confidentiality.

Special Restrictions in Relationship to Other Services

Medication Administration is billed in conjunction with injection code J2315.

Vivitrol Injection (VI)

Purpose

This code is the specific Injectable Medication, provided by a qualified health care professional with a medical prescription or order. The purpose of the treatment is to restore, maintain, or improve a beneficiary's behavior or substance use disorder.

Service Description

The qualified health care professional must ensure the injection medication order is properly completed and included in the medical record to confirm the initial and any subsequent administration to the beneficiary. The procedure code for the injection is billed in conjunction with procedure code 96372.

Medical Necessity Criteria

Beneficiaries eligible for these services must have a substance use disorder or co-occurring substance use and mental health disorders.

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Staff Qualifications

A qualified health care professional who is authorized in the state of South Carolina to give an injectable medication can render this service.

Service Documentation

Injectable Medication is required to be listed on the PMO. The injection must be documented on the CSN as the service. The documentation should include the following items in order to provide a relevant clinical description, ensure the service conforms to the service description, and authenticate the charges:

- The medication administered
- The quantity and strength of the dosage given
- The injection route (I.M., I.D., I.V.)
- The injection site
- The side effects or adverse reactions of the medication

Billing Frequency

The injectable procedure code is billed as an encounter and is rendered only one time a month to the beneficiary.

Billable Places of Service

The only excluded settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or a setting that is convenient for both the beneficiary and the health care professional and that affords an adequate therapeutic environment that protects the beneficiary's rights to privacy and confidentiality.

Special Restriction in Relationship to Other Services

A qualified health care professional must provide a prescription for the injection.

The medication administration code is billed in conjunction with the injection code. Both services are documented on the same CSN, but must be billed separately.

Substance Abuse Outpatient Treatment Services

To provide services all providers must meet appropriate federal and state licensure, and all requirements outlined in the SCDHHS provider enrollment policy and this manual.

Substance abuse treatment facilities must follow the Rehabilitative Health provider requirements. Providers with a facility rendering services 24 hours per day, seven days per week are limited to 16 or fewer beds in order to

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Substance Abuse Outpatient Treatment Services (Cont'd.)

receive Medicaid reimbursement (Federal law prohibits Medicaid payment to institutions of Mental Disease as described the Code of Federal Regulations, 42 CFR 435.1009.-101) and must follow the manual requirements.

Medicaid beneficiaries will have free choice of any qualified enrolled Medicaid provider. The provider must assure that the provision of services will not restrict the beneficiary's freedom of choice and it is not in violation of section 1902(a)(23) of the Social Security Act.

Purpose

The purpose of this array of services is to provide intervention for the treatment and management of substance use disorders or co-occurring substance use and mental health disorders in an outpatient or residential treatment settings. Services must have a rehabilitative and a recovery focus designed to promote skills for coping with and managing behavioral health and/or substance use symptoms and behaviors. Services must address the beneficiary's lifestyle, disposition and behavioral problems that have the potential to undermine the participation and successful completion of the treatment. Treatment services assist the beneficiary with managing withdrawal from substances of abuse and achieving abstinence, effectively responding to or avoiding identified precursors or triggers that would put them at risk of use and relapse in their natural environment. Participation in services that provide supportive counseling, focused therapeutic interventions, emotional and behavioral management, problem solving, social and interpersonal skills, psychotherapy services, psychosocial rehabilitation, family support and medication management and daily and independent living skills in order to improve functional stability to adapt to community living.

The beneficiary must be assessed to establish medical necessity for the treatment of services. The beneficiary must meet the diagnostic criteria for a substance use disorder or co-occurring substance use and mental health disorders as defined by the current edition of the DSM or ICD to establish medical necessity for treatment services. The provider should refer to the most current ASAM-PPC-2R as the basis for the beneficiary placement in the appropriate level of care.

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Purpose (Cont'd.)

Outpatient Substance Abuse Treatment includes an array of services delivered in an outpatient setting consistent with the beneficiary's treatment needs. The treatment must be rehabilitative and recovery focused and designed to promote coping skills to manage substance abuse symptoms and behaviors. Services are delivered on an individual or group basis in a wide variety of settings.

Alcohol and/or Drug Services - Intensive Outpatient Treatment Program (IOP): Level II.I

IOP services are provided to beneficiaries who are in need of more than discrete outpatient treatment services or as an alternative to residential treatment. The appropriate level of care takes into consideration the beneficiary's cognitive and emotional experiences that have contributed to substance abuse or dependency. IOP allows the beneficiary opportunities to practice new coping skills and strategies learned in treatment, while still within a supportive treatment relationship and their "real world" environment.

Medical Necessity Criteria

Beneficiaries eligible for these services must have a diagnosis of a substance use disorder or co-occurring substance use and mental health disorders.

The beneficiary must meet ASAM criteria for this level of care placement, with documentation reflecting applicable medical necessity on each of the ASAM dimensions listed below:

- Direct admission to Level II.I is warranted for the beneficiary who meets specifications on Dimension 2 (if any biomedical conditions or have existing substance use problems), on Dimension 3 (if any emotional, behavioral, cognitive conditions or problems exist), and on one specification of Dimension 4, 5, or 6.
- Transfer to Level II.I is warranted for a beneficiary who has met essential treatment objectives at a more intensive level of care and requires Level II.I service intensity in at least one dimension.
- Transfer to Level II.I may be warranted when services provided at Level I have been insufficient to address the beneficiary's needs or when motivational interventions provided at Level I have prepared the beneficiary for participation in a more intensive level of service, and the beneficiary meets criteria for that level.

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Service Description

The IOP service is comprised of the following services:

Individual Psychotherapy, Family Psychotherapy, Group Psychotherapy, AOD/Substance Abuse Counseling, Peer Support Services, PRS, Family Support, and Medication Management.

The following services may be billed as discrete services:

Psychiatric Diagnostic Evaluation, Psychological Testing and Reporting, AOD Assessment, AOD Assessment Nursing Services, AOD Screening, SPD, Medical Evaluation and Management, Crisis Intervention, Injection (Vivitrol), and Medication Administration.

Staff providing services:

Services are provided by qualified clinical professionals and paraprofessionals within their scope of practice as listed in the Staff Qualifications chart.

Length of Stay Criteria / Continued Stay Criteria

IOP generally provides 9 – 19 hours of programming per week based on the beneficiary's plan of care. The duration of treatment varies with the severity of the beneficiary's illness, and response to treatment. The amount, frequency, and intensity of the services must reflect the needs of the beneficiary and must address the goals and objectives of the beneficiary's plan of care. The 19 hours can be exceeded via transfer to another level of service when services provided at this level have been insufficient to address the beneficiary's needs, and the beneficiary meets the ASAM criteria for another level of service.

Service Documentation

The CSN must identify the service being provided and list all of the components of the treatment. The staff assigned to the beneficiary is responsible for checking those services provided and writing a summary of those services.

The IPOC should list the specific short-and long-term goals and objectives addressing the expected outcome of treatment.

The development of a discharge plan is required to provide guidelines to the beneficiary on what is expected to continue in the program and guidance on how to maintain stability in their natural environment.

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Service Documentation (Cont'd.)

Providers must maintain medical records that include a copy of the individual treatment plan, medical and clinical assessments, clinically service notes, and progress update.

A bachelor's level staff, with a CAC II or higher, must sign for the services to be rendered and qualified health care professionals must sign for the treatment as listed by their scope of practice.

Staff-to-Beneficiary Ratio

The staff-to-beneficiary ratio must not exceed the allowed ratio set by specific services listed in this manual. The ratio applies to all beneficiaries receiving services by a provider, regardless of whether or not the beneficiary is Medicaid eligible.

Billing Frequency

IOP services are billed as an hourly inclusive rate.

Billable Place of Service

The only excluded settings are acute care hospitals. Services can be rendered in a substance abuse facility, or setting that is convenient for the both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

Special Restrictions in Relationship to Other Services

All services must be authorized except for Diagnostic assessments, AOD assessment, AOD screening, AOD Nursing assessment, Service Plan Development, Crisis intervention, and Medical Evaluation and Management services. Services which exceed the initial authorization must be approved for re-authorization prior to service delivery.

Alcohol and/or Drug Treatment – Day Treatment/Partial Hospitalization: Level II.5

The treatment program is a structured and supervised intense treatment program that provides frequent monitoring/ management of the beneficiary's medical and emotional concerns in order to avoid hospitalization. The program has access to psychiatric, medical, and laboratory services. Intensive services at this level of care provide additional clinical support in a community setting

These conditions will provide the beneficiary with the opportunity to practice skills learned in treatment and apply them in their natural environment.

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Medical Necessity Criteria

Beneficiaries eligible for these services must have a diagnosis of substance use disorder or co-occurring substance use and mental health disorders.

The beneficiary must meet ASAM criteria for this level of care placement, with documentation reflecting applicable medical necessity on each of the ASAM dimensions below:

- Direct admission to Level II.5 is warranted for the beneficiary who meets specification on Dimension 2 (if any biomedical conditions or problems exist) and specifications in one of Dimensions 4, 5, or 6.
- Transfer to Level II.5 is warranted for the beneficiary who has met treatment objectives at a more intensive level of care and requires Level II.5 service intensity in at least one dimension.
- Transfer to Level II.5 may be warranted when services provided at Level I or Level II.1 has been insufficient to address the beneficiary's needs. In addition, transfer to this level is appropriate when motivational interventions provided have prepared the beneficiary for participation in a more intensive level of care.

Service Description

<u>The Day Treatment/Partial Hospitalization program is comprised of the following services:</u>

Individual Psychotherapy, Family Psychotherapy, Group Psychotherapy, AOD/Substance Abuse Counseling, Peer Support Services, PRS, Family Support, and Medication Management.

<u>The following may be billed as discrete services:</u>

Psychiatric Diagnostic Evaluation, Psychological Testing and Reporting, AOD Assessment, AOD Assessment Nursing Services, AOD Screening, SPD, Medical Evaluation and Management, Crisis Intervention, Injection (Vivitrol), and Medication Administration.

<u>Staff providing services:</u>

Services are provided by qualified clinical professionals and paraprofessionals within their scope of practice as listed in the Staff Qualifications section.

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Service Description (Cont'd.)

Length of Stay Criteria / Continued Stay Criteria:

Day Treatment/Partial Hospitalization generally provides a minimum of 20 hours of programming per week based on individual plan of care. The duration of treatment varies with the severity of the beneficiary's illness, and response to treatment.

Service Documentation

The CSN must identify the service being provided and list all of the components of the treatment. The staff assigned to the beneficiary is responsible for checking those services provided and writing a summary of those services.

The IPOC should list the specific short-and long-term goals and objectives addressing the expected outcome of treatment.

The development of a discharge plan is required to provide guidelines to the beneficiary on what is expected to continue in the program and guidance on how to maintain stability in their natural environment

Providers must maintain medical records that include a copy of the individual treatment plan, medical and clinical assessments, clinical service notes, and progress update or continued stay authorization form.

A bachelor's level staff, with a CAC II or higher, must sign for the services to be rendered and qualified health care professionals must sign for the treatment as listed by their scope of practice.

Staff-to-Beneficiary Ratio

The staff-to-beneficiary ratio must not exceed the allowed ratio set by specific services listed in this manual. The ratio applies to all beneficiaries receiving services by a provider, regardless of whether or not the beneficiary is Medicaid eligible.

Billing Frequency

Alcohol and/or Drug Treatment Outpatient - Day Treatment/Hospitalization services are billed as an hourly inclusive rate.

Billable Place of Service

The only excluded settings are acute care hospitals. Services can be rendered in a substance abuse facility, or setting that is convenient for the both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Special Restrictions in Relationship to Other Services

All services must be authorized except for Diagnostic assessments, AOD assessment, AOD screening, AOD Nursing assessment, Service Plan Development, Crisis intervention, and Medical Evaluation and Management services. Services which exceed the initial authorization must be approved for re-authorization prior to service delivery.

Discharge/Transition Criteria from Outpatient Programs

Beneficiaries should be considered for discharge or transfer to another level of care when any of the following criteria are met:

- The beneficiary's level of functioning has significantly improved
- The beneficiary has made limited or no progress with respect to the goals outlined in the IPOC
- The beneficiary has achieved the goals as outlined in the IPOC or reached maximum benefit
- The beneficiary has developed the skills and resources needed to transition to a lower level of care
- The beneficiary requested to be discharged from treatment and is not imminently dangerous to self or others
- The beneficiary requires a higher level of care (*i.e.*, inpatient hospitalization or PRTF)
- The beneficiary displays the inability to actively participate in the program or no longer is working or participating toward their goals.

The beneficiary should be re-evaluated for services before discharged from a particular level of care.

RESIDENTIAL SUBSTANCE ABUSE TREATMENT

Residential Substance Abuse Treatment Services include an array of services consistent with the beneficiary's assessed treatment needs, with a rehabilitative and recovery focus designed to promote coping skills and manage substance abuse symptoms and behaviors in a residential setting. Services include physician monitoring, nursing care, and observation as needed, based on clinical judgment.

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

RESIDENTIAL SUBSTANCE ABUSE TREATMENT (CONT'D.)

In accordance with the Code of Federal Regulations, 42 CFR 435.1009.-101, these services are not available for beneficiaries residing in an institution of more than 16 beds.

Medicaid will not reimburse for the following:

1. room and board services, including custodial care;
2. educational, vocational and job training services;
3. habilitation services;
4. services to inmates in public institutions as defined in 42 CFR §435.1010;
5. services to individuals residing in institutions for mental diseases as described in 42 CFR§435.1010;
6. recreational and social activities; and
7. services that must be covered elsewhere in the state Medicaid plan.

The beneficiary must be assessed to establish medical necessity for the treatment of services. The beneficiary must meet the diagnostic criteria for a substance use disorder or co-occurring substance use and mental health disorders as defined by the current edition of the DSM or ICD to establish medical necessity for treatment services. The provider should refer to the most current ASAM-PPC-2R as the basis for the beneficiary placement in the appropriate level of care.

Residential Substance Abuse Treatment includes an array of services delivered in a residential setting consistent with the beneficiary's treatment needs. The treatment must be rehabilitative and recovery focused and designed to promote coping skills to manage substance abuse symptoms and behaviors. Services are delivered on an individual or group basis in a wide variety of settings.

Alcohol and/or Drug Sub-Acute Detox - Clinically Managed Residential Detoxification: Level III.2-D

The program relies on established clinical protocols and services delivered by staffs, which provide 24-hour supervision, observation, and support for beneficiaries who are intoxicated or experiencing withdrawal. Staff will supervise self-administered medications for the management of substance use or alcohol withdrawal. However, the full resources of a medically monitored residential detoxification service are not necessary.

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Medical Necessity Criteria

Beneficiaries eligible for these services must have a diagnosis of a substance use disorder or co-occurring substance use and mental health disorders.

The beneficiary must meet ASAM criteria for this level of care placement, with documentation reflecting applicable medical necessity on each of the ASAM dimensions:

- The beneficiary is experiencing signs and symptoms of withdrawal or there is evidence that withdrawal is imminent
- The beneficiary is assessed as not being at risk of severe withdrawal syndrome, and moderate withdrawal is safely manageable at this level of service
- The beneficiary is assessed as not requiring medication, but requires this level of service to complete detoxification and enter into continued treatment or self-help recovery because of inadequate home supervision or support structure.

Service Description

The program is comprised of the following services:

AOD Assessment Nursing Services, Individual Psychotherapy, Family Psychotherapy, Group Psychotherapy, AOD/Substance Abuse Counseling, Peer Support Services, PRS, Family Support, and Medication Management.

The following may be billed as discrete services:

Psychiatric Diagnostic Evaluation, Psychological Testing and reporting, AOD Assessment, AOD Screening, SPD, Medical Evaluation and Management, Crisis Intervention, Injection (Vivitrol), and Medication Administration.

The following services are included in the program:

- 24-hour medical observation, monitoring, and treatment
- Emergency medical services available as needed
- Referral to medically managed detox, if clinically appropriate
- Laboratory screening as needed
- Medication ordered by a qualified health care professional

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Service Description (Cont'd.)

- Physical examination within 48 hours after admission for beneficiaries in 24-hour facilities (EXCEPTION: If a client is admitted after 5:00 P.M. on Friday, a 24-hour facility has until close-of business the next workday to obtain the admission physical examination.)

Staff providing services:

Services are provided by qualified clinical professionals and paraprofessionals within their scope of practice as listed in the Staff Qualifications section.

Length of Stay/Continued Stay Criteria:

Beneficiaries whose intoxication and/or withdrawal is sufficient to warrant 24-hour support, treatment typically lasts 3–5 days. The duration of treatment varies with the severity of the beneficiary's illness, and response to treatment.

The following guidelines are used to determine length of stay:

- The beneficiary's withdrawal signs and symptoms are sufficiently resolved and symptoms can be safely managed at a less intensive level of care
- The beneficiary's signs and symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of detoxification is indicated.
- The beneficiary may be transferred to a more intensive level of care or the addition of other clinical services are needed when the following occurs:
    - The Beneficiary is unable to complete detoxification at this level of care despite an adequate trial.
    - Symptoms complicating the withdrawal indicate the need to transfer the beneficiary to another level of care.

Service Documentation

An assessment and physical will be documented to substantiate medical necessity, diagnosis and placement in appropriate level of care. A Withdrawal Assessment – Clinical Institute Withdrawal Assessment of Alcohol

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Service Documentation (Cont'd.)

(CIWA-Ar) will be used to monitor the client's withdrawal from substances.

The CSN must identify the service being provided and list all of the components of the treatment. The staff assigned to the beneficiary is responsible for checking those services provided and writing a summary of those services.

The IPOC should list the specific short-and long-term goals and objectives addressing the expected outcome of treatment.

The development of a discharge plan is required to provide guidelines to the beneficiary on what is expected to continue in the program and guidance on how to maintain stability in their natural environment.

Providers must maintain medical records that include a copy of the individual treatment plan, medical and clinical assessments, clinical service notes, and progress update or continued stay authorization form.

A bachelor's level staff, with a CAC II or higher, must sign for the services to be rendered and qualified health care professionals must sign for the treatment as listed by their scope of practice.

Staff-to-Beneficiary Ratio

The staff-to-beneficiary ratio must not exceed the allowed ratio set by specific services listed in this manual. The ratio applies to all beneficiaries receiving services by a provider, regardless of whether or not the beneficiary is Medicaid eligible.

Billing Frequency

Alcohol and/or Drug Sub-acute Detox - Clinically Managed Residential Detoxification services are billed at a daily per diem rate.

Billable Place of Service

Services can only be rendered in a 16 bed or less substance abuse facility.

Special Restrictions in Relationship to Other Services

All services must be authorized except for Diagnostic assessments, AOD assessment, AOD screening, AOD Nursing assessment, Service Plan Development, Crisis intervention, and Medical Evaluation and Management services. Services which exceed the initial authorization must be approved for re-authorization prior to service delivery.

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Alcohol and/or Drug Acute Detox – Medically Monitored Residential Detoxification Services: Level III.7-D

The program provides 24-hour supervision, observation, and support for beneficiaries who are intoxicated or experiencing withdrawal in a residential setting.

At this level of care, physicians are available 24 hours per day and are available to assess the beneficiary within 24 hours of admission (or sooner, if medically necessary) and must be available to provide onsite monitoring of care and further evaluation on a daily basis.

Primary emphasis is placed on ensuring that the beneficiary is medically stable (including the initiation and tapering of medications used for the treatment of substance use withdrawal), assessing for adequate bio-psychosocial stability, intervening immediately to establish bio-psychosocial stability and facilitating effective linkage to other appropriate residential and outpatient services.

A registered nurse, or other qualified nursing specialist, will be present to administer a Nursing Admission History. A nurse is responsible for overseeing the monitoring of the beneficiary's progress and medication administration on an hourly basis, if needed.

Medical Necessity Criteria

Adult beneficiaries eligible for these services must have a diagnosis of a substance use disorder or co-occurring substance use and mental health disorders.

The beneficiary must meet ASAM criteria for this level of care placement, with the appropriate documentation reflecting applicable medical necessity on each of the ASAM dimensions:

- The beneficiary is experiencing signs and symptoms of severe withdrawal, or there is evidence that a severe withdrawal syndrome is imminent and assessed as manageable at this level of care.
- There is strong likelihood that the beneficiary (who requires medication) will not complete detoxification at another level of care, enter continued treatment or self-help recovery.

Service Description

The program is comprised of the following services:

AOD Assessment Nursing Services, Individual Psychotherapy, Family Psychotherapy, Group

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Service Description (Cont'd.)

Psychotherapy, AOD/Substance Abuse Counseling, Peer Support Services, PRS, Family Support, and Medication Management.

The following may be billed as discrete services:

Psychiatric Diagnostic Evaluation, Psychological Testing evaluation and reporting, AOD Assessment, AOD Screening, SPD, Medical Evaluation and Management, Crisis Intervention, Injection (Vivitrol), and Medication Administration

The following services are included in the program:

- 24-hour medical observation, monitoring, and treatment
- Emergency medical services available as needed
- Laboratory screening as needed
- Medication order by a qualified health care professional
- Physical examination within 24 hours after admission or sooner

Staff providing services:

Services are provided by qualified clinical professionals and paraprofessionals within their scope of practice as listed in the Staff Qualifications section.

Length of Stay/Continued Stay Criteria:

Treatment typically lasts 3-5 days, and duration of treatment varies with the severity of the beneficiary's illness and response to treatment. The 5 days may be exceeded by continued receipt of the service based on medical necessity, and/or transfer to a another level of service when services provided at this level have been insufficient to address the beneficiary's needs, and the beneficiary meets the ASAM criteria for another level of service. . The following guidelines are used to determine length of stay:

- The beneficiary's withdrawal signs and symptoms are sufficiently resolved to be safely managed at a less intensive level of care
- The beneficiary's withdrawal signs and symptoms have failed to respond to treatment and have intensified

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Service Documentation

A Nursing Admission History and a Medical Evaluation will be provided upon initial contact to establish medical necessity and admission to appropriate level of care. A Withdrawal Assessment – Clinical Institute Withdrawal Assessment of Alcohol (CIWA-Ar) will be used throughout detox to assess the severity of withdrawal symptoms and measure progress toward discharge/transfer to treatment services.

The CSN must identify the services being provided and list all of the components of the treatment. The staff assigned to the beneficiary is responsible for checking those services provided and writing a summary of those services.

The IPOC should list the specific short-and long-term goals and objectives addressing the expected outcome of treatment.

The development of a discharge plan is required to provide guidelines to the beneficiary on what is expected to continue in the program and guidance on how to maintain stability in their natural environment.

Providers must maintain medical records that include a copy of the individual treatment plan, medical and clinical assessments, clinical service notes, and progress update.

A bachelor's level staff, with a CAC II or higher, must sign for the services to be rendered and qualified health care professionals must sign for the treatment as listed by their scope of practice.

Staff-to-Beneficiary Ratio

The staff-to-beneficiary ratio must not exceed the allowed ratio set by specific services listed in this manual. The ratio applies to all beneficiaries receiving services by a provider, regardless of whether or not the beneficiary is Medicaid eligible.

Billing Frequency

Services are billed at a daily per diem rate.

Billable Place of Service

Services can only be rendered in a 16 bed or less substance abuse facility.

Special Restrictions in Relationship to Other Services

All services must be authorized except for Diagnostic assessments, AOD assessment, AOD screening, AOD Nursing assessment, Service Plan Development, Crisis intervention, and Medical Evaluation and Management

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Special Restrictions in Relationship to Other Services (Cont'd.)

services. Services which exceed the initial authorization must be approved for re-authorization prior to service delivery.

Behavioral Health Long Term Residential Treatment Program - Clinically Managed High-Intensity Residential Treatment: Level III.5-R

The program is designed to promote abstinence from substances and antisocial behavior and to effect an overall change in the lifestyle, attitude and values of persons who have significant social and psychological problems. The defining characteristics of these beneficiaries are found in their emotional/behavioral and cognitive conditions (Dimension 3) and their living environments (Dimension 6). This service provides comprehensive, multi-faceted treatment to beneficiaries who have multiple deficits and psychological problems (including serious and persistent mental disorders) in a residential setting.

Medical Necessity Criteria

Adult beneficiaries eligible for these services must have a diagnosis of a substance use disorder or co-occurring substance use and mental health disorders.

The beneficiary must meet ASAM criteria for this level of care placement, with documentation reflecting applicable medical necessity on each of the ASAM Dimensions:

- The beneficiary has no withdrawal signs or symptoms or withdrawal can be safely managed in this level of care
- Biomedical problems are stable or not severe enough to warrant hospital treatment, but are sufficient to distract from treatment or recovery efforts
- Emotional, behavioral, or cognitive conditions render the beneficiary unable to control substance use and the resulting level of dysfunction precludes participation in less structured level of care
- The beneficiary has not reached the motivational stage of change required due to intensity and chronicity of the substance use problem
- The beneficiary has not developed insight into connection between substance use and life problems and blames external factors for his or her problems

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Medical Necessity Criteria (Cont'd.)

- The beneficiary does not recognize relapse triggers and is not committed to continuing care
- The beneficiary is unable to control substance use, little ability to interrupt the relapse process
- The beneficiary is experiencing addiction symptoms and is unable to employ skills to prevent a relapse
- The beneficiary is in a crisis situation with imminent danger of a relapse
- The beneficiary continues to use substances despite recent active participation in the treatment program at a less intensive level of care
- The beneficiary's living environment is characterized by high risk of victimization, criminal behavior, antisocial norms and values, or other factors that make it unlikely he or she will be able to achieve or maintain recovery at a less intensive level of care.

Service Description

The program is comprised of the following services:

AOD Assessment Nursing Services, Individual Psychotherapy, Family Psychotherapy, Group Psychotherapy, AOD/Substance Abuse Counseling, Peer Support Services, PRS, Family Support, and Medication Management.

The following may be billed as discrete services:

Psychiatric Diagnostic Evaluation, Psychological Testing and reporting, AOD Assessment, AOD Screening, SPD, Medical Evaluation and Management, Crisis Intervention, Injection (Vivitrol), and Medication Administration.

The following services are included in the program:

- 24-hour medical observation, monitoring, and treatment
- Emergency medical services available as needed
- Laboratory screening as needed
- Medication order by a qualified health care professional

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Service Description (Cont'd.)

- Physical examination within 24 hours after admission
- The provision of priority admission for pregnant women, as needed

Staff providing services:

Services are provided by qualified clinical professionals and paraprofessionals within their scope of practice as listed in the Staff Qualifications section.

Length of Stay/Continued Stay Criteria:

Treatment hours consist of six hours a day, Monday through Friday and five hours a day, Saturday and Sunday. Level III.5-R is based on the severity of the beneficiary's illness, and response to treatment. The duration of treatment tends to be longer than in more intensive medically managed levels of care. The average length of stay is three months.

Transfer to a higher level of care is warranted when services are insufficient to address the beneficiary's needs and he or she meets the criteria for a higher level of care.

Service Documentation

An assessment and medical evaluation will be used to establish medical necessity, diagnosis and placement in appropriate level of care.

The CSN must identify the service being provided and list all of the components of the treatment. The staff assigned to the beneficiary is responsible for checking those services provided and writing a summary of those services.

The IPOC should list the specific short-and long-term goals and objectives addressing the expected outcome of treatment

The development of a discharge plan is required to provide guidelines to the beneficiary on what is expected to continue in the program and guidance on how to maintain stability in their natural environment.

Providers must maintain medical records that include a copy of the individual treatment plan, medical and clinical assessments, clinical service notes, and progress update or continued stay authorization form.

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Service Documentation (Cont'd.)

A bachelor's level staff, with a CAC II or higher, must sign for the services to be rendered and qualified health care professionals must sign for the treatment as listed by their scope of practice.

Staff-to-Beneficiary Ratio

The staff-to-beneficiary ratio must not exceed the allowed ratio set by specific services listed in this manual. The ratio applies to all beneficiaries receiving services by a provider, regardless of whether or not the beneficiary is Medicaid eligible.

Billing Frequency

Behavioral Health Long Term Residential - Clinically Managed High-Intensity Residential Treatment services are billed at a daily per diem rate.

Billable Place of Service

Services can only be rendered in a 16 bed or less substance abuse facility.

Special Restrictions in Relationship to Other Services

All services must be authorized except for Diagnostic assessments, AOD assessment, AOD screening, AOD Nursing assessment, Service Plan Development, Crisis intervention, and Medical Evaluation and Management services. Services which exceed the initial authorization must be approved for re-authorization prior to service delivery.

Behavioral Health Short Term Residential Treatment Program – Medically Monitored Intensive Residential Treatment: Level III.7-R

The program provides a planned regimen of professionally directed services that are appropriate for beneficiaries whose sub-acute biomedical and emotional, behavioral, or cognitive problems are so severe that residential care is required.

The beneficiaries of this service have functional deficits effecting ability to manage intoxication/withdrawal, bio-medical symptoms and complications, and/or emotional, behavioral or cognitive conditions and complications that interfere with or distract from recovery efforts.

Medical Necessity Criteria

Beneficiaries eligible for these services must have a diagnosis of a substance use disorder or co-occurring substance use and mental health disorders.

The beneficiary must meet ASAM PPC-2 admission criteria for this level of care placement, which require the beneficiary to meet specifications in at least two of the six dimensions:

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Medical Necessity Criteria (Cont'd.)

- At least one criterion must be in Dimension 1, 2, or 3. These dimensions are acute intoxication and/or withdrawal potential; biomedical conditions and complications; or emotional, behavioral, or cognitive conditions and complications. Beneficiaries with a greater severity of illness in these dimensions require use of more intensive staffing patterns and support services due to functional deficits.
- Dimensions 4, 5 and 6 address readiness's to change, relapse, continued use or continued problem potential, and recovery potential. A problem in at least one of the dimensions puts the beneficiary at risk of use and/or continued use of illicit substance(s) and/or at risk of harm to themselves or from others .This is in addition to a combination of deficits in Dimensions 1, 2 or 3, which indicates a need for the intensity of services in Level III.7-R.

Service Description

The program is comprised of the following services:

AOD Assessment Nursing Services, Individual Psychotherapy, Family Psychotherapy, Group Psychotherapy, AOD/ Substance Abuse Counseling, Peer Support Services, PRS, Family Support, and Medication Management.

The following may be billed as discrete services:

Psychiatric Diagnostic Evaluation, Psychological Testing Evaluation and Reporting, AOD Assessment, AOD Screening, SPD, Medical Evaluation and Management, Crisis Intervention, Injection (Vivitrol) and Medication Administration

The following services are included in the program:

- 24-hour medical observation, monitoring, and treatment
- Emergency medical services available as needed
- Laboratory screening as needed
- Medication order by a qualified health care professional

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Service Description (Cont'd.)

- Physical examination within 24 hours after admission and provide face-to face evaluations at least once a week.
- A registered nurse will be responsible for overseeing the monitoring of the beneficiary's progress and medication administration.

Staff providing services:

Services are provided by qualified clinical professionals and paraprofessionals within their scope of practice as listed in the Staff Qualifications section.

Length of Stay/Continued Stay Criteria:

The duration of treatment varies with the severity of the beneficiary's illness and response to treatment. The treatment program must provide at least six hours of clinical services, Monday through Friday and five hours on the weekends. The average length of stay is 30 days.

The beneficiary must be discharged from Level III.7. R by the physician or reviewed by the physician before the beneficiary is transferred to a lesser level of care within the same treatment system.

Service Documentation

An assessment and medical evaluation will be used to establish medical necessity, diagnosis and placement in appropriate level of care.

The CSN must identify the service being provided and list all of the components of the treatment. The staff assigned to the beneficiary is responsible for checking those services provided and writing a summary of those services.

The IPOC should list the specific short-and long-term goals and objectives addressing the expected outcome of treatment.

The development of a discharge plan is required to provide guidelines to the beneficiary on what is expected to continue in the program and guidance on how to maintain stability in their natural environment.

Providers must maintain medical records that include a copy of the individual treatment plan, medical and clinical assessments, clinically service notes, and progress update.

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Service Documentation (Cont'd.)

A bachelor's level staff, with a CAC II or higher, must sign for the services to be rendered and qualified health care professionals must sign for the treatment as listed by their scope of practice.

Staff-to-Beneficiary Ratio

The staff-to-beneficiary ratio must not exceed the allowed ratio set by specific services listed in this manual. The ratio applies to all beneficiaries receiving services by a provider, regardless of whether or not the beneficiary is Medicaid eligible.

Billing Frequency

Behavioral Health Short Term Residential - Medically Monitored Intensive Residential Treatment services are billed at a daily per diem rate.

Billable Place of Service

Services can only be rendered in a 16 bed or less substance abuse facility.

Special Restrictions in Relationship to Other Services

All services must be authorized except for Diagnostic assessments, AOD assessment, AOD screening, AOD Nursing assessment, Service Plan Development, Crisis intervention, and Medical Evaluation and Management services. Services which exceed the initial authorization must be approved for re-authorization prior to service delivery.

Behavioral Health Short Term Residential Treatment Program – Medically Monitored High-Intensity Residential Treatment Services: Level III.7-RA

The program is designed to provide a regimen of 24 hour medical monitoring, evaluations and addiction treatment in a residential setting. The program functions under a defined set of policies, procedures and clinical protocols. The program is focused toward children and adolescent beneficiaries, whose sub-acute biomedical and emotional, behavioral, or cognitive problems are so severe that they require residential treatment. However, for this level of service, the beneficiary does not need the full resources of an acute care general hospital or a medically managed residential treatment program.

Treatment program may include the following activities:

- Activities designed to develop and apply recovery skills and promote development of a social network supportive of recovery,
- Enhance the beneficiary's understanding of addictions,

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Behavioral Health Short Term Residential Treatment Program – Medically Monitored High-Intensity Residential Treatment Services: Level III.7-RA (Cont'd.)

- Promote successful involvement in regular productive daily activity,
- Enhance personal responsibility and developmental maturity,
- Promote successful reintegration into community living.

Medical Necessity Criteria

Beneficiaries eligible for these services must have a diagnosis of a substance use disorder or co-occurring substance use and mental health disorders.

The beneficiary must meet ASAM PPC-2 admission criteria specifications in at least two of the six dimensions below:

- At least one criterion must be in Dimension 1, 2 or 3: Acute Intoxication and/or withdrawal potential, Biomedical Conditions and complications or Emotional, Behavioral or Cognitive Conditions and Complications.
  - The beneficiary may have problems that require direct medical or nursing services; however, problems in Dimension 3 are the most common reason for admission to Level III.7.RA.
- Dimensions 4, 5 and 6 addresses readiness to change, relapse, continued use or continued problem potential, and recovery potential.
  - A problem in at least one of the dimensions that puts the beneficiary at risk of use/continued use of illicit substance(s) and/or risk of harm, to themselves or from others.
- Placement decisions are based on the symptomatic functional impairment rather the any specific categorical diagnosis.
  - The beneficiary may be admitted directly to Level III.7.RA programs or transferred from a less intensive level of care as symptoms become more severe; or
  - The beneficiary may be transferred from a Level IV program when that level of intensity is no longer required.

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Service Description

The program comprises the following services:

AOD Assessment Nursing Services, Individual Psychotherapy, Family Psychotherapy, Group Psychotherapy, AOD/ Substance Abuse Counseling, Peer Support Services, PRS, Family Support, and Medication Management.

The following may be billed as discrete services:

Psychiatric Diagnostic Evaluation, Psychological Testing and reporting, AOD Assessment, AOD Screening, SPD, Medical Evaluation and Management, Crisis Intervention, Injection (Vivitrol) and Medication Administration.

The following services are included in the program:

- 24-hour medical observation, monitoring and treatment
- Emergency medical services available as needed
- Laboratory screening as needed
- Medication order by a qualified health care professional
- Physical examination within 24 hours after admission and provide face-to face evaluations at least once a week.
- The beneficiary must have a registered nurse who is responsible for overseeing the monitoring of the beneficiary's progress and medication administration.

Staff providing services:

Services are provided by qualified clinical professionals and paraprofessionals within their scope of practice as listed in the Staff Qualifications section.

Length of Stay/Continued Stay Criteria:

The treatment program must provide at least six hours of clinical services, Monday through Friday and five hours on the weekends. The duration of treatment varies with the severity of the beneficiary's illness, and response to treatment. The average length of treatment maybe up to six months.

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Service Description (Cont'd.)	The beneficiary must be discharged from Level III.7. R A by the physician or reviewed by the physician before the beneficiary is transferred to a lesser level of care within the same treatment system.
Service Documentation	An assessment and medical evaluation will be used to establish medical necessity, diagnosis and placement in appropriate level of care. The CSN must identify the service being provided and list all of the components of the treatment. The staff assigned to the beneficiary is responsible for checking those services provided and writing a summary of those services. The IPOC should list the specific short-and long-term goals and objectives addressing the expected outcome of treatment. The development of a discharge plan is required to provide guidelines to the beneficiary on what is expected to continue in the program and guidance on how to maintain stability in their natural environment. Providers must maintain medical records that include a copy of the individual treatment plan, medical and clinical assessments, clinically service notes and progress updates. A bachelor's level staff, with a CAC II or higher must sign for the services to be rendered and qualified health care professionals must sign for the treatment as listed by their scope of practice
Staff-to-Beneficiary Ratio	The staff-to-beneficiary ratio must not exceed the allowed ratio set by specific services listed in this manual. The ratio applies to all beneficiaries receiving services by a provider, regardless of whether or not the beneficiary is Medicaid eligible.
Billing Frequency	Services are billed at a daily per diem rate.
Billable Place of Service	Services can only be rendered in a substance abuse facility.
Special Restrictions in Relationship to Other Services	All services must be authorized except for Diagnostic assessments, AOD assessment, AOD screening, AOD Nursing assessment, Service Plan Development, Crisis intervention, Medical Evaluation and Management services. Services which exceed the initial authorization must be approved for re-authorization prior to service delivery.

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Special Restrictions in Relationship to Other Services (Cont'd.)

Modifier HA will be used with this code to indicate services for children and adolescents.

Discharge/Transition Criteria from Residential Services

Beneficiaries should be considered for discharge or transfer to another level of care when any of the following criteria are met:

- The beneficiary's level of functioning has significantly improved
- The beneficiary has made limited or no progress with respect to the goals outlined in the IPOC.
- The beneficiary has achieved the goals as outlined in the IPOC or reached maximum benefit.
- The beneficiary has developed the skills and resources needed to transition to a lower level of care.
- The beneficiary requested to be discharged from treatment and is not imminently dangerous to self or others.
- The beneficiary requires a higher level of care (*i.e.*, inpatient hospitalization or PRTF).
- The beneficiary displays the inability to actively participate in the program or no longer is working or participating toward their goals.

The beneficiary should be re-evaluated for services before discharged from a particular level of care.

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,

SECTION 3 BILLING PROCEDURES

GENERAL INFORMATION

Copayment Exclusions (Cont'd.)

End Stage Renal Disease (ESRD) services, Infusion Center 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.

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 PROCESSING

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, Clinical Modification (ICD-CM).*

SC Medicaid will not accept billing of discontinued codes for dates of service after the date on which the code is

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Diagnostic Codes (Cont'd.)

discontinued. Physicians, practitioners, and 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. Valid diagnosis coding can only be obtained from the most current edition of the ICD-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 first-listed or principal diagnosis.

A current edition of the ICD-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
AF	Specialty physician (psychiatrist)
HP	Doctoral level (MD)
UB	Pharmacist

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Modifiers (Cont'd.)

AM	Physician team member svc (PA)
SA	Nurse practitioner (APRN)
AH	Clinical psychologist
HO	Master's level
TD	Registered nurse (RN)
TE	Licensed practical nurse (LPN)
HN	Bachelor's level
HM	Less than bachelor's level

Place of Service Key

Place of Service Codes

Code	Description
03	School
11	Office
12	Home
19	Off Campus Hospital
22	Outpatient Hospital
23	Emergency Room - Hospital
53	Community Mental Health Center
55	Residential Substance Abuse Treatment Facility
57	Non-Residential Substance Abuse Treatment Facility
99	Other Place of Service

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.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

National Provider Identifier and Medicaid Provider Number (Cont'd.)

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.

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 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.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

CMS-1500 Form Completion Instructions (Cont'd.)

Field	Description
*	Required for claim to process
**	Required if applicable (based upon the specific program area requirements)

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

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.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

CMS-1500 Form Completion Instructions (Cont'd.)

Field	Description
*	Required for claim to process
**	Required if applicable (based upon the specific program area requirements)

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").

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.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

CMS-1500 Form Completion Instructions (Cont'd.)

Field	Description
*	Required for claim to process
**	Required if applicable (based upon the specific program area requirements)

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.

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

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

CMS-1500 Form Completion Instructions (Cont'd.)

Field	Description
*	Required for claim to process
**	Required if applicable (based upon the specific program area requirements)

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.

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.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

CMS-1500 Form Completion Instructions (Cont'd.)

Field **Description**

* Required for claim to process

** Required if applicable (based upon the specific program area requirements)

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, 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**

A valid prior authorization number must be entered in this field, if applicable. This Prior

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

CMS-1500 Form Completion Instructions (Cont'd.)

Field **Description**

* Required for claim to process

** Required if applicable (based upon the specific program area requirements)

Authorization is not applicable for providers who are rendering services directly.

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.

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

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

CMS-1500 Form Completion Instructions (Cont'd.)

Field **Description**

* Required for claim to process

** Required if applicable (based upon the specific program area requirements)

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 t**he 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

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."

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

CMS-1500 Form Completion Instructions (Cont'd.)

Field **Description**

* Required for claim to process

** Required if applicable (based upon the specific program area requirements)

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.

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.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

CMS-1500 Form Completion Instructions (Cont'd.)

Field **Description**

* Required for claim to process

** Required if applicable (based upon the specific program area requirements)

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.

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

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

CMS-1500 Form Completion Instructions (Cont'd.)

Field **Description**

* Required for claim to process

** Required if applicable (based upon the specific program area requirements)

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.

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.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

CMS-1500 Form Completion Instructions (Cont'd.)

Field	Description
*	Required for claim to process
**	Required if applicable (based upon the specific program area requirements)

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 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

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Trading Partner Agreement (Cont'd.)

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

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 EDI Support Center via the SCDHHS Medicaid 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:

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Companion Guides (Cont'd.)

- 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 SC Medicaid.

The following options may be used also to submit claims electronically:

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.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

SC Medicaid Web-based Claims Submission Tool (Cont'd.)

- 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
- 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.

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CLAIM PROCESSING

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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:

SECTION 3 BILLING PROCEDURES

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

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Electronic Funds Transfer (EFT) (Cont'd.)

will be required to submit an EFT form and bank account verification from their financial institution.

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

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Cost Avoidance (Cont'd.)

about the insurance carrier address and telephone number may be found in Appendix 2 of this manual. Providers can 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 form

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Third-Party Liability Exceptions (Cont'd.)

can be found in the Forms section of this manual. The reasonable effort document must demonstrate 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.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

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, 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.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Carrier Codes (Cont'd.)

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 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

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

CLAIM ADJUSTMENTS (CONT'D.)

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 later in this section. 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 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

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Claim-Level Adjustments (Cont'd.)

"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.

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 re-file the claim with the corrected information. A Void/Replacement claim should be used to:

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Void Only and Void/Replacement Claims (Cont'd.)

- 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 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.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Form 130 Instructions (Cont'd.)

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.

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

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Visit Counts (Cont'd.)

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.

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

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Gross-Level Adjustments (Cont'd.)

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:

South Carolina Healthy Connections
Post Office Box 101110
Columbia, SC 29211-9804

Fax: (803) 462-2582
Phone: 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

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Gross-Level Adjustments (Cont'd.)

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 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.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Refund Checks (Cont'd.)

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.

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CLAIM PROCESSING

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SECTION 4

PROCEDURE CODES

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UNITS OF SERVICE

Rehabilitative Behavioral Health Services are billed using frequency limits, procedure codes, and modifier combinations. Each service has its own maximum number of units billable per beneficiary per day. SCDHHS will continue to monitor utilization for outliers.

SERVICE NAME	PROC CODE	MODIFIER / DESCRIPTION		UNIT FREQ	FREQ. LIMITS
Screening and Diagnostic Assessment Services					
Psychiatric Diagnostic Evaluation without Medical (Comprehensive Diagnostic Assessment – Initial)	90791	AH HO	Licensed Psychologist Master's level	Encounter = 1 unit	1 Encounter per 6 months
Psychiatric Diagnostic Evaluation with Medical Services	90792	AF AM SA	Specialty physician (psychiatrist) Physician team member svc (PA) Nurse practitioner (APRN)	Encounter = 1 unit	1 Encounter per 6 months
Psychological Testing and Evaluation	96101	AH	Licensed Psychologist	1 unit = 60 minutes	10 units per week 20 units per year
Behavioral Health Screening	H0002	AF HP AM SA AH HO HN	Specialty physician (psychiatrist) Doctoral level (MD) Physician team member svc (PA) Nurse practitioner (APRN) Licensed Psychologist Master's level Bachelor's level	15 minutes = 1 unit	2 units per day
Mental Health Comprehensive Diagnostic Assessment – Follow–up	H0031	AH HO	Licensed Psychologist Master's level	Encounter = 1 unit	12 Encounters per year
Child Adolescent Level of Care Utilization System (CALOCUS)	H2000	AH HO	Licensed Psychologist Master's level	Encounter = 1 unit	1 Encounter per 6 months

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SERVICE NAME	PROC CODE	MODIFIER / DESCRIPTION		UNIT FREQ	FREQ. LIMITS
Service Plan Development					
Service Plan Development – Team Conference w/Client/Family	99366			Encounter = 1 unit	6 Encounters per rolling 12 months
Service Plan Development – Team Conference w/o Client/Family	99367			Encounter = 1 unit	6 Encounters per rolling 12 months
Mental Health Service Plan Development – Non–Physician	H0032	AH HO HN	Licensed Psychologist Master's level Bachelor's level	15 minutes = 1 unit	10 units per week
Core Treatment and Psychotherapy Services					
Psychotherapy, 30 minutes	90832	AF AM SA AH HO	Specialty physician (psychiatrist) Physician team member svc (PA) Nurse practitioner (APRN) Licensed Psychologist Master's level	Encounter = 1 unit Unit = 1 session	1 per date of service IP can be rendered in a variety of combinations, 6 sessions per month.
Psychotherapy, 45 minutes	90834	AF AM SA AH HO	Specialty physician (psychiatrist) Physician team member svc (PA) Nurse practitioner (APRN) Licensed Psychologist Master's level	Encounter = 1 unit Unit = 1 session	1 per date of service IP can be rendered in a variety of combinations, 6 sessions per month.
Psychotherapy, 60 minutes	90837	AF AM SA AH HO	Specialty physician (psychiatrist) Physician team member svc (PA) Nurse practitioner (APRN) Licensed Psychologist Master's level	Encounter = 1 unit Unit = 1 session	1 per date of service IP can be rendered in a variety of combinations, 6 sessions per month.

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SERVICE NAME	PROC CODE	MODIFIER / DESCRIPTION		UNIT FREQ	FREQ. LIMITS
Family Psychotherapy, 50 minutes	90846	HP AH HO	Doctoral level (MD) Licensed Psychologist Master's level	Encounter = 1 unit Unit = 1 session	1 per date of service 4 sessions per month
Family Psychotherapy, including patient 50 minutes	90847	HP AH HO	Doctoral level (MD) Licensed Psychologist Master's level	Encounter = 1 unit Unit =1 session	1 per date of service 4 sessions per month
Multiple Family Group Psychotherapy	90849	AH HO	Licensed Psychologist Master's level	Encounter = 1 unit Unit =1 session	8 sessions per month
Group Psychotherapy	90853	AH HO	Licensed Psychologist Master's level	Encounter = 1 unit Unit =1 session	8 sessions per month
Medication Management	H0034	AF HP AM SA TD TE	Specialty physician (psychiatrist) Doctoral level (MD) (Pharm) Physician team member svc (PA) Nurse practitioner (APRN) Registered nurse (RN) Licensed Practical Nurse (LPN)	15 minutes = 1 unit	8 units per day
Crisis Management	H2011	AF HP AM SA AH HO TD HN	Specialty physician (psychiatrist) Doctoral level (MD) Physician team member svc (PA) Nurse practitioner (APRN) Licensed Psychologist Master's level Registered nurse (RN) Bachelor's level	15 minutes = 1 unit	16 units per day 80 units annually

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SERVICE NAME	PROC CODE	MODIFIER / DESCRIPTION		UNIT FREQ	FREQ. LIMITS
Community Support Services					
Peer Support Service – **Provided by DMH and DAODAS only**	H0038			15 minutes= 1 unit	16 units per day
Behavior Modification	H2014	AF HP AM SA AH HO TD HN HM TE	Specialty physician (psychiatrist) Doctoral level (MD) Physician team member svc (PA) Nurse practitioner (APRN) Licensed Psychologist Master's level Registered nurse (RN) Bachelor's level Less than bachelor's degree Licensed Practical Nurse (LPN)	15 minutes = 1 unit	32 units per day
Psychosocial Rehabilitation Service	H2017	U1 U2 U3 U4 U5	Licensed Psychologist Master's level Bachelor's level Registered nurse (RN) Less than bachelor's degree	15 minutes = 1 unit	24 units per day
		U6 U7 U8 U9 UA	Licensed Psychologist - **Group** Master's Level - **Group** Bachelor's Level - **Group** Register Nurse - **Group** Less than bachelor's - **Group**		
Family Support	S9482	AF HP AM SA AH HO TD HN HM TE	Specialty physician (psychiatrist) Doctoral level (MD) Physician team member svc (PA) Nurse practitioner (APRN) Licensed Psychologist Master's level Registered nurse (RN) Bachelor's level Less than bachelor's degree Licensed Practical Nurse (LPN)	15 minutes = 1 unit	32 units per day

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SERVICE NAME	PROC CODE	MODIFIER / DESCRIPTION		UNIT FREQ	FREQ. LIMITS
Therapeutic Child Care	H2037	U1	Licensed Psychologist	15 minutes = 1 unit	24 units per day
		U2	Master's level		
		U3	Bachelor's level		
		U4	Registered nurse (RN)		
		U6	Licensed Psychologist - **Group**		
		U7	Master's Level - **Group**		
		U8	Bachelor's Level - **Group**		
		U9	Register Nurse - **Group**		
Community Integration Services	H2030	U6	Licensed Psychologist - **Group**	15 minutes = 1 unit	24 units per day
		U7	Master's Level - **Group**		
		U8	Bachelor's Level - **Group**		
		U9	Register Nurse - **Group**		

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SECTION 4 PROCEDURE CODES

DAODAS ONLY PROCEDURE CODES

UNITS OF SERVICE —

The South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) are billing codes combinations for Rehabilitative Behavioral Health Services. These services are rendered by SC Alcohol and Drug Abuse Commissions and are billed using frequency limits, procedure codes, and modifiers. Each service has its own maximum number of units billable per beneficiary per day.

If a Healthy Connections Medicaid member is enrolled with one of the state's contracted MCO's, DAODAS must receive prior approval and claim reimbursement directly from the member's MCO for services covered under the managed care service package. Please refer to the managed care policy and procedure manual at msp.scdhhs.gov/managedcare/site-page/mco-contract-pp for additional information regarding substance abuse services.

SERVICE NAME	PROC CODE	MODIFIER / DESCRIPTION		UNIT FREQ	FEE FOR SERVICE FREQ. LIMITS	MCO FREQ. LIMITS	NOTES
Assessment, Psychotherapy, and Support Services							
Psychiatric Diagnostic Evaluation with Medical Services	90792	AF AM SA	Physician/psychiatrist Physician team member (PA) Nurse practitioner (APRN)	Encounter = 1 unit	1 per every 6 months	1 per every 6 months Outside of Bundle package	
Psychological Testing and Reporting	96101	AH	Licensed Psychologist	Encounter = 1 unit Unit = 1 session	20 units per year	20 units per year Outside of Bundle package	
Psychological Testing and Reporting	96102	HO	Master's level	Encounter = 1 unit Unit = 1 session	20 units per year	20 units per year Outside of Bundle package	

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DAODAS ONLY PROCEDURE CODES

SERVICE NAME	PROC CODE	MODIFIER / DESCRIPTION		UNIT FREQ	FEE FOR SERVICE FREQ. LIMITS	MCO FREQ. LIMITS	NOTES
Assessment, Psychotherapy, and Support Services							
Alcohol and Drug Assessment – Initial w/o Physical	H0001	AH HO HN	Licensed Psychologist Master's level Bachelor's level	Encounter = 1 unit (1.5 hour session)	1 per every 6 months	1 per every 6 months Outside of Bundle package	
Alcohol and Drug Assessment Follow-up w/o Physical	H0001	TS	Follow-up	Encounter = 1 unit (1 hour session)	1 per every 6 months	1 per every 6 months Outside of Bundle package	
Alcohol and Drug Assessment Nursing Services	H0001	U2	Performed by a LPN or higher medical staff	15 minutes = 1 unit	22 units per rolling 12 months	22 units per rolling 12 months Outside of Bundle package	
Alcohol and Drug Screening (ADS) and Brief Intervention Service	99408	AF AM AH SA HO HN TD TE	Physician/psychiatrist Physician team member (PA) Licensed Psychologist Nurse practitioner (APRN) Master's level Bachelor's level Registered nurse (RN) Licensed practical nurse (LPN)	Encounter = 1 unit Unit = 1 session	12 units per rolling 12 months	12 units per rolling 12 months Outside of Bundle package	H0001 and 99408 cannot be billed on the same date of services.
Service Plan Development Interdisciplinary Team w/Client	99366		Not covered as of 6-1-13	Encounter = 1 unit Unit = 1 session	6 units per rolling 12 months		Master's level staff and above must sign the IPOC
Service Plan Development Interdisciplinary Team w/o Client	99367		Not covered as of 6-1-13	Encounter = 1 unit Unit = 1 session	6 units per rolling 12 months		Master's level staff and above must sign the IPOC
Mental Health Service Plan Development – Non–Physician w/ Client	H0032	HF		Encounter = 1 unit Unit = 1 session	6 units per rolling 12 months	6 units per rolling 12 months	

SECTION 4 PROCEDURE CODES

DAODAS ONLY PROCEDURE CODES

SERVICE NAME	PROC CODE	MODIFIER / DESCRIPTION		UNIT FREQ	FEE FOR SERVICE FREQ. LIMITS	MCO FREQ. LIMITS	NOTES
Assessment, Psychotherapy, and Support Services							
Mental Health Service Plan Development – Non–Physician w/out client	H0032		No modifier	Encounter = 1 unit Unit = 1 session	6 units per rolling 12 months	6 units per rolling 12 months	
Psychotherapy, 30 minutes	90832	AF AM AH SA HO	Physician/psychiatrist Physician team member (PA) Licensed Psychologist Nurse practitioner (APRN) Master's level	Encounter = 1 unit Unit = 1 session	1 per date of service IP can be rendered in a variety of combinations. 6 sessions per month	Contact the MCO to prior authorize frequency limits	
Psychotherapy, 45 minutes	90834	AF AM AH SA HO	Physician/psychiatrist Physician team member (PA) Licensed Psychologist Nurse practitioner (APRN) Master's level	Encounter = 1 unit Unit = 1 session	1 per date of service IP can be rendered in a variety of combinations. 6 sessions per month	Contact the MCO to prior authorize frequency limits	
Psychotherapy, 60 minutes	90837	AF AM AH SA HO	Physician/psychiatrist Physician team member (PA) Licensed Psychologist Nurse practitioner (APRN) Master's level	Encounter = 1 unit Unit = 1 session	1 per date of service IP can be rendered in a variety of combinations 6 sessions per month	Contact the MCO to prior authorize frequency limits	
Psychotherapy, 30 minutes	90833	AF AM SA	Physician/psychiatrist Physician team member svc (PA) Nurse practitioner (APRN)	Encounter = 1 unit Unit = 1 session	1 per date of service	Contact the MCO to prior authorize frequency limits	Must use when providing Medical evaluation and management 99203 or 99213

SECTION 4 PROCEDURE CODES

DAODAS ONLY PROCEDURE CODES

SERVICE NAME	PROC CODE	MODIFIER / DESCRIPTION		UNIT FREQ	FEE FOR SERVICE FREQ. LIMITS	MCO FREQ. LIMITS	NOTES
Assessment, Psychotherapy, and Support Services							
Psychotherapy, 45 minutes	90836	AF AM SA	Physician/psychiatrist Physician team member svc (PA) Nurse practitioner (APRN)	Encounter = 1 unit Unit = 1 session	1 per date of service	Contact the MCO to prior authorize frequency limits	Must use when providing Medical evaluation and management 99203
Medical evaluation and Management (New Patient: 30 minutes)	99203	AF AM SA	Physician/psychiatrist Physician team member svc (PA) Nurse practitioner (APRN)	Encounter = 1 unit	1 per date of service	1 per date of service This code is outside of the bundle package.	
Medical evaluation and Management (Established Patient: 15 minutes)	99213	AF AM SA	Physician/psychiatrist Physician team member svc (PA) Nurse practitioner (APRN)	Encounter = 1 unit	1 per date of service	1 per date of service This code is outside of the bundle package.	
Family Psychotherapy, 50 minutes	90846	AF AM AH SA HO	Physician/psychiatrist Physician team member (PA) Licensed Psychologist Nurse practitioner (APRN) Master's level	Encounter = 1 unit Unit = 1 session	1 per date of service 4 sessions per month	Contact the MCO to prior authorize frequency limits	
Family Psychotherapy including patient, , 50 minutes	90847	AF AM AH SA HO	Physician/psychiatrist Physician team member (PA) Licensed Psychologist Nurse practitioner (APRN) Master's level	Encounter = 1 unit Unit = 1 session	1 per date of service 4 sessions per month	Contact the MCO to prior authorize frequency limits	
Multiple Family Group Psychotherapy	90849	AF AM AH SA HO	Physician/psychiatrist Physician team member (PA) Licensed Psychologist Nurse practitioner (APRN) Master's level	Encounter = 1 unit Unit = 1 session	1 per date of service 8 sessions per month	Contact the MCO to prior authorize frequency limits	

SECTION 4 PROCEDURE CODES

DAODAS ONLY PROCEDURE CODES

SERVICE NAME	PROC CODE	MODIFIER / DESCRIPTION		UNIT FREQ	FEE FOR SERVICE FREQ. LIMITS	MCO FREQ. LIMITS	NOTES
Assessment, Psychotherapy, and Support Services							
Group Psychotherapy	90853	AF AM AH SA HO	Physician/psychiatrist Physician team member (PA) Licensed Psychologist Nurse practitioner (APRN) Master's level	Encounter = 1 unit Unit = 1 session	1 per date of service 8 sessions per month	Contact the MCO to prior authorize frequency limits	
Alcohol and Drug Counseling Individual	H0004			15 minutes = 1 unit	32 units per week	32 units per week	
Alcohol and Drug Counseling Group	H0005			Encounter = 1 unit	3 units per week	3 units per week	
Medication Management	H0034	UB AH HO HN TD TE	Pharmacist Licensed Psychologist Master's level Bachelors' level Registered nurse (RN) Licensed practical nurse (LPN)	15 minutes = 1 unit	18 units per rolling 12 months	18 units per rolling 12 months	Cannot be billed on same date of service as 90833 and 90836
Crisis Management	H2011	00 HF	Face-to face - no modifier Telephonic	15 minutes = 1 unit	16 units per day	16 units per day	Documentation must be signed off by a BA staff with CAC II or higher credential staff
Family Support	S9482	00	No modifier	15 minutes = 1 unit	32 units per week	32 units per week	Documentation must be signed off by a BA staff with CAC II or higher credential staff

SECTION 4 PROCEDURE CODES

DAODAS ONLY PROCEDURE CODES

SERVICE NAME	PROC CODE	MODIFIER / DESCRIPTION		UNIT FREQ	FEE FOR SERVICE FREQ. LIMITS	MCO FREQ. LIMITS	NOTES
Assessment, Psychotherapy, and Support Services							
Peer Support	H0038	00 HQ	Individual – no modifier Group	15 minutes = 1 unit	32 units per week	32 units per week	Documentation must be signed off by a BA staff with CAC II or higher credential staff
Psychosocial Rehabilitation Service	H2017	00 HQ	Individual – no modifier Group	15 minutes = 1 unit	32 units per week	32 units per week	Documentation must be signed off by a BA staff with CAC II or higher credential staff
Skills Training and Development Service	H2014			15 minutes = 1 unit	32 units per day	32 units per day	
Medication Administration	96372		Must be provided by Medical staff within their scope of practice	1 unit	1 per date of service Billed in conjunction with J2315	1 per day of service Billed in conjunction with J2315	
Vivitrol Injection	J2315		Must be provided by Medical staff within their scope of practice	380 units	1 per month	1 per month	

AOD Treatments					
SERVICE NAME	PROC CODE	MODIFIER	UNIT/ FREQ	FREQUENCY LIMITS	BRIEF DESCRIPTION
Alcohol and /or Drug Services – Intensive Outpatient Treatment	H0015	00	Encounter	All inclusive hourly rate	Level II.1 Intensive Outpatient Treatment Program
Alcohol and /or Drug Treatment – Day Treatment/Partial Hospitalization	H2035	00	Encounter	All inclusive hourly rate	Level II.5 Day Treatment/Partial Hospitalization
Alcohol and/or Drug Sub-Acute Detox - Clinically Managed Residential Detoxification	H0010	00	Encounter	Daily Per–diem	Level III.2–D Clinically Managed Residential Detoxification

SECTION 4 PROCEDURE CODES

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AOD Treatments					
SERVICE NAME	**PROC CODE**	**MODIFIER**	**UNIT/ FREQ**	**FREQUENCY LIMITS**	**BRIEF DESCRIPTION**
Alcohol and/or Drug Acute Detox – Medically Monitored Residential Detoxification Services	H0011	00	Encounter	Daily Per–diem	Level III.7–D Medically Monitored Residential Detoxification
Behavioral Health Long Term Residential Treatment Program - Clinically Managed High-Intensity Residential Treatment	H0019	00	Encounter	Daily Per–diem	Level III.5–R Clinically Managed High Intensity Residential Treatment
Behavioral Health Short Term Residential Treatment Program – Medically Monitored Intensive Residential Treatment	H0018	00	Encounter	Daily Per–diem	Level III.7–R Medically Monitored Intensive Residential Treatment
Behavioral Health Short Term Residential Treatment Program – Medically Monitored High-Intensity Residential Treatment Services	H0018	HA	Encounter	Daily Per–diem	Level III.7–RA Medically Monitored High–Intensity (Adolescent) Residential Treatment

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, with telephone numbers and addresses for county SCDHHS offices.

CORRESPONDENCE AND INQUIRIES

All correspondence to South Carolina 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.

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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.

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	08/2017
	Duplicate Remittance Advice Request Form	09/2017
	Claim Reconsideration Form	11/2018
CMS-1500 (02/12)	Sample Claim Form Showing TPL Denial with NPI	02/2012
	Sample Remittance Advice (four pages)	04/2014
	Fax Cover Sheet for RBHS Exception	03/2018
	Request for Rehabilitative Behavioral Health Services Limit Exception (two pages)	03/2018
	Rehabilitative Behavioral Health Services (RBHS) Referral Form (four pages)	03/2018
	Accreditation Crosswalk for Rehabilitative Behavioral Health Services	04/2017
	Accreditation for Rehabilitative Behavioral Health Services	04/2017
	Program Changes for Rehabilitative Behavioral Health Services	04/2017
	Voluntary Termination Notification for Rehabilitative Behavioral Health Services	04/2017
	Rehabilitative Behavioral Health Services (RBHS) Parent/Caregiver/Guardian Agreement to Participate in Community Support Service (two pages)	04/2017
	Rehabilitative Behavioral Health Services (RBHS) Parent/Caregiver/Guardian Agreement to Participate in Community Support Service - Spanish (two pages)	04/2017
	Community Integration Services Provider Credentialing Request (three pages)	03/2018
	Therapeutic Childcare Center Credentialing Request (three pages)	03/2018

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: _____

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

Alcohol & Drug Rehabilitation Services
Sample Claim Form Showing TPL Denial
with NPI

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, 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: A1111111

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

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): 0 00

c. RESERVED FOR NUCC USE: 22

c. OTHER ACCIDENT? YES | NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME: 401

d. INSURANCE PLAN NAME OR PROGRAM NAME: 401

10d. CLAIM CODES (Designated by NUCC): 1

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. 295 32 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		H0001			102 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 X

26. PATIENT'S ACCOUNT NO.: DOE1234

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE $ 102 00

29. AMOUNT PAID $ 0 00

30. Rsvd for NUCC Use 102 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 Provider
111 Main Street
Anytown, SC 22222-2222

a. 1234567890 b. ZZ1212121212

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Sample Remittance Advice (page 1)

This page of the sample Remittance Advice shows a paid claim, suspended claim and rejected claim.

PROVIDER ID. AB00080000

DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

PROFESSIONAL SERVICES
REMITTANCE ADVICE

PAYMENT DATE: 02/14/2014

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
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: $0.00

MEDICAID PG TOT: $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 1304711253670430A 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 $0.00 | MEDICAID PG TOT $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 O D	ORG CHECK DATE	ORIGINAL CCN
ABB222222	14052000777000000U				513.00-	197.71-	P	1112233333	CLARK M	000	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	DEBIT BALANCE PRIOR TO THIS REMITTANCE	MEDICAID TOTAL	CERTIFIED AMT	TO BE REFUNDED IN THE FUTURE
0.00	0.00	$243.71	0.00	0.00

ADJUSTMENTS	YOUR CURRENT DEBIT BALANCE	CHECK TOTAL	CHECK NUMBER
$193.71-	0.00	$50.00	4197304

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 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: 0.00

DEBIT BALANCE PRIOR TO THIS REMITTANCE: 0.00

YOUR CURRENT DEBIT BALANCE: 0.00

MEDICAID TOTAL: 0.00

ADJUSTMENTS: -4338.95

CHECK TOTAL: 0.00

CERTIFIED AMT: 0.00

CHECK NUMBER:

TO BE REFUNDED IN THE FUTURE: 0.00

PROVIDER NAME AND ADDRESS

ABC HEALTH PROVIDER
PO BOX 000000
FLORENCE SC 00000

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Henry McMaster
Governor

Joshua D. Baker
Director

FAX COVER SHEET

CONFIDENTIAL INFORMATION ENCLOSED

DATE: _____

TO: SCDHHS – Division of Behavioral Health
Attn: RBHS Exceptions
Fax #: 803-255-8204

FROM: _____
Telephone #: _____
Contact Person: _____

Total Number of Pages Transmitted: _____ (Including Cover Sheet)

COMMENTS:

Long Term Care and Behavioral Health Services
P. O. Box 8206 Columbia South Carolina 29202-8206
(803) 898-2565 Fax (803) 255-8204

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Henry McMaster GOVERNOR
Joshua D. Baker DIRECTOR
P.O. Box 8206 > Columbia, SC 29202
www.scdhhs.gov

Request for Rehabilitative Behavioral Health Services Limit Exception

Beneficiary Information	
Name:	
Address:	
Medicaid ID #:	
Date of Birth:	

Provider Information	
Provider Name:	
Provider NPI:	
Address:	
City / State / Zip Code	
Phone Number	
Fax Number	

Diagnosis - Code / Description:	/
Diagnosis - Code / Description:	/
Diagnosis - Code / Description:	/

Clinical Rationale for Request

Community Support Services (PRS, B-Mod, FS, TCC and CIS only)			
Procedure Code	**Service Name**	**# of Daily Units Currently Authorized**	**# of Daily Units Requested**

All Other Rehabilitative Behavioral Health Services			
Procedure Code	**Service Name**	**# of Units Requested**	**# of Encounters Requested**

LPHA Name: _____

Credentials: _____

Signature: _____

Date: _____

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Henry McMaster GOVERNOR
Joshua D. Baker DIRECTOR
P.O. Box 8206 > Columbia, SC 29202
www.scdhhs.gov

Rehabilitative Behavioral Health Services (RBHS) Referral Form

This form shall be completed only by state agencies and submitted to private RBHS providers in accordance with HIPAA regulations as it contains Protected Health Information (PHI) of Medicaid beneficiaries.

Referring State Agency	☐ Department of Social Services Region: ☐ Department of Mental Health CMHC: ☐ Continuum of Care Region: ☐ Department of Alcohol and Other Drug Abuse Services Commission:	☐ Department of Disabilities and Special Needs Region: ☐ Department of Juvenile Justice Region: ☐ Department of Education District:

Provider (Referred to)				**NPI**	
Address					
City		**State**		**Zip**	
Phone Number		**Fax Number**			

Beneficiary Name					
Legally Responsible Person(s)					
Address					
City		**State**		**Zip**	
Date of Birth		**Gender**	☐ Female	☐ Male	
Social Security Number (last 4 digits)		**Medicaid Number**			

Medical Necessity	
Diagnosis – Code / Description	/
Diagnosis – Code / Description	/
Diagnosis – Code / Description	/
Clinical Rationale for Rehabilitative Behavioral Health Services Recommendations	

I recommend that the above-named Medicaid beneficiary receive Rehabilitative Behavioral Health Services. This beneficiary meets the Medical Necessity criteria for services as evidenced by a mental health and/or substance use disorder from the current edition of the DSM or the ICD.

Name of LPHA: _____ Credentials: _____

Signature of LPHA: _____ Date: _____

Recommendations for Rehabilitative Behavioral Health Services							
	Service Description	Procedure Code	Unit	Total Units Authorized	Start Date	End Date	Specific Frequency (# of units per day, # of days per week)
SCREENING AND ASSESSMENT SERVICES							
☐	Behavioral Health Screening	H0002	15 minutes				
☐	Psychiatric Diagnostic Assessment without Medical Services - Initial	90791	Encounter				
☐	Psychiatric Diagnostic Assessment with Medical Services – Initial	90792	Encounter				
☐	Mental Health Comprehensive Diagnostic Assessment – Follow–up	H0031	Encounter				
☐	Psychological Testing / Evaluation	96101	60 minutes				
☐	Comprehensive Evaluation – Initial	H2000	Encounter (average of 3 hours)				
☐	Comprehensive Evaluation – Follow up	H0031	Encounter				
SERVICE PLAN DEVELOPMENT							
☐	Mental Health Service Plan Development (Non-physician)	H0032	15 minutes				
☐	Service Plan Development (Team Conference w/ Client/Family)	99366	Encounter (minimum 30 minutes)				
☐	Service Plan Development (Team Conference w/o Client/Family)	99367	Encounter (minimum 30 minutes)				
CORE TREATMENT – PSYCHOTHERAPY AND COUNSELING SERVICES							
☐	Individual Psychotherapy	90832	30 minutes				
☐	Individual Psychotherapy	90834	45 minutes				

Recommendations for Rehabilitative Behavioral Health Services							
	Service Description	Procedure Code	Unit	Total Units Authorized	Start Date	End Date	Specific Frequency (# of units per day, # of days per week)
☐	Individual Psychotherapy	90837	60+ minutes				
☐	Group Psychotherapy	90853	60+ minutes				
☐	Family Psychotherapy w/o Client	90846	60+ minutes				
☐	Family Psychotherapy w/ Client	90847	60+ minutes				
☐	Multiple Family Group Psychotherapy	90849	60+ minutes				
☐	Crisis Management	H2011	15 minutes				
☐	Medication Management	H0034	15 minutes				
COMMUNITY SUPPORT SERVICES							
☐	Psychosocial Rehabilitation Service (PRS)	H2017	15 minutes				
☐	Behavior Modification (B-Mod)	H2014	15 minutes				
☐	Family Support (FS)	S9482	15 minutes				
☐	Therapeutic Child Care	H2037	15 minutes				
☐	Community Integration Services	H2030	15 minutes				

Note: Prior authorized periods of time for Community Support Services are as follows:

- Beneficiaries ages 0 to 21: Up to 90 days
- Beneficiaries age 22 and older: Up to 180 days

State Agency Representative Authorization (optional, per internal state agency processes)

Name: _____

Phone: _____

Title: _____

Signature: _____ Date: _____

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Accreditation Crosswalk for Rehabilitative Behavioral Health Services

Commission on Accreditation of Rehabilitation Facilities (CARF)

General Program Standards: For an organization to achieve quality services, the persons served are active participants in the planning, prioritization, implementation, and ongoing evaluation of the services offered. The service planning process is individualized, establishing goals and objectives that incorporate the unique strengths, needs, abilities, and preferences of the persons served. General programs standards typically require the following (but should be verified and reviewed within Section 2 of the CARF CYS & BHS Manuals):

- Comprehensive Program Structure
- Screening and Access to Services
- Person Centered Plans
- Transition/Discharge Planning
- Medication Use
- Non-Violent Practices
- Records of Persons Served
- Quality Records Management

Behavioral Health Field Categories: For each behavioral health core program selected for accreditation from Section 3, an organization must identify which behavioral health field category the core program operates. Field categories are used to characterize the purpose, intent, and overall focus of a core program. A field category is not required for any program under the Child and Youth Services Manual.

- **Providers must choose one of the following field categories:**
  - Alcohol and Other Drugs/Addictions
  - Mental Health
  - Psychosocial Rehabilitation
  - Family Services
  - Integrated AOD/Mental Health
  - Integrated DD/Mental Health

Specific Population Designation: Child and adolescent providers must demonstrate evidence of designation

- Children and Adolescents (CA) (up to age 18)

Accepted Levels of Accreditation Decisions:

- Three-Year Accreditation
- Provisional Accreditation
- One-Year Accreditation

CARF's standards can be accessed at: http://www.carf.org/home/

CARF STANDARDS	Covered Rehabilitative Services
Assessment and Referral **(BH Manual or CYS Manual)**	Behavioral Health Screening (BHS), Diagnostic Assessment (DA), Psychological Testing and Evaluation (PTE), Service Plan Development (SPD)
Behavioral Consultation **(CYS Manual)**	BHS, Behavior Modification (B-Mod), DA, PTE
Case Management/Services Coordination **(BH Manual or CYS Manual)**	BHS, DA, PTE, SPD

Community Employment Services **(BH Manual)**	SPD, MM (Medication Management), Individual Psychotherapy (IP), Group Psychotherapy (GP)
Community Integration **(BH Manual)**	BHS, Community Integration Services (CIS), DA, PRS, PTE, SPD
Counseling/Outpatient **(CYS Manual)**	BHS, DA, Family Psychotherapy (FP), Family Support (FS), GP, IP, Multiple Family Group Psychotherapy (MFGP), Psychosocial Rehabilitation Services (PRS), PTE, SPD, Therapeutic Childcare Center (TCC)
Crisis Intervention **(BH Manual or CYS Manual)**	BHS, Crisis Management (CM), DA, PTE, SPD
Day Treatment **(BH Manual or CYS Manual)**	BHS, DA, FP, GP, MFGP, IP, PTE, SPD
Early Childhood Development **(CYS Manual)**	BHS, B-Mod, DA, PRS, PTE, SPD, TCC
Foster Family and Kinship Care **(CYS Manual)**	BHS, B-Mod, DA, FP, FS, GP, IP, MFGP, PRS, PTE, SPD
Intensive Family Based Services **(BH Manual or CYS Manual)**	BHS, B-Mod, CM, DA, FP, FS, GP, IP, MFGP, MM, PRS, PTE, SPD, TCC
Intensive Outpatient Treatment **(BH Manual or CYS Manual)**	BHS, DA, FP, FS, GP, MFGP, IP, PTE, SPD, TCC
Out-of-Home Treatment Mental Health **(BH Manual)**	BHS, B-Mod, CM, DA, FP, FS, GP, IP, MFGP, PTE, SPD
Outpatient Treatment **(BH Manual)**	BHS, DA, FP, FS, GP, IP, MFGP, PRS, PTE, SPD, TCC
Residential Treatment **(BH Manual or CYS Manual)**	BHS, B-Mod, CM, DA, FP, FS, GP, IP, MFGP PRS, PTE, SPD
Specialized or Treatment Foster Care **(BH Manual or CYS Manual)**	BHS, B-Mod, DA, FP, FS, GP, IP, MFGP MM, PTE, SPD
Supported Living **(BH Manual)**	BHS, DA, FS, MM, PRS, PTE, SPD

Council on Accreditation (COA)

Administration and Management and Service Delivery Administration Standards

All organizations are required to implement COA's Administration and Management and Service Delivery Administration Standards which include:

- Ethical Practice (ETH)
- Financial Management (FIN)
- For-Profit Administration and Financial Management (AFM)*
- Governance (GOV)
- Human Resources Management (HR)
- Network Administration (NET)**
- Performance and Quality Improvement (PQI)
- Risk Prevention and Management (RPM)
- Administrative and Service Environment (ASE)
- Behavior Support and Management (BSM)

- Client Rights (CR)
- Training and Supervision (TS)

**This standard is only applicable to for-profit entities*
***This standard is only applicable to network management entities*

Service Standards

As a result of COA's comprehensive structure of its Service Standards, Core Rehabilitative Services, Core Treatment, and Community Support Services can be contained within many different COA Service Standards as they are components of a larger program. The chart below details the varying applicable COA Service Standard sections.

Organizations currently accredited for Outpatient Mental Health Services (MH) and/or Services for Substance Use Conditions (SA) will maintain this designated accreditation until they transition to Services for Mental Health and/or Substance Use Disorders (MHSU).

Organizations currently accredited for Foster Care Services (FC) and/or Kinship Care Services (KC) will maintain this designated accreditation until they transition to Family Foster Care and Kinship Care (FKC).

Accepted Levels of Accreditation Decisions:
Accreditation or Reaccreditation Approval (effective for a period of four years)

COA's standards can be accessed at: www.coanet.org

COA STANDARDS	Covered Rehabilitative Services
Adult Day Services	Service Plan Development (SPD), Behavioral Health Screening (BHS), Diagnostic Assessment (DA), & Community Integration Services (CIS)
Child and Family Development and Support Services (CFD)	SPD, BHS, DA, Psychosocial Rehabilitation Services (PRS), Behavior Modification (B-Mod), & Family Support (FS), & Therapeutic Childcare Center (TCC)
Counseling, Support, and Education Services (CSE)	BHS, PRS, B-Mod, FS & CIS
Crisis Response and Information Services	BHS, DA, Crisis Management (CM)
Day Treatment Services (DTX)	BHS, DA, SPD, PRS, B-Mod, FS, Individual Psychotherapy (IT), Group Psychotherapy (GT), Multiple Family Group Psychotherapy (MFT), Family Psychotherapy (FT), CM, CIS, & TCC
Family Foster Care and Kinship Care (FKC)	Psychological Testing and Evaluation (PTE), DA, BHS, SPD, IT, FT, CM, PRS, B-Mod, & FS
Family Preservation and Stabilization Services (FPS)	BHS , DA, SPD, IT, FT, CM, PRS, B-Mod, FS, & TCC
Foster Care Services (FC)	BHS, DA, SPD, IT, FT, PRS, B-Mod, FS, & CM
Group Living Services (GLS)	PTE, BHS , DA, SPD, IT, GT, MFT, FT, PRS, B-Mod, & FS
Kinship Care Services (KC)	BHS, DA, SPD, IT, FT, CM, PRS, B-Mod, & FS
Medication Control and Administration	Medication Management (MM)
Outpatient Mental Health Services (MH)	PTE, BHS, DA, SPD, IT, GT, MFT, FT, CM, PRS, B-Mod, FS, CIS, & TCC
Psychiatric Rehabilitation Services (PSR)	BHS, DA, SPD, PRS, & CIS
Residential Treatment Services (RTX)	PTE, DA, BHS, SPD, IT, GT, MFT, FT, PRS, B-Mod, FS, & CM
Services for Mental Health and/or Substance Use	PTE, BHS, DA, SPD, IT, GT, MFT, FT, CM, PRS, B-Mod,

Disorders (MHSU)	FS, CIS, & TCC
Services for Substance Use Conditions (SA)	PTE, BHS, DA, SPD, IT, MFT, GT, FT, CM, PRS, B-Mod, FS, & CIS
Shelter Services (SH)	BHS, DA, SPD, PRS, B-Mod, & FS
Supervised Visitation and Exchange	SPD, BHS, DA, IT, & FT
Supported Community Living Services (SCL)	SPD, BHS, DA, PRS & CIS
Vocational Rehabilitation Services (VOC)	SPD, BHS, DA, & CIS
Youth Independent Living Services (YIL)	BHS, DA, SPD, & PRS

The Joint Commission (TJC)

Comprehensive Accreditation Manual for Behavioral Health Care: Providers are required to demonstrate compliance with all applicable standards contained in the Behavioral Health Care Manual.

The standards-based performance areas for all behavioral health care organizations are:

- Care, Treatment and Services (CTS)
- Environment of Care (EC)
- Emergency Management (EM)
- Human Resources Management (HRM)
- Infection Prevention and Control (IC)
- Information Management (IM)
- Leadership (LD)
- Life Safety (LS) (in 24 hour settings)
- Medication Management (MM)
- National Patient Safety Goals (NPSG)
- Performance Improvement (PI)
- Record of Care, Treatment and Services (RC)
- Rights and Responsibilities of the Individual (RI)
- Waived Testing (WT) (when applicable)

Accepted Levels of Accreditation Decisions:

- Accreditation

TJC's standards can be accessed at: http://www.jointcommission.org/

CORE REHABILITATIVE SERVICE STANDARDS	TJC STANDARDS
Service Plan Development	Care, Treatment, and Services
Behavioral Health Screening (BHS)	Care, Treatment, and Services
Diagnostic Assessment (DA)	Care, Treatment, and Services
Psychological Testing and Evaluation	Care, Treatment, and Services
CORE TREATMENT	**TJC STANDARDS**
Individual Psychotherapy (IT)	Outpatient Mental Health/Substance Use Services
Group Psychotherapy (GT)	Outpatient Mental Health/Substance Use Services
Multiple Family Group Psychotherapy (MFT)	Outpatient Mental Health/Substance Use Services
Family Psychotherapy (FT)	Outpatient Mental Health/Substance Use Services
Crisis Management (CM)	Outpatient Mental Health/Substance Use Services
Medication Management (MM)	Outpatient Mental Health/Substance Use Services
COMMUNITY SUPPORT SERVICES	**TJC STANDARDS**
Psychosocial Rehabilitation Services (PRS)	If provided in an office - Outpatient Mental Health/Substance Use Services

	If provided in the community and not in an office - Community Support Services
Behavior Modification (B-Mod)	If provided in an office - Outpatient Mental Health/Substance Use Services If provided in the community and not in an office - Community Support Services
Family Support (FS)	If provided in an office - Outpatient Mental Health/Substance Use Services If provided in the community and not in an office - Community Support Services
Therapeutic Childcare Services (TCC)	BHC Day Treatment, Mental Health, Child/Youth Category
Community Integration Services (CIS)	BHC Day Treatment, Mental Health, Adult and Community Integration

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Accreditation for Rehabilitative Behavioral Health Services

This form shall be completed and submitted to the Division of Behavioral Health for each office location via the following options:
Email: behavioralhealth002@scdhhs.gov or Fax: (803) 255-8204.

The applicable accreditation letter, certificate, and most recent survey report must be submitted as evidence with this form.

PROVIDER INFORMATION			
Legal Name of Organization:			
Address:			Suite:
City:	State:		Zip Code:
Phone:	Fax:		
NPI#:	Medicaid ID#:		
Primary Contact Name:	Primary Contact Title:		
Primary Contact Phone:	Primary Contact Fax:		
Primary Contact Email Address:			

Column A: List each service the provider requests to render to Medicaid beneficiaries (limit of one service per row)	Column B: List the accreditation organization / List the corresponding accreditation standard per the accreditation crosswalk for each service listed in Column A
Example: Psychosocial Rehabilitation Services	*Example: CARF / Community Integration*
	/
	/
	/
	/
	/
	/
	/
	/
	/
	/
	/

Signature of Provider Representative:	Date:

SCDHHS Use Only	
Date received:	Received by:
Actions taken:	

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Program Changes for Rehabilitative Behavioral Health Services

This form shall be completed and submitted to the Division of Behavioral Health for each office location via the following options:

Email: behavioralhealth002@scdhhs.gov or Fax: (803) 255-8204.

PROVIDER INFORMATION		
Legal Name of Organization:		
Address:		Suite:
City:	State:	Zip Code:
Phone:	Fax:	
NP #I:	Medicaid ID #:	
Primary Contact Name:	Primary Contact Title:	
Primary Contact Phone:	Primary Contact Fax:	
Primary Contact Email Address:		

PROGRAM CHANGES	
• Provide pertinent details for each applicable change, including but not limited to: name(s) of new staff, effective date of each change, conditions of status changes, expiration dates, etc. • Evidence for each applicable change must be submitted with this form • Refer to the Reporting Program Changes section of the RBHS manual for further information	
Change in Administrator (CEO/Director):	
Change in Clinical Director:	
Change in the number of RBHS staff resulting in less than two professional or paraprofessional staff available to provide services at any time :	
Adverse event(s) concerning staff licensure:	

Any change in accreditation status:	
Any change in facility license:	
Other:	
Other:	

Signature of Provider Representative:	Date:

SCDHHS Use Only	
Date received:	Received by:
Actions taken:	

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Voluntary Termination Notification for Rehabilitative Behavioral Health Services

This form shall be completed and submitted to the Division of Behavioral Health via the following options:
Encrypted Email: behavioralhealth002@scdhhs.gov or Fax: (803) 255-8204.

PROVIDER INFORMATION		
Legal Name of Organization:		
Address:		Suite:
City:	State:	Zip Code:
Phone:	Fax:	
NPI#:	Medicaid ID#:	
Primary Contact Name:	Primary Contact Title:	
Primary Contact Phone:	Primary Contact Fax:	
Primary Contact Email Address:		

Level of Change (select only one):

☐ **Voluntary Termination**

Intent to completely terminate enrollment as an RBHS provider. This change requires adequate notice to beneficiaries. Evidence of such notification shall be retained by the provider.

☐ **Voluntary Reduction in Array of Services**

Intent is to reduce the array of services offered/rendered to beneficiaries as an RBHS provider; is not a full termination of enrollment as a provider. This change requires adequate notice to beneficiaries. Evidence of such notification shall be retained by the provider.

Please answer each item below for either level:

1. Effective date of termination/reduction:
2. Rationale for voluntary termination/reduction:
3. Service(s) to be voluntarily terminated/reduced (identify each service to be terminated and population(s) of each service to be terminated):
4. Number of beneficiaries affected:
5. Plans for either (1) discharge or (2) assistance with referral and linkage to follow-up services for continuity of care for affected beneficiaries (attach supporting documentation as evidence):
6. Impact on Staff:
7. Records management and security plan:
8. Other entities notified of voluntary termination/reduction:

This letters serves to notify the Division of Behavioral Health that

has elected to voluntarily terminate participation in the South Carolina Medicaid Program. I understand that the organization must reapply for enrollment and be approved before rendering services again to beneficiaries in the future.

Signature of Provider Representative:	Date:

SCDHHS Use Only	
Date received:	Received by:
Actions taken:	

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Rehabilitative Behavioral Health Services (RBHS)
Parent/Caregiver/Guardian Agreement to Participate in Community Support Services

Name of Beneficiary: Date of Birth:
Medicaid Number:

What are Rehabilitative Behavioral Health Services (RBHS) Community Support Services? RBHS Community Support Services help the child and you develop skills to live successfully in the home and community. Services include Psychosocial Rehabilitation Services (PRS), Behavior Modification (B-Mod), Family Support (FS), and Therapeutic Child Care (TCC). These services are for youth with mental health and/or substance use disorders. Services are not for summer camps, after-school programs, recreation or mentoring services.

The child has been diagnosed with the following mental health and/or substance use disorder(s). Please list both code and description (*your provider is <u>required</u> to explain the diagnoses to you*):

Diagnosis - Code / Description	/
Diagnosis - Code / Description	/
Diagnosis - Code / Description	/
Diagnosis - Code / Description	/
Diagnosis - Code / Description	/

The provider has recommended the following services (check all that apply):

☐ <u>Psychosocial Rehabilitation Services (PRS)</u>: PRS helps the child build skills to successfully live in the home and community, succeed in school and/or work and build healthy relationships with family, friends and others.

☐ <u>Behavior Modification (B-Mod)</u>: B-Mod helps the child to reduce undesirable behaviors. You and the child will receive training in managing these behaviors. This training will help the child replace undesired behaviors with suitable ones, during and after treatment.

☐ <u>Family Support (FS)</u>: FS helps you to serve as an active member of the child's treatment team and improve your ability to care for the child's behavioral health needs. FS can connect you to groups that support youth with mental health needs. FS may also encourage you to participate in other types of groups which may be helpful to you.

☐ <u>Therapeutic Child Care (TCC)</u>: TCC helps children with severe emotional and/or behavioral problems. You and your child will work on your relationship in order to reduce the impact of traumatic experiences. TCC helps children to gain social and emotional skills needed to interact well with parents, adults, and playmates.

What will be asked of you?
You will be asked to:

- Participate in treatment planning meetings
- Participate in training sessions where you will be taught skills to help the child like modeling, redirecting, coaching, and reinforcing
- Monitor the child's behaviors and report to the treatment team
- Based on the child's needs, you may be asked to participate in other activities the treatment team recommends

What can you expect of _____ staff?
(Provider Name)

- Explain all treatments in language you will understand
- Explain all known benefits and risks of the treatment in a way you will understand

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Name of Beneficiary: Date of Birth:
Medicaid Number:

- Treat you and all your family members with respect
- Treat you as an essential member of the treatment team
- Work with you to schedule visits, and notify you in advance if the provider must cancel or reschedule
- Discuss the child's progress with you during every visit
- Answer any questions you have regarding the child's treatment
- Respond to your concerns in a timely and respectful manner
- Provide information about community resources

Because your participation is a key to success, you will be asked to confirm your willingness to participate in these services every ninety (90) days.

By signing this form:

- I, _____, agree to participate in the following recommended RBHS
  (Name of Parent/Caregiver/Guardian)
  Community Support Services:

  ☐ Psychosocial Rehabilitation Services (PRS)
  ☐ Behavior Modification (B-Mod)
  ☐ Family Support (FS)
  ☐ Therapeutic Child Care (TCC)

- I give permission for _____, to participate in the following
  (Name of Beneficiary)
  recommended RBHS Community Support Services:

  ☐ Psychosocial Rehabilitation Services (PRS)
  ☐ Behavior Modification (B-Mod)
  ☐ Family Support (FS)
  ☐ Therapeutic Child Care (TCC)

- I agree the provider has explained the mental health and/or substance use disorder diagnoses to me.

I understand that at any time I can let staff know, either verbally in or writing, that I (a) no longer wish to participate in these services and/or (b) no longer wish for the child to receive these services. I also understand that I can end these services at any time, unless participation is court-ordered.

_____ _____
Printed Name of Parent/Caregiver/Guardian Relationship to Beneficiary

_____ _____
Signature of Parent/Caregiver/Guardian Date

_____
Printed Name of Staff

_____
Name of Provider

_____ _____
Signature and Credentials of Staff Date

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Servicios de Salud Conductual y Rehabilitación (RBHS)
Acuerdo del padre/la madre/el cuidador/el tutor legal para participar en servicios de apoyo comunitario

Nombre del beneficiario: Fecha de nacimiento:
Número de Medicaid:

¿Qué son los servicios de apoyo comunitario de los Servicios de Salud Conductual y Rehabilitación (Rehabilitative Behavioral Health Services, RBHS)?
Los servicios de apoyo comunitario de RBHS ayudan al niño y a usted a desarrollar habilidades para vivir satisfactoriamente en el hogar y en la comunidad. Los servicios incluyen Servicios de Rehabilitación Psicosocial (Psychosocial Rehabilitation Services, PRS), modificación conductual (Behavior Modification, B-Mod), y apoyo familiar (Family Support, FS). Estos servicios son para los jóvenes con trastornos de salud mental o con trastornos por el uso de sustancias. Los servicios no son para servicios de guardería infantil, tutoría ni recreación.

El niño ha sido diagnosticado con los siguientes trastornos de salud mental o trastorno por el uso de sustancias. Enumere el código y la descripción (*su proveedor debe explicarle el diagnóstico*):

Diagnóstico: código/descripción	/
Diagnóstico: código/descripción	/
Diagnóstico: código/descripción	/
Diagnóstico: código/descripción	/
Diagnóstico: código/descripción	/

El proveedor ha recomendado los siguientes servicios (marque todos los que correspondan):

☐ Servicios de Rehabilitación Psicosocial (Psychosocial Rehabilitation Services, PRS): PRS ayuda al niño a desarrollar habilidades para vivir con éxito en el hogar y en la comunidad, a tener éxito en la escuela o en el trabajo, y a desarrollar relaciones saludables con la familia, los amigos y otras personas.

☐ Modificación del comportamiento (Behavior Modification, B-Mod): B-Mod ayuda al niño a reducir los comportamientos no deseados. Usted y el niño recibirán capacitación para controlar estos comportamientos. Esta capacitación ayudará al niño a reemplazar los comportamientos no deseados con comportamientos adecuados, durante y después del tratamiento.

☐ Apoyo familiar (Family Support, FS): FS le ayuda a servir como miembro activo en el equipo de tratamiento del niño y a mejorar su capacidad para atender las necesidades de salud conductual del niño. FS puede ponerle en contacto con grupos que apoyan a los jóvenes con necesidades de salud mental. FS también le recomienda que participe en otros tipos de grupos que podrían ser útiles para usted.

¿Qué se le pedirá?
Se le solicitará:
- Participar en las reuniones de planificación del tratamiento.
- Participar en las sesiones de capacitación en donde se le enseñarán habilidades para ayudar al niño, como modelado, redirección, entrenamiento y refuerzo.
- Supervisar la conducta del niño y reportarla al equipo de tratamiento.
- Con base en las necesidades del niño, es posible que se le pida participar en otras actividades que recomiende el equipo de tratamiento.

¿Qué puede esperar del _____(miembro del personal)?
(Nombre del proveedor)
- Que le explique todos los tratamientos en un lenguaje que usted entienda.
- Que le explique todos los beneficios y riesgos conocidos del tratamiento de una manera que usted entienda.

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Nombre del beneficiario: Fecha de nacimiento:
Número de Medicaid:

- Que le trate a usted y a sus familiares con respeto.
- Que le trate como miembro esencial del equipo de tratamiento.
- Que trabaje con usted para programar las visitas y que le informe por anticipado si el proveedor debe cancelar o reprogramar la cita.
- Que hable sobre el progreso del niño con usted durante cada visita.
- Que responda todas las preguntas que usted tenga respecto al tratamiento del niño.
- Que responda sus inquietudes de manera oportuna y respetuosa.
- Que le dé información sobre los recursos de la comunidad.

Debido a que su participación es clave para el éxito, se le pedirá que confirme su disposición para participar en estos servicios cada noventa (90) días.

Al firmar este formulario:

- Yo, _____, acepto participar en los siguientes servicios de apoyo
  (Nombre del padre/la madre/el cuidador/el tutor legal)
  comunitario recomendados de los RBHS.

  ☐ Servicios de rehabilitación psicosocial (Psychosocial Rehabilitation Services, PRS)
  ☐ Modificación del comportamiento (Behavior Modification, B-Mod)
  ☐ Apoyo familiar (Family Support, FS)

- Yo doy mi permiso para que _____ participe en los siguientes
  (Nombre del beneficiario)
  servicios de apoyo comunitario recomendados de los RBHS:

  ☐ Servicios de Rehabilitación Psicosocial (Psychosocial Rehabilitation Services, PRS)
  ☐ Modificación del comportamiento (Behavior Modification, B-Mod)
  ☐ Apoyo familiar (Family Support, FS)

- Acepto que el proveedor me ha explicado el diagnóstico del trastorno de salud mental o del trastorno por el uso de sustancias.

Entiendo que, en cualquier momento, puedo informar al personal, ya sea verbalmente o por escrito que (a) ya no quiero participar en estos servicios o (b) ya no quiero que el niño reciba estos servicios. También entiendo que puedo cancelar estos servicios en cualquier momento, a menos que mi participación sea por orden judicial.

_____ _____
Nombre, en letra de molde, del padre/la madre/el cuidador/el tutor legal — Relación con el beneficiario

_____ _____
Firma del padre/la madre/el cuidador/el tutor legal — Fecha

_____
Nombre del miembro del personal en letra de molde

_____
Nombre del proveedor

_____ _____
Firma y credenciales del miembro del personal — Fecha

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Henry McMaster GOVERNOR
Joshua D. Baker DIRECTOR
P.O. Box 8206 > Columbia, SC 29202
www.scdhhs.gov

Community Integration Services Provider Credentialing Request

Provider Information	
Provider Name	
Provider NPI	
Provider Medicaid ID #	
Address	
City / State / Zip Code	
Phone Number	
Fax Number	
Email Address	

Accreditation Information			
Accreditation Body	Accreditation Program/Standard	Date Accredited	Expiration Date

Program Information	
Days of Operation	Hours of Operation (list open and closing times OR "closed")
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	

Evidenced Based/Best Practice Treatment Model (s)	Staff credentialed

Description of Population Served (Ages, diagnoses, length of time in treatment)		
Age Range	Primary Diagnoses	Average length of time in treatment

Description of Program	
Description of Program Structure	
Types of Educational and Pre-vocational activities	
Cognitive and Adult role competencies	
Personal Adjustment Competencies	
Social and Interpersonal Competencies	
Community Living Competencies	

Staff Information		
Staff Name	Staff Credentials	Supervisory Responsibilities (Y/N)

Staff Information		
Staff Name	Staff Credentials	Supervisory Responsibilities (Y/N)

I attest that the aforementioned information is accurate.

Owner name (printed) _____

Signature_____

Date _____

Please attach the following supporting documentation:

1. Copies of all accreditation documentation (i.e. certificate, letter and survey)
2. Copies of credentialing documentation for all staff who will be providing the service of CIS

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

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Therapeutic Childcare Center Credentialing Request

Provider Information	
Provider Name:	
Provider NPI:	
Provider Medicaid ID #	
Address:	
City / State / Zip Code	
Phone Number	
Fax Number	
Email Address	

Licensing and Accreditation Information			
Accreditation Body	Accreditation Program/Standard	Date Accredited	Expiration Date
SCDSS License or Approval Number		Date Licensed	Expiration Date

Program Information	
Days of Operation	Hours of Operation (list open and closing times OR "closed")
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	

Evidenced Based/Best Practice Treatment Model (s)	Staff credentialed

Description of Population Served (Ages, diagnoses, length of time in treatment)		
Age Range	Primary Diagnoses	Average length of time in treatment

Description of Program

Staff Information		
Staff Name	Staff Credentials	Supervisory Responsibilities (Y/N)

I attest that the aforementioned information is accurate.

Owner name_____

Signature_____

Date: _____

Please attach the following supporting documentation:

1. Copies of all accreditation documentation (i.e. certificate, letter and survey)
2. Copies of current DSS daycare license or approval and most recent site visit survey
3. Copies of credentialing documentation for all staff who will be providing the service of TCC

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.

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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.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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.

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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)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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).

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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.

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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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Edit Code	Description	CARC	RARC	Resolution
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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Edit Code	Description	CARC	RARC	Resolution
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.

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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	

APPENDIX 2 CARRIER CODES

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

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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

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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	

APPENDIX 2 CARRIER CODES

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

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

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

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

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	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
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

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
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

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
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	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
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	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
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 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.

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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.

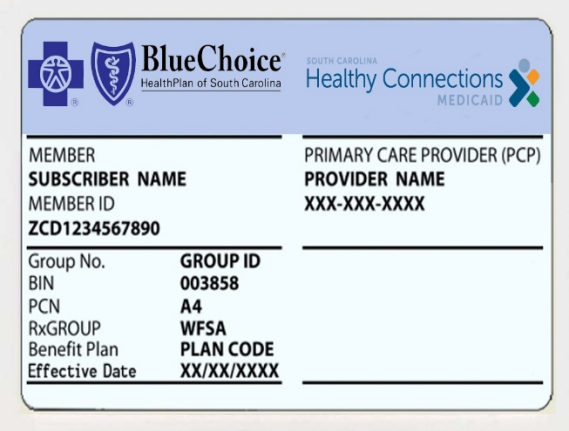
MANAGED CARE SUPPLEMENT

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



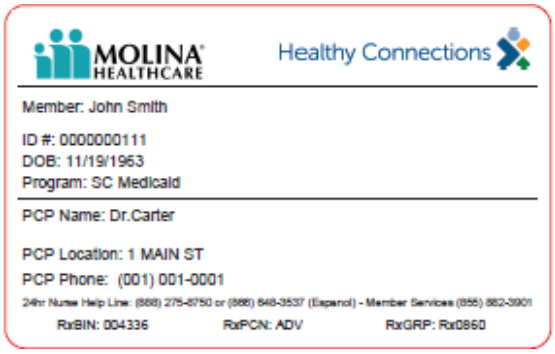
MANAGED CARE SUPPLEMENT

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.

THIRD-PARTY LIABILITY SUPPLEMENT

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.

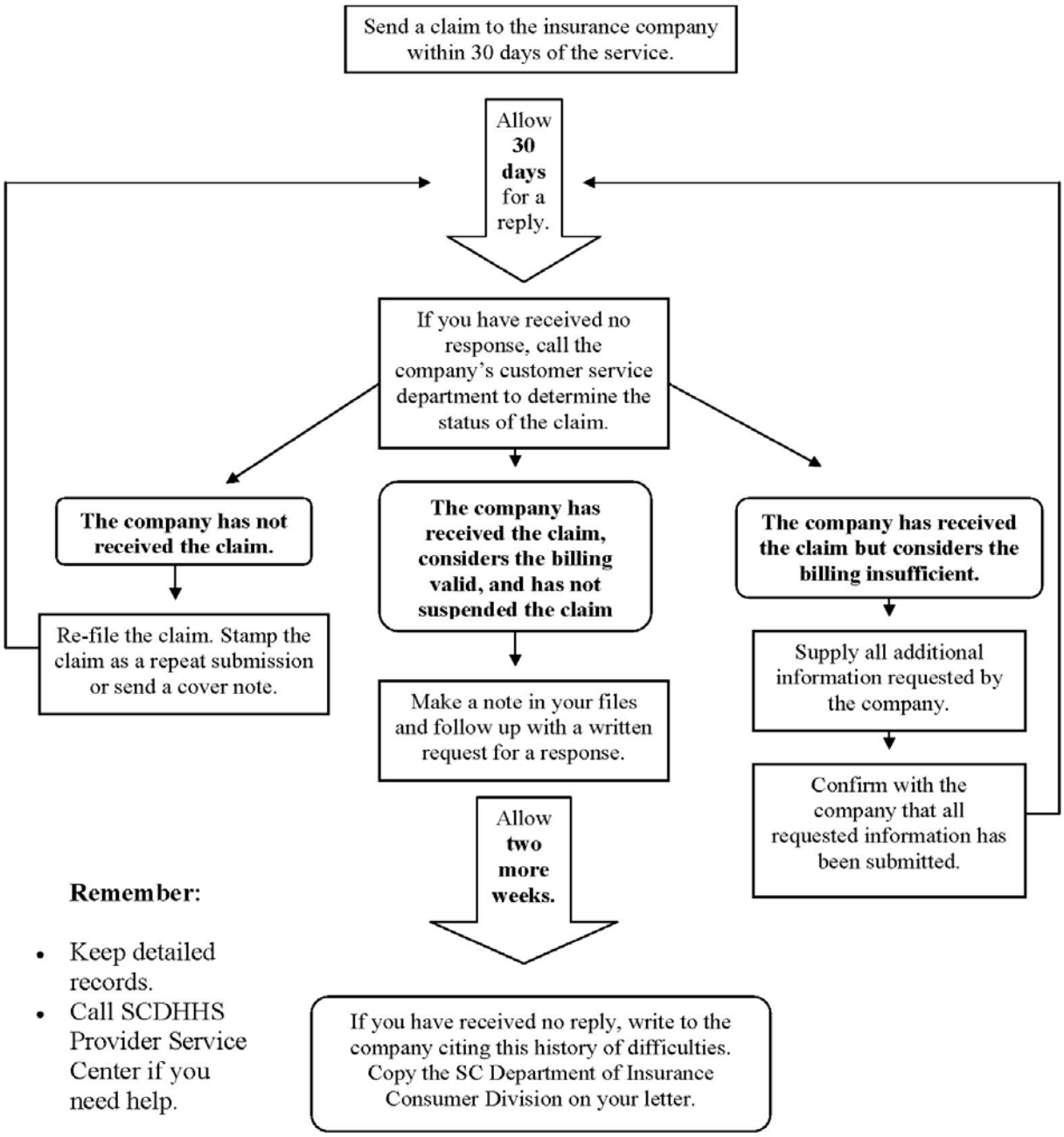
Betty Smith 06/03/10
(SIGNATURE AND DATE)

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:

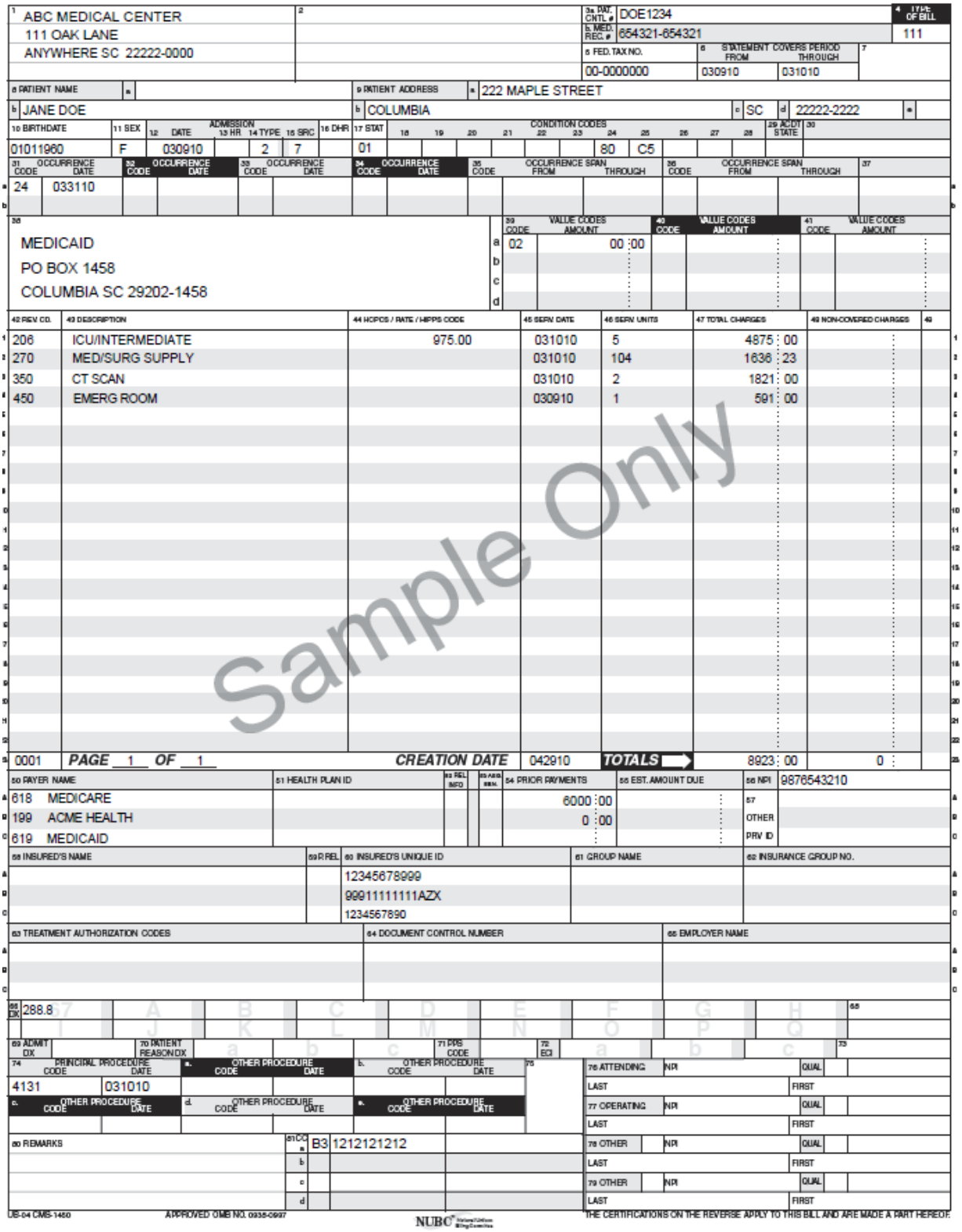
Primary insurance payment received after Medicaid payment.

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	

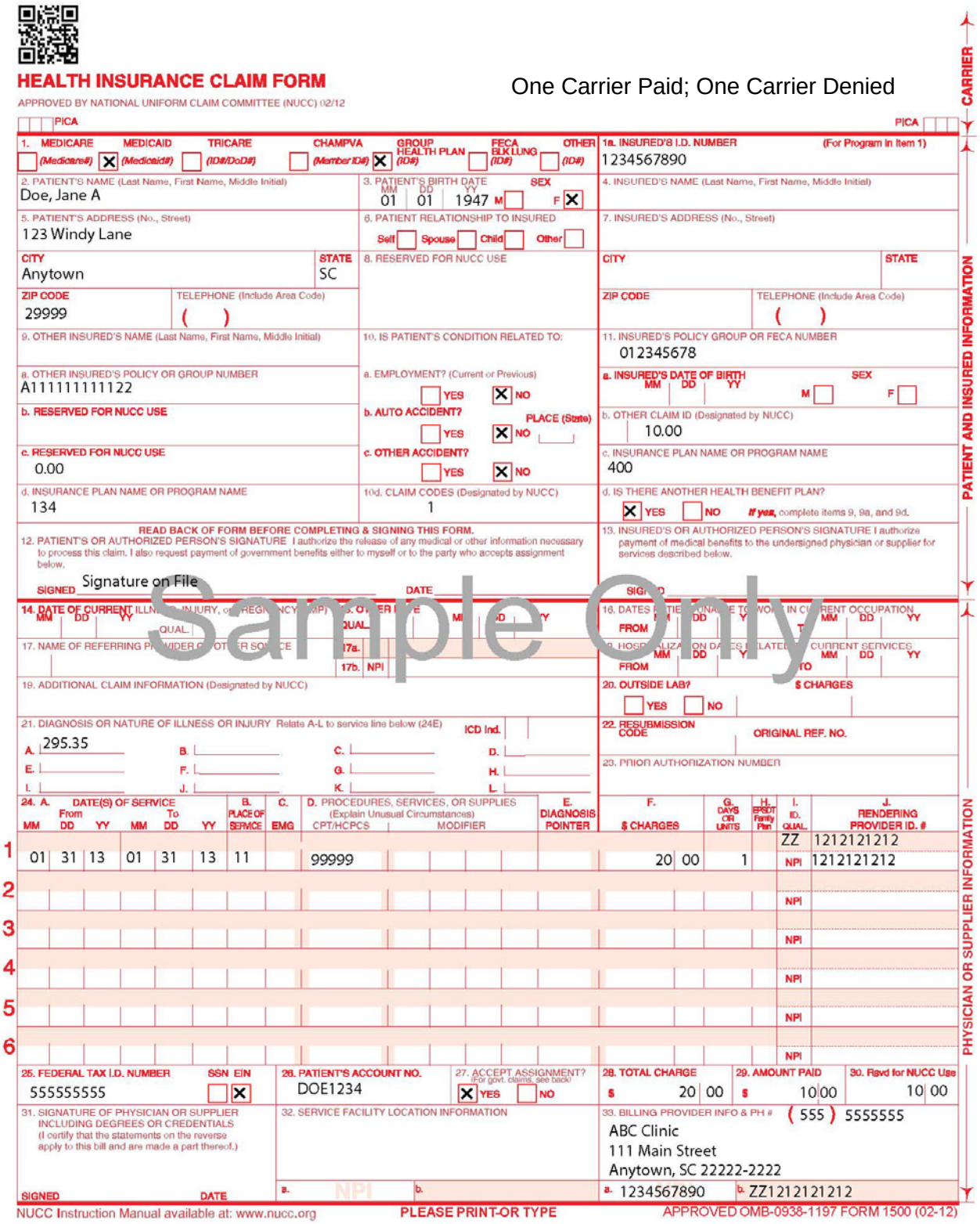
80 REMARKS

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

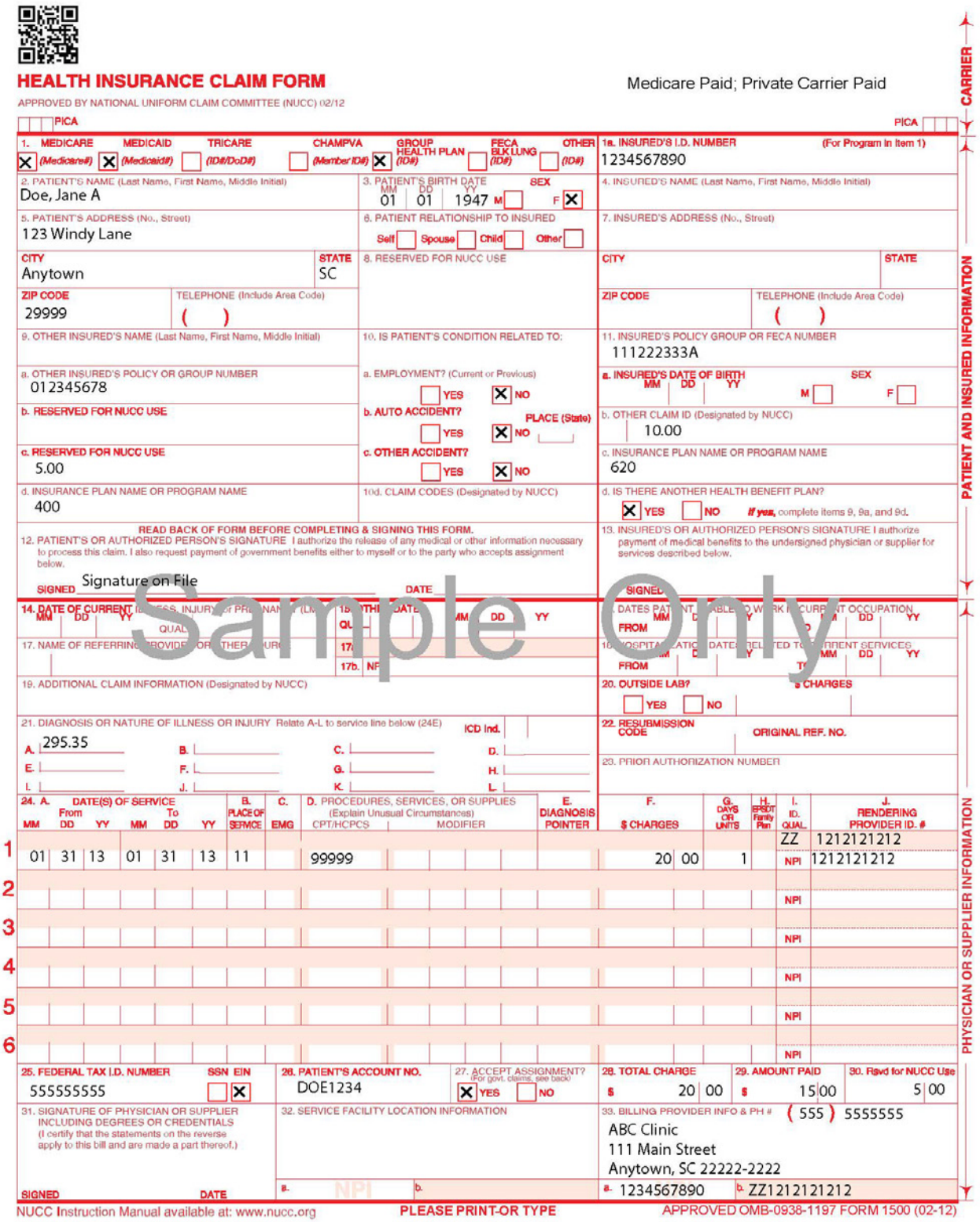
PATIENT AND INSURED INFORMATION

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.

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SIGNED

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15. OTHER DATE QUAL MM DD YY

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17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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A. 295.35 B. C. D.

E. F. G. H.

I. J. K. L.

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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.)

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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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