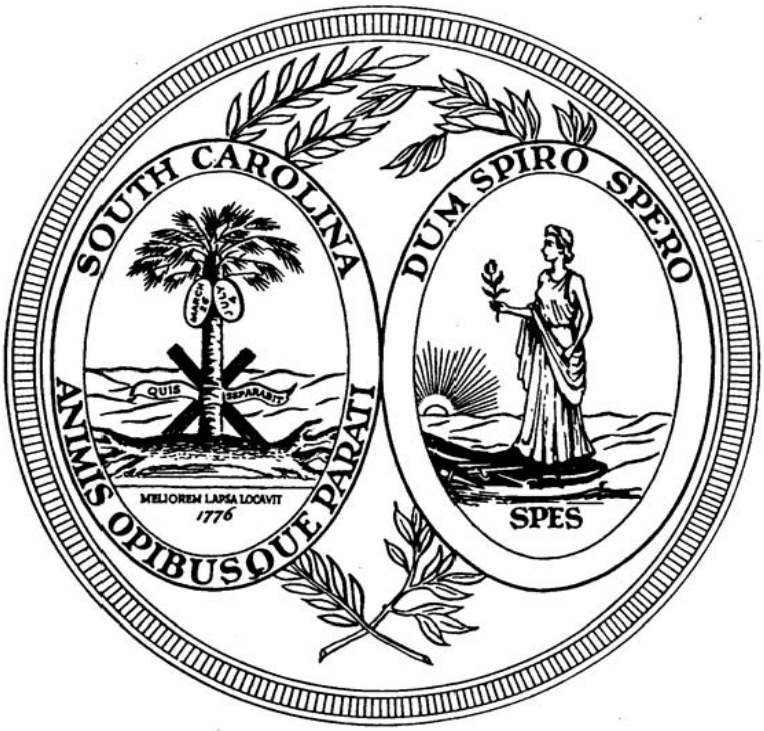
South Carolina Health & Human Services




# SOUTH CAROLINA HEALTHY CONNECTIONS (MEDICAID) PROVIDER MANUAL

## INTEGRATED PERSONAL CARE

March 1, 2005
Updated January 1, 2013

South Carolina
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
Post Office Box 8206
Columbia, South Carolina 29202-8206
**www.dhhs.state.sc.us**

March 16, 2005

***NF-CRCF 05-01***

# MEDICAID BULLETIN

**TO:** **Integrated Personal Care Providers**

**SUBJECT:** **Medicaid Policy Manual for Integrated Personal Care Providers**

The enclosed compact disc (CD) contains a copy of the revised Integrated Personal Care Medicaid Provider Manual in Portable Document Format (PDF). You will need to put the CD in the disc drive of your computer. To access the file, you will need Adobe Acrobat Reader software, which is pre-installed on most computers and also available for free download at **www.adobe.com/support.**

The manual is effective March 1, 2005 and includes all previous HIPAA changes and Medicaid policy bulletins. It is to be used for program information and requirements, billing procedures, and provider services guidelines. **Due to several substantial changes in policy, providers are urged to carefully review this revision.**

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

The revised manual is organized generally 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 Integrated Personal Care program.

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

Section 4, **Administrative Services,** contains contact information for DHHS state and county offices and examples of all forms referenced throughout the manual, as well as some generic forms.

The most current version of the provider manual is maintained on the DHHS Web site at **www.dhhs.state.sc.us.** [From the DHHS home page, scroll down and click on the link for Resource Library; next, click on the link for Manuals, and scroll down to the listings located beneath the heading Service Providers.]

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

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 Integrated Personal Care program at (803) 898-2590. Thank you for your continued support of the South Carolina Medicaid program.

Robert M. Kerr
Director

RMK/bgav

Enclosure

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

# GENERAL TABLE OF CONTENTS

# CHANGE CONTROL RECORD

| Date | Section | Page(s) | Change |
|---|---|---|---|
| 01-01-13 | 4 | 11<br>13 | • Added Chester county Zip+4 code<br>• Updated Greenville PO Box address |
| 01-01-13 | Appendix 1 | - | Added Change Log for section changes |
| 12-03-12 | 1 | 6<br>7-8<br>27-32<br>33-41 | • Updated web addresses for provider information and provider training<br>• Revised heading and language to reflect new provider enrollment requirements<br>• Updated Program Integrity language (entire section)<br>• Revised heading and language for Medicaid Anti-Fraud Provisions/Payment Suspension/Provider Exclusions/Terminations (entire section) |
| 12-03-12 | 3 | 13 | Updated Electronic Funds Transfer (EFT) |
| 13-03-12 | Forms | - | Deleted Application for Participation forms |
| 12-01-12 | 4 | 3<br>15 | • Updated web address for provider information<br>• Updated McCormick county office telephone number |
| 12-01-12 | Appendix 1 | 24, 26, 27, 32, 33<br>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<br>• 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 | 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 |

# CHANGE CONTROL RECORD

| Date | Section | Page(s) | Change |
|---|---|---|---|
| 08-01-12 | 1 | 2, 8, 9, 12, 13, 15, 25, 34 | Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012 |
| 08-01-12 | 3 | 1<br><br>13 | • Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012<br>• Updated hyperlinks |
| 08-01-12 | 4 | 1<br><br><br>5<br><br><br>7 | • Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012<br>• Removed fax request information for SCDHHS forms<br>• Added SCDHHS forms online order information<br>• Updated telephone number for Greenville county office |
| 08-01-12 | Forms | - | • Deleted forms 140 and 142<br>• Updated Duplicate Remittance Advice Request Form |
| 08-01-12 | Appendix 1 | -<br><br>1, 24, 60, 65, 66-67,70-72<br>15, 31, 69<br>8, 10, 29, 31<br>10, 11, 14, 34, 48 | • Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012<br>• 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<br>• Added edit codes 349, 590, 978, 990, 991-995<br>• Deleted edit codes 166, 205, 573, 574, 593, 596<br>• Updated resolution for edit codes 170-172, 171, 174, 210, 321, 711, 798 |
| 08-01-12 | Managed Care Supplement | 1-2<br><br>7<br><br>11<br><br>17 | • Changed Division of Care Management to Bureau of Managed Care<br>• Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012<br>• Removed language limiting enrollment to 2500 members<br>• Update contact information for Palmetto Physician Connections |

# CHANGE CONTROL RECORD

| Date | Section | Page(s) | Change |
|---|---|---|---|
| | | 19 | • Added to "Medicaid" to BlueChoice HealthPlan |
| 08-01-12 | TPL Supplement | 5, 6, 10,17, 24 | Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012 |
| 04-01-12 | 1 | 4 | Replaced South Carolina Healthy Connections card |
| 04-01-12 | 4 | 15<br>16 | • Updated address for Marion County<br>• Updated phone number for Newberry County |
| 03-01-12 | Change Control Record | 1<br>2 | • Replaced section 5 with section 4 for date 01-01-12<br>• Added entry for update to Forms section date 01-01-11 |
| 03-01-12 | 3 | 2 | Added SC Medicaid Web-Based Claims Submission Tool |
| 02-01-12 | 4 | 13 | Updated the Fairfield county office number |
| 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 | -<br>12 | • Updated hyperlinks throughout section<br>• Updated EFT information |
| 01-01-12 | 4 | 1 | Deleted IVRS Information per "Retirement of Toll Free Eligibility Verification Line" bulletin released 11-18-11 |
| 01-01-12 | Managed Care Supplement | 9 | 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 | 4 | 5 | Updated CLTC Regional Offices addresses |
| 09-01-11 | 1 | 19 | Deleted information regarding National Correct Coding Initiative |
| 09-01-11 | 4 | 6 | Updated zip code for Spartanburg County office |
| 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 |

# CHANGE CONTROL RECORD

| Date | Section | Page(s) | Change |
|---|---|---|---|
| 07-01-11 | 4 | 6 | Deleted PO Box address for the Spartanburg County Office |
| 06-01-11 | 4 | 9 | Corrected Abbeville County PO Box Zip+4 Code |
| 05-01-11 | 1 | 8, 11 | Added language prohibiting payment to institutions or entities located outside of the United States |
| 04-01-11 | 4 | 10 | Updated telephone number for Beaufort County |
| 04-01-11 | Forms | - | Updated Electronic Funds Transfer Form |
| 03-01-11 | 1 | 7, 9 | Updated to reflect Medicaid Bulletin dated February 9, 2011 – Provider Service Center |
| 03-01-11 | 3 | 11, 15 | Updated to reflect Medicaid Bulletin dated February 9, 2011 – Provider Service Center |
| 03-01-11 | 4 | 4<br><br>9 | Updated to reflect Medicaid Bulletin dated February 9, 2011 – Provider Service Center<br>Added toll free number for Aiken County |
| 02-01-11 | Cover | - | Updated cover date |
| 01-01-11 | 1 | 7<br><br>19-20 | • Updated the South Carolina Medicaid Web-based Claims Submission Tool section<br>• Updated to reflect Medicaid Bulletin dated December 8, 2010 – Information on NCCI Edits |
| 01-01-11 | 3 | 11, 15<br>11 | • Updated electronic remittance package information<br>• Updated to reflect Medicaid Bulletin dated December 10, 2010 – Requests for Duplicate Remittance Package |
| 01-01-11 | 4 | 17 | Added toll-free telephone number for Saluda county |
| 01-01-11 | Forms | - | Added Duplicate Remittance Request Form |
| 12-01-10 | Cover | - | Replaced “Medicaid Provider Manual” with “South Carolina Healthy Connections (Medicaid)” |

# CHANGE CONTROL RECORD

| Date | Section | Page(s) | Change |
|---|---|---|---|
| 12-01-10 | Supplements | - | Replaced "South Carolina Medicaid" with "South Carolina Healthy Connections (Medicaid)" in the headers |
| 10-01-10 | 1 | <br><br><br><br><br>1<br>7<br><br><br><br>10 | • Removed all reference to the SCHIP program to reflect Medicaid Bulletin dated August 19, 2010 – Changes to the Healthy Connections Kids (HCK) Program<br>• Updated Program Description section<br>• 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<br>• Updated Freedom of Choice section |
| 10-01-10 | 4 | | Correct McCormick county office street address |
| 10-01-10 | Managed Care Supplement | <br><br><br><br><br>1<br>2<br><br>3<br>4<br>5<br>6<br>13<br>17 | • Removed all references to the SCHIP program to reflect Medicaid Bulletin dated August 19, 2010 – Changes to the Healthy Connections Kids (HCK) Program<br>• Updated Managed Care Overview<br>• Updated Managed Care Organizations and Core Benefits paragraphs<br>• Updated MCO Program ID card paragraph<br>• Updated MHN Program ID card paragraph<br>• Updated Core Benefits<br>• Updated Exempt Services<br>• Updated Overview<br>• Deleted "Medicaid Managed" from "Current Medicaid Managed Care Organizations" heading and following paragraph |
| 09-01-10 | 4 | 9<br><br>12<br><br>15<br><br>CCR | • Removed County Commissioner's Building from the Aiken County address<br>• Deleted Dorchester County physical address telephone number<br>• Removed Highway 28 N from the McCormick County address<br>• For the 08/01/10 date, change section to 4 |

# CHANGE CONTROL RECORD

| Date | Section | Page(s) | Change |
|---|---|---|---|
| 08-01-10 | Change Control Record | 1 | Removed July 1 entries for Appendix 1 and Appendix 2 |
| 08-01-10 | 4 | 5, 9, 11-13<br>6 | • Updated the zip codes for Aiken, Edgefield, McCormick, Newberry, and Saluda counties<br>• Updated the address for Barnwell County<br>• Updated the telephone number for Beaufort County |
| 07-01-10 | 4 | - | Updated telephone numbers and zip codes for multiple county offices |
| 06-01-10 | Managed Care Supplement | 1<br>3<br>17<br>20, 23, 25 | • Updated Managed Care Overview section<br>• Updated Manage Care Organization (MCO), Core Benefits section<br>• Updated the Managed Care Disenrollment Process, Overview section<br>• Updated to reflect Medicaid Bulletin dated March 18, 2010 — Managed Care Organizational Change |
| 05-01-10 | 4 | 1 | • Removed reference to the sample form at the end of this section<br>• Replaced reference to the sample form in the Forms section of this manual |
| 03-01-10 | Cover | - | Replaced the manual cover |
| 03-01-10 | Change Control Record | 1 | Added Time Limit for Submitting Claims Medicaid Bulletin date to section 1 entry dated 12-01-09 |
| 02-01-10 | Appendix 1 | 13<br>36 | • Added New Edit Codes 356,357 and 358<br>• Updated Edit Code 738 |
| 02-01-10 | Appendix 2 | All | Updated Carrier Code List |
| 01-01-10 | 4 | 9<br>14<br>16 | • Updated Physical Address for Allendale County Office<br>• Replaced Jasper County DSS with Jasper County DHHS<br>• Replaced Orangeburg County DSS with Orangeburg County DHHS |

# CHANGE CONTROL RECORD

| Date | Section | Page(s) | Change |
|---|---|---|---|
| 12-01-09 | 1 | 8<br><br><br>25 | • Updated policy to reflect Medicaid Bulletin dated November 13, 2009 – Electronic Remittance Package<br>• Updated Timely Filing for Submitting Claims section to reflect Medicaid Bulletin dated November 24, 2009 |
| 12-01-09 | 3 | 11, 12, 14-15 | Updated policy to reflect Medicaid Bulletin dated November 13, 2009 – Electronic Remittance Package |
| 12-01-09 | 4 | 12 | Updated the Dorchester County office street address |
| 10-01-09 | 1 | 3-4<br><br><br>4-6<br><br><br>26 | • Updated the Medicare/Medicaid Eligibility section to include Qualified Medicare Beneficiaries (QMBs)<br>• Updated SC Medicaid Healthy Connections language throughout section<br>• Updated South Carolina Medicaid Bulletins and Newsletters<br>• Changed heading to Medicare Cost Sharing |
| 10-01-09 | 4 | 14<br>15<br><br>16 | • Updated physical address for Jasper County office<br>• Updated telephone number for Lexington County office<br>• Updated zip codes for Orangeburg County office |
| 10-01-09 | Appendix 1 | 3<br>60 | • Updated edit code 065<br>• Updated edit code 852 |
| 09-08-09 | Managed Care Supplement | 20 | Replaced the Absolute Total Care Medicaid beneficiary card sample |
| 09-01-09 | Managed Care Supplement | 21<br><br>20, 25 | • Removed all references to CHCcares to reflect Medicaid Bulletin dated August 3, 2009<br>• Updated Absolute Total Care entries as following:<br>o Changed the company's name to Absolute Total Care<br>o Replaced the beneficiary card samples<br>o Corrected contact information |
| 08-01-09 | 2 | 28 | Corrected formatting throughout section |

# CHANGE CONTROL RECORD

| Date | Section | Page(s) | Change |
|---|---|---|---|
| 08-01-09 | 4 | 18 | Updated telephone number for York County office |
| 07-01-09 | 4 | 10, 16<br><br>12<br>13 | • Updated address for Bamberg and Orangeburg County offices<br>• Updated office zip code for Darlington County<br>• Updated telephone number for Fairfield County office |
| 05-01-09 | 1 | 1-6, 11<br><br>2<br><br>3<br><br>5<br><br><br>28-33 | • Updated to reflect managed care policies and procedures effective May 1, 2009<br>• Updated the Eligibility subsection<br>• Added the beneficiary contact telephone number to the South Carolina Healthy Connections Medicaid Card subsection<br>• Removed the program start date from the SC Healthy Connections Kids SCHIP Dental Coverage subsection<br>• Updated the Medicaid Program Integrity subsection |
| 05-01-09 | 4 | 17 | Updated telephone number for Union County office |
| 05-01-09 | Managed Care Supplement | - | Updated supplement to include general policies and procedures effective May 1, 2009 |
| 04-01-09 | 1 | 2, 3, 8 | Updated hyperlinks |
| 04-01-09 | 3 | 14 | Updated hyperlinks |
| 04-01-09 | 4 | 15 | Updated telephone number for Lexington County office |
| 03-01-06 | 2 | - | Removed highlighting throughout document |
| 03-01-09 | 4 | 3<br>12<br><br>9, 15-17 | • Updated hyperlink<br>• Corrected Dorchester County's Orangeburg Road telephone number<br>• Change DSS to DHHS in addresses for Abbeville, McCormick, Newberry, and Saluda counties |
| 03-01-09 | Managed Care Supplement | 1, 7, 10, 17, 23, 25-30, 35 | Updated hyperlinks |

# CHANGE CONTROL RECORD

| Date | Section | Page(s) | Change |
|---|---|---|---|
| 02-01-09 | 4 | 9 | Updated Allendale County office PO Box zip code |
| 02-01-09 | Forms | - | Updated Authorization Agreement for Electronic Funds Transfer (EFT) form |
| 01-01-09 | 1 | 8 | Updated hyperlink for bulletin.scdhhs.gov |
| 01-01-09 | 4 | 15 | Updated Lee County office address |
| 11-01-08 | 1 | 8 | Added e-bulletin information to reflect Medicaid Bulletin dated August 26, 2008 |
| 11-01-08 | 3 | 14 | Added EFT information to reflect Medicaid Bulletin dated August 26, 2008 |
| 10-01-08 | 4 | 13, 17 | • Updated address for Lake City<br>• Updated phone number for Sumter County office |
| 09-01-08 | 4 | 10 | Updated phone number for Berkeley County office |
| 09-01-08 | 4 | 14 | Updated phone number for Kershaw County office |
| 08-01-08 | Appendix | 3 | Updated Edit Code 062 |
| 08-01-08 | 4 | 11 | Deleted the PO Box for Chester County |
| 07-01-08 | 4 | 15 | Deleted the PO Box for Lancaster County |
| 07-01-08 | Managed Care Supplement | 27 | Replaced Web site address for BlueChoice |
| 06-01-08 | 4 | 16 | Updated telephone number for Orangeburg County office |
| 04-01-08 | 4 | 12 | Updated address and phone number for Dorchester County office |
| 03-01-08 | 1 | 3-5<br><br>7 | • Replaced sample Partners for Health Medicaid card with new Healthy Connections card and updated card information.<br>• Deleted information about location of supervising entities – requirements will be included in Section 2 where applicable |

# CHANGE CONTROL RECORD

| Date | Section | Page(s) | Change |
|---|---|---|---|
| 03-01-08 | Forms | - | Replaced Form 931 with new version dated January 2008 |
| 01-01-08 | 4 | 14 | Updated address for Lancaster County office |
| 01-01-08 | Managed Care Supplement | 1<br>3 | • Removed PhyTrust from the list of MHNs<br>• Added Carolina Crescent to the list of MCOs |
| 11-01-07 | 4 | 13, 14<br><br>14 | • Updated telephone numbers for Florence and Kershaw counties<br>• Updated Horry County address to 1601 11th Ave., 1st Floor |
| 10-01-07 | 1 | 1-2<br>3<br><br>4<br><br><br>12<br>15<br><br>25 | • Removed PEP information<br>• Added information about managed care enrollment broker and Managed Care Supplement<br>• Removed managed care sample cards (cards and other information will appear in the new Managed Care Supplement).<br>• Clarified that "days" refers to business days<br>• Clarified which sections of manual may contain PA information<br>• Expanded provider list under Program Integrity |
| 10-01-07 | - | - | Added Managed Care Supplement |
| 07-01-07 | 1 | All | Revised policies and procedures throughout section |
| 07-01-07 | Forms | - | Updated DHHS Form 2506 |
| 06-01-07 | Forms | - | Updated DHHS forms to add National Provider Identifier field |
| 06-01-07 | 4 | 10-12<br><br>16<br>- | • Added toll-free number for Berkeley, Charleston, and Darlington county offices<br>• Updated phone number for Oconee County<br>• Split forms and exhibits from Section 4 to create separate Forms section |
| 04-01-07 | 4 | 12 | Updated phone number for Darlington county office |

# CHANGE CONTROL RECORD

| Date | Section | Page(s) | Change |
|---|---|---|---|
| 03-01-07 | 4 | 10 | Updated Barnwell county office address |
| 11-01-06 | 4 | - | Updated county office addresses |
| 10-01-06 | 4 | - | Updated county office addresses |
| 09-01-06 | 4 | - | Updated county office addresses |
| 01-01-06 | 4 | - | Updated Authorization Agreement for Electronic Funds Transfer |
| 01-01-06 | 1 | 4 & 5 | Removed SILVERxCARD sample and program description |
| 11-01-05 | 1 | 6, 7 | Removed “HIPAA” from names of S.C. Medicaid Provider Outreach and S.C. Medicaid EDI Support Center |
| 11-01-05 | 4 | 9-18 | Updated list of DHHS county offices |
| 10-01-05 | 4 | 9-18 | Updated list of DHHS county offices |

# SECTION 1

# GENERAL INFORMATION AND ADMINISTRATION

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**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 two Medicaid Managed Care Programs:

- Medicaid Managed Care Organization (MCO) Program
- Primary Care Case Management/Medical Homes Networks (PCCM or PCCM/MHN)

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, for certain eligibility categories. SCDHHS pays a capitated rate per member per month, according to age, gender, and category of eligibility to MCOs. Payments for core services provided to MCO members are the responsibility of MCOs, not the fee-for-service Medicaid program.

The Medical Homes Network (MHN) Program is a Primary Care Case Management (PCCM) program. An MHN is composed of a Care Coordination Services Organization (CSO) and the primary care providers (PCPs) enrolled in that network. The CSO supports the member physicians by providing care coordination, disease management, and data management. The PCPs manage the health care of their patient members either by directly

# SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

## SOUTH CAROLINA MEDICAID PROGRAM

### PROGRAM DESCRIPTION (CONT'D.)

providing medically necessary health care services or authorizing another provider to treat the beneficiary. The Network receives a per-member-per-month (PMPM) care coordination fee. Reimbursement for medical services provided is made on a fee-for-service basis.

Both MHNs and 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 filed in person or by mail. Applications may be obtained and completed at outstationed locations such as county health departments, some federally qualified health centers, most hospitals, and SCDHHS county eligibility offices. Individuals can also visit the SCDHHS Web site at http://www.scdhhs.gov to download an application for Medicaid.

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 a Point of Sale (POS) device, 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.

# SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

## SOUTH CAROLINA MEDICAID PROGRAM

### ELIGIBILITY DETERMINATION (CONT'D.)

If the beneficiary is enrolled in a MCO or MHN/PCCM, certain services will require prior approval and/or coordination through the MCO or MHN/PCCM providers. For questions regarding MCO or MHN/PCCM programs, please visit the SCDHHS Web site at http://scdhhs.gov to view the MCO or MHN Policy and Procedure Guide.

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

### ENROLLMENT COUNSELING SERVICES

SCDHHS provides enrollment counseling services to Medicaid beneficiaries through a contract with a private vendor, Maximus, Incorporated. 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.

# SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

## SOUTH CAROLINA MEDICAID PROGRAM

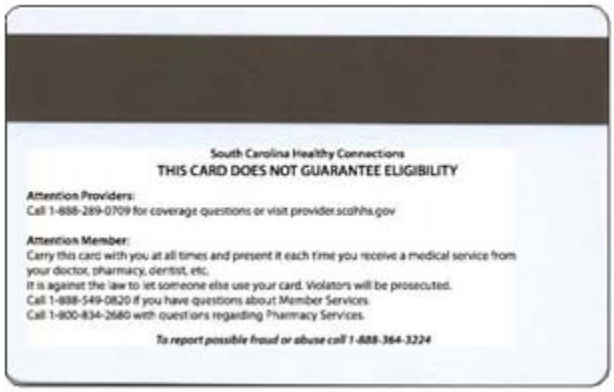
### MEDICARE / MEDICAID ELIGIBILITY (CONT'D.)

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

### 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.

The following is an example of a South Carolina Healthy Connections card:


The back of the Healthy Connections Medicaid card includes:

- A number that providers may call for prior authorization of services outside the normal practice pattern or outside a 25-mile radius of South Carolina
- A magnetic strip that may be used in POS devices to access information regarding Medicaid eligibility, third-party insurance coverage, beneficiary special programs, and service limitations 24 hours a day, seven days a week in a

# SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

## SOUTH CAROLINA MEDICAID PROGRAM

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

real time environment. There is a fee to providers for such POS services.

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

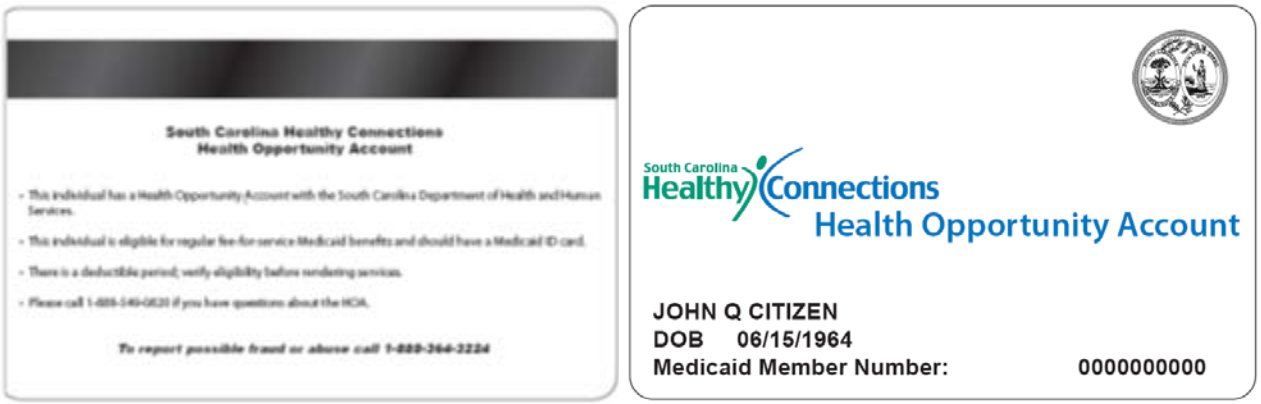
Providers are urged to report inappropriate use of a Medicaid card by a beneficiary (such as abuse, card-sharing, etc.) to the Division of Program Integrity's toll-free Fraud and Abuse Hotline at 1-888-364-3224.

Beneficiaries who choose to enroll with a Medicaid Managed Care Organization (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.

### SC HEALTHY CONNECTIONS HEALTH OPPORTUNITY ACCOUNT

The South Carolina Healthy Connections Health Opportunity Account (HOA) was implemented by SCDHHS in May 2008. It is a Medicaid option that allows beneficiaries to manage their own health care spending and set aside money to be used when they no longer need Medicaid. Routine claims filing procedures apply to HOA participants.

The following is an example of a South Carolina Healthy Connections Health Opportunity Account card:



# SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

## SOUTH CAROLINA MEDICAID PROGRAM

### SC HEALTHY CONNECTIONS HEALTH OPPORTUNITY ACCOUNT (CONT'D.)

The back of the South Carolina Healthy Connections Health Opportunity Account card includes a toll-free number for questions about enrollment, Medicaid-covered services, or eligibility.

### SOUTH CAROLINA MEDICAID WEB-BASED CLAIMS SUBMISSION TOOL

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

**Note:** Dental claims can no longer be submitted on the Web Tool. Please contact the DentaQuest Call Center at 1-888-307-6553 for billing instructions.

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 Web site 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 package, 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 e-Learning Web site at: http://MedicaideLearning.com or contact the SC Medicaid EDI Support Center via the SCDHHS Provider Service Center at 1-888-289-0709. A list of training opportunities is also located on the Web site. For Web Tool training dates, click on "Training Options."

### SOUTH CAROLINA MEDICAID BULLETINS AND NEWSLETTERS

SCDHHS Medicaid bulletins and newsletters are distributed electronically through e-mail and are available online at the SCDHHS Web site.

To ensure that you receive important SC Medicaid information, visit the Web site at http://www.scdhhs.gov/ or enroll to receive bulletins and newsletters via e-mail, go to bulletin.scdhhs.gov to subscribe.

# SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

## SOUTH CAROLINA MEDICAID PROGRAM

# 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.
- Continuously meet South Carolina licensure and/or certification requirements of their respective professions or boards in order to maintain Medicaid enrollment.
- Comply with all federal and state laws and

# SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

## SOUTH CAROLINA MEDICAID PROGRAM

### PROVIDER PARTICIPATION (CONT'D.)

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.

MCO network providers/subcontractors do not have to be Medicaid-enrolled providers. Fee-for-service reimbursement from SCDHHS may only be made to Medicaid-enrolled providers.

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 Provider Service Center 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. Mailing information is located in the Correspondence and Inquiries section.

### 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 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 Managed Care

# SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

## SOUTH CAROLINA MEDICAID PROGRAM

### Extent of Provider Participation (Cont'd.)

Organization'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 to the managed care provider or the Bureau of Managed Care at (803) 898-4614.

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

### Non-Discrimination

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

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

# SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

## SOUTH CAROLINA MEDICAID PROGRAM

### 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 managed care option, the beneficiary is required to follow that plan'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 managed care option.

*Medical Necessity*

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

# SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

## RECORDS/ DOCUMENTATION REQUIREMENTS

### GENERAL INFORMATION

As a condition of participation in the Medicaid program, providers are required to maintain and provide access to records. These records should fully disclose the medical necessity for treatment and the extent of services provided to Medicaid beneficiaries. Unless program policy otherwise allows, this documentation must be present in the beneficiaries' records before the provider files claims for reimbursement. For the purpose of reviewing and reproducing documents, providers shall grant to staff of SCDHHS, the State Auditor's Office, the South Carolina Attorney General's Office, the Government Accountability Office (GAO), and the U.S. Department of Health and Human Services (USDHHS) and/or any of their designees access to all records concerning Medicaid services and payment. These records may be reviewed during normal business hours, with or without notice.

A provider record or any part thereof will be considered illegible if at least three medical or other professional staff members who regularly perform post-payment reviews are unable to read the records or determine the extent of services provided. If this situation should occur, a written request for a translation may be made. In the event of a negative response or no response, the reimbursed amount will be subject to recoupment.

Assuming that the information is in a reasonably accessible format, the South Carolina Medicaid Program will accept records and clinical service notes in accordance with the Uniform Electronic Transactions Act (S.C. Code Ann. §26-6-10 *et seq.*). Reviewers and auditors will accept electronic documentation as long as they can access them and the integrity of the document is ensured. Furthermore, providers must comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191.

The minimum retention period for Medicaid records is five years. Exceptions include providers of hospital and nursing home services, who are required to maintain records

# SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

## RECORDS / DOCUMENTATION REQUIREMENTS

### GENERAL INFORMATION (CONT'D.)

pertaining to Medicaid beneficiaries for a period of six years. Other Medicaid provider agreements/contracts may require differing periods of time for records retention.

Providers should contact the PSC or submit an online inquiry at http://scdhhs.gov/contact-us for specific information regarding the documentation requirements for the services provided. In all cases, records must be retained until any audit, investigation, or litigation is resolved, even if the records must be maintained longer than normally required. Medicaid providers generally maintain on-site all medical and fiscal records pertaining to Medicaid beneficiaries.

Medical and fiscal records pertaining to Medicaid beneficiaries that a provider may maintain at an off-site location/storage facility are subject to the same retention policies, and the records must be made available to SCDHHS within five business days of the request. For reviews by the SCDHHS Division of Program Integrity, requested Medicaid records should be provided within two business days.

**Note: These requirements pertain to retention of records for Medicaid purposes only; other state or federal rules may require longer retention periods.**

### 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

# SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

## RECORDS / DOCUMENTATION REQUIREMENTS

### DISCLOSURE OF INFORMATION BY PROVIDER (CONT'D.)

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.

### 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

# SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

## RECORDS / DOCUMENTATION REQUIREMENTS

### SAFEGUARDING BENEFICIARY INFORMATION (CONT'D.)

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 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

# SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

## RECORDS / DOCUMENTATION REQUIREMENTS

### SPECIAL / PRIOR AUTHORIZATION (CONT'D.)

specifically subject to prior authorization and approval are as follows:

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

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

# SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

## RECORDS / DOCUMENTATION REQUIREMENTS

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# SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

## REIMBURSEMENT

### CHARGE LIMITS

Providers may not charge Medicaid any 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, determined by the program, or the provider's charges. The Medicaid program will not pay for services or items that are furnished gratuitously without regard to the beneficiary's ability to pay, or where no payment from any other source is expected, such as free x-rays or immunizations provided by health organizations.

### 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 NCCI edits and its related coding policy to control improper coding.

The CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. The purpose of the NCCI edits is 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 should not be reported together for a variety of reasons.

# SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

## REIMBURSEMENT

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

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 http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html provides overview information to providers on Medicare'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 covered by the capitation arrangement. Managed care

# SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

## REIMBURSEMENT

### MEDICAID AS PAYMENT IN FULL (CONT'D.)

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.

### PAYMENT 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, <u>only</u> if the agent's compensation is:
   a) Related to the cost of processing the billing
   b) <u>Not</u> related on a percentage or other basis to the amount that is billed or collected
   c) <u>Not</u> dependent upon the collection of the payment

   If the agent's compensation is tied to the amount billed or collected or is dependent upon the collection of the payment, Medicaid is <u>not</u> allowed

# SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

## REIMBURSEMENT

### REASSIGNMENT OF CLAIMS (CONT'D.)

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 Healthy Connections Medicaid Insurance card with a Point of Sale (POS) device or by using 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 materials for billing instructions). Under the federally mandated Cost Avoidance program, 42 CFR §433.139, claims for certain services to beneficiaries who have health

# SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

## REIMBURSEMENT

### Health Insurance

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 resulting Edit Correction Form (ECF) for the rejected claim will contain the carrier code, policy number, and name of the policyholder for each third-party carrier. SCDHHS will not reprocess the claim unless the provider returns a correctly coded ECF 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 (803) 264-6847.

# 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-pay

# SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

## REIMBURSEMENT

### Provider Responsibilities – TPL (Cont'd.)

and/or co-insurance.) 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 a POS system or 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 and related ECFs 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 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

Effective December 1, 2009, claims and related ECFs 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 or ECF within the above time frames:

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

# SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

## REIMBURSEMENT

Retroactive Eligibility (Cont'd.)

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

*Payment Information*

SCDHHS establishes reimbursement rates for each Medicaid-covered service. Specific service rates for covered services can be found in the appropriate section of this provider manual. Providers should contact the PSC or submit an online inquiry for additional information.

# SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

## REIMBURSEMENT

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# SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

## MEDICAID PROGRAM INTEGRITY

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

### PROGRAM INTEGRITY

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

- The toll-free Fraud and Abuse Hotline for complaints of provider and beneficiary abuse. The number is 1-888-364-3224.
- Complaints of provider or beneficiary abuse reported using the Fraud and Abuse email address: 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

# SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

## MEDICAID PROGRAM INTEGRITY

PROGRAM INTEGRITY (CONT'D.)

exception reports that identify excessive or aberrant billing practices.

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
- 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

Most Program Integrity on-site reviews are unannounced. The medical records and all other necessary documents obtained/received from the provider must contain documentation sufficient to disclose the extent of services delivered, medical necessity, appropriateness of treatment, and quality of care. Program Integrity staff thoroughly review all the documentation and notify the provider of the post-payment review results.

If the Program Integrity review finds that excessive, improper, or unnecessary payments have been made to a provider, the provider will be required to refund the overpayment or have it taken from subsequent Medicaid reimbursement. Failure to provide sufficient medical records within the timeframe allowed, or refusal to allow access to records, will also result in denial of the claim(s) involved, and Medicaid reimbursement for these claims must be refunded. Even if a provider terminates his or her agreement with Medicaid, the provider is still liable for any penalties or refunds identified by a Program Integrity review or audit. Failure to repay an identified overpayment may result in termination or exclusion from the Medicaid

# SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

## MEDICAID PROGRAM INTEGRITY

### PROGRAM INTEGRITY (CONT'D.)

program and other sanctions, which will be reported to the Federal Office of Inspector General (OIG).

For claims selected for a Program Integrity review, the provider cannot void, replace, or tamper with any claim records and documentation until the review is finalized.

Providers who disagree with the review findings are instructed to follow the process outlined in the certified letter of notification. The process affords providers the opportunity to discuss and/or present evidence to support their Medicaid claims.

### 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 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.
- That each Medicaid RAC also hires certified coders (unless the State determines that certified coders are

# SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

## MEDICAID PROGRAM INTEGRITY

### RECOVERY AUDIT CONTRACTOR (CONT'D.)

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.

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 four 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 identifies beneficiaries who may be misusing or overusing Medicaid services. Claims for services provided to identified persons are analyzed for patterns of possible fraudulent or abusive use of services. Referral to the State Attorney General's Office or other law enforcement agencies for investigation will be made based on the severity of the misuse. When a referral is not warranted, an educational letter may be sent to the beneficiary encouraging them to select a primary care

# SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

## MEDICAID PROGRAM INTEGRITY

### BENEFICIARY OVERSIGHT (CONT'D.)

physician and one pharmacy to ensure they receive quality care from a health care provider of their choice.

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

SCDHHS implemented a Medicaid Beneficiary Lock-In Program in December 2008. The purpose of the Beneficiary Lock-In Program is to address 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 profiles in order to identify patterns of inappropriate, excessive, or duplicative use of pharmacy services, such as using four or more pharmacies in a six-month period. If beneficiaries meet the lock-in criteria established by SCDHHS, they will be placed in the Medicaid Lock-In Program for one year to monitor their drug utilization and to require them to utilize one designated pharmacy. The beneficiary has the opportunity to select a pharmacy and has the right to appeal. The pharmacy provider selected is also notified of the lock-in, so that adequate time is allowed for selection of another provider should the first provider find he or she cannot 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 continuously 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.

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:

# SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

## MEDICAID PROGRAM INTEGRITY

### DIVISION OF AUDITS (CONT'D.)

- 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.

# SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

## MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / 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 must 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. SCDHHS refers suspected cases of Medicaid fraud by health care providers to the Medicaid Fraud Control Unit 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 SUSPENSION

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

#### 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:

# SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

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

### Suspension of Provider Payments for Credible Allegation of Fraud (Cont'd.)

- 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

#### *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 ("MFCU").

# SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

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

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

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 beneficiary's 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 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:

# SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

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

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

- 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.

### 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:

# SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

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

### PROVIDER EXCLUSIONS (CONT'D.)

- 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 US Department of Health and Human Services, Office of Inspector General (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 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 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 OIG maintains the LEIE (List of Excluded Individuals and Entities), a database accessible to the general public that

# SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

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

### PROVIDER EXCLUSIONS (CONT'D.)

provides information about parties excluded from participation in Medicare, Medicaid, and all other Federal health care programs. Visit the OIG Web site 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 Web site. 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
- Peer review
- Financial sanctions, including recoupment of overpayment or inappropriate payment
- Termination or exclusion
- Referral to licensing/certifying boards or agencies

# SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

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

### 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 United States Department of Health and Human Services (USDHHS), Office of Inspector General (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 USDHHS OIG. Appeals to the 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 federal government (USDHHS OIG). It is the provider's responsibility to satisfy these requirements. If the individual was excluded by the Office of Inspector General (HHS-OIG), then the individual must first apply to HHS-OIG for reinstatement and follow any federal requirements.

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.

# SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

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

REINSTATEMENT (CONT'D.)

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 US DHHS 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 send a letter requesting a hearing along with a copy of the notice of adverse action or the remittance advice reflecting the denial in question. Letters requesting an appeal hearing should be sent to the following address:

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

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

# SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

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

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# SECTION 2

## POLICIES AND PROCEDURES

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## POLICIES AND PROCEDURES

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# SECTION 2 POLICIES AND PROCEDURES

## PROGRAM DESCRIPTION

### OVERVIEW

The objective of the Integrated Personal Care (IPC) program is to promote and sustain the health of Medicaid beneficiaries in licensed Community Residential Care Facilities (CRCFs). This is done through the provision of IPC services. IPC services are necessary to improve the quality of life and care of beneficiaries meeting specific medical criteria. IPC services may also prevent or delay institutionalization. IPC services may only be provided to beneficiaries receiving Optional State Supplementation (OSS) services in a CRCF.

# SECTION 2 POLICIES AND PROCEDURES

## PROGRAM DESCRIPTION

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# SECTION 2 POLICIES AND PROCEDURES

## PROGRAM REQUIREMENTS

### PROVIDER QUALIFICATIONS

#### Licensing

A Community Residential Care Facility (CRCF) must meet all current state licensure standards and maintain a current license from the Department of Health and Environmental Control (DHEC) to participate in the Integrated Personal Care (IPC) service program. The CRCF shall be operating without a waiver of any current requirement not issued as a provider-wide exception to licensing regulations.

The CRCF must have corrected all Class I and Class II violations of licensing regulations to provide IPC services. CRCFs that are cited with deficiencies at DHEC inspection must submit a plan to correct the identified problem. Before an IPC contract is issued there must be evidence that the plan of correction has been implemented and the problem has been addressed.

The CRCF must also be enrolled as an Optional State Supplementation (OSS) provider in good standing with DHHS. Please see OSS manual for more detailed information.

#### Provider Responsibilities

The CRCF is responsible for meeting certain facility, staff, and documentation requirements to provide IPC services.

The CRCF will meet specific basic requirements of the Americans with Disabilities (ADA) Act, including wheelchair accessibility, to be qualified to provide IPC services.

The CRCF will implement admission policies that facilitate maintaining, at a minimum, the following bathroom accommodations for beneficiaries:

- There shall be at least one accessible and fully functioning toilet and sink on the accessible path.
- There shall be at least one accessible and fully functioning toilet and sink for every six physically impaired residents.

# SECTION 2 POLICIES AND PROCEDURES

## PROGRAM REQUIREMENTS

Provider Responsibilities (Cont'd.)

- There shall be at least one fully functioning toilet and sink for every six residents.

The CRCF will maintain compliance with all DHEC licensing requirements and correct any deficiencies identified during licensing inspections.

The CRCF will provide the supplies needed to provide personal care to the resident and to maintain his or her personal cleanliness. These include, but are not limited to:

- Soap
- Shampoo
- Toothbrush or denture brush
- Toothpaste or denture cleaner
- Diapers, briefs, or pads
- Razors
- Shaving lotion or shaving cream
- Dry skin lotions
- Towels
- Washcloths
- Brush and/or comb

The CRCF will provide a private area for use by DHHS personnel to either conduct an assessment of the resident's need for IPC services and/or to accommodate the hearing of an appeal requested by a resident who is assessed and determined not to meet the IPC level of care.

The CRCF will designate in writing an individual to serve as a facility administrator and an administrator's designee. This person will employ qualified personnel and ensure adequate staff education, in-service training, and employee evaluations. The CRCF will notify DHHS within three business days in the event of a change in the administrator, address, phone number, or an extended absence of the administrator.

The CRCF will have on staff a full-time facility administrator who meets **all** of the following requirements:

- Currently licensed by the South Carolina Board of Examiners for Long Term Health Care Administrators

# SECTION 2 POLICIES AND PROCEDURES

## PROGRAM REQUIREMENTS

Provider Responsibilities (Cont'd.)

- At least two years supervisory or management experience in a health care setting, and the ability to direct and manage staff
- At least a high school diploma or equivalent

The CRCF will designate, in writing, the organizational structure, administrative control, and line of authority for the delegation of responsibility for every level of service delivery. This should be readily accessible to all staff and shall include an organizational chart. A copy of this document shall be forwarded to DHHS staff at the time the application for participation is submitted. Any future revisions or modifications shall be distributed to all staff and to DHHS within three business days of said change. If the administrator does not have a high school diploma or equivalent, then there must be a qualified person designated to perform the daily supervision of the staff delivering care to the beneficiaries.

Administrative and supervisory functions shall not be delegated to another agency, facility, or organization.

The CRCF will acquire liability insurance to protect all paid and volunteer staff, including board members, from liability incurred while acting on behalf of the CRCF. This insurance will be maintained during the life of the IPC service contract. The CRCF will furnish a copy of the insurance policy to DHHS upon request.

The CRCF will ensure that key staff members, including the facility administrator, are available during compliance review audits conducted by DHHS and/or its agents.

The CRCF will employ or contract with a registered nurse to develop the service care plan.

The CRCF will have an adequate number of trained resident assistant(s) awake and on duty in the CRCF 24 hours a day, seven days a week to meet the beneficiaries' scheduled and unpredicted needs and to provide supervision for the safety and security of the beneficiaries.

The CRCF will ensure that all persons with access to confidential information regarding the beneficiaries are informed of agency policies and regulations with respect to safeguarding confidential information.

# SECTION 2 POLICIES AND PROCEDURES

## PROGRAM REQUIREMENTS

### Provider Responsibilities (Cont'd.)

The CRCF will maintain an accurate daily census log that accounts for all CRCF residents, regardless of their pay source. The daily census log must be faxed or mailed to the IPC program assistant by the 10th day of the following month. (The daily census log is discussed later in this section. A sample of the daily census log can be found in the Forms section.)

The CRCF will make available all resident and personnel records, including financial records regarding beneficiaries' personal needs allowance, to any DHHS staff member 24 hours a day, seven days a week.

The CRCF will ensure that timely claims are submitted according to DHHS billing procedures.

### Standards of Practice

The CRCF will participate and cooperate in pre-contractual and ongoing evaluations of standards of practice at the CRCF. Problems identified during the evaluations may delay or halt the contract process or result in termination of an existing IPC contract. This may happen whether or not the CRCF has been cited with a violation of licensing regulations for the practice.

Examples of practices and/or conditions that may result in denial of an IPC contract or termination of an existing contract include, but are not limited to, the following:

- Admitting or maintaining a resident whose needs cannot or are not being met by the accommodations and services provided
- Admitting or maintaining a resident with a need for short-term intermittent nursing care without immediately arranging for the provision of that service by a home health agency or through other arrangements allowed under Regulation 61-84
- Failing to develop and implement appropriate and effective interventions that protect residents from abuse
- Failing to provide the degree of personal care required by residents
- Recording inadequate or inaccurate information in the resident's record or on the medication administration record (MAR)

# SECTION 2 POLICIES AND PROCEDURES

## PROGRAM REQUIREMENTS

### Standards of Practice (Cont'd.)

- Admitting or maintaining residents in excess of the licensed bed capacity
- Failing to provide adequate and appropriately trained competent staff on duty in the facility at all times
- Implementing the use of a restraint or other device to restrain any resident not permitted in Regulation 61-84
- Locking any resident in or out of his or her room, common usage area(s) of the facility, or the facility itself, except as provided for in Regulation 61-84
- Failing to implement a plan of correction that resolves the problem(s) that resulted in the deficiency being cited
- Imposition of a fine by DHEC for repeat violations of Class I or Class II licensing violations

### Institution for Mental Disease (IMD) Classification Risk

The CRCF should not be at risk of classification as an Institution for Mental Disease. A CRCF that is licensed for more than 16 beds or is part of a larger entity that exceeds 16 beds shall not admit or maintain a census of more than 45% of residents whose current need for placement as determined by DHHS is due to a mental illness. Before issuing an IPC contract, DHHS will make a preliminary analysis of the case mix of the CRCF, based upon the information available, regarding the percent of residents placed due to mental illness.

The CRCF will be notified of this preliminary determination and be given an opportunity to submit any documentation that might impact the outcome of the case mix analysis.

The following criteria will be used to determine whether the resident has a mental illness and whether the mental illness is the problem causing the need for placement at the CRCF:

- Diagnosis
- Psychotropic drugs prescribed
- Presence or absence of a co-existing medical condition

# SECTION 2 POLICIES AND PROCEDURES

## PROGRAM REQUIREMENTS

### Institution for Mental Disease (IMD) Classification Risk (Cont'd.)

- Presence or absence of a co-existing functional deficit(s)/ dependence
- The DHHS nurse and program coordinator will evaluate additional documentation submitted by the CRCF in response to the preliminary case mix determination and make any appropriate adjustment to the case mix analysis. The CRCF may request a reconsideration of this determination by the DHHS medical consultant who makes the final determination.

### Request for Participation

The Application for Participation (See the Forms section) in the IPC program must be submitted to the DHHS Division of Community and Facility Services. In addition, the following must be submitted:

- Copy of the administrator's license
- Copy of the administrator's high school diploma or equivalent
- Copy of confirmation of current nursing licenses
- Confirmation of compliance with ADA
- Copies of general inspection report findings for the most recent full inspection and any subsequent complaint investigation findings
- Facility's response to the above referenced inspection reports
- W-9 (Tax form)
- Organizational chart indicating the organization, administrative control, and lines of authority for delegation of responsibility down to the hands-on service delivery staff members
- Copy of emergency plan/sheltering agreement

Forms to be attached if applicable:

- Memorandum of Agreement (MOA) with the Department of Mental Health (DMH)
- Contract with DMH to provide enhanced services
- Contract with any entity that reimburses the CRCF for services rendered to any OSS resident

# SECTION 2 POLICIES AND PROCEDURES

## PROGRAM REQUIREMENTS

### Initial On-Site Visit

After the application has been received and reviewed, a DHHS nurse will contact the CRCF administrator and schedule a site visit. The purpose of this visit is to determine whether the CRCF meets the requirements for IPC participation and to provide the CRCF staff with detailed information about the IPC program.

During this on-site visit, the DHHS nurse will:

- Explain IPC operations
- Confirm ADA compliance
- Review corrected DHEC violations from prior inspections
- Review current census and case mix analysis (*i.e.*, percentage of residents placed in the CRCF due to a mental illness)
- Observe CRCF to evaluate the capacity to provide a quality service as evidenced by:
    - Facility cleanliness
    - Maintenance of proper infection control practices
    - Adequate supervision for resident population
    - Proper grooming and hygiene of beneficiaries
    - Medications properly administered and documented
    - Individualized care plans that accurately profile the beneficiaries and their needs
    - Meaningful recreational activities appropriate for the beneficiaries
    - A safe and humane environment
    - Dignity and respect displayed toward beneficiaries
- Review program requirements that must be addressed in the CRCF's policy and procedure manual.

The CRCF staff should be prepared to:

- Conduct a tour of the CRCF

# SECTION 2 POLICIES AND PROCEDURES

## PROGRAM REQUIREMENTS

### Initial On-Site Visit (Cont'd.)

- Provide documents used at the CRCF
- Discuss CRCF operations and how the IPC program could work within the existing CRCF structure
- Provide current resident census
- Show evidence that plans of correction required due to licensing violation(s) were implemented and the problem(s) were corrected
- Provide medication administration records for review and possible demonstration of medication pass

Following the pre-contractual on-site visit, the DHHS nurse will make a determination regarding the CRCF's readiness to participate in the IPC program. The DHHS nurse will use professional judgment to assess the quality of care and services provided at the CRCF, relating those findings to the IPC program requirements for participation. This assessment will include an analysis of the site visit, a re-evaluation of the application submitted by the CRCF, and a review of agency reports, such as those provided by DHEC, Protection and Advocacy, and DHHS. The nurse will consider the ability of the CRCF to provide IPC services to eligible beneficiaries.

If the DHHS nurse has concerns about the CRCF's ability to meet all of the IPC program requirements, then a staff meeting will be conducted with another DHHS nurse and the IPC program coordinator. A follow-up visit may be necessary to obtain more information before approving the CRCF for IPC program participation.

### Participation Decision

The IPC program representative will notify the CRCF via letter specifying any changes the CRCF must make prior to entering a contract with DHHS as an IPC program provider. The CRCF administration should weigh the investment it would require in terms of the physical plant alterations and staffing enhancement (if any) against the potential for increased revenue and make a decision as to whether to pursue participation in the program.

### IPC Section of Policy and Procedure Manual

A CRCF that meets the provider requirements for participation and chooses to participate in the IPC program

# SECTION 2 POLICIES AND PROCEDURES

## PROGRAM REQUIREMENTS

IPC Section of Policy and Procedure Manual (Cont'd.)

must develop an IPC section of its policy and procedure manual and submit it to the DHHS IPC office for approval.

This section must describe how the CRCF will ensure compliance with the IPC conditions of participation and include the following (Each item below is discussed in more detail later in this section.):

1. The CRCF will obtain the consent of the resident or authorized representative prior to making a referral for IPC services and will fax or mail the consent along with the referral information to DHHS.
2. Development and/or approval of the service care plan will be accomplished by a registered nurse, nurse practitioner, or physician, either under contract or employed by the IPC service provider.
3. Prior to delivering any IPC service, the unlicensed resident assistant will be trained and determined competent to provide the IPC service(s) by a licensed nurse.
4. On-site monitoring and supervision of IPC services delivered by unlicensed resident assistants will be conducted at least weekly by a licensed nurse.
5. The CRCF will identify the position and qualifications of the individual who will provide the daily supervision of unlicensed resident assistants. When this supervision is to be provided by an individual other than a licensed nurse, that person is trained by a licensed nurse to supervise the IPC service delivery and that person has been determined by the licensed nurse to be competent to perform the daily on-site supervision and monitoring function.
6. The CRCF will maintain the necessary arrangements to have:
   - A registered nurse to be responsible for service care planning
   - A licensed nurse to be responsible for training and weekly on-site monitoring of the unlicensed resident assistant providing IPC services
   - Licensed nursing staff available for consultation with the DHHS nurse upon request

# SECTION 2 POLICIES AND PROCEDURES

## PROGRAM REQUIREMENTS

IPC Section of Policy and Procedure Manual (Cont'd.)

- Licensed nursing staff available to the unlicensed personnel for consultation upon request

7. The CRCF will make arrangements for the contracted or employed nursing staff to be available to the DHHS for consultation at the time of a resident's assessment for participation in the IPC program or to discuss any problems or concerns the DHHS nurse may have regarding an OSS resident who receives or requests IPC services.
8. The CRCF will maintain a current daily census of all residents (regardless of pay source) that includes identifiers for OSS beneficiaries, IPC beneficiaries, and specifies whether the resident was on medical or non-medical leave, admitted or discharged on that date, or was transported for emergency treatment.
9. CRCFs that are owned or operated by an entity that also owns or operates any other health care entity must include a policy statement that no IPC staff will perform any function for the IPC program while on duty at any other health care entity. Any substantial finding that such a violation has occurred will be reported to the Board of Nursing, Board of Long Term Health Care Administrators, and the Bureau of Long Term Care Certification.
10. The CRCF shall post in a prominent area of the CRCF that is easily accessible to beneficiaries and visitors:
    - The CRCF's most recent full general inspection report and the CRCF's response
    - Any subsequent complaint inspection reports and the CRCF's response

    The location of the posted inspection report(s) must be specified in the IPC section of the CRCF's policy and procedure manual and approved by the DHHS nurse.
11. The CRCF's emergency plan (sheltering agreement), as required by licensing regulations is to be included in the IPC section of the policy and procedure manual.

# SECTION 2 POLICIES AND PROCEDURES

## PROGRAM REQUIREMENTS

### IPC Section of Policy and Procedure Manual (Cont'd.)

Upon approval of the IPC section of the CRCF's policy and procedure manual, the CRCF will be issued an IPC service contract. By signing the IPC service contract, the provider agrees to comply with all federal and state laws and regulations pertaining to the Medicaid program.

### RESIDENT REQUIREMENTS

#### Eligibility

A resident must receive OSS and be determined by a DHHS nurse to need IPC level of care to receive IPC services. The resident must be found to have one functional dependency and one cognitive impairment, or two functional dependencies, to be considered IPC level of care and authorized to receive IPC services.

The CRCF must have a signed service authorization to provide IPC services before initiating the services. To complete the authorization, a DHHS nurse must approve a service care plan developed by the CRCF registered nurse for the resident.

#### *Medical Ineligibility*

When a resident has been found to be medically ineligible, the case will be "team staffed" with another DHHS nurse, with input from the IPC program coordinator as needed. The assessing DHHS nurse will verify the information that has been provided, re-contacting the CRCF staff and/or responsible party as needed.

The DHHS nurse will formally notify the resident and/or responsible party, the CRCF, and referral source via the IPC Notification form (See the Forms section).

#### *Resident Exceeds DHEC Guidelines*

When the IPC resident requires daily nursing services that exceed DHEC guidelines for determining appropriate CRCF placement, IPC services may be authorized for 30 days in order for the CRCF to find appropriate placement for the resident. Additional time may be given if the DHHS nurse deems it necessary.

#### Referrals

A referral to the IPC program may originate from a number of sources such as:

- Community Residential Care Facility (CRCF) licensed nurse
- Department of Social Services (DSS)

# SECTION 2 POLICIES AND PROCEDURES

## PROGRAM REQUIREMENTS

Referrals (Cont'd.)

- Department of Health and Environmental Control (DHEC)
- Department of Mental Health (DMH)
- Department of Health and Human Services Community Long Term Care (DHHS CLTC)
- Department of Disabilities and Special Needs (DDSN)
- Other public or private home health agencies
- Any individual, organization, or institution involved with the resident

*Intake Criteria*

Referrals received in the DHHS central office must be taken through the intake process and assigned to a DHHS nurse within five working days of receipt of the referral.

The following criteria must be met in order for a referral to be considered appropriate for intake:

- The resident who is requesting services from the IPC program must be 18 years of age or older.
- The resident must be approved for OSS by the DHHS eligibility staff and have been assigned a slot by CLTC.
- The resident must be a resident of South Carolina and currently residing in or planning to enter a licensed CRCF in one of the geographical regions of the state.
- The resident must have a mental or physical impairment that results in a functional dependency as follows:
  - Continence
  - Transferring
  - Toileting
  - Dressing
  - Bathing
  - Locomotion
  - Eating

# SECTION 2 POLICIES AND PROCEDURES

## PROGRAM REQUIREMENTS

*Intake Criteria (Cont'd.)*

A signed consent form should be submitted with the referral. If a consent form does not accompany a referral, the consent form must be faxed or mailed to the DHHS nurse prior to the scheduled assessment.

If the OSS slot assignment is not verified by Medicaid Management Information System (MMIS), the CRCF must provide a current CRCF-02 (See OSS manual) via mail or fax.

Arrangements should be made to facilitate referrals anytime between 8:30 a.m. and 5:00 p.m. Monday through Friday. If needed, the DHHS central office can reach a DHHS nurse.

Information about beneficiaries referred to the IPC program should be safeguarded in accordance with the provisions of the Health and Human Services regulations governing confidentiality (Regulation 126-70, et seq., Code of Laws of South Carolina (1976) Volume 27, as amended). More information concerning confidentiality can be found in Section 1.

*Referral Modes*

Referrals to the IPC program may be made in the following ways:

1. Telephone

   The CRCF licensed nurse or other referral source may call the DHHS central office to initiate an application. The referral information will be entered on the IPC Program Referral Form (DHHS Form 2501) (See the Forms section). The intake criteria policy will be followed by the program assistant to determine whether the referral is appropriate for intake. The program assistant will consult with a DHHS nurse when necessary.

2. Mail/Fax

   The CRCF licensed nurse or other referral source may initiate a referral by submitting the IPC Program Referral form to the DHHS central office.

If the written request does not provide adequate information for intake purposes, the program assistant will contact the referral source or the CRCF by telephone or mail. Referrals must have the necessary information to be accepted for the intake process. The CRCF will be

# SECTION 2 POLICIES AND PROCEDURES

## PROGRAM REQUIREMENTS

*Referral Modes (Cont'd.)*

responsible for ensuring that all requested information is provided to the DHHS central office.

*Follow-Up*

When a completed referral is made to the IPC program, the case will be referred to a DHHS nurse for assessment completion.

When a resident does not meet the referral intake criteria, the referral source will be notified in writing of the decision and a copy shall be sent to the resident/ responsible party. The IPC Notification Form is the form used for this notification.

# SECTION 2 POLICIES AND PROCEDURES

## PROGRAM SERVICES

### COVERED SERVICES

IPC services are provided in units. The unit of service is a total of one hour per day of documented services provided in the CRCF. IPC services must be both authorized and delivered to be eligible for reimbursement. The resident must be physically present in the CRCF and receive the appropriate IPC services in order for the CRCF to legitimately bill for the service. This is unlike the room and board payment under the OSS program, where a bed hold policy applies.

The services provided to the resident are dependent upon the individual resident's needs as set forth in the service care plan. The CRCF shall assist the resident with the following, as specified in the resident's service care plan:

- Bathing
- Dressing
- Toileting and maintaining continence
- Eating
- Transferring
- Ambulating
- Incontinence care

The CRCF will also be responsible for:

- Observing and monitoring the resident's overall condition to include temperature, pulse rate, respiratory rate, and blood pressure
- Reporting changes in the resident's condition to the appropriate supervisor
- Responding appropriately and accordingly to planned approaches in response to behavioral symptoms

### SERVICE DELIVERY

#### Overview

A referral is submitted to DHHS for a resident 18 years of age or older to be eligible for IPC services. This referral must contain specific demographic information and be

# SECTION 2 POLICIES AND PROCEDURES

## PROGRAM SERVICES

Overview (Cont'd.)

accompanied by a signed consent form. The DHHS nurse will not assess the resident for services until the consent form is signed and forwarded to DHHS.

The DHHS nurse shall complete the initial assessment, approve the initial service care plan completed by the participating CRCF, and subsequently authorize the IPC service, as appropriate. The DHHS nurse will also provide technical assistance, evaluate the CRCF's initial and ongoing compliance, and monitor the resident's service needs to ensure continued appropriateness of the service plan and placement of beneficiaries.

The initial assessment will determine the medical necessity of and eligibility for a service and must be completed prior to implementing the service.

The participating CRCF shall maintain a record for each resident who is enrolled in the IPC program. This record should include a current individual service care plan and a daily task log (DHHS Form 2507) (See Section 4). The individual service care plan should be completed by the CRCF and approved by the DHHS nurse. The daily task log should be completed daily by the aide and reviewed weekly by the licensed nurse. Instructions for completing the daily task log may be found on the reverse side of the form in the Forms section. This daily task log identifies the services that were delivered to the resident as described by the service care plan. Payment for IPC services will be recouped if the service is not delivered and documented as required.

The facility administrator and staff members responsible for implementing the service plan will meet at least quarterly with the nurse employed or contracted by the CRCF. At this meeting, they will discuss the resident's condition, appropriateness of the care plan, and any changes in the service needs of the resident. The resident, aides, family members, and any other interested parties should be included in this meeting when possible. The resident's record will reflect the date and the persons attending this monthly meeting.

The CRCF will be responsible for verifying the resident's Medicaid eligibility at the time of referral for IPC services and monthly thereafter. The CRCF nurse will contact the DHHS nurse in writing within 10 business days if any of

# SECTION 2 POLICIES AND PROCEDURES

## PROGRAM SERVICES

### Overview (Cont'd.)

the following major changes occur:

- The resident's condition has changed to the point that the resident requires more care than may be provided according to current DHEC licensing regulations.
- The service care plan no longer meets the resident's needs.

A resident will remain in the IPC program as long as he or she meets the IPC level of care and remains eligible for Medicaid.

A resident's case may be closed for the following reasons:

- The resident no longer meets IPC level of care.
- The resident loses Medicaid eligibility.
- A service interruption occurs and the resident does not receive IPC services for **two months** for whatever reason (hospitalization, vacation, etc., or refusal of IPC services).

If a resident's case is closed for any reason, and later IPC services are desired, the case must be reopened and all of the steps described earlier in this section must be repeated in the same manner as when the resident initially applied for IPC services.

The CRCF is responsible for coordinating placement when the CRCF nurse or DHHS nurse determines the resident can no longer be adequately cared for in the CRCF.

### Consent Form

The resident or responsible party must sign the Consent Form (DHHS Form 2502) (See the Forms section). The consent should be obtained prior to the referral. (See Referrals later in this section.) The purpose of the consent form is to ensure that the resident or a responsible family member gives consent for the IPC Program to exchange information with the resident's health care providers and others as needed and to ensure that the resident is involved in the planning for the care, whenever possible. It will remain in full force for one year from the date signed or until it is revoked in writing, either by the resident or responsible party. If a case is closed for any reason and later reopened, a new Consent Form must be obtained.

The consent form may be signed by a responsible party

# SECTION 2 POLICIES AND PROCEDURES

## PROGRAM SERVICES

### Consent Form (Cont'd.)

only when the resident is not competent, is physically unable to sign the form, or at the resident's request. When a determination is made that there is not an available responsible party, the CRCF's licensed nurse may sign the consent on behalf of the resident. The consent must be signed prior to the case being assigned to the DHHS nurse.

### Assessment

*Assessment Form*

It is the responsibility of the DHHS nurse to ensure the assessment is completed. The DHHS nurse will visit the resident and complete the assessment within 25 working days of the case assignment date. A level of care decision will be rendered within five working days of assessment completion.

Any exceptions to these time frames will be documented in the Case Management System (CMS).

The LTC assessment form must be completed accurately and should contain all available information. As part of the initial assessment, the DHHS nurse will interview the resident and may consult with CRCF staff, the resident's physician, or a responsible party. The medical record will also be reviewed with regard to the resident's cognitive and functional abilities. A visit to the CRCF for a face-to-face interview with the resident is required to determine level of care. Accurate observation can only be made when the DHHS nurse actually sees and speaks to the resident. The DHHS nurse must attempt to involve the resident as much as possible in the actual assessment process. The IPC program coordinator must approve any deviation from the required visit.

When a resident is physically or mentally unable to participate in an assessment, a relative, guardian, caseworker, responsible party, resident assistant, or other staff member may be interviewed for completion of the assessment. Every effort will be made to include the resident in the process.

Section II of the LTC assessment form is the medical summary. This section must be completed on all beneficiaries and reviewed by the DHHS nurse for a final level of care determination. When the DHHS nurse completes the assessment, he or she will contact, as necessary, more informed sources to obtain both functional

# SECTION 2 POLICIES AND PROCEDURES

## PROGRAM SERVICES

*Assessment Form (Cont'd.)*

and medical information: physician, physician's staff, medical record, home health agency or agency working with resident, resident's family, and/or knowledgeable others. The DHHS nurse is responsible for obtaining the most reliable and accurate information available. The DHHS nurse will not delay the level of care decision in an effort to have Section II of the assessment form information verified, unless there is doubt regarding the resident's level of care or need for the service.

*Assessment Completion for IPC Program*

The DHHS nurse must conduct the required resident assessment. The assessment must provide accurate information for the CRCF registered nurse to use in developing the service care plan. The assessment must provide information regarding the resident's functional and cognitive abilities as well as psychobehavioral status, with comments as needed to support assessment codes. In addition, other information will be entered into the resident's record such as the setting during the interview process, persons present, and the degree of the resident's involvement in the assessment process. Also, other information will be noted concerning the medical supplies and/or equipment used by the resident.

The assessment will be completed within 25 working days following case assignment. The DHHS nurse has five working days following the completion of the assessment to determine the level of care.

Level of Care Determination

When the DHHS nurse determines that adequate resident information has been obtained, the level of care (LOC) determination will be made. Level of care (LOC) determination is the process used to measure the extent of a person's cognitive and functional dependencies, in a standardized format. By applying specific measures regarding these dependencies, the resident's need for IPC services is determined.

A resident will meet IPC LOC if dependent on staff for assistance in **any two** of the following functional areas:

- Transfer
- Locomotion
- Dressing

# SECTION 2 POLICIES AND PROCEDURES

## PROGRAM SERVICES

Level of Care Determination (Cont'd.)

- Eating
- Toilet Use
- Bathing
- Incontinence care (bowel, bladder, or both)

Dependency on staff for assistance does not mean that CRCF staff must provide total care to the resident in a functional area. The resident may only need assistance in some portion of the activity. For example, a resident would meet a dressing dependency if assistance were required in putting on shoes and socks. A bathing dependency would be met if the resident needed assistance in the shower by having his or her back and lower legs bathed by the resident assistant. Hands-on assistance is not the only way a resident can have a dependency. Continuous cueing and prompting and/or giving step-by-step instructions are also ways in which a dependency would be met. For example, in transferring from a chair to a wheelchair, the resident may need guidance for correct positioning of limbs for safety. An example of an eating dependency is a resident that needs to be fed or needs continuous staff encouragement to eat. Food preparation, serving meals, and opening containers does not constitute a dependency in eating. Incontinence does not automatically result in a dependency. Some incontinent beneficiaries are self-care in that they change their own brief or pad and provide for their own personal hygiene. The incontinent resident who needs the assistance of staff in changing or in personal hygiene would be regarded as dependent in the area of incontinence.

A second way a resident can meet IPC LOC is by having **one** of the above functional dependencies along with a cognitive impairment. A cognitive impairment may result from one or a combination of the following: short- or long-term memory problem; impaired decision-making (judgment); and mood or behavior problem.

In order for a cognitive impairment to be counted as impairment, the resident must require the daily assistance of staff to provide for his or her safety and well being.

The resident with a cognitive impairment may require continuous reminders, cues, and supervision in planning and organizing daily routine. Dementia or a mental illness

# SECTION 2 POLICIES AND PROCEDURES

## PROGRAM SERVICES

**Level of Care Determination (Cont'd.)**

diagnosis does not automatically qualify the resident for a cognitive impairment.

If there are any questions regarding the appropriate level of care determination, the nurse will work with another DHHS nurse in order to make the level of care decision. A level of care decision will be made in accordance with the IPC level of care manual.

**Service Care Plan**

When the resident has been determined to meet IPC level of care and Medicaid eligibility has been verified, the assessment may be faxed or mailed to the participating CRCF within five working days of assessment completion for use by the CRCF nurse in developing the Service Care Plan (See the Forms section). The CRCF nurse will review the assessment, complete the Service Care Plan Elements Form (DHHS 2505) (See the Forms section), and fax or mail a copy of it to the DHHS nurse within 10 working days for approval and subsequent authorization of services. The CRCF may not legitimately bill for any IPC services until the DHHS nurse has authorized the services.

The service care plan is fundamental to the provision of IPC services. The CRCF registered nurse develops the service care plan and oversees the tasks completed by the resident assistants. Initially, service care planning encompasses a review of the resident's problems as identified through the DHHS assessment process.

A service care plan involves four steps:

1. Assessment
2. Planning
3. Implementation
4. Evaluation and reassessment

The successful completion of each step is critical to the ultimate goal of the program, which is to improve the quality of care and to prevent or delay institutionalization of beneficiaries.

The CRCF registered nurse is responsible for completing and implementing the service care plan.

***Purpose of the Service Care Plan***

The service care plan is a document that directs the provision of personal care services. A completed service care plan is required for each resident enrolled in the IPC

# SECTION 2 POLICIES AND PROCEDURES

## PROGRAM SERVICES

*Purpose of the Service Care Plan (Cont'd.)*

program. A service care plan must be individualized for the particular resident whose needs it is designed to meet. It must be completed in such a way that that the IPC resident assistant caring for the resident will have a clear picture of the assistance needed by the resident.

*Development of the Service Care Plan*

The service care plan will be developed by the CRCF registered nurse, utilizing information from the assessment form along with any other relevant resident information obtained from CRCF staff, the resident, and if appropriate, the party responsible for the resident. The CRCF registered nurse must sign and date the service care plan. The service care plan must be mailed or faxed to the DHHS nurse within 10 working days of the date of completion.

*Service Care Plan Elements*

The Service Care Plan Elements form contains the elements that should be incorporated in the resident's service care plan. The following elements are:

1. Date
2. Problem(s)

   A problem must be clearly defined in order to develop a plan for tasks. The problems listed on the service care plan should address those dependencies/impairments which the DHHS nurse identified on the assessment. Other problems that the resident, responsible party, and CRCF staff have identified may be addressed here as well. Each listed problem must have corresponding goals and tasks.

3. Goals/Objectives

   To evaluate the effectiveness of a service care plan, a goal must be identified for each of the problems stated. All goals, rehabilitative or maintenance, must be resident focused. A goal is developed as a joint effort between the resident, the CRCF registered nurse, and the CRCF staff.

   A goal must be:

   - Limited in time, so it is known when to expect and measure an achievement
   - Stated in positive terms, not in terms of what

# SECTION 2 POLICIES AND PROCEDURES

## PROGRAM SERVICES

*Service Care Plan Elements (Cont'd.)*

should be avoided

- Defined in terms of the expected outcome (a result or condition to be achieved)
- Written in quantifiable (measurable) terms so that all involved persons may know when the goal is reached
- Achievable, taking into consideration known resources and limitations
- Written to achieve a single end, not a conglomerate of expected outcomes

4. Target date(s)

   A target date for expected resolution of the problem should be included in the goal statement.

5. Tasks

   Tasks must be selected and documented specific to the identified problems and goals of the resident

   Tasks that may be assigned to IPC resident assistants are:

   - Resident needs for personal hygiene
   - Resident needs relating to nutrition
   - Resident needs relating to ambulation and transfer
   - Resident needs relating to taking vital signs
   - Resident needs relating to maintenance of asepsis
   - Resident needs relating to elimination
   - Addressing behavioral symptoms
   - Observing, recording, and reporting any of the above tasks

     **Note:** Observing, recording, and reporting are continuous tasks for the IPC resident assistant. The ability to recognize change in a resident's functional or cognitive condition is based on understanding of what is expected or normal for that resident. Change must be reported accurately and promptly to the CRCF nurse or

# SECTION 2 POLICIES AND PROCEDURES

## PROGRAM SERVICES

*Service Care Plan Elements (Cont'd.)*

the supervising staff member.

6. Person assigned to perform task

The required elements of the service care plan may be addressed in an independent document or incorporated into the individual care plan required in SCDHEC Regulation Number 61-84, Section 703 (II). If the service care plan is incorporated into the existing DHEC required care plan, the CRCF registered nurse's dated signature must be present to verify involvement/concurrence.

*Staff Training*

Staff training related to the service care plan must be completed prior to IPC service delivery and annually thereafter. It is the responsibility of the CRCF to ensure that resident assistants and the supervising staff are competent to perform the tasks identified in the service care plan.

The facility administrator and/or any staff person with daily supervisory responsibilities for resident assistants must also be trained. The Annual Competency Evaluation Documentation form (DHHS Form 2503) (See the Forms section) is in addition to the training requirements of DHEC.

Regulation 61-84 and must include:

- Hand washing and basic infection control procedures
- Assisting the resident with dressing, transferring, ambulation, bathing, personal grooming, toileting, and eating
- Providing incontinence care
- Providing a bed bath
- Taking and recording vital signs
- Addressing behavioral symptoms
- Observing, recording, and reporting tasks
- Identifying and reporting problems/changes

Instructions for completing the Annual Competency Evaluation Documentation form may be found on the reverse side of the form in the Forms section. The form must be dated and signed by the CRCF nurse and

# SECTION 2 POLICIES AND PROCEDURES

## PROGRAM SERVICES

*Staff Training (Cont'd.)*

maintained in the CRCF's personnel records. The IPC Personnel Competency Evaluation Form (DHHS 2504) (See the Forms section) is to be used to document training not covered by the above. The instructions for completing the IPC Personnel Competency Evaluation Form may be found on the reverse side of the form in the Forms section. It is the responsibility of the CRCF licensed nurse to conduct the training and evaluate competency. CRCF staff that have not been determined competent to perform the tasks involved may not provide IPC services. IPC services will not be reimbursed if delivered by staff members that are not trained and determined competent to perform all the tasks.

*Approval and Implementation*

The completed service care plan must be maintained in the resident's permanent record. A copy must be mailed or faxed within 10 working days of completion to the assigned DHHS nurse for approval. Approval of the plan by the assigned DHHS nurse will prompt the resident's enrollment in the IPC program. The Service Authorization recorded on the Service Provision Form (DHHS Form 175) (See the Forms section) will be faxed or mailed to the CRCF with the effective date for services indicated on the form. The Medicaid Management Information System (MMIS) will be updated to reflect the resident entering the IPC program in the Resident Special Programs system.

*Service Care Plan Revisions*

The Service Care Plan shall be reviewed and revised by the CRCF registered nurse every six months, and/or as indicated by significant changes in the resident's condition. The revisions signed and dated by the CRCF registered nurse must be maintained in the resident's record.

Service Authorization

Service authorization is the process of issuing a Service Provision Form notifying the CRCF contracted with DHHS to initiate IPC services for qualifying beneficiaries. The service authorization is based on the finalized individual service care plan for the IPC resident. Implementation of the IPC services will begin on the effective date of authorization indicated on the service provision form.

**Note:** Policy prohibits retroactive authorization/ payment.

# SECTION 2 POLICIES AND PROCEDURES

## PROGRAM SERVICES

### Duplication of Services

The CRCF must ensure that there is no duplication of services when a resident is receiving IPC services and Home Health Services are being considered or delivered.
The CRCF must notify the DHHS nurse when the resident's physician has ordered Home Health services. This should be done as soon as the CRCF discovers a referral has been made.

### Interruption of IPC Services

A change in the resident's location and/or condition may cause an interruption of IPC services. An interruption of IPC services must be reported to DHHS via the Community Residential Care Facility Form (CRCF-01) (See the Forms section).

The CRCF-01 should be attached to the turn-around document (TAD) when the claim is submitted.

Interruptions in IPC services may occur if the resident:

- Is admitted to a nursing facility
- Is admitted to medical institution or mental facility
- Is readmitted from a medical institution, mental health facility, or nursing facility
- Is transferred to another CRCF
- Is terminated/discharged
- Dies
- Is on a temporary non-medical absence

The effective date of the interruption is the first date the service was not provided regardless of when the DHHS office is notified of the interruption. The facility administrator must also document the interruption on the daily census record.

### Program Transfer

If a resident transfers from one CRCF to another participating CRCF in a different geographical area, the transfer may be accomplished by phone and the records must be transferred from one DHHS nurse to another.

### Program Termination

An IPC Service Termination Notice (DHHS 175-B) (See the Forms section) authorizes the provider to terminate IPC services.

IPC services will be officially terminated in the following

# SECTION 2 POLICIES AND PROCEDURES

## PROGRAM SERVICES

### Program Termination (Cont'd.)

situations:

- A resident no longer requires the service or the resident becomes medically or financially ineligible to receive the service.
- A CRCF has been terminated from the IPC program for any reason. Each resident's IPC services will terminate in this situation. Assistance will be provided if the resident wishes to transfer to another CRCF participating in the IPC program.
- A resident is transferred from one CRCF to another. A new authorization may be issued if the resident transfers to a participating CRCF and a new service care plan is approved.
- A resident leaves the CRCF permanently (for example, to return home or to be admitted to a nursing home for permanent placement).
- A resident's condition is such that continued CRCF placement is unlawful according to DHEC guidelines and the CRCF has not made an adequate effort to seek alternative placement.

### Appeals

A resident dissatisfied with the level of care decision by the IPC program has the right to request an appeal of the action. The CRCF must assist the resident in providing a timely request for appeal.

The resident, with the assistance of CRCF staff, when needed, must write a letter requesting an appeal within 30 days of the date of the official written notification issued by the IPC program and include a copy of the notification being appealed.

The letter should be addressed to:

Appeals and Hearing Division
S.C. Dept of Health & Human Services
Post Office Box 8206
Columbia, SC 29202-8206

Information regarding the resident's right to appeal and instructions for initiating an appeal are printed on the Notification Form (DHHS Form 171) (See the Forms section).

The appeal will be scheduled and heard at the CRCF.

# SECTION 2 POLICIES AND PROCEDURES

## PROGRAM SERVICES

### Appeals (Cont'd.)

Once an appeal has been arranged, the appeals examiner will notify the central office and they will notify the appropriate DHHS nurse of the date, time, and location of the hearing. The DHHS nurse is primarily responsible for organizing the IPC program's presentation at the hearing. The central office will provide technical assistance to staff in preparation for the hearing.

The CRCF nurse must assist the resident by testifying to the resident's condition at the hearing.

All other parties will be notified regarding the necessary steps in the appeals process by the appeals office via certified letter.

In a contested case, a subpoena may be issued for the attendance and testimony of witnesses and the production and examination of records. If a subpoena is needed, the appeals examiner must be notified 10-15 days prior to the date of the hearing. It is preferable that the witness participate in the hearing voluntarily, but if this is doubtful, the subpoena should be requested by the DHHS nurse. The DHHS nurse should alert the witness that the subpoena will be served.

There will be times when legal representation will be necessary. The DHHS central office should be notified so a request can be sent to the DHHS Office of General Counsel. The attorney must have time to review the case and make contact with the appropriate parties.

### PROGRAM MONITORING

The DHHS nurse will monitor the CRCF for continued compliance.

All criteria must be met by a CRCF and its beneficiaries prior to IPC participation, including service authorization by a DHHS nurse.

The DHHS nurse shall complete the initial assessment, approve the CRCF's initial service care plan completed by the CRCF registered nurse, and authorize the IPC services as appropriate. The DHHS nurse will terminate IPC service authorization and/or close the resident's case when necessary.

The DHHS nurse shall make, at a minimum, annual on-site visits to the CRCF to monitor the resident's service needs, ensure continued appropriateness of the service care

# SECTION 2 POLICIES AND PROCEDURES

## PROGRAM SERVICES

### PROGRAM MONITORING (CONT'D.)

plan, and conduct a re-evaluation via the assessment form.

The DHHS nurse will also provide technical assistance to the staff and ensure initial as well as ongoing compliance with requirements specified in the CRCF's contract with DHHS.

The CRCF's registered nurse and other professional staff shall be responsible for CRCF-related monitoring duties specified in the provider manual as well as the contract including, but not limited to:

1. RN Duties:
    - The involvement/concurrence of the service care plan
    - Oversight and monitoring of the service care plan
    - Evaluation of the effectiveness of the planned tasks
2. RN/LPN Duties:
    - Orienting, training, evaluating, and documenting the competency of the IPC resident assistants to perform/provide IPC services prior to the delivery of services and to provide at least annual in-service training specific to the delivery of the services specified in the service care plans for the IPC beneficiaries in the CRCF
    - Monitoring and supervision of IPC resident assistants on site weekly
    - Training of the administrator and any staff person with daily supervisory responsibilities for the IPC resident assistants
    - Attending annual IPC training meetings
3. Facility Administrator or other designated licensed staff person:
    - Daily supervision of IPC resident assistants delivering IPC services to beneficiaries
    - Notification to the DHHS nurse when/if significant changes occur with the IPC beneficiaries

The DHHS nurse may, at on-site visits, review the following required documentation:

# SECTION 2 POLICIES AND PROCEDURES

## PROGRAM SERVICES

### PROGRAM MONITORING (CONT'D.)

- Bi-annual service care plan
- Daily census log
- Task list/resident care log
- Documented training of staff
- Weekly verification by CRCF nurse of task list/resident care log

**Note:** A site visit may also include, but is not limited to, a face-to-face interview with the resident and a review of resident's record, progress notes, and Medication Administration Record (MAR).

### Daily Census Log

The purpose of the daily census log is to indicate on a daily basis the location and type of residents at the CRCF. An example of the daily census log is in the Forms section.

The following are instructions for completing the daily census log:

1. Name of Facility: Enter the name of the CRCF.
2. Medicaid Provider ID: Enter the assigned OSS Provider number.
3. Month and Year: Enter the month and year of the reporting period.
4. OSS or IPC: For a resident enrolled in the IPC program, enter an "I"; for residents only receiving OSS enter an "O". If not in IPC or OSS, leave blank.
5. W/C: For a resident that has used a wheelchair during the month, enter a w/c in the block preceding the resident's name.
6. Name of Resident: Enter the names of all residents at the CRCF during the month of the reporting period.
7. Calendar Days 1 – 31: Using the "Codes for Calendar" at the bottom of the form, use checkmarks to indicate residents at the CRCF and use the other designated abbreviations as indicated.
8. Signature and Date: The facility administrator or designee dated signature certifies the correctness of the form.

# SECTION 2 POLICIES AND PROCEDURES

## PROGRAM SERVICES

### Daily Census Log (Cont'd.)

Another daily census form or monthly roster of residents can be used in place of this form provided the substituted form can be altered to provide the information requested.

The original of this form should be maintained at the CRCF. The IPC program facility administrator will mail or fax a copy of the daily census log to the IPC program assistant on or before the 10th of the following month.

The address and fax are as follows:

IPC Program
Attention: IPC Program Assistant
S.C. Dept of Health & Human Services
Post Office Box 8206
Columbia, SC 29202-8206
FAX: (803) 255-8209

### IPC Re-evaluation

The DHHS nurse will complete periodic re-evaluations on IPC program beneficiaries. A re-evaluation visit is made annually with each IPC resident. Re-evaluations routinely will be completed during the month in which the original authorization was issued. Special circumstances, such as balancing caseload activities, re-distributing cases geographically, or changes in the resident's condition/location, which result in a re-evaluation, could interrupt the annual cycle.

When necessary, the DHHS nurse may complete re-evaluations at the CRCF in order to access the resident's record and discuss the resident's condition with CRCF staff. During this visit, the DHHS nurse may also check the individual service care plan, aide competency records, and completion of administrative requirements as called for in the CRCF's contract with DHHS.

A re-evaluation must include completion of the assessment form with a re-determination of the resident's level of care. The DHHS nurse will mail or fax the completed assessment form to the CRCF nurse for the service care plan to be updated.

### Case Termination

A resident's case may be closed for a variety of reasons. The CRCF will be informed by DHHS via the notification form and the service termination form when a case has been closed. Referral to Community Long Term Care (CLTC) for Medicaid sponsorship for nursing home

# SECTION 2 POLICIES AND PROCEDURES

## PROGRAM SERVICES

Case Termination (Cont'd.)

placement is the responsibility of the CRCF, the resident, or the responsible party for the resident.

A resident will remain in the IPC program as long as he or she meets the IPC level of care and remains Medicaid eligible. If for some reason Medicaid eligibility is lost, or the resident no longer meets the IPC level of care, then the case will be closed. When Medicaid eligibility is reinstated or the resident's condition changes, the case may be reopened by another referral to DHHS. The resident must be screened again by the DHHS nurse, and all steps, including approval of the individual service care plan and subsequent authorization for services, must be taken.

# SECTION 3
# BILLING PROCEDURES

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# SECTION 3 BILLING PROCEDURES

## GENERAL INFORMATION

### BILLING OVERVIEW

The S.C. Department of Health and Human Services (SCDHHS) strives to make billing as simple for providers as possible. This section contains a "how-to" manual on billing procedures such as how to file a claim, what to do with a rejected claim, etc. 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.

SCDHHS uses a computer-generated tally sheet referred to as a Turn Around Document (TAD) (See the Forms section) to process payment to providers of Integrated Personal Care (IPC) services. Optional State Supplementation (OSS) policies and procedures must be adhered to and followed in the billing process. A monthly TAD for OSS and Integrated Personal Care (IPC) residents is used to enhance efficiency and decrease paperwork burden on providers.

The CRCF will receive a TAD each month listing all the OSS and IPC residents in the CRCF based on the previous month. This TAD must be corrected and returned along with a Notice of Admission, Authorization & Change of Community Residential Care Facility (CRCF-01) (See the Forms section) for each change or addition made on the TAD for the month. The facility is required to confirm that all residents listed are still in the facility, add any new residents, verify the number of days that each resident was in the facility during the month, and indicate any discharges, transfers, terminations, or deaths that occurred during the month by following the administrative procedures detailed in this section.

Payment is made monthly by electronic funds transfer. The monthly Remittance Advice shows actions taken on all submitted claims.

# SECTION 3 BILLING PROCEDURES

## GENERAL INFORMATION

### SC MEDICAID WEB-BASED CLAIMS SUBMISSION TOOL

The SC Medicaid Web-based Claims Submission Tool is a free, online Web-based application. The Web Tool offers the following features:

- 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 and associated ECFs.
- Providers can change their own passwords.
- List Management allows users to develop their own list of frequently used information
- No additional software is required to use this application.
- Data is automatically archived.

The minimum requirements necessary for using the Web Tool are:

- Signed SC Medicaid Trading Partner Agreement (TPA) Enrollment Form
- Microsoft Internet Explorer (version 6.0 or greater)
- Internet Service Provider (ISP)
- Pentium series processor (recommended)
- Minimum of 32 megabytes of memory
- Minimum of 20 megabytes 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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# SECTION 3 BILLING PROCEDURES

## CLAIM FILING

### TURN AROUND DOCUMENT (TAD)

During the first 10 days of each month, the CRCF will receive its TAD from the claims processing unit for the preceding month.

The facility's authorized representative must review the TAD and make any changes that occurred during the previous month, such as a transfer, termination, death, or a change in the number of days a resident was in the facility.

For each change or addition of a resident on the TAD, there must be a matching CRCF-01. Income changes and new admissions require the signature of the eligibility caseworker on the CRCF-01.

The CRCF mails the TAD and appropriate documentation to arrive by the 17th day of each month to:

Claims Receipt – CRCF
Claims Section
Post Office Box 67
Columbia, SC 29202-0067

See the Forms section for a sample TAD. Below is an explanation of the various fields on the TAD.

### Description of Fields

**Field** **Title and Description**

**1** **CRCF Number**

The CRCF's six-digit ID number

**2** **Name and Address**

The name and mailing address of the CRCF

**3** **Line Number**

Self-explanatory

**4** **County**

Resident's county of residence by number

**5** **Recipient's Name**

Resident's first name, middle initial, and last name

**6** **Recipient's Medicaid**

Resident's 10-digit Medicaid ID number

# SECTION 3 BILLING PROCEDURES

## CLAIM FILING

Description of Fields (Cont'd.)

**Field Title and Description**

**7 Recipient's Monthly Income**

Resident's countable income for the current month

**8 Dates of Service**

The month and year for which payment is being claimed. On a new admission, this is the Authorization to Begin Payment date or the admission date, whichever is later.

**9 CRCF Days**

Total number of days the resident resided in the facility during the billing month and did not receive IPC services

**10 IPC Days**

Total number of IPC days

**11 Changed CRCF Days**

If the resident does not stay in the facility the entire month, indicate the number of days the resident was in the CRCF for the month here. Always count days on a calendar; subtracting from the number of days in a month does not work, since the day of admission is covered, but day of discharge is not.

**12 Changed IPC Days**

Total number of IPC days for the month

**13 Delete From Next Month's**

Place an X in this space if the resident should not appear on the next month's TAD (*i.e.*, death, transfer, termination).

**14 Signature, Title, Date**

The authorized representative of the CRCF must sign, document title, and record the date of signature here.

Special Notes

- If a resident is discharged and readmitted during the same month, enter all days of residency on one line. Use a separate line for each month if changes occur in two successive months.

# SECTION 3 BILLING PROCEDURES

## CLAIM FILING

### Special Notes (Cont'd.)

- All changes and additions must be supported by an attached CRCF-01. In the case of a resident newly authorized for IPC services, a copy of the service authorization form must be attached to the TAD used for the initial IPC billing.
- All CRCF-01s for transfer and new admissions must be signed and dated by county eligibility staff.
- Add new residents at the end of the TAD.
- A CRCF is not reimbursed for and may not request payment for the day of discharge, unless the resident entered and died on the same day. In this case, the CRCF may request payment for the day of discharge.
- The facility's authorized representative understands that the IPC payment is made from state and federal funds and any falsification or concealment of a material fact may be prosecuted under state and/or federal laws.
- If any of the residents listed will not be in the facility for the next month, enter an "X" in the column titled "Delete from next month's TAD."

### Temporary Absences

In the event that an IPC resident is temporarily absent from the CRCF, the CRCF must reduce the number of IPC days and claim only CRCF days for the period of absence. A CRCF-01 must be attached to the TAD for each period of absence.

For any resident absence from the CRCF, including a non-medical absence, reimbursement for IPC services will not be allowed and payment reverts to the OSS daily rate for any days away from the facility.

The facility must attach a CRCF-01 to the TAD for any absence of a resident during the reporting month. Each absence episode must be reported on a separate CRCF-01. The absence will also be recorded on the Daily Census Log and faxed/mailed to the regional DHHS nurse on or before the 10$^{th}$ of the following month.

# SECTION 3 BILLING PROCEDURES

## CLAIM FILING

### CRCF-01

The Notice of Admission, Authorization, and Change of Status for Community Residential Care Facility (DHHS CRCF-01) is used by CRCFs, DHHS Regional Office (DRO), and/or the eligibility office. The CRCF-01 authorizes DHHS for OSS reimbursement of CRCF services rendered to eligible OSS residents. A separate CRCF-01 must be prepared to initiate or change the payment for each eligible resident receiving services; that is, all changes made on a TAD must be authorized by an attached CRCF-01.

The county eligibility worker must sign and date each form for all new admissions, including those admissions resulting from a resident transfer. This also applies to those transfers between facilities located on the same property or owned by the same operator. An eligibility worker signature is not required for most termination actions. However, the county eligibility office and the DRO must be informed of all terminations, transfers, discharges, and deaths within 72 hours of the action.

Please see the OSS Manual for a sample CRCF-01.

### Description of Fields

**Section I — Identification of Provider and Patient**

Completed by the CRCF or eligibility office

| Field | Title and Action |
|---|---|
| **1** | **Resident's Name**<br>Enter the resident's first name, middle initial, and last name. |
| **2** | **Birth Date**<br>Enter two digits each for the month, day, and year. |
| **3** | **Medicaid ID Number**<br>Enter the 10-digit Medicaid ID number. |
| **4** | **Resident's Address**<br>Enter the street name and number, the city, and the state in which the resident lives. |
| **5** | **County of Residence**<br>Enter the county in which the resident resides. |

# SECTION 3 BILLING PROCEDURES

## CLAIM FILING

Description of Fields (Cont'd.)

**6 Social Security Number**

Enter the resident's social security number.

**7 CRCF's Name and Address**

Enter the name and address of the CRCF.

**8 CRCF's ID Number**

Enter the CRCF's six-digit identification number.

**9 Date of Request**

Enter the date the form was prepared.

**Section II — Admission, Income, Transfer, Termination, Change of Status**

Completed by the CRCF or county eligibility office

| Field | Title and Action |
|---|---|

**A Admitted to this CRCF on**

Enter the date the resident was admitted to the CRCF.

**B Authorization to Begin Payment**

County eligibility office enters appropriate date.

**C Resident's Countable Income**

County eligibility office enters effective date and appropriate amount of income and personal needs allowance.

**D Transferred to another CRCF**

Enter the date the resident transferred and the name and county of the CRCF to which he or she transferred.

**E Termination / Discharge**

Enter the effective date of termination. If the patient died, enter the date of death. Specify the reason for termination or other change of status if not covered by the above. Enter any changes not listed above.

# SECTION 3 BILLING PROCEDURES

## CLAIM FILING

Description of Fields (Cont'd.)

**Section III – Medical Absences**

Completed by the CRCF

| Field | Title and Action |
|---|---|
| **A** | **Admitted to nursing facility**<br>Enter the date the resident was admitted to the nursing facility and the name of the facility. |
| **B** | **Admitted to a medical institution, mental health facility or nursing facility**<br>Enter the date the resident was admitted to the medical institution or mental health facility and the name of the facility. |
| **C** | **Readmitted from a medical institution, mental health facility or nursing facility**<br>Enter the date the resident was readmitted to the CRCF from the medical institution, mental health facility, or nursing facility, and the name of the facility. |
| **D** | **Temporary Medical Absence**<br>Enter the beginning date of the temporary medical absence and the expected ending date of the medical absence. |
| **E** | **Temporary Non-Medical Absence**<br>Enter the beginning date of the temporary non-medical absence and the expected ending date of the non-medical absence. Must exceed one calendar day. |

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

### REMITTANCE PACKAGE

If the TAD is received at the CRCF Claims Section by the 17th day of each month, the TAD will be processed, an electronic payment will be deposited, and a Remittance Advice will be generated. TADs for the next month's billing will be mailed on the first Friday of the next month; receipt will depend on post office delivery.

The electronic funds transfer will be sent on this same date to the bank designated by the facility designee during enrollment.

SCDHHS only 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 Provider Service Center at 1-888-289-0709.

Providers must access their remittance packages 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 another provider. Electronic remittance packages are available on Friday for claims processed during the previous week. Remittance advices and associated ECFs for the most recent 25 weeks will be accessible.

Payment dates are subject to change. All providers will be informed of changes to the payment dates.

### Duplicate Remittance Package

Effective December 2010, SCDHHS will charge for requests of duplicate Remittance Advice(s) including ECFs. Providers must use the Remittance Advice Request Form located in the Forms Section of this provider manual. Providers will have the option of requesting the complete remittance package, the remittance pages only, or the ECF pages only. The charges associated with the request will be deducted from a future Remittance Advice and will appear as a debit adjustment.

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

### Remittance Advice

The Remittance Advice is an explanation of payments and action taken on all claim forms and adjustments processed. The information on the Remittance Advice is drawn from claims submitted for payment. After claims are processed by the system, a Remittance Advice is generated which reflects the action taken. This advice is available to the provider each month on the Web Tool.

The numbered data fields on the Remittance Advice are explained below. A sample Remittance Advice may be found in the Forms section.

### Description of Fields

| Field | Title and Description |
|---|---|
| **01** | **Date**<br>The date the Remittance Advice was produced |
| **02** | **CRCF No.**<br>The CRCF's six-digit identification number |
| **03** | **Check Date**<br>The actual date of the electronic deposit |
| **04** | **Check Number**<br>The number of the electronic deposit |
| **05** | **Check Amount**<br>Total amount paid |
| **06** | **Bank Name**<br>Bank to which the EFT was sent |
| **07** | **Bank Number**<br>Number of bank to which the EFT was sent |
| **08** | **Account Number**<br>Provider's bank account number to which the EFT was sent |
| **09** | **Recipient Name**<br>Name of the OSS resident |
| **10** | **Recipient ID Number**<br>Recipient's 10-digit Medicaid ID Number |

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

### Description of Fields (Cont'd.)

**Field** **Title and Description**

**11** **Date of Service**

The first date of service during the month of residence under OSS

**12** **OSS/IPC Days**

The number of days of residency under OSS and IPC being paid

**13** **Income**

OSS resident's income used to calculate the OSS payment

**14** **OSS/IPC Payment**

First line is the amount paid for OSS; second line is the amount paid for IPC

**15** **Status Code**

An alpha character in this field indicates the present status of the claim.

P = Payment

R = Rejected

S = Suspended or in process

**16** **Edit Code**

For each rejected claim designated by an "R" in the STATUS CODE field (item 15), an appropriate edit code will appear in this field. This code will indicate the reason the claim was rejected.

**17** **Claim Control Number**

A computer-generated number unique to each line/claim on the TAD

### Edit Resolution

If a Remittance Advice shows a rejected claim, the provider should call the Medicaid PSC at 1-888-289-0709.

Some of the edit codes that can appear on an OSS/IPC Remittance Advice are:

**007** Patient's daily recurring income is greater than the nursing facility's daily rate.

**051** Date of death inconsistent with date of service.

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

### Edit Resolution (Cont'd.)

**509** Date of service over two years old.

**510** Date of service over one year old.

**852** Duplicate of previously paid procedure code for the same date of service.

**858** Inpatient hospital and nursing facility billing conflict with allowed days for bed reserve.

**866** Recipient receiving same or similar service from multiple providers for same date of service.

**900** Provider ID is not on file.

**902** Pay-to provider not eligible on date of service. Provider was not enrolled when service was rendered.

**924** OSS recipient must be a pay category 85 or 86.

**940** Billing provider is not the recipient's IPC physician.

**950** Patient ID is not on file.

**951** Recipient not eligible for Medicaid on the date of service.

**958** IPC days exceeded or not authorized on date of service.

**959** Silvercard beneficiary, service not pharmacy.

### Reimbursement Payment

SCDHHS no longer issues paper checks for Medicaid payments. Providers receive reimbursement from SC Medicaid via electronic funds transfer.

The reimbursement represents an amount equaling the sum total of all claims on the Remittance Advice with status P (paid) will be enclosed.

**Note**: Newly enrolled providers will receive a hard copy check until the Electronic Funds Transfer (EFT) 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.

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

Electronic Funds Transfer (EFT) (Cont'd.)

**Prior to revoking or revising the EFT authorization agreement, the provider must provide 30 days written notice to:**

Medicaid Provider Enrollment
PO 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.

Providers may view their Remittance Advice (RA) on the Web Tool for payment information. The last four digits of the bank account are reflected on the RA.

When SCDHHS is notified that the provider's bank account is closed or the routing and/or bank account number is no longer valid, the provider will be notified and will be required to submit an EFT form and bank account verification from their financial institution.

Each time banking information changes, the 15-day pre-certification period will occur and the provider will receive reimbursement via copy checks.

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

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# SECTION 4

## ADMINISTRATIVE SERVICES

# TABLE OF CONTENTS

# SECTION 4 ADMINISTRATIVE SERVICES

## GENERAL INFORMATION

### ADMINISTRATION

The Department of Health and Human Services (DHHS) administers the South Carolina Medicaid Program. This section outlines the available resources for Medicaid providers, with telephone numbers, and addresses for county and regional DHHS 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, provider may submit an online inquiry at http://www.scdhhs.gov/contact-us. Inquiries concerning specific claims should also be directed to the PSC, but only after corrections have been made on rejected claims and all claims filing requirements have been met. Medicaid Provider Inquiry (DHHS Form 140) may be used to check the status on outstanding claims. (See the blank form in the Forms section.) Always include the provider's Medicaid number, the resident's Medicaid number, and the date of service when requesting the status of outstanding claims. **Allow 45 days from the submission date before requesting the status of the claim.**

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. To verify eligibility status, please use the South Carolina Medicaid Web-based Claims Submission Tool (Web Tool). For information on the Web Tool, please contact the PSC at 1-888-289-0709.

# SECTION 4 ADMINISTRATIVE SERVICES

## GENERAL INFORMATION

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# SECTION 4 ADMINISTRATIVE SERVICES

## PROCUREMENT OF FORMS

### 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 http://provider.scdhhs.gov for the most current version of this manual.

To order a paper or CD 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.

### PROGRAM-SPECIFIC FORMS

Providers should contact the DHHS regional nurse assigned to their area to order forms specific to the Integrated Personal Care Program.

# SECTION 4 ADMINISTRATIVE SERVICES

## PROCUREMENT OF FORMS

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# SECTION 4 ADMINISTRATIVE SERVICES

## CLTC REGIONAL OFFICES

| Office | Counties Served | Contact Information |
|---|---|---|
| **Area 1 Greenville** | Greenville<br>Pickens | 620 North Main St.<br>Greenville, SC 29601<br>Phone: (864) 242-2211<br>Toll Free:1-888-535-8523<br>Fax: (864) 242-2107 |
| **Area 2 Spartanburg** | Cherokee<br>Spartanburg<br>Union | 1411 W. O. Ezell Blvd., Suite 6<br>Spartanburg, SC 29301<br>Phone: (864) 587-4707<br>Toll Free: 1-888-551-3864<br>Fax: (864) 587-4716 |
| **Area 3 Greenwood** | Abbeville<br>Edgefield<br>Greenwood<br>Laurens<br>McCormick<br>Saluda | 617 South Main St.<br>Post Office Box 3088<br>Greenwood, SC 29648<br>Phone: (864) 223-8622<br>Toll Free: 1-800-628-3838<br>Fax: (864) 223-8607 |
| **Area 4 Rock Hill** | Chester<br>Lancaster<br>York | 1890 Neely's Creek Rd.<br>Rock Hill, SC 29732<br>Phone: (803) 327-9061<br>Toll Free: 1-888-286-2078<br>Fax: (803) 327-9065 |
| **Area 5 Columbia** | Fairfield<br>Newberry<br>Lexington<br>Richland | 7499 Parklane Rd., Suite 164<br>Columbia, SC 29223<br>Phone: (803) 741-0826<br>Toll Free: 1-888-847-0908<br>Fax: (803) 741-0830 |
| **Area 6 Orangeburg** | Allendale<br>Bamberg<br>Barnwell<br>Calhoun<br>Orangeburg | 191 Regional Parkway, Building A<br>Orangeburg, SC 29118<br>Phone: (803) 536-0122<br>Toll Free: 1-888-218-4915<br>Fax: (803) 534-2358 |

# SECTION 4 ADMINISTRATIVE SERVICES

## DEPARTMENT OF HEALTH AND HUMAN SERVICES REGIONAL OFFICES

| Office | Counties Served | Contact Information |
|---|---|---|
| **Area 6A**<br>**Aiken Satellite**<br>**Office** | Aiken<br>Barnwell | 2230 Woodside Executive Court<br>Aiken, SC 29803<br>Phone: (803) 641-7680<br>Toll Free: 1-888-364-3310<br>Fax: (803) 641-7682 |
| **Area 7**<br>**Sumter** | Clarendon<br>Kershaw<br>Lee<br>Sumter | 30 Wesmark Ct.<br>Sumter, SC 29150<br>Phone: (803) 905-1980<br>Toll Free: 1-888-761-5991<br>Fax: (803) 905-1987 |
| **Area 8**<br>**Florence** | Chesterfield<br>Darlington<br>Dillon<br>Florence<br>Marlboro | 201 Dozier Blvd.<br>Florence, SC 29501<br>Phone: (843) 667-8718<br>Toll Free: 1-888-798-8995<br>Fax: (843) 667-9354 |
| **Area 9**<br>**Conway** | Georgetown<br>Horry<br>Marion<br>Williamsburg | 1601 11th Ave.<br>Conway, SC 29528<br>Post Office Box 2150<br>Conway, SC 29526<br>Phone: (843) 248-7249<br>Toll Free: 1-888-539-8796<br>Fax: (843) 248-3809 |
| **Area 10**<br>**Charleston** | Berkeley<br>Charleston<br>Dorchester | 4130 Faber Place Drive, Suite 303 N.<br>Charleston, SC 29405<br>Phone: (843) 529-0142<br>Toll Free: 1-888-805-4397<br>Fax: (843) 566-0171 |
| **Area 10A**<br>**Ridgeland**<br>**Satellite Office** | Beaufort<br>Colleton<br>Hampton<br>Jasper | 10175 South Jacob Smart Blvd.<br>Post Office Box 2065<br>Ridgeland, SC 29936<br>Phone: (843) 726-5353<br>Toll Free: 1-800-262-3329<br>Fax: (843) 726-5113 |

# SECTION 4 ADMINISTRATIVE SERVICES

## DEPARTMENT OF HEALTH AND HUMAN SERVICES REGIONAL OFFICES

| Office | Counties Served | Contact Information |
|---|---|---|
| **Area 11**<br>**Anderson** | Anderson<br>Oconee | 3215 Martin Luther King Blvd, Suite H<br>Anderson, SC 29625<br><br>Post Office Box 5947<br>Anderson, SC 29623-5947<br>Phone: (864) 224-9452<br>Toll Free: 1-800-713-8003<br>Fax: (864) 225-0871 |

# SECTION 4 ADMINISTRATIVE SERVICES

## DEPARTMENT OF HEALTH AND HUMAN SERVICES REGIONAL OFFICES

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# SECTION 4 ADMINISTRATIVE SERVICES

## DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

| | County | Telephone No. | Address |
|---|---|---|---|
| **1.** | Abbeville County | (864) 366-5638 | Medicaid Eligibility<br>Abbeville County DHHS<br>Human Services Building<br>903 W. Greenwood St.<br>Abbeville, SC 29620-5678<br><br>Post Office Box 130<br>Abbeville, SC 29620-0130 |
| **2.** | Aiken County | (803) 643-1938<br><br>Toll Free:<br>1-888-866-8852 | Medicaid Eligibility<br>Aiken County DHHS<br>1410 Park Ave. S.E.<br>Aiken, SC 29801-4776<br><br>Post Office Box 2748<br>Aiken, SC 29802-2748 |
| **3.** | Allendale County | (803) 584-8137 | Medicaid Eligibility<br>Allendale County DHHS<br>521 Barnwell Highway<br>Allendale, SC 29810<br><br>Post Office Box 326<br>Allendale, SC 29810 |
| **4.** | Anderson County | (864) 260-4541 | Medicaid Eligibility<br>Anderson County DHHS<br>224 McGee Rd.<br>Anderson, SC 29625<br><br>Post Office Box 160<br>Anderson, SC 29622-0160 |

# SECTION 4 ADMINISTRATIVE SERVICES

## DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

| County | Telephone No. | Address |
|---|---|---|
| **5.** Bamberg County | (803) 245-3932 | Medicaid Eligibility<br>Bamberg County DHHS<br>374 Log Branch Rd.<br>Bamberg, SC 29003<br><br>Post Office Box 544<br>Bamberg, SC 29003 |
| **6.** Barnwell County | (803) 541-3825 | Medicaid Eligibility<br>Barnwell County DHHS<br>10913 Ellenton Street<br>Barnwell, SC 29812<br><br>Post Office Box 648<br>Barnwell, SC 29812 |
| **7.** Beaufort County | (843) 255-6095 | Medicaid Eligibility<br>Beaufort County DHHS<br>1905 Duke St.<br>Beaufort, SC 29902-4403<br><br>Post Office Box 1255<br>Beaufort, SC 29901-1255 |
| **8.** Berkeley County | (843) 719-1170<br><br>Toll Free:<br>1-800-249-8751 | Medicaid Eligibility<br>Berkeley County DSS<br>2 Belt Dr.<br>Moncks Corner, SC 29461-2801<br><br>Post Office Box 13748<br>Charleston, SC 29422-3748 |
| **9.** Calhoun County | (803) 874-3384 | Medicaid Eligibility<br>Calhoun County DHHS<br>2831 Old Belleville Rd.<br>St. Matthews, SC 29135<br><br>Post Office Box 378<br>St. Matthews, SC 29135 |

# SECTION 4 ADMINISTRATIVE SERVICES

## DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

| County | Telephone No. | Address |
|---|---|---|
| **10.** Charleston County | (843) 740-5900 | Medicaid Eligibility<br>Charleston County DHHS<br>326 Calhoun St.<br>Charleston, SC 29401-1124 |
| | Toll Free:<br>1-800-249-8751 | Post Office Box 13748<br>Charleston, SC 29422-3748 |
| **11.** Cherokee County | (864) 487-2521 | Medicaid Eligibility<br>Cherokee County DHHS<br>1434 N. Limestone St.<br>Gaffney, SC 29340-4734 |
| | | Post Office Box 89<br>Gaffney, SC 29342 |
| **12.** Chester County | (803) 377-8135 | Medicaid Eligibility<br>Chester County DHHS<br>115 Reedy St.<br>Chester, SC 29706-1881 |
| **13.** Chesterfield County | (843) 623-5226 | Medicaid Eligibility<br>Chesterfield County DHHS<br>201 N. Page St.<br>Chesterfield, SC 29709-1201 |
| | | Post Office Box 855<br>Chesterfield, SC 29709-0855 |
| **14.** Clarendon County | (803) 435-4305 | Medicaid Eligibility<br>Clarendon County DSS<br>3 S. Church St.<br>Manning, SC 29102 |
| | | Post Office Box 788<br>Manning, SC 29102 |

# SECTION 4 ADMINISTRATIVE SERVICES

## DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

| County | Telephone No. | Address |
|---|---|---|
| **15.** Colleton County | (843) 549-1894 | Medicaid Eligibility<br>Colleton County DHHS<br>Bernard Warshaw Building<br>215 S. Lemacks St.<br>Walterboro, SC 29488<br><br>Post Office Box 110<br>Walterboro, SC 29488 |
| **16.** Darlington County | (843) 398-4427 | Medicaid Eligibility<br>Darlington County DHHS<br>300 Russell St., Room 145<br>Darlington, SC 29532-3340<br><br>Post Office Box 2077<br>Darlington, SC 29540-2077 |
| | (843) 332-2289 | 404 S. Fourth St., Suite 300<br>Hartsville, SC 29550-5718 |
| **17.** Dillon County | (843) 774-2713 | Medicaid Eligibility<br>Dillon County DHHS<br>1213 Highway 34 W.<br>Dillon, SC 29536-8141<br><br>Post Office Box 351<br>Dillon, SC 29536-0351 |
| **18.** Dorchester County | (843) 821-0444<br>Toll Free:<br>1-800-249-8751 | Medicaid Eligibility<br>Dorchester County DSS<br>216 Orangeburg Rd<br>Summerville, SC 29483-8945<br><br>Post Office Box 13748<br>Charleston, SC 29422-3748 |
| **19.** Edgefield County | (803) 637-4040 | Medicaid Eligibility<br>Edgefield County DHHS<br>120 W. A. Reel Dr.<br>Edgefield, SC 29824-1607<br><br>Post Office Box 386<br>Edgefield, SC 29824-0386 |

# SECTION 4 ADMINISTRATIVE SERVICES

## DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

| County | Telephone No. | Address |
|---|---|---|
| **20.** Fairfield County | (803) 589-8035 | Medicaid Eligibility<br>Fairfield County DHHS<br>1136 Kincaid Bridge Rd.<br>Winnsboro, SC 29180-7116<br><br>Post Office Box 1139<br>Winnsboro, SC 29180-5139 |
| **21.** Florence County | (843) 673-1761 | Medicaid Eligibility<br>Florence County DHHS<br>2685 S. Irby St., Box I<br>Florence, SC 29505-3440 |
| | (843) 394-8575 | 345 S. Ron McNair Blvd<br>Lake City, SC 29560-3434 |
| **22.** Georgetown County | (843) 546-5134 | Medicaid Eligibility<br>Georgetown County DSS<br>330 Dozier St.<br>Georgetown, SC 29440-3219<br><br>Post Office Box 371<br>Georgetown, SC 29442 |
| **23.** Greenville County | (864) 467-7800 | Medicaid Eligibility<br>Greenville County DSS<br>301 University Ridge, Suite 6700<br>Greenville, SC 29601<br><br>Post Office Box 100101<br>Columbia, SC 29202-3101 |
| **24.** Greenwood County | (864) 229-5258 | Medicaid Eligibility<br>Greenwood County DHHS<br>1118 Phoenix St.<br>Greenwood, SC 29646-3918<br><br>Post Office Box 1016<br>Greenwood, SC 29648-1016 |

# SECTION 4 ADMINISTRATIVE SERVICES

## DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

| County | Telephone No. | Address |
|---|---|---|
| **25.** Hampton County | (803) 914-0053 | Medicaid Eligibility<br>Hampton County DHHS<br>102 Ginn Altman Ave., Suite B<br>Hampton, SC 29924<br><br>Post Office Box 693<br>Hampton, SC 29924 |
| **26.** Horry County | (843) 381-8260 | Medicaid Eligibility<br>Horry County DHHS<br>1601 11th Ave., 1st Floor<br>Conway, SC 29526<br><br>Post Office Box 290<br>Conway, SC 29528 |
| **27.** Jasper County | (843) 726-7747 | Medicaid Eligibility<br>Jasper County DHHS<br>10908 N. Jacob Smart Blvd.<br>Ridgeland, SC 29936<br><br>Post Office Box 1150<br>Ridgeland, SC 29936 |
| **28.** Kershaw County | (803) 432-3164 | Medicaid Eligibility<br>Kershaw County DHHS<br>110 E. DeKalb St.<br>Camden, SC 29020-4432<br><br>Post Office Box 220<br>Camden, SC 29021-0220 |
| **29.** Lancaster County | (803) 286-8208 | Medicaid Eligibility<br>Lancaster County DHHS<br>1599 Pageland Highway<br>Lancaster, SC 29720-2409 |

# SECTION 4 ADMINISTRATIVE SERVICES

## DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

| County | Telephone No. | Address |
|---|---|---|
| **30.** Laurens County | (864) 833-6109 | Medicaid Eligibility<br>Laurens County DHHS<br>93 Human Services Rd.<br>Clinton, SC 29325-7546<br><br>Post Office Box 388<br>Laurens, SC 29360-0388 |
| **31.** Lee County | (803) 484-5376 | Medicaid Eligibility<br>Lee County DHHS<br>820 Brown St.<br>Bishopville, SC 29010-4207<br><br>Post Office Box 406<br>Bishopville, SC 29010-0406 |
| **32.** Lexington County | (803) 785-2991<br>(803) 785-5050 | Medicaid Eligibility<br>Lexington County DHHS<br>605 West Main St.<br>Lexington, SC 29072-2550 |
| **33.** McCormick County | (864) 465-5221 | Medicaid Eligibility<br>McCormick County DHHS<br>215 N. Mine St.<br>McCormick, SC 29835-8363 |
| **34.** Marion County | (843) 423-5417 | Medicaid Eligibility<br>Marion County DHHS<br>137 Airport Ct., Suite J<br>Mullins, SC 29574 |
| **35.** Marlboro County | (843) 479-4389 | Medicaid Eligibility<br>Marlboro County DHHS<br>County Complex<br>1 Ag St.<br>Bennettsville, SC 29512-4424<br><br>Post Office Box 1074<br>Bennettsville, SC 29512-1074 |

# SECTION 4 ADMINISTRATIVE SERVICES

## DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

| County | Telephone No. | Address |
|---|---|---|
| **36.** Newberry County | (803) 321-2159 | Medicaid Eligibility<br>Newberry County DHHS<br>County Human Services Center<br>2107 Wilson Rd.<br>Newberry, SC 29108-1603<br><br>PO Box 1225<br>Newberry, SC 29108-1225 |
| **37.** Oconee County | (864) 638-4420 | Medicaid Eligibility<br>Oconee DHHS<br>223 B Kenneth St.<br>Walhalla, SC 29691 |
| **38.** Orangeburg County | (803) 515-1793 | Medicaid Eligibility<br>Orangeburg County DHHS<br>2570 Old St. Matthews Rd., N.E.<br>Orangeburg, SC 29118<br><br>Post Office Box 1407<br>Orangeburg, SC 29116-1407 |
| **39.** Pickens County | (864) 898-5815 | Medicaid Eligibility<br>Pickens County DHHS<br>212 McDaniel Ave.<br>Pickens, SC 29671<br><br>Post Office Box 160<br>Pickens, SC 29671-0160 |
| **40.** Richland County | (803) 714-7562<br>(803) 714-7549 | Medicaid Eligibility<br>Richland County DHHS<br>3220 Two Notch Rd.<br>Columbia, SC 29204-2826 |
| **41.** Saluda County | (864) 445-2139<br>Toll Free:<br>1-800-551-1909 | Medicaid Eligibility<br>Saluda County DHHS<br>613 Newberry Highway<br>Saluda, SC 29138-8903<br><br>Post Office Box 245<br>Saluda, SC 29138-0245 |

# SECTION 4 ADMINISTRATIVE SERVICES

## DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

| County | Telephone No. | Address |
|---|---|---|
| **42.** Spartanburg County | (864) 596-2714 | Medicaid Eligibility<br>Spartanburg County DHHS<br>Pinewood Shopping Center<br>1000 N. Pine St., Suite 23<br>Spartanburg, SC 29303 |
| **43.** Sumter County | (803) 774-3447 | Medicaid Eligibility<br>Sumter County DHHS<br>105 N. Magnolia St., 3rd Floor<br>Sumter, SC 29150-4941<br><br>Post Office Box 2547<br>Sumter, SC 29151-2547 |
| **44.** Union County | (864) 424-0227 | Medicaid Eligibility<br>Union County DHHS<br>200 S. Mountain St.<br>Union, SC 29379<br><br>Post Office Box 1068<br>Union, SC 29379 |
| **45.** Williamsburg County | (843) 355-5411 | Medicaid Eligibility<br>Williamsburg County DSS<br>831 Eastland Ave.<br>Kingstree, SC 29556<br><br>Post Office Box 767<br>Kingstree, SC 29556 |
| **46.** York County | (803) 366-1900 | Medicaid Eligibility<br>York County DHHS<br>1890 Neelys Creek Road<br>Rock Hill, SC 29730<br><br>Post Office Box 710<br>Rock Hill, SC 29731-6710 |

# SECTION 4 ADMINISTRATIVE SERVICES

## DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

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# FORMS

| Number | Name | Revision Date |
|---|---|---|
| DHHS 931 | Health Insurance Information Referral Form | 01/2008 |
| | Authorization Agreement For Electronic Funds Transfer | 03/2011 |
| | Duplicate Remittance Advice Request Form | 10/2012 |
| | Sample Remittance Advice | |
| | Sample Turn Around Document | |
| DHHS 2503 | Annual Competency Evaluation Documentation (two pages) | 01/2003 |
| DHHS 2504 | IPC Personnel Competency Evaluation Form (two pages) | 01/2003 |
| DHHS 2501 | IPC Program Referral | 11/2003 |
| DHHS 2502 | Consent Form | 01/2003 |
| DHHS 2505 | IPC Service Care Plan Elements (two pages) | 01/2003 |
| DHHS 2500 | Sample Service Care Plan | 01/2003 |
| DHHS 175 | IPC Service Provision Form | 07/1992 |
| DHHS 2507 | Daily Task Log (two pages) | 01/2003 |
| DHHS 2506 | Daily Census Log (two pages) | 07/2007 |
| | IPC Notification Form | |
| CRCF-01 | Notice of Admission, Authorization & Change of Community Residential Care Facility | 01/2003 |
| DHHS 175-B | IPC Service Termination Notice | 07/1994 |

# 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:** | **or** | **Mail:** |
|---|---|---|
| 803-252-0870 | | Post Office Box 101110<br>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:** | **or** | **Mail:** |
|---|---|---|
| 803-255-8225 | | Post Office Box 8206, Attention TPL<br>Columbia, SC 29202-8206 |

**South Carolina**
**Department of Health and Human Services**
***Electronic Funds Transfer (EFT) Authorization Agreement***

## PROVIDER INFORMATION

Provider Name _____

Medicaid Provider Number _____

Provider NPI Number _____

Provider Address _____

City _____ State _____ Zip _____

## BANKING INFORMATION (*Please include a copy of the electronic deposit information on bank letterhead. This is required and the information will be used to verify your bank account information).*

Financial Institution Name _____

Financial Institution Address _____

City _____ State _____ Zip _____

Routing Number (nine digit) _____

Account Number _____

Type of Account (check one) ☐Checking ☐Savings

I (we) hereby 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 my account indicated below and the financial institution named below, to credit and/or debit the same to such account. These credit entries will pertain only to the Department of Health and Human Services payment obligations resulting from Medicaid services rendered by the provider.

I (we) understand that credit entries to the account of the above named payee 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 (we) certify that the information shown is correct. I (we) agree to provide thirty (30) days written notice to the address shown below prior to revoking or revising this authorization.

Contact Name: _____ Phone Number: _____

Signed _____ *(Signature)*

_____ *(Print)*

Title _____ Date _____

***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.***

*RETURN COMPLETED FORM & BANK VERIFICATION DOCUMENT TO:*

**Department of Health and Human Services**
**Medicaid Provider Enrollment**
**P.O. BOX 8809, COLUMBIA, S.C. 29202-8809**
**FAX (803) 870-9022**

EFT/Revised 03/11

# 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 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: _____** **4. Telephone Number: _____**

5. **Requesting:**

   ☐ **Complete Remittance Package** ☐ **Remittance Pages Only** ☐ **Edit Correction Pages Only**

6. **Please list the date(s) of the remittance advice for which you are requesting a duplicate copy:**

   _____
   _____
   _____
   _____
   _____

7. **Street Address for delivery of request:**

   **Street: _____**
   **City: _____**
   **State: _____**
   **Zip Code: _____**

8. **Charges for a duplicate remittance advice 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**

NHM4530R03
RUN DATE 12/09/2002 (1)

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
COMMUNITY RESIDENTIAL CARE
OPTIONAL STATE SUPPLEMENTATION REMITTANCE ADVICE



CRCF NO. RC0XXX (2)

CHECK DATE:12/13/02 (3)
CHECK NUMBER:2999994 (4)
CHECK AMOUNT:$000.00 (5)

BANK NAME: (6)
BANK NUMBER: (7)
ACCOUNT NUMBER: (8)

| LINE | (9) RECIPIENT NAME | | (10) RECIPIENT ID NO | (11) DATE OF SERVICE | (12) CRCF DAYS | (13) INCOME | (14) OSS/IPC PAYMENT | (15) STATUS CODE | (16) EDIT CODE | (17) CLAIM CONTROL NUMBER |
|---|---|---|---|---|---|---|---|---|---|---|
| 01 | GERALDINE | ALSTON | 2889990001 | 11/01/02 | 10 | $000.00 | $0.00 | 8 P | , , | 0233199999130000G |
| 01 | | | | | | | $000.00 | | | |
| 02 | | | | | | | | | | |
| 02 | | | | | | | | | | |
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REPORT NH4545R1 SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES PAGE 1
DATE 12/16/2002 COMMUNITY RESIDENTIAL CARE
FOR MONTH OF FEBRUARY

(1) CRCF NO. RC0999 HAPPY HOME (2)
111 VALLEY ST
LEXINGTON SC 29687

| | | | | | (8) | | | ENTER CHANGES | | |
|---|---|---|---|---|---|---|---|---|---|---|
| (3) | (4) | (5) | (6) | (7) | DATE OF | (9) | (10) | (11) | (12) | (14) |
| LINE | COUNTY | RECIPIENT NAME | RECIPIENT ID NO | MONTHLY INCOME | SERVICE MO/YR | CRCF DAYS | IPC DAYS // | CHANGED CRCF DAYS | CHANGED IPC DAYS | DELETE FROM NEXT MONTH'S TA |
| 01 | 32 | MARY SMITH | 1234567801 | | 02/03 | 28 | | | | |
| 02 | 32 | SAM PERKINS | 9876543201 | | 02/03 | | 28 | | | |
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1) IF THE ABOVE INFORMATION IS CORRECT AND THERE HAVE BEEN NO ADMISSIONS OR DISCHARGES, SIGN AND DATE AS INDICATED BELOW.
2) IF THERE HAS BEEN A NEW OSS APPROVED ADMISSION TO YOUR FACILITY DURING THE MONTH OF DECEMBER , ENTER A NEW LINE FOR THAT RESIDENT WITH THE NAME, ID NUMBER, DATE OF ADMISSION, AND NUMBER OF DAYS IN YOUR FACILITY.
3) IF THE FACILITY HAS RECEIVED AUTHORIZATION FROM SCDHHS TO PROVIDE INTEGRATED PERSONAL CARE (IPC) SERVICES TO ANY OSS RESIDENT, REDUCE THE NUMBER OF CRCF DAYS BY THE NUMBER OF DAYS THE RESIDENT WAS AUTHORIZED FOR AND RECEIVED IPC SERVICES AND INSERT THE NUMBER OF DAYS THE RESIDENT RECEIVED AUTHORIZED IPC SERVICES IN THE IPC DAYS COLUMN.
4) IF THERE HAS BEEN A DISCHARGE/DEATH FROM YOUR FACILITY DURING THE MONTH OF DECEMBER, INDICATE THE NUMBER OF DAYS, NOT COUNTING THE DATE OF DISCHARGE/DEATH THAT THE RESIDENT WAS IN YOUR FACILITY IN THE COLUMN TITLED "CHANGED CRCF DAYS". IF THE RESIDENT WAS AUTHORIZED FOR AND RECEIVED IPC SERVICES, ENTER THE NUMBER OF DAYS, NOT COUNTING THE DATE OF DISCHARGE/DEATH THAT THE RESIDENT WAS IN YOUR FACILITY AND WAS AUTHORIZED FOR AND RECEIVED IPC SERVICES IN THE "CHANGED IPC DAYS" COLUMN.
5) IF ANY OF THE RESIDENTS LISTED WILL NOT BE IN YOUR FACILITY NEXT MONTH, ENTER AN 'X' IN THE COLUMN TITLED 'DELETE FROM NEXT MONTH'S TAD'.

I CERTIFY THAT THE INFORMATION SHOWN ON THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THIS INFORMATION WILL BE USED TO GENERATE PAYMENTS OF STATE FUNDS, AND I UNDERSTAND THAT SUBMITTING FALSE OR MISLEADING INFORMATION IS AGAINST THE LAW AND COULD RESULT IN CRIMINAL PROSECUTION.

SIGNATURE TITLE DATE

# ANNUAL COMPETENCY EVALUATION DOCUMENTATION

**Required Training/Evaluation For Unlicensed Staff Providing or Supervising Care**

Trainee's Name _____ SS# _____
LPN or RN Conducting Training/Evaluation _____

| AREA EVALUATED | SATISFACTORY/UNSATISFACTORY | DATE | NURSE INITIALS |
|---|---|---|---|
| Handwashing and basic infection control procedures | | | |
| Assisting the resident with dressing | | | |
| Assisting the resident with transferring | | | |
| Assisting the resident with ambulation | | | |
| Assisting the resident with bathing | | | |
| Assisting the resident with personal grooming | | | |
| Assisting the resident with toileting | | | |
| Assisting the resident to eat | | | |
| Providing incontinence care | | | |
| Providing a bed bath | | | |
| Taking and recording vital signs | | | |
| Addressing behavioral symptoms | | | |
| Observing, recording and reporting tasks | | | |
| Identifying and reporting problems/changes | | | |

If additional training was required on any of the above components, document below the instruction provided and the date(s) retested.

_____
_____
_____

## Statement to Nurse Trainers

**Staff training and evaluation must be completed prior to IPC service delivery and annually thereafter. It is the responsibility of the IPC facility to ensure that IPC resident aides and the supervising staff are competent to perform the tasks identified in the Service Care Plan of each IPC resident. The facility administrator and /or any staff person with daily supervisory responsibilities for the IPC resident aids must also be trained. Evidence of training/evaluation must be maintained in personnel records by the IPC service provider and made available to DHHS staff upon request. The training/evaluation for IPC is in addition to the annual training requirements for licensure by DHEC. For additional information, please call your regional DHHS IPC nurse.**

Signature of RN or LPN _____ Date _____

DHHS Form 2503 (Jan 03)

# INSTRUCTIONS: SCDHHS IPC FORM 2503

## ANNUAL COMPETENCY EVALUATION DOCUMENTATION

**PURPOSE:** This is a form to validate competency of staff in skills or tasks necessary for the provision of IPC services.

**ITEM BY ITEM INSTRUCTIONS:**

1. **Name of Personal Care Aide or Supervisor:** Enter name of trainee. All IPC aides and supervisors must be assessed as competent in tasks or skills that are necessary for providing IPC services
2. **Area Evaluated:** All skills/tasks listed must be evaluated.
3. **S/U:** Indicate with an S for satisfactory performance or U for unsatisfactory performance for each task or skill evaluated. Any additional training or retesting should be indicated in the lined space provided below the Table.
4. **Date:** Enter date that skill or task was evaluated.
5. **Initials of Nurse:** RN or LPN that conducted evaluation enters her/his initials.
6. **Signature:** Full signature, and title (RN OR LPN) of nurse(s) conducting the evaluation signify that evaluation was completed in compliance with written Statement to Nurse Trainers.

**SUBSTITUTION OF ANOTHER FORM:** Another staff training or competency evaluation form can be used provided it was approved as part of the facility's IPC Policies and Procedures.
**FILING:** This form should be retained at the facility with other staff training documents.

# Integrated Personal Care (IPC)
## Personnel Competency Evaluation Form

Name of Resident Assistant or Supervisor _____

| ---------- Skills or Tasks ---------- | ----S/U ---- | -- ---Date----- | Initials of Nurse |
|---|---|---|---|
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S=Satisfactory Performance
U=Unsatisfactory Performance

Place a full signature to correspond with each set of initials appearing above.

| Initials | Corresponding Signature of Nurse | Title |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

# INSTRUCTIONS: SCDHHS Form 2504
# Personnel Competency Evaluation Documentation

**PURPOSE:** This is a form to validate competency of staff in skills or tasks necessary for the provision of IPC services. Tasks or skills not listed on the Annual Competency Evaluation Form that are necessary to deliver IPC or other services identified in the service care plan must be specified.

**ITEM BY ITEM INSTRUCTIONS:**

1. **Name of Personal Care Aide or Supervisor:** Enter name of trainee. All IPC aides and supervisors must be assessed as competent in tasks or skills that are necessary for providing IPC services
2. **Area Evaluated:** List skills/tasks to be evaluated.
3. **S/U:** Indicate with an S for satisfactory performance or U for unsatisfactory performance for each task or skill evaluated. Any additional training or retesting should be indicated in the lined space provided below the Table.
4. **Date:** Enter date that skill or task was evaluated.
5. **Initials of Nurse:** RN or LPN that conducted evaluation enters her/his initials.
6. **Signature:** Full signature, and title (RN OR LPN) of nurse(s) conducting the evaluation signify that evaluation was completed in compliance with written Statement to Nurse Trainers.

**SUBSTITUTION OF ANOTHER FORM:** Another staff training or competency evaluation form can be used provided it was approved via the IPC policies and procedures.

**FILING:** This form should be retained at the facility with other staff training documents.

# IPC PROGRAM REFERRAL

| | | |
|---|---|---|
| **RESIDENT NAME:** | | **ROOM#:** |
| **CURRENT ADDRESS:** | | |
| **Street:** | | |
| **City:** | **State:** | **Zip Code:** |
| **County:** | | |
| **Mailing Address:** | | |
| **City:** | **State:** | **Zip Code:** |
| **Phone#: ( )** | **Date of Birth:** | |
| **SS#:** | **Medicare#:** | |
| **Medicaid#:** | | |

## FACILITY INFORMATION

| | | |
|---|---|---|
| **Facility Name:** | | **Provider ID#:** |
| **Address:** | | **Phone#:** |
| **City:** | **State:** | **Zip Code:** |

## RESPONSIBLE PARTY INFORMATION

| | | |
|---|---|---|
| **Name:** | **Relationship:** | |
| **Address:** | | |
| **City:** | **State:** | **Zip Code:** |
| **Phone#: ( )** | **2nd Phone#:** | |

## RESIDENT STATISTICAL INFORMATION

| | | |
|---|---|---|
| **Marital Status:** | **Race:** | **Sex: M ☐ F ☐** |

**Primary Language: ENGLISH ☐ SPANISH ☐ OTHER _____**

## RESIDENT DEFICIENCIES (CHECK)

**LOCOMOTION ☐ DRESSING ☐ TOILET USE ☐ TRANSFER ☐**

**INCONTINENT ☐ EATING ☐ BATHING ☐**

**Cognitive Impairment/Diagnosis:**

**Is Resident Aware of Referral: YES ☐ No ☐**

**If No, Please Explain:**

_____

| | |
|---|---|
| **Person Making this Referral:** | **Phone#: ( )** |

## PHYSICIAN INFORMATION

**PRIMARY PHYSICIAN:**

**Address:**

| | | |
|---|---|---|
| **CITY:** | **State:** | **Zip Code:** |

**Phone#: ( )**

**FAX THIS COMPLETED FORM AND SIGNED CONSENT TO: (803) 255-8209**

# SOUTH CAROLINA INTEGRATED PERSONAL CARE PROGRAM

## CONSENT FORM

Resident Name: _____

Social Security Number: _____

I understand that as part of my application for services in a participating Integrated Personal Care Facility, my condition must be evaluated by the South Carolina Integrated Personal Care Program.

This evaluation includes information provided by:

a. my physician and medical records;
b. professionals, organizations and facility staff members involved with my care; and,
c. an interview with me and, if necessary, with my family.

I hereby authorize any social service professionals, organizations, doctors, nurses or other medical personnel or medical facilities involved in my care to release to the South Carolina Integrated Personal Care Program any medical information regarding my diagnosis, functional abilities and recommended treatment.

I hereby authorize the South Carolina Integrated Personal Care Program to release information on my behalf to the following: physicians, hospitals, health and human service organizations, health and human service agencies, family members, the residential care facility and/or other persons directly involved with my care.

I understand that if my current or future diagnosis includes Alzheimer's Disease, senile dementia or a similar disorder, my records may be reviewed by the Statewide Alzheimer's Disease and Related Disorders Registry, and that I or my responsible party may be contacted for additional information. Also, if an extraordinary situation should arise, I understand that photographs may be taken and used to document suspected problems.

Use the space below to indicate the name of any organization, agency or person to whom you do not choose to release information.

---

---

This consent shall remain in effect for one year from the date the consent is signed or until revoked by me in writing, or until such time as my case is closed by the Integrated Personal Care Program.

_____ _____

Date Signature of Client or Responsible Party

_____

If signed by Responsible Party, state relationship and authority to do so

_____ _____

Date Signature of Witness

DHHS Form 2502 (Revised Jan 03)

Facility _____

Resident _____

Medicaid ID #_____

# IPC Service Care Plan Elements

| Date & Sign | Problem | Goal/Objective | Target Date | Tasks | Date Achieved |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

**INSTRUCTIONS: DHHS IPC Service Care Plan Elements**

**PURPOSE:** This form contains the elements that are to be incorporated into the individualized service care planning document on each IPC resident which directs the provision of personal care. The plan is developed and signed by a registered nurse.

**ITEM BY ITEM INSTRUCTIONS:**

1. **Facility Name:** Enter the name of the CRCF.
2. **Resident:** Enter the name of the resident.
3. **Medicaid ID #:** Enter the Medicaid identification number of the resident.
4. **Date and Sign:** Enter the date when the plan is developed and provided signature.
5. **Problem:** Clearly defined, addressing dependencies/impairments identified on the SCDHHS Form 1718.
6. **Goal:** A positive, measurable statement of what is to be achieved.
7. **Target Date:** Date for expected resolution of the problem.
8. **Tasks:** Enter tasks that may be assigned to IPC facility aides.
9. **Date Achieved:** Enter the date when the registered nurse evaluates whether or not the problem was resolved.

**NOTE:**

1. Service Care Plan practices shall be in compliance with Individual Care Plan Standards set forth in Section 703 of the DHEC Standards for Licensing Community Residential Care Facilities, Regulation Number 61-84.

2. Dependencies or impairments identified in the IPC assessment must be addressed in the service care plan.

**REVISIONS:** The service care plan must be revised by the registered nurse at least every six months and more frequently if changes in the resident's condition necessitate a change in the plan of care.

**SUBSTITUTION OF ANOTHER FORM:** The Service Care Plan elements can be incorporated into an existing care plan format.

**FILING:** The service care plan must be maintained in the permanent record of the resident and be available to all staff that provide care to the residents. The initial service care plan should be faxed/mailed to the regional DHHS nurse for approval. Subsequent service care plans will be reviewed by the DHHS nurse on site visits.

# Service Care Plan

Facility _____

Resident _____

| Date & Sign | Problem | Goal/Objective | Target Date | Tasks | Date Achieve |
|---|---|---|---|---|---|
| 6/19/02 | 1) Incontinence of urine during sleeping hours | Be continent at all times. | 8/19/02 | 1) No fluids after 8 PM<br>2) Assist to bathroom just before bedtime<br>3) Awaken at 6AM. and assist to bathroom.<br>3) Record incontinence on daily log<br>4) Avoid using adult pads/briefs<br>5) Offer to assist to toilet every 2 hours during awake hours | |
| 6/19/02 | 2) Lack of interest in daily activities | 1) Demonstrate an increased interest in self-care activities by getting up in the morning without being prompted more than once. | 8/19/02 | 1) Assist in laying out clothing the night before.<br>2) Before bedtime talk with resident about the next day's activities<br>3) List things the resident says they enjoy doing<br>4) Attempt to have meaningful activities for the resident to engage in. | |

**Integrated Personal Care**
**Service Provision Form**

PROVIDER: VERIFY
MEDICAID ELIGIBILITY MONTHLY

TYPE OF AUTHORIZATION:
New

From: IPC Program
P.O.Box 8206
7th Floor Suite
Columbia, SC 29202-8206

**AUTHORIZATION IS HEREBY GIVEN TO PROVIDE THE FOLLOWING SERVICE(S) UNDER YOUR CONTRACT WITH THE STATE DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR THE PROVISION THEREOF.**

Service(s) Authorized: IPC Waiver Services

IPC PROCEDURE CODE: _____

Authorized Start Date: _____

Authorized End Date: _____ (if applicable)

Comments:

Total Units Authorized: 7 Sun 1 Mon 1 Tue 1 Wed 1 Thur 1 Fri 1 Sat 1

CLIENT INFORMATION

| NAME | | | BIRTHDATE | SEX |
|---|---|---|---|---|
| ADDRESS | | | | |
| TELEPHONE NO. | IPC CLIENT NO. | SOCIAL SEC NO. | MEDICAID NO. | ELIGIBILITY TYPE |

RESPONSIBLE PARTY

| NAME | | |
|---|---|---|
| ADDRESS | | |
| RELATIONSHIP | HOME TELEPHONE | WORK TELEPHONE |

Physician: _____

Directions to client's home:

Case Manager's Signature: _____ Date: _____

Sent: _____ Date: _____ Initials: _____ ☐ PROVIDER ☐ BILLING CLERK ☐ FILE

SCDHHS FORM 175 JUL 92

**Division of Community and Facility Services**
***Integrated Personal Care Program***

# DAILY TASK LOG

**Month/Year** _____

| *TASK* | HOUR | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **DIET** ☐<br>G-good 75% F-fair 50% P-poor 25%<br>R-refused<br>S_____ A_____ T_____ | Break<br>Lunch<br>Dinner<br>Snack | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **BATHING** ☐<br>S-shower T-tub P-partial<br>S_____ A _____ T _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **DRESSING** ☐<br>S _____ A _____ T _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **LOCOMOTION** ☐<br>W-walks WA-walker WC-wheelchair C-cane<br>S _____ A _____ T _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **TRANSFER** ☐<br>S _____ A _____ T _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **TOILETING** ☐<br>T-toileting program D-pads or briefs<br>S _____ A _____ T _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **BLADDER** ☐<br>C-continent I-incontinent<br>S _____ A _____ T _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **BOWEL** ☐<br>C-continent I-Incontinent<br>S _____ A _____ T _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **BEHAVIOR** ☐ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Weight** ☐ Monitor _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Vital Signs** ☐ Monitor _____Blood Pressure<br>_____ Temperature<br>_____ Pulse<br>_____ Respirations | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **AIDE'S INITIALS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **WEEKLY MONITOR NURSE SIGNATURE/DATE** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| **RESIDENT'S NAME** | **ROOM/BED NUMBER** | **MEDICAID NUMBER** |
|---|---|---|
| | | |

| Initials | Signature | Initials | Signature |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**INSTRUCTIONS: SCDHHS IPC FORM 2507**
**DAILY TASK LOG**
PURPOSE: This is a form to indicate the amount of assistance a resident is requiring on a daily basis that is kept for the entire month.

ITEM BY ITEM INSTRUCTIONS:

At the top:

1. Month/year: Enter the current month and the current year that these activities are taking place.
2. Diet: Enter for each day of the month, the letter for the amount of food consumed for each meal and check the amount of assistance that was required for them to eat.
3. Bathing: Enter the type of bath the resident required and check the level of assistance needed.
4. Dressing: Enter the amount of assistance given.
5. Locomotion: Enter how the resident locomotors and check the amount of assistance given to complete this activity.
6. Transfer: Enter/check the amount of assistance given.
7. Toileting: Enter if the resident receives a toileting program or uses pads/briefs.
8. Bladder: Enter whether the resident is continent or incontinent for each day, then check the amount of assistance given to the resident for cleanup.
9. Bowel: Enter whether the resident is continent or incontinent, then check the amount of assistance that is given for cleanup.
10. Behavior: Enter the daily resident's behavior.
11. Weight: Enter how often the weight is monitored, then place the weight in the appropriate days box.
12. Vital Signs: Enter/check which vital sign is taken and how often by "Monitor" then place the vital sign recording in the appropriate days block.
13. Aide's Initials: Enter the initials of the aide providing majority of personal care each day.

At the bottom:

14. Weekly Monitor Nurse Signature/Date: The licensed nurse will sign and date the weekly review for completion of the form.
15. Resident's Name: Enter the name of the resident that the log is being kept for.
16. Room/Bed Number: Enter which room and bed the resident is in.
17. Medicaid Number: Enter the resident's Medicaid identification number.
18. Name of CRCF: Enter the name of the facility.
19. Provider Number: Enter the facility's Medicaid provider number.

Back of Form, Top Section:

20. Initial/Signature: Any aide documenting on the form must place initials and corresponding signature in this Section.

SUBSTITUTION OF ANOTHER FORM: Another Personal Care Log or Record can be used provided that there is a record initialed daily by the aide assisting the resident with Activities of Daily Living and that a licensed nurse must record monitoring for completeness weekly.
FILING: This record is to be maintained in each resident's chart for the period of time as required by DHEC Regulation 61-84.

DIVISION OF COMMUNITY AND FACILITY SERVICES
Optional State Supplementation
Integrated Personal Care Program

# DAILY CENSUS LOG

| Name of Facility | Provider ID No. | Month/Year |
|---|---|---|
| | | |

| OSS or IPC | H | W / C | Last, First Name of Resident----- | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
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**Codes**
I = IPC Participant
O = OSS only
W/C = wheelchair
H = hospice client

DHHS FORM 2502 (revised JULY 2007)
THIS IS A TWO-SIDED FORM

**Codes for Calendar**
A = Admitted
E= Expired
D = Discharged
RC = Transferred to CRCF
NH = Transferred to nursing home
X = Other (specify at bottom)
H = Transferred home
PL = Personal Leave
HL = Hospital Leave

**This is to certify that this is a correct daily census of all residents for the month/year of** _____.

_____ )knalb( tneseroP =
Signature/ Facility Administrator/Designee Date

**INSTRUCTIONS: SCDHHS IPC FORM: DAILY CENSUS LOG**

**PURPOSE:** This is a form to indicate on a daily basis the location and type of residents at the CRCF.

**ITEM BY ITEM INSTRUCTIONS:**

1. **Name of Facility:** Enter the name of the CRCF.
2. **Provider ID Number:** Enter the assigned OSS Provider number.
3. **Month and Year:** Enter the month and year of the reporting period.
4. **OSS or IPC:** For a resident enrolled in the IPC Program enter an "I"; for residents only receiving OSS enter an "O". If not in IPC or OSS, leave blank.
5. **W/C or hospice:** For a resident that has used a wheelchair during the month, enter a w/c in the block preceding the resident's name. For a resident that has enrolled in a Hospice Care program, enter an H.
6. **Name of Resident:** Enter the names of all residents at the CRCF during the month of the reporting period.
7. **Calendar Days 1 – 31:** Using the "Codes for Calendar" at the bottom of the form, leave date blank for residents at the CRCF and use the other designated abbreviations as indicated.
8. **Signature and Date:** The facility administrator or designee dated signature certifies the correctness of the form.

**SUBSTITUTION OF ANOTHER FORM:** Another daily census form or monthly roster of residents can be used in place of this form provided the substituted form can be altered to provide the information requested.

**FILING/SUBMISSION OF FORM:** The original of this form should be maintained at the CRCF; a copy should be mailed/faxed to the IPC Central Office by the 10th of the following month. Address and Fax are as follows:

IPC Program
Attention: IPC Program Assistant
SC Dept of Health & Human Services
PO Box 8206
Columbia, SC 29202-8206
FAX: (803) 255-8209

# INTEGRATED PERSONAL CARE NOTIFICATION FORM

TO:

FROM:

IPC Program
P.O.Box 8206
7th Floor Suite
Columbia, SC 29202-8206
(803)898-2590

Client: SSN#: MA#:

- Comments: Comments in this section would relate to specific resident status in the IPC Program.

IPC Signature:_____ Date:_____

COPIES SENT TO:

[ ] Client
[ ] LTC Facility
[ ] County DSS
[ ] Caregiver/Responsible Party
[ ] Hospital
[ ] Physician
[ ] Other

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**OPTIONAL STATE SUPPLEMENTATION & INTEGRATED PERSONAL CARE PROGRAMS**
**NOTICE OF ADMISSION, AUTHORIZATION & CHANGE OF STATUS FOR COMMUNITY RESIDENTIAL CARE FACILITY**

SECTION 1 – IDENTIFICATION OF PROVIDER AND RESIDENT

| 1. RESIDENTS NAME (FIRST, M. INITIAL, LAST) | 2. BIRTH DATE<br>_____ \| _____ \| ____<br>(MO.) (DAY) (YR.) | 2. RESIDENTS MEDICAID I.D. NUMBER<br>__ __ __ __ __ __ __ __ __ __ |
|---|---|---|
| 4. RESIDENTS ADDRESS | 5. COUNTY NAME | 6. SOCIAL SECURITY NO.<br>__ __ __ \|__ __ \| __ __ __ __ |
| 7. CRCFS NAME & ADDRESS (ST. NAME, CITY, STATE) | 8. CRCFS I.D. # | 9. DATE OF REQUEST<br>__ __ \| __ __ \| __ __<br>(MO.) (DAY) ( YR.) |

SECTION II – ADMISSION, INCOME, TRANSFER, TERMINATION OR CHANGE IN STATUS

* (A) ADMITTED TO THIS CRCF ON _____
(MO.) (DAY) (YR.)

(B) AUTHORIZATION TO BEGIN PAYMENT _____
(MO.) (DAY) (YR.)

(C) RESIDENTS COUNTABLE INCOME EFFECTIVE: _____ $ _____ $_____
(MO.) (YR.) AMOUNT PERSONAL NEEDS AMOUNT

(D) TRANSFERRED TO ANOTHER CRCF _____ _____ _____
(MO.) (DAY) (YR.) NAME OF FACILITY COUNTY

* (E) TERMINATION/DISCHARGE _____ IF DECEASED, SPECIFY DATE OF DEATH _____
(MO.) (DAY) (YR.) (MO.) (DAY) (YR.)

SPECIFY REASON FOR TERMINATION OR OTHER CHANGE IN STATUS IF NOT COVERED BY ABOVE ITEMS _____

_____

_____

***REMINDER: DATE OF ADMISSION IS BILLED, DATE OF DISCHARGE IS NOT**

SECTION III – ABSENCES

(A) ADMITTED TO A NURSING FACILITY _____ _____
(MO.) (DAY) (YR.) NAME OF FACILITY

(B) ADMITTED TO A MEDICAL INSTITUTION OR MENTAL HEALTH FACILITY _____ _____
(MO.) (DAY) (YR.) NAME OF FACILITY

(C) READMITTED FROM A MEDICAL INSTITUTION, MENTAL HEALTH FACILITY OR NURSING FACILITY _____ _____
(MO.) (DAY) (YR.) NAME OF FACILITY

(D) TEMPORARY MEDICAL ABSENCE – BEGINNING _____ ENDING_____
(MO.) (DAY) (YR.) (MO.) (DAY) (YR.)

(E) TEMPORARY NON-MEDICAL ABSENCES – BEGINNING _____ ENDING _____
(MO). (DAY) (YR.) (MO). (DAY) (YR.)

_____ _____
AUTHORIZED ELIGIBILITY WORKER SIGNATURE DATE

_____ _____
AUTHORIZED COMMUNITY RESIDENTIAL CARE FACILITY SIGNATURE DATE

**Integrated Personal Care**
**Service Termination Notice**

PROVIDER: VERIFY
MEDICAID ELIGIBILITY MONTHLY

From: IPC Program
P.O.Box 8206
7th Floor Suite
Columbia, SC 29202-8206

**AUTHORIZATION IS HEREBY GIVEN TO TERMINATE THE FOLLOWING SERVICE(S) UNDER YOUR CONTRACT WITH THE STATE DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR THE PROVISION THEREOF.**

Service(s) Authorized: _____ IPC PROCEDURE CODE: _____

Authorized Start Date: _____ Authorized End Date: (if applicable) _____

Reason for Termination: _____

Total Units Authorized: 7 Sun 1 Mon 1 Tue 1 Wed 1 Thur 1 Fri 1 Sat 1

CLIENT INFORMATION

| NAME | | BIRTHDATE | SEX |
|---|---|---|---|
| ADDRESS | AIKEN, SC 29803 | | |
| TELEPHONE NO. | IPC CLIENT NO. | SOCIAL SEC NO. | MEDICAID NO. | ELIGIBILITY TYPE |

RESPONSIBLE PARTY

| NAME | | |
|---|---|---|
| ADDRESS | | |
| RELATIONSHIP | HOME TELEPHONE | WORK TELEPHONE |

Physician: _____

Directions to client's home:

Case Manager's Signature: _____ Date: _____

Sent: _____ Date: _____ Initials: _____ ☐ PROVIDER ☐ BILLING CLERK ☐ FILE

SCDHHS FORM 175-B JUL 94

# PROVIDER MANUAL SUPPLEMENT
# MANAGED CARE

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# PROVIDER MANUAL SUPPLEMENT
# MANAGED CARE

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# MANAGED CARE SUPPLEMENT

## MANAGED CARE OVERVIEW

Managed Care is a health care delivery model implemented by the South Carolina Department of Health and Human Services (SCDHHS) to establish a medical home for all Medicaid Managed Care eligible beneficiaries. The goals of a medical home include:

- Provide accessible, comprehensive, family-centered coordinated care
- Manage the beneficiary's health care, perform primary and preventive care services, and arrange for any additional needed care
- Provide beneficiaries access to a "live voice" 24 hours a day, 7 days a week, to ensure access to appropriate care
- Provide beneficiary 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 health plans. These additional benefits vary from plan to plan according to the contracted terms and conditions between SCDHHS and the managed care entity. Beneficiaries and providers should contact the health plan 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
- Adult dental services

The Bureau of Managed Care administers the program for Medicaid-eligible beneficiaries by contracting with Managed Care Organizations (MCOs) and Care Services Organizations (CSOs) to offer health care services (*CSOs support the Medical Homes Network (MHN) managed care health delivery model*). 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 Medicaid.

This Managed Care supplement is intended to provide an overview of the Managed Care program. Providers should review the MCO and MHN Policy and Procedure Guides for detailed program-specific requirements. Both guides are located on the SCDHHS website (www.scdhhs.gov) within the Managed Care section.

The Exhibits section of this supplement provides contact information for MCOs and MHNs currently participating in the Medicaid Managed Care program as MCOs and MHNs are subject to change at any time. Providers are encouraged to visit the SCDHHS website

# MANAGED CARE SUPPLEMENT

## MANAGED CARE OVERVIEW

(www.scdhhs.gov) for the most current listing of health plans, 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 Bureau of Managed Care at the following address:

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

### PROGRAM DESCRIPTIONS

#### 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.

Primary care providers (PCP) must be accessible within a 30-mile radius, while specialty care providers, to include hospitals, must be accessible within a 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 neighboring 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. Only services rendered on a fee-for-service (FFS) basis require providers be enrolled in SC Medicaid, as those claims are paid by SCDHHS. (Core services are discussed further in the **Core Benefits** section of this supplement.)

##### *Core Benefits*

Managed Care Organizations are fully capitated plans that provide a core benefits package similar to the current FFS Medicaid plan. MCO plans are required to provide beneficiaries with "medically necessary" care at current limitations for all contracted services. Unless otherwise specified, service limitations are based on the State fiscal year (July 1 through June 30). 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.

# MANAGED CARE SUPPLEMENT

## MANAGED CARE OVERVIEW

MCOs may offer SCDHHS-approved additional benefits. These are benefits that go beyond the core package. Additions, deletions, or modifications to additional benefits made during the contract year 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.

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 and service limitations.

### *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 beneficiaries' 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 MCO Policy and Procedures Guide on www.scdhhs.gov.

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

Managed Care Organizations issue an identification card to beneficiaries within 14 calendar days of the selection of a primary care provider, or the date of receipt of the beneficiary's enrollment data from SCDHHS, whichever is later.

To ensure immediate access to services, the provider should verify eligibility and enrollment regardless of a beneficiary's ability to supply a SC Medicaid or MCO card. The MCO ID card must include at least the following information:

- The MCO name
- The 24-hour telephone number for the beneficiary to use in urgent or emergency situations and to obtain any additional information
- The name of the primary care physician
- The beneficiary'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 beneficiaries 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 beneficiaries. An exception is services

# MANAGED CARE SUPPLEMENT

## MANAGED CARE OVERVIEW

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 are contained in Section 4, **Emergency Medical Services**, of the MCO contract.

### *Prior Authorizations and Referrals*

Providers, both in and out of network, should contact the beneficiary's MCO for assistance with prior authorization (PA) requirements before administering services. Each MCO may have different prior authorization requirements and services requiring PA may 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 plan for their requirements. The physician component for inpatient services **always** requires prior authorization. Specialist referrals for follow-up care after a hospital discharge also require prior authorization.

### Medical Homes Networks (MHNs)

Medical Homes Networks (MHNs) are Medicaid's 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. They work in partnership with the beneficiary 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 beneficiaries and for managing beneficiaries' care. The CSO supports the physicians and enrolled beneficiaries by providing care coordination, disease management, and data management. All providers participating in an MHN must be enrolled SC Medicaid providers, as all services are paid on a fee-for-service (FFS) basis.

The outcomes of the medical home initiative are a healthier, better educated Medicaid beneficiary, 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.

MHNs are under contract with the CSO, who, in turn, contracts with SCDHHS. Providers must be in good financial standing with SCDHHS. MHN contracts with SCDHHS must receive CMS approval. A sample of an MHN contract can be reviewed on the SCDHHS website.

### MHN Program Identification (ID) Card

Medicaid Homes Networks do not issue a separate identification card. Beneficiaries enrolled in an 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.

# MANAGED CARE SUPPLEMENT

## MANAGED CARE OVERVIEW

### *Core Benefits*

Services provided under the 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 with the following exceptions:

- All beneficiaries, regardless of age, receive unlimited ambulatory visits

For additional information concerning core services and limitations, please refer to the MHN Policy and Procedures manual, or program specific provider manuals for the applicable area (Physicians, Hospitals, etc.). Manuals are located on the agency website at www.scdhhs.gov

### *Prior Authorizations and Referrals*

The PCP is contractually required to either provide medically necessary services or authorize another provider to treat the beneficiary via a referral. Even if a physician in the same practice, but at a different practice location with a different Medicaid "pay-to or group" provider ID, treats a beneficiary, the services rendered still need a referral from the PCP. If a beneficiary has failed to establish a medical 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 beneficiary 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 beneficiary 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 beneficiary 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 beneficiary'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 beneficiary's eligibility on the date of service.

# MANAGED CARE SUPPLEMENT

## MANAGED CARE OVERVIEW

For a list of services requiring a referral number from the PCP, along with noted exceptions, please refer to the MHN Policy and Procedures Guide. 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

### Referrals for a Second Opinion

PCPs are required to refer a beneficiary for a second opinion at his or her request when surgery is recommended.

### Referral Documentation

All referrals must be documented in the beneficiary'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

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 [1] Services

# MANAGED CARE SUPPLEMENT

## MANAGED CARE OVERVIEW

- 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.

The above list is not all-inclusive. For a complete list of exempt services, refer to the MHN Policy and Procedures Guide on the SCDHHS website (www.scdhhs.gov). 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 http://scdhhs.gov/contact-us and a provider service representative will respond to you directly.

### *Primary Care Provider Requirements*

The primary care provider is required to either provide services or authorize another provider to treat the beneficiary. 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 (see the MHN Policy and Procedure Guide on the SCDHHS Web site (www.scdhhs.gov) for guidelines)

# MANAGED CARE SUPPLEMENT

## MANAGED CARE OVERVIEW

### 24-Hour Coverage Requirements

The MHN requires PCPs to provide access to medical advice and care for enrolled beneficiaries 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 beneficiary's presentation or notification. PCPs must have at least one telephone line that is answered by office staff during regular office hours.

### *Women, Infants, and Children (WIC) Program Referrals*

Federal law mandates coordination between Medicaid Managed Care programs and the WIC program. PCPs are required to refer potentially eligible beneficiaries to the local WIC program agency. The beneficiary must sign a WIC Referral Form and a Medical Records Release Form. Both forms are submitted to the local WIC agency for follow up.

For more information, providers should contact the local WIC agency at their county health department.

# MANAGED CARE SUPPLEMENT

## MANAGED CARE ELIGIBILITY

Individuals must apply for SC Medicaid as outlined in Section 1 of this manual. If the applicant meets the established eligibility requirements, he or she may be eligible for participation in the Managed Care program. Not all Medicaid beneficiaries are eligible to participate in the Managed Care program.

The following Medicaid beneficiaries are **not eligible** to participate in a **Managed Care Organization**:

- Dually eligible beneficiaries (Medicare and Medicaid )
- Beneficiaries 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
- Beneficiaries covered by an MCO/HMO through third-party coverage
- Beneficiaries enrolled in another Medicaid managed care plan

The following Medicaid beneficiaries are **not eligible** to participate in a **Medical Homes Network**:

- PACE participants
- Individuals institutionalized in a public facility
- Beneficiaries in a nursing home payment category (Residents of a nursing home)
- Participants in limited benefits programs such as Family Planning, Specified Low Income Beneficiaries, Emergency Services Only, etc.
- Beneficiaries enrolled in another Medicaid managed care program
- Beneficiaries covered by an MCO/HMO through third-party coverage

Providers should verify beneficiaries' eligibility through the Web Tool or a point-of-service (POS) terminal prior to delivering services.

# 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 beneficiaries into a managed care plan. Beneficiaries may enroll online, by telephone, by mail, or by fax. Managed Care eligible Medicaid beneficiaries are encouraged to actively enroll with a managed care plan. Medicaid beneficiaries may currently select among the following Medicaid service delivery options:

- Managed Care Organization
- Medical Homes Network

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, a health plan regardless of how long a beneficiary has been enrolled in their current health plan.

Not all Medicaid beneficiaries are eligible to participate in managed care. Beneficiaries who are eligible for participation are made aware of their eligibility via an outreach or enrollment mailing from SCHCC.

An **enrollment packet** is mailed to beneficiaries 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 beneficiary's payment category or Recipient Special Program (RSP) indicator, and is effective according to the published cut-off schedule.

If a Medicaid beneficiary enrolled in a managed care plan looses Medicaid eligibility, but regains it within 60-days, he or she will be automatically reassigned to the same plan and will forego a new 90-day choice period.

Beneficiaries cannot enroll directly with the MCO or the MHN. Beneficiaries must contact SCHCC to enroll in a managed care plan, or to change or discontinue their plan. A member can only change or disenroll without cause within the first 90 days of enrollment. If the beneficiary is approved to enroll in a managed care plan, or changes his or her plan, and is entered into the system before the established cut-off date, the beneficiary appears on the plan's member listing for the next month. If the beneficiary is approved, and entered into the system after the established cut-off date, the beneficiary will appear on the plan's member listing for the following month.

# MANAGED CARE SUPPLEMENT

## MANAGED CARE ENROLLMENT

### ENROLLMENT PROCESS

Medicaid beneficiaries receive a managed care enrollment packet or an outreach packet by mail within two days of first becoming eligible for Medicaid, or 30 to 60 days prior to their annual Medicaid review. Beneficiaries enrolled in a managed care plan will also receive a reminder letter from their health plan prior to their annual review date.

Beneficiaries are always encouraged to open, read, and respond to the enrollment packets to avoid plan assignment. While managed care enrollment is encouraged during annual review, FFS Medicaid beneficiaries may contact SCHCC to enroll at anytime. They do not need to wait to receive enrollment information. Beneficiaries enrolled in a managed care plan at the time of their annual review will remain in their health plan unless they contact SCHCC during their open enrollment (90-day choice period) to request a change.

When enrollment packets are mailed, beneficiaries have at least 30 days from the mail date to choose a health plan. If a beneficiary fails to act on the initial enrollment packet, outbound calls are placed in an effort to encourage plan selection. If, after the multiple outreach efforts, a beneficiary still fails to respond, he or she will be assigned to a managed care plan.

The assignment process places beneficiaries into health plans available in the county where the beneficiary resides based on the following criteria:

- The health plan, if any, in which the beneficiary was previously enrolled
- The health plan, if any, in which family members are enrolled
- The health plan selected by a random assignment process if no health plan was identified

There are three easy ways for beneficiaries 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 beneficiary is enrolled in a Managed Care plan for a period of 12 months. The beneficiary shall remain enrolled in the plan unless one of the following occurs:

- The beneficiary becomes ineligible for Medicaid and/or Managed Care enrollment
- The beneficiary forwards a written request to transfer plans for cause
- The beneficiary initiates the transfer process during the annual re-enrollment period
- The beneficiary requests transfer within the first 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 managed care plan. If, at the time of delivery, the mother is enrolled with an MCO, the baby will be automatically enrolled into the same MCO. If, however, the mother is enrolled with an MHN, or is FFS, the baby will revert to FFS Medicaid

for the first year of life. If the mother was enrolled in an MHN at the time of delivery, the CSO overseeing the MHN will outreach to encourage enrollment into the MHN. Newborns in FFS are still eligible to enroll in managed care and may be enrolled at anytime by contacting SCHCC.

Babies automatically enrolled into the mother's MCO have a 90-day choice period following birth during which a change to their health plan may be made. Following the 90-day choice period, the newborn enters into his or her lock-in period and may not change health plans 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.

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 managed care plan, all beneficiaries are "assigned" to a primary care provider (PCP). If the beneficiary calls SCHCC and chooses a health plan, he or she is asked to select a PCP at that time. If, however, SCHCC assigns the beneficiary to a health plan, the PCP "selection" is handled differently.

For beneficiaries assigned to an MCO, the MCO is responsible for assigning the PCP. For beneficiaries assigned to an MHN, SCHCC is responsible for assigning the PCP. After assignment, beneficiaries may elect to change their PCP. **There is no lock-in period with respect to changing PCPs.** Enrolled beneficiaries may change their PCP at any time and as often as necessary.

MCO members must call their designated Member Services area to change their PCP. MHN members may call either their Member Services area or speak with their current PCP to enact a change.

The name of the designated PCP will appear on all MCO cards. Should an MCO member change his PCP, he will be issued a new health plan 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

Beneficiaries not required to participate in managed care may request to disenroll and return to fee-for-service Medicaid. Beneficiaries required to participate in managed care may only request to transfer to another health plan as fee-for-service Medicaid is no longer an option for this population.

Disenrollment/transfer requests are processed through the enrollment counselor, SCHCC. The beneficiary, the MCO, the MHN, or SCDHHS may initiate the process. During the 90 days following the date of initial enrollment with the managed care plan, beneficiaries may change plans without cause. Only one change may be requested during this period. Once a change has been requested, or the 90 days following the date of initial enrollment has expired, beneficiaries move into their "lock-in" period. Requests to change health plans made during the lock-in period are processed only for "just cause." Please refer to the MCO or MHN Policy and Procedures Guide for additional information concerning just cause.

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 beneficiary 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 health plan to discuss his or her issues, as well as the person with whom the beneficiary spoke. Failure to provide all required information results in denial of the disenrollment request as all such requests must be reviewed by the SCDHHS Managed Care staff.

Upon review by Managed Care staff, the managed care plan is notified of the request to disenroll so that a plan representative may follow up with the beneficiary in an effort to address the concerns raised. Managed care plans are required to notify SCDHHS within 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 beneficiary remains in the managed care plan. A beneficiary's request to transfer is honored if a decision has not been reached within 60 days of the initial request. The final decision to accept the beneficiary's request is made by SCDHHS.

If the beneficiary believes he or she was disenrolled/transferred in error, it is the beneficiary's responsibility to contact SCHCC or the managed care plan for resolution. The beneficiary may be required to complete and submit a new enrollment form to SCHCC.

### INVOLUNTARY BENEFICIARY DISENROLLMENT

A beneficiary may be involuntarily disenrolled from a managed care plan at any time deemed necessary by SCDHHS or the plan, with SCDHHS approval.

The plan's request for beneficiary disenrollment must be made in writing to SCHCC using the applicable form, and the request must state in detail the reason for the disenrollment. The request must also include documentation verifying any change in the beneficiary's status. SCDHHS determines if the plan has shown good cause to disenroll the beneficiary and informs SCHCC of

# MANAGED CARE SUPPLEMENT

## MANAGED CARE DISENROLLMENT PROCESS

their decision. SCHCC notifies both the plan and the beneficiary of the decision in writing. The plan and the beneficiary have the right to appeal any adverse decision. Managed care plans are required to inform providers of those beneficiaries disenrolling from their programs. Providers should always check the Medicaid eligibility status of beneficiaries before rendering service.

The plan may not terminate a beneficiary's enrollment because of any adverse change in the beneficiary's health. An exception would be when the beneficiary's continued enrollment in the plan would seriously impair the plan's ability to furnish services to either this particular beneficiary or other beneficiaries.

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 or MHN Policy and Procedures Guide.

# MANAGED CARE SUPPLEMENT

## EXHIBITS

### MANAGED CARE PLANS BY COUNTY

A map of the Managed Care plans by county is available on the SCDHHS website at www.scdhhs.gov. Not all MCOs are authorized to operate in every county within the state. Providers should refer to the map for SCDHHS-approved MCOs operating within their service area.

The **Exhibits** section provides the contact information and a card sample for each MCO currently operating in South Carolina.

### CURRENT MEDICAID MEDICAL HOMES NETWORK (MHNS)

The following MHNs are participants in the South Carolina Healthy Connections (Medicaid) Managed Care program. MHN beneficiaries should present their South Carolina Healthy Connections Medicaid Insurance card in order to receive health care services. No additional card is necessary.

#### Carolina Medical Homes

250 Berryhill Road, Suite 202
Columbia, SC 29210
(803) 509-5377 or (800) 733-1108
www.carolinamedicalhomes.com

#### Palmetto Physician Connections

531 South Main Street, Suite 307
Greenville, SC 29601
(888) 781-4371
www.palmettophysicianconnections.com

#### South Carolina Solutions

132 Westpark Blvd
Columbia, South Carolina 29210
(803) 612-4120 or (866) 793-0006
(803) 612-4152 or (888) 893-0018
www.sc-solutions.org

# MANAGED CARE SUPPLEMENT

## CURRENT MEDICAID MANAGED CARE ORGANIZATIONS

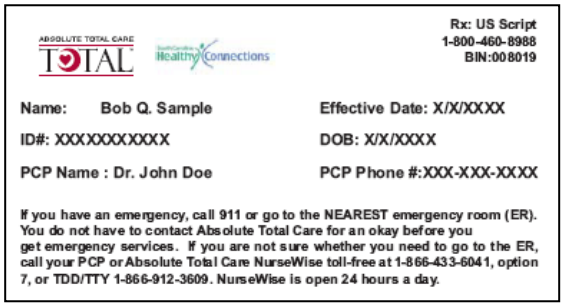
South Carolina Healthy Connections (Medicaid) Managed Care Organizations are required to issue a plan identification card to enrolled beneficiaries. Beneficiaries should present both the MCO-issued identification card and the Healthy Connections Medicaid card. MCO cards contain important information on the beneficiary (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. Not all MCOs are authorized to operate in every county of the state. Please consult the SCDHHS website at www.scdhhs.gov for the current list of authorized plans and counties.

### Absolute Total Care

Centene Corporation
(866) 433-6041
www.absolutetotalcare.com

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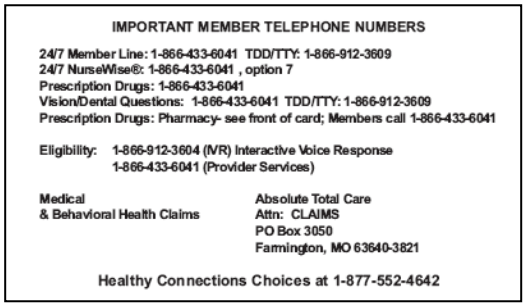


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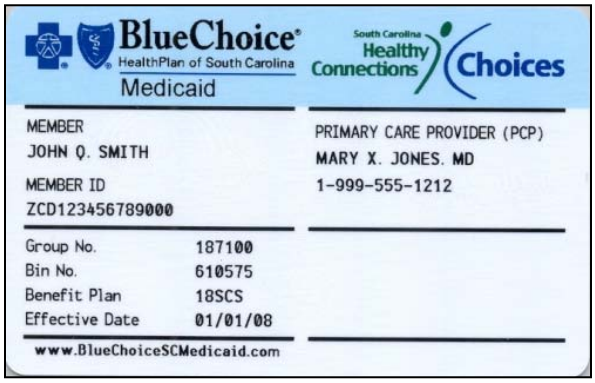
# MANAGED CARE SUPPLEMENT

## BlueChoice

BlueChoice HealthPlan of South Carolina Medicaid
(866) 781-5094
www.bluechoicesc.com

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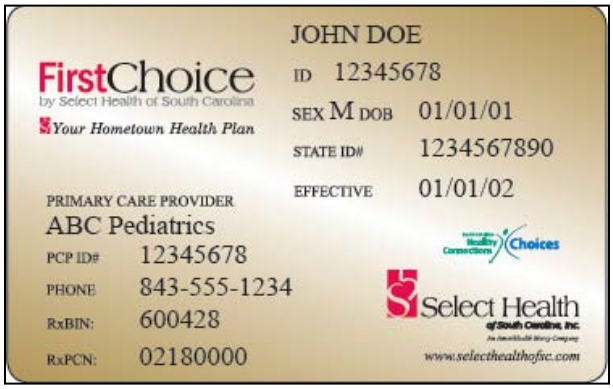
## First Choice by Select Health

Select Health of South Carolina, Inc.
(888) 276-2020
www.selecthealthofsc.com

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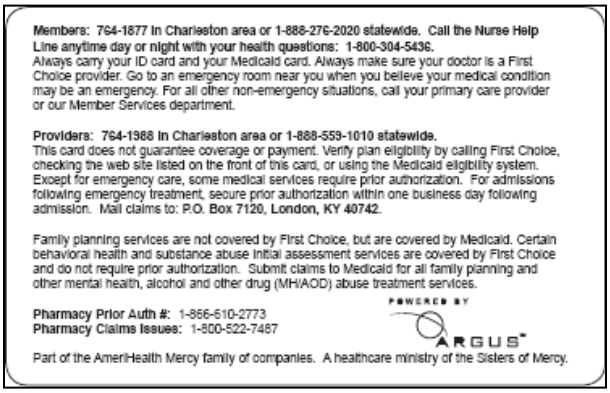


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# MANAGED CARE SUPPLEMENT

## UnitedHealthcare Community Plan

UnitedHealthcare Community Plan
(800) 414-9025
www.uhccommunityplan.com


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