Healthy Connections

PROVIDER MANUAL

Community Long Term Care

Established February 1, 2005
Updated December 1, 2016

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections
MEDICAID

South Carolina
DEPARTMENT OF HEALTH AND HUMAN SERVICES
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January 11, 2005

MEDICAID BULLETIN

CLTC *05-01*

TO: **Community Long Term Care (CLTC) Providers**

SUBJECT: **Medicaid Policy Manual for Community Long Term Care Providers**

The enclosed revised Community Long Term Care Medicaid Provider Manual is effective February 1, 2005, and includes all previous HIPAA changes and Medicaid policy bulletins.

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

In addition to inclusion of policy changes specific to the CLTC 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 new 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 CLTC 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 contains procedure codes.

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

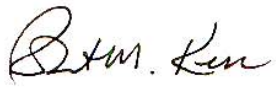
The **appendices** include the following:

- Edit Codes, CARCs & RARCs, and Resolutions
- Carrier Codes

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

The manual is not subject to copyright regulations and may be reproduced in its entirety.

If you have any questions regarding this provider manual, please contact your program coordinator in the Division of Community Long Term care at (803) 898-2590. Thank you for your continued support of the South Carolina Medicaid program.



Robert M. Kerr
Director

RMK/bgaw

Enclosures

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

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CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
12-01-16	3	7 8 17	• Updated Diagnostic Codes • Updated Place of Service Key • Updated CMS-1500 Instructions, field 24D
12-01-16	Forms	-	Updated Claim Reconsideration Form
11-01-16	Appendix 2	-	Updated carrier codes
10-01-16	1	5 6	Deleted SC Healthy Connections Checkup Program language and moved sample Checkup card to South Carolina Healthy Connections Medicaid Card section
10-01-16	6	40-51	Updated Case Management
09-01-16	6	16	Updated Adult Day Health Care (ADHC) Services
09-01-16	Appendix 1	67	Updated edit code 979
09-01-16	Appendix 2	-	Updated carrier codes
08-01-16	1	2, 4, 5, 24, 27	Updated to reflect Medicaid Bulletin dated July 11, 2016 – New Medicaid Cards
08-01-16	Appendix 1	22, 23, 66	Updated edit codes 527, 532, and 965
07-01-16	Appendix 1	3, 65	Updated edit codes 062 and 974
06-01-16	5	- 1 3 5-6	• Updated hyperlinks throughout section • Updated Administration section • Updated Procurement of Forms section • Updated CLTC Regional Offices addresses
06-01-16	Appendix 1	44 3, 14, 29, 30, 63	Added new edit codes 801 and 802 Updated CARC for edit codes 079, 356, 357, 605, 693, and 958
05-01-16	Appendix 1	6, 63, 67	Updated edit codes 150, 953, 989, 990
05-01-16	Appendix 2	-	Updated carrier codes
04-01-16	Managed Care Supplement	18-19	Replaced sample MCO cards
03-01-16	Appendix 1	19, 23	Added edit codes 450 and 532

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
02-01-16	1	-	Updated the following sections to reflect Medicaid Bulletin dated January 26, 2016 – Updates to Section 1 – All Provider Manuals: • South Carolina Medicaid Program o Program Description o SC Healthy Connections Medicaid Card(s) • Records/Documentation Requirements o General Information o Signature Policy • Medicaid Program Integrity o Program Integrity • Appeals
01-01-16	Cover	-	Inserted page 2 of Medicaid Bulletin dated January 11, 2005
01-01-16	1	19	Updated to reflect Medicaid Bulletin dated December 9, 2015 - Charge Limits
01-01-16	Appendix 1	21	Added edit code 527
12-01-15	Cover	-	December 1, 2015 - Replaced manual cover
11-01-15	Appendix 1	19, 44-47	• Revised edit code 507, 821, 837, 838, 839
10-01-15	1	7 10	• Updated to add SCDHHS alerts • Updated Provider Participation
10-01-15	Appendix 1	1 1 All 4, 20, 23, 27, 43	• Updated general instructions • Updated the following to reflect Medicaid Bulletin dated June 1, 2015 — ICD-10 Clinical Modification/ Procedure Coding System o Added note to general instructions o Replaced ICD-9 with ICD-CM throughout section • Deleted edit codes 102-109, 112-116, 503, 527, 566, 791, 792
09-01-15	3	 14-15 23	• Updated the following sections to reflect Medicaid Bulletin dated June 1, 2015 - ICD-10 Clinical Modification/ Procedure Coding System: o CMS-1500 Claim From Completion Instructions, field 21 • Updated SC Medicaid Web-based Claims Submission Tool to reflect Medicaid Bulletin dated June 19, 2015 – Claim Submission Web

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
			Portal (Webtool) Enhancement SC Medicaid Web-based Claims Submission Tool
09-01-15	Appendix 1	5, 14	• Added edit codes 270 and 271 and updated edit code 110 to reflect Medicaid Bulletin dated June 1, 2015 — ICD-10 Clinical Modification/Procedure Coding System
07-01-15	Appendix 3	1-2	Updated Copayment Schedule
05-01-15	2	31-33	• Updated CLTC Standards for Bathroom Safety Products
05-01-15	6	60	• Updated Transition Coordination Service
03-13-15	3	13-14 23	• Updated CMS-1500 Claim Form Completion Instructions • Updated SC Medicaid Web-based Claims Submission Tool (Web Tool)
03-03-15	6	3	Correct typo in Standard for Waiver Services heading
03-01-15	Appendix 2		Updated carrier codes
01-01-15	Forms		Updated Claim Reconsideration form
12-01-14	1	9, 10	Updated Provider Participation to reflect Medicaid Bulletin dated October 31, 2014 – Update to Section 1 of All Provider Manuals
12-01-14	3	3-5 27-28	Added the following policies: • Copayment • Claim Reconsideration
12-01-14	Forms		Added Claim Reconsideration form
12-01-14	Appendix 1	6, 50	Updated edit codes 121 and 839
12-01-14	Appendix 3	1-2	Added to manual
12-01-14	Managed Care Supplement	2	Updated Managed Care Organizations (MCOs) to reflect Medicaid Bulletin dated October 31, 2014 – Update to Section 1 of All Provider Manuals
11-01-14	5	5	Updated CLTC Regional Office listing

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
11-01-14	6	40-51	Updated Case Management
11-01-14	Appendix 1	70	Updated edit code 989
10-01-14	1	33-34	Updated Medicaid Beneficiary Lock-In Program
10-01-14	Appendix 1	3, 31, 36, 48-49, 61 46	• Updated edit code 079, 637, 719, 820, 821, 908, 909 • Added new edit code 790
09-01-14	6	1 3 40 58 66 78 83 99 101, 117 153 26-29 168-175	• Updated the following sections: o Changed Mandatory Training to Mandatory Meeting o Adult Day Health Care (ADHC) o Case Management o Companion o Individual Companion o Nursing o Pediatric Medical Day Care o Personal Care I o Personal Care II, HASCI Attendant Care, HASCI Respite and Medically Complex Children (MCC) Respite Services o Skilled Respite • Add scopes of services for Adult Day Health Care – Nursing and Telemonitoring
08-01-14	1	6	Updated to reflect Medicaid Bulletin dated July 22, 2014 – Coverage of New Screening Services for Healthy Connections Checkup
08-01-14	2	1 2 3, 14, 35, 45, 46, 56, 65, 66, 83, 84, 97, 98, 116, 136, 139 40 41 70, 110, 127 130	• Added Medicaid Eligibility • Updated Mandatory Training • Added Mandatory Reporter • Updated the following: o Conditions of Participation o Case Management Training o Compliance o Conduct of Service o Description of Services to be provided

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
08-01-14	Appendix 1	51, 69 24, 48-51, 58	• Deleted edit codes 845 and 969 • Updated edit codes 537, 837-839, 843, 844, and 892
07-01-14	6	-	New section - Standards for Waiver Services
07-01-14	Appendix 1	15	Updated resolution for edit code 349
06-01-14	Appendix 1	3, 12	Updated resolutions for edit codes 079, 227, and 239
06-01-14	Appendix 2	All	Updated carrier codes
05-01-14	General Table of Contents	1	Removed DHHS county office listing
05-01-14	5	1 23	• Replaced reference to county office listing with the Where To Go for Help web address • Removed DHHS county office listing
05-01-14	Appendix 1	1, 2, 4, 45, 46, 62, 64, 92, 93	Updated edit codes 007, 052, 079, 715, 719, 837, 839, 977, 984
04-01-14	1	6, 23, 25 29-31 32 33 37 39 41-44	• Updated the following sections to reflect Medicaid Bulletin dated December 3, 2013 – Discontinuation of Edit Correction Form • Updated the following sections: o Program Integrity o Recovery Audit Contractor o Beneficiary Oversight o Fraud o Referrals to the Medicaid Fraud Control Unit o Updated acronym for U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG)
04-01-14	2	9 24	• Updated Prior Authorization for Hospice Participants to reflect Medicaid Bulletin dated December 3, 2013 – Discontinuation of Edit Correction Form • Updated Billing Procedures and Service Monitoring
04-01-14	3	1-33	• Updated to reflect Medicaid Bulletin dated December 3, 2013 – Discontinuation of Edit

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		5 9- 21 21 23-24	Correction Form • Updated Care Call • Updated to reflect Medicaid Bulletin dated November 30, 2013 – Transition to the CMS-1500 Health Insurance Claim Forms (02/12) version • Updated Trading Partner Agreement • Updated SC Medicaid Web-based Claims Submission Tool (Web Tool)
04-01-14	5	28	Updated Horry County address
04-01-14	Forms		• Updated Reasonable Effort Documentation and Duplicate Remittance Advice Request forms • Removed note on CMS-1500 (02/12) version claim form • Removed CMS-1500 (08/05) version claim form (s) • Removed Sample Edit Correction Form • Updated Sample Remittance Advice
04-01-14	Appendix 1	35 -	• Added edit code 527 • Entire section: o Updated to reflect Medicaid Bulletin dated December 3, 2013 – Discontinuation of Edit Correction Form o Updated to reflect Medicaid Bulletin dated November 30, 2013 – Transition to the CMS-1500 Health Insurance Claim Forms (02/12) version
04-01-14	TPL Supplement	5 6-8 9-10 10-11 13-14 15-16 22-23 30-31	• Updated the following sections to reflect Medicaid Bulletin dated December 3, 2013 – Discontinuation of Edit Correction Form: o Timely Filing Requirements o Reasonable Effort o Nursing Facility Claims o Professional, Institutional, and Dental Claims o Rejected Claims o Recovery o Sample Forms – Reasonable Effort o Sample Forms – ECF (deleted)
02-01-14	Cover	-	January 1, 2014 - Replaced manual cover

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
02-01-14	3	2	Corrected Medicare timely filing requirement
02-01-14	5	27	Updated Florence County office telephone number
01-01-14	1	1, 2, 11 6, 23, 25 1-2 4 6 26 29-30 32 32	Updated to reflect the following bulletins: • Managed Care Organizational Changes dated November 15, 2013 • Discontinuation of Edit Correction Forms (ECFs) dated December 3, 2013 Updated the following sections: • Eligibility Determination • South Carolina Health Connections Medicaid card • South Carolina Web-based Claims Submissions Tool • Retroactive Eligibility • Program Integrity • Recovery Audit Contractor • Beneficiary Explanation of Medical Benefits Program
01-01-14	2	8 9	Updated entire section to reflect the following bulletins: • Claim Forms (02/12) version dated November 20, 2014 Transition to the CMS-1500 Health Insurance Claim Forms (02/12) version dated November 20, 2014 • Discontinuation of Edit Correction Forms (ECFs)s dated December 3, 2013
01-01-14	3	-	Updated entire section to reflect the following bulletins: • Discontinuation of Edit Correction Forms (ECFs)s dated December 3, 2013 • Transition to the CMS-1500 Health Insurance Claim Forms (02/12) version dated November 20, 2014 • Managed Care Organizational Changes dated November 15, 2013
01-01-14	5	1 3-4	Updated the following sections • Correspondence and Inquiries • Procurement of Forms
01-01-14	Forms		• Added CMS-1500 (02/12) version claim form

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
			• Added note to CMS-1500 (05/85) version claim form • Updated Duplicate Remittance Advice Request and EFT Authorization Agreement form
01-01-14	Appendix 1		Updated to reflect the following bulletins: • Discontinuation of Edit Correction Forms (ECFs)s dated December 3, 2013 • Transition to the CMS-1500 Health Insurance Claim Forms (02/12) version dated November 20, 2014 • Managed Care Organizational Changes dated November 15, 2013
01-01-14	Managed Care Supplement		Updated to reflect bulletin Managed Care Organizational Changes dated November 15, 2013
01-01-14	TPL Supplement		• Updated to reflect bulletin Transition to the CMS-1500 Health Insurance Claim Forms (02/12) version dated November 20, 2014
12-01-13	5	30	Updated Orangeburg mailing address zip codes
11-01-13	5	31	Updated York County mailing address
11-01-13	MC Supplement	18	Replaced BlueChoice MCO Medicaid card
10-01-13	5	30 31	• Updated Orangeburg office and mailing address • Updated York County office address
10-01-13	Appendix 1	- 5, 39 69 37, 42, 44	• Updated CARCs/RARCs throughout section • Added edit codes 110 and 725 • Deleted edit code 961 • Revised edit codes 720, 749, 750, 758, and 759
10-01-13	MC Supplement	20	• Added WellCare MCO Medicaid card and contact information
09-01-13	5	26 28 31	• Updated Darlington County zip code • Updated Laurens County phone number • Updated York County office address
08-01-13	2		Revised CLTC Standards for Bathroom Safety Products to include the following specifications: • Bariatric Raised Toilet Seats • Bariatric Shower Transfer Benches

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
			• Bariatric Shower Seats
08-01-13	5	31	Updated York County physical address
08-01-13	Appendix 1	1 50, 51 72	• Updated resolution for edit code 007 • Updated RARC and resolution for edit codes 820 and 821 • Deleted edit codes 954, 955, and 956
08-01-13	Appendix 2	All	Updated carrier codes
07-01-13	5	25 29	• Updated Colleton County office telephone number • Deleted Newberry County PO Box address
06-01-13	5	31	• Updated Richland county office telephone number
06-01-13	Appendix 1	5, 11, 15, 33, 40 30	• Updated resolutions for edit codes 107, 219, 339 673, 720 • Deleted edit code 577
04-01-13	1	6	Corrected the URL for MedicaideLearning.com
04-01-13	Appendix 1	2 20, 25, 28 4, 39, 52, 53, 57, 59 73 50, 51 67, 69	• Changed edit code description reference DMR and MR/RD to ID/RD for edit code 052 • Updated CARCs for edit codes 460, 544, 569 • Updated resolutions for edit codes 079, 722, 837, 838, 855, 865, 960 • Added edit codes 820, 821 • Updated edit code 935, 938, 939
04-01-13	Appendix 2	-	Updated carrier code list
03-01-13	5	29	Deleted Jasper County PO Box address
03-01-13	Appendix 1	i 2, 38, 70 38, 54, 70	Deleted Change Log Changed edit code description reference to DMR and MR/RD to ID/RD for edit codes 052, 053, 712, and 953 Updated resolutions for edit codes 714, 851, and 953
03-01-13	Managed Care Supplement	7	Deleted the Department of Alcohol and Other Drug Abuse from agencies exempt from prior authorizations
02-01-13	1	18	Updated URL address for the National Correct

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
			Coding Initiative (NCCI)
01-01-13	5	23 25	• Added Chester county Zip+4 code • Updated Greenville PO Box address
01-01-13	Appendix 1	-	Added Change Log for section changes
12-03-12	1	6 7-8 27-32 33-41	• Updated web addresses for provider information and provider training • Revised heading and language to reflect new provider enrollment requirements • Updated Program Integrity language (entire section) • Revised heading and language for Medicaid Anti-Fraud Provisions/Payment Suspension/Provider Exclusions/Terminations (entire section)
12-03-12	3	9 13 22, 41, 43 27-28	• Updated National Provider Identifier and Medicaid Provider Number • Updated fields 17, 17b to add requirement for referring or ordering provider NPI • Updated provider information web addresses • Updated Electronic Funds Transfer (EFT)
12-01-12	5	6 27	• Updated web address for provider information • Updated McCormick county office telephone number
12-03-12	Forms	-	• Removed provider enrollment forms •
12-01-12	Appendix 1	24, 26, 27, 32, 33 19, 27, 40, 44, 45, 47, 49, 50, 55, 56, 57, 59, 60, 61,	• Updated CARCs for edit codes 538, 552, 555, 561, 562, 563, 636, 637, 690 • Updated resolutions for edit codes 402, 561, 562, 563, 721, 722, 748, 749, 752, 753, 769, 791, 795, 852, 853, 856, 860, 884, 887, 892, 897, 925, 926
12-01-12	TPL Supplement	8, 9, 17	Updated web addresses for provider information and provider training
11-01-12	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

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
10-01-12	1	4	Replaced back of Healthy Connections Medicaid card
10-01-12	Appendix 1	-	Updated edit code information through document
09-01-12	2	27-31	Updated general ramp specifications
09-01-12	5	-	Updated formatting throughout document
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, 26, 35, 38-39 9, 20, 27	• Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012 • Updated hyperlinks
08-01-12	5	1 5 7	• Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012 • Removed fax request information for SCDHHS forms • Added SCDHHS forms online order information • Updated telephone number for Greenville county office
08-01-12	Forms	-	• Deleted forms 140 and 142 • Updated Duplicate Remittance Advice Request Form
08-01-12	Appendix 1	- 1, 24, 60, 65, 66-67,70-72 15, 31, 69 8, 10, 29, 31 10, 11, 14, 34, 48	• Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012 • Replaced CARC 141 or CARC A1 for edit codes 52, 053, 517, 600, 924-926, 929, 954, 961, 964, 966, 967, 969, 980, 985-987 • Added edit codes 349, 590, 978, 990, 991-995 • Deleted edit codes 166, 205, 573, 574, 593, 596 • Updated resolution for edit codes 170-172, 171, 174, 210, 321, 711, 798
08-01-12	Managed Care Supplement	1-2 7	• Changed Division of Care Management to Bureau of Managed Care • Updated program area contact information to

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		11 17 19	reflect Medicaid Bulletin dated June 29, 2012 • Removed language limiting enrollment to 2500 members • Update contact information for Palmetto Physician Connections • Added to "Medicaid" to BlueChoice HealthPlan
08-01-12	TPL Supplement	5, 6, 10,17, 24	Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012
07-01-12	Appendix 1	16, 48 45	• Deleted edit codes 386 and 868 • Added edit codes 837, 838, 839
08-01-12	TPL Supplement	5, 6, 10,17, 24	Changed all contact information for program areas/representatives to the PSC per Medicaid Bulletin dated June 29, 2012
07-01-12	Appendix 2	-	Updated carrier codes
05-01-12	Appendix 1	62	Updated edit code 975
04-01-12	1	4	Replaced South Carolina Healthy Connections card
04-01-12	5	16 17	• Updated address for Marion County • Updated phone number for Newberry County
02-07-12	Cover	-	Manual cover updated January 1, 2012
02-07-12	Appendix 1	18 24 30	• Updated edit code 402 • Updated edit code 544 • Updated edit code 636, 637, and 642
02-01-12	2	22 27-36 38	• Updated Staffing and Operating Procedures Section • Added section for CLTC Waiver Supply Providers • Deleted Environmental Modifications section
02-01-12	3	23 27	• Added a note regarding The Web Tool • Updated the Remittance Advice -835 Transaction
02-01-12	5	9	Updated the Fairfield county office number

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
02-01-12	Appendix 1	18 30 42 49	• Updated edit code 402 • Updated edit code 637 • Updated edit code 766 • Updated edit code 867
01-01-12	1	2-5, 20, 24	Deleted IVRS Information per "Retirement of Toll Free Eligibility Verification Line" bulletin released 11-18-11
01-01-12	3	- 27	• Updated hyperlinks throughout section • Updated EFT information
01-01-12	5	1	Deleted IVRS Information per "Retirement of Toll Free Eligibility Verification Line" bulletin released 11-18-11
01-01-12	Appendix 1	62 -	• Deleted IVRS Information per "Retirement of Toll Free Eligibility Verification Line" bulletin released 11-18-11 • Updated CARCs and RARCs throughout the document
01-01-12	Managed Care Supplement	9	Deleted IVRS Information per "Retirement of Toll Free Eligibility Verification Line" bulletin released 11-18-11
01-01-12	TPL Supplement	2	Deleted IVRS Information per "Retirement of Toll Free Eligibility Verification Line" bulletin released 11-18-11
11-01-11	1	24	Updated TPL contact information
11-01-11	2	14 16 23	• Added paragraph 2, shipping requirements, for Authorizations for Incontinence Products • Added "Medline" to bullet #2 • Add delivery confirmation slips policy under Documentation Requirements
11-01-11	3	35, 38, 44, 46	Updated TPL contact information
11-01-11	5	5	Updated CLTC Regional Offices addresses
11-01-11	TPL Supplement	6, 15	• Changed Medicare timely filing requirement to two years and six months

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		12 3, 17, 19	• Deleted policy to use Medicaid legacy provider number on the same line as the Medicaid carrier code • Deleted sample legacy number from UB-04 TPL Fields table • Updated TPL contact information
10-01-11	Appendix 1	14, 29 47	• Added edit codes 334 and 584 • Updated edit code 845
09-01-11	1	19	Deleted information regarding National Correct Coding Initiative
09-01-11	5	29	Updated zip code for Spartanburg County office
09-01-11	Appendix 1	15, 29, 30	Added edit code 361, 591, 596 and 605
08-01-11	2	i-iv 11-24	Updated the Table of Contents Added CLTC Waiver Supply Providers section
08-01-11	3	-	Updated language throughout section to reflect the current billing policies including claim processing, claim submission, and copayments
08-01-11	Appendix 1	8	Updated edit codes 165 and 166
08-01-11	Managed Care Supplement	1, 5	Updated to reflect the new beneficiary copayment requirements in accordance with Public Notice posted July 8, 2011
07-01-11	2	18-20	Updated the Intensive Behavioral Intervention section
07-01-11	5	29	Deleted PO Box address for the Spartanburg County Office
07-01-11	Appendix 1	43 56	• Added edit codes 840 and 841 • Updated Provider Enrollment Contact information in edit codes 941 and 944
06-01-11	5	21	Corrected Abbeville County PO Box Zip+4 Code

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
05-01-11	1	8, 11	Added language prohibiting payment to institutions or entities located outside of the United States
05-01-11	Appendix 1	43	Updated edit code 796
04-01-11	5	6	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	20, 27, 28	Updated to reflect Medicaid Bulletin dated February 9, 2011 – Provider Service Center
03-01-11	5	4 22	Updated to reflect Medicaid Bulletin dated February 9, 2011 – Provider Service Center Added toll free number for Aiken County
03-01-11	Appendix 1	- 67	Added SCDHHS Medicaid Provider Service Center (PSC) information at top of each page in header section Made change to Edit Code 990 description
03-01-11	Appendix 2	-	Updated alpha and numeric carrier code lists to reflect Web site update on 12/14/10
03-01-11	TPL Supplement	17 24, 25	• Changed the name of the Provider Outreach Web site to Provider Enrollment and Education • Updated the descriptions for Form130s
02-01-11	Appendix 1	3	Added edit codes 079 and 080
01-01-11	1	7 19-20	• Updated the South Carolina Medicaid Web-based Claims Submission Tool section • Updated to reflect Medicaid Bulletin dated December 8, 2010 – Information on NCCI Edits
01-01-11	3	20, 21, 25, 26, 28 18, 33	• Updated electronic remittance package information • Updated to reflect Medicaid Bulletin dated

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		25	December 10, 2010 – Reporting Patient Liability on Claims • Updated to reflect Medicaid Bulletin dated December 10, 2010 – Requests for Duplicate Remittance Package
01-01-11	5	30	Added toll-free telephone number for Saluda county
01-01-11	Forms	-	Added Duplicate Remittance Request Form
01-01-11	Appendix 1	9	Added edit codes 165 and 166
01-01-11	TPL Supplement	8, 10 8 10 13 15 15	• Removed references to Dental claims • Removed language to contact program areas for missing carrier codes • Added reference to CMS-1500 for correcting edit code 151 on the ECF • Added edit code 165 to other TPL-related insurance edit codes list • Updated Retro Medicare section to include the following: o Changed the timely filing requirement from 90 days of the invoice to 30 days o Added SCDHHS TPL recovery language • Updated the Retro Health and Pay & Chase section
12-01-10	Cover	-	Replaced “Medicaid Provider Manual” with “South Carolina Healthy Connections (Medicaid)”
12-01-10	Appendices	-	Replaced “South Carolina Medicaid” with “South Carolina Healthy Connections (Medicaid)” in the headers
12-01-10	Supplements	-	Replaced “South Carolina Medicaid” with “South Carolina Healthy Connections (Medicaid)” in the headers
11-01-10	Appendix 1	8 16 32	• Edit code 202: added information to Resolution section • Edit codes 421 and 424 deleted • Edit code 733 information updated in Resolution section: “Adjust the net charge in field” changed

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		51 52	from 26 to 29 • Deleted edit code 959 • Deleted edit codes 962 and 963
11-01-10	TPL Supplement	3, 8, 13-14, 18-19 6, 15-17	• Updated to reflect Medicaid Bulletin dated July 8, 2010 – Transfer of the Dental Program Administration to DentaQuest • Updated to reflect Medicaid Bulletin dated September 13, 2010 – Changes to the Third Party Liability Medicare Recovery Cycle
10-01-10	1	- 1 7 10	• Removed all reference to the SCHIP program to reflect Medicaid Bulletin dated August 19, 2010 – Changes to the Healthy Connections Kids (HCK) Program • Updated Program Description section • Updated the SC Medicaid Web-Based Claims Submission Tool section to reflect Medicaid Bulletin dated July 8, 2010-Transfer of the Dental Program Administration to DentaQuest • Updated Freedom of Choice section
10-01-10	5	28	Correct McCormick county office street address
10-01-10	Managed Care Supplement	- 1 2 3 4 5 6 13 17	• Removed all references to the SCHIP program to reflect Medicaid Bulletin dated August 19, 2010 – Changes to the Healthy Connections Kids (HCK) Program • Updated Managed Care Overview • Updated Managed Care Organizations and Core Benefits paragraphs • Updated MCO Program ID card paragraph • Updated MHN Program ID card paragraph • Updated Core Benefits • Updated Exempt Services • Updated Overview • Deleted “Medicaid Managed” from “Current Medicaid Managed Care Organizations” heading and following paragraph
09-01-10	3		Updated the following sections to reflect Medicaid Bulletin dated July 8, 2010 – Transfer of the Dental Program Administration to DentaQuest:

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		21 22 40	• Companion Guides • South Carolina Medicaid Web-based Claims Submission Tool • Claim-Level Adjustments
09-01-10	5	22 25 28	• Removed County Commissioner's Building from the Aiken County address • Deleted Dorchester County physical address telephone number • Removed Highway 28 N from the McCormick County address
09-01-10	Appendix 1	9 -	• Added edit code 225 • Removed all references to the ADA Claim in the Resolution column
09-01-10	TPL Supplement	12 13 18	• Updated the Dental Paper Claims section to delete paper claims submission instructions and added the DentaQuest contact information • Updated the Web-Submitted Claims section with the exception to Dental claims • Updated the TPL Resources section to include the DentaQuest contact information for TPL questions
08-01-10	5	22, 26 28-30 23	• Updated the zip codes for Aiken, Edgefield, McCormick, Newberry, and Saluda counties • Updated the address for Barnwell County • Updated the telephone number for Beaufort County
08-01-10	Appendix 1	20 51, 52 59	• Deleted edit code 520 • Deleted Provider Enrollment e-mail address from codes 941 and 944 • Changed resolution for edit code 994
07-01-10	5	-	Updated telephone numbers and zip codes for multiple county offices
07-01-10	Appendix 1	32 35	• Updated edit code 714 • Updated edit code 738
07-01-10	Appendix 2	21, 22, 25,	Changed First Health to Magellan Medicaid

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		63, 89	Administration
06-01-10	Managed Care Supplement	1 3 17 20, 23, 25	• Updated Managed Care Overview section • Updated Manage Care Organization (MCO), Core Benefits section • Updated the Managed Care Disenrollment Process, Overview section • Updated to reflect Medicaid Bulletin dated March 18, 2010 — Managed Care Organizational Change
05-01-10	5	1	• Removed reference to sample form at the end of this section • Replaced reference to sample form in the Forms section of this manual
03-01-10	Cover	-	Replaced the manual cover
03-01-10	Change Control Record	1	Added Time Limit for Submitting Claims Medicaid Bulletin date to section 1 and section 3 entries dated 12-01-09
03-01-10	3	5, 22	Removed modem as an electronic claims transmission method
02-01-10	Appendix 1	13 36	• Added New Edit Codes 356,357 and 358 • Updated Edit Code 738
02-01-10	Appendix 2	All	Updated Carrier Code List
01-01-10	5	22 27 29	• Updated Physical Address for Allendale County Office • Replaced Jasper County DSS with Jasper County DHHS • Replaced Orangeburg County DSS with Orangeburg County DHHS
01-01-10	Appendix 1	49	Updated Edit Code 932
12-01-09	1	8 25	• Updated policy to reflect Medicaid Bulletin dated November 13, 2009 – Electronic Remittance Package • Updated Timely Filing for Submitting Claims section to reflect Medicaid Bulletin dated

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
			November 24, 2009
12-01-09	3	1-3 20, 22, 25-28	• Updated Claim Filing Timeliness section • Updated policy to reflect Medicaid Bulletin dated November 13, 2009 – Electronic Remittance Package to reflect Medicaid Bulletin dated November 24, 2009
12-01-09	5	12	Updated the Dorchester County office street address
12-01-09	Appendix 1	- - 18, 19 20	• Replaced CARC 17 with CARC 16 • Updated CARC A1 • Updated codes 509 and 510 • Added code 533
11-01-09	Appendix 2	All	Updated carrier code list
10-01-09	1	3-4 4-6 26	• Updated the Medicare/Medicaid Eligibility section to include Qualified Medicare Beneficiaries (QMBs) • Updated SC Medicaid Healthy Connections language throughout section • Updated South Carolina Medicaid Bulletins and Newsletters • Changed heading to Medicare Cost Sharing
10-01-09	5	26 27 28	• Updated physical address for Jasper County office • Updated telephone number for Lexington County office • Updated zip codes for Orangeburg County office
10-01-09	Appendix 1	3 60	• Updated edit code 065 • Updated edit code 852
09-08-09	Managed Care Supplement	20	Replaced the Absolute Total Care Medicaid beneficiary card sample
09-01-09	Managed Care Supplement	21 20, 25	• Removed all references to CHCcares to reflect Medicaid Bulletin dated August 3, 2009 • Updated Absolute Total Care entries as following: o Changed the company's name to Absolute

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
			Total Care o Replaced the beneficiary card samples o Corrected contact information
08-01-09	5	30	Updated telephone number for York County office
08-01-09	Appendix 1	3	Updated edit code 062
08-01-09	Appendix 2	-	Updated carrier code list
07-01-09	5	22, 28 24 25	• Updated address for Bamberg and Orangeburg County offices • Updated office zip code for Darlington County • Updated telephone number for Fairfield County office
06-01-09	3	i	Correct formatting
06-01-09	TPL Supplement	19	Updated Department of Insurance Web site address
05-01-09	1	1-6, 11 2 3 5 28-33	• Updated to reflect managed care policies and procedures effective May 1, 2009 • Updated the Eligibility subsection • Added the beneficiary contact telephone number to the South Carolina Healthy Connections Medicaid Card subsection • Removed the program start date from the SC Healthy Connections Kids SCHIP Dental Coverage subsection • Updated the Medicaid Program Integrity subsection
05-01-09	5	29	Updated telephone number for Union County office
05-01-09	Appendix 1	43	Deleted edit code 694
05-01-09	Appendix 2	-	Updated list of carrier codes
05-01-09	Managed Care Supplement	-	Updated supplement to include general policies and procedures effective May 1, 2009

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
04-01-09	1	2, 3, 8	Updated hyperlinks
04-01-09	3	6, 9, 20, 25, 33, 36	Updated hyperlinks
04-01-09	5	27	Updated telephone number for Lexington County office
03-01-09	5	3-4 24 21, 27-29	• Update hyperlinks • Corrected Dorchester County's Orangeburg Road telephone number • Change DSS to DHHS in addresses for Abbeville, McCormick, Newberry, and Saluda counties
03-01-09	Appendix 1	43 72	• Added new edit codes 693 and 694 • Changed edit code 945 Resolution to input "26"modifier in field 18
03-01-09	Managed Care Supplement	1, 7, 10, 17, 23, 25-30, 35	Updated hyperlinks
03-01-09	TPL Supplement	8, 9, 19	Updated hyperlinks
02-01-09	4	4-5	Updated page formatting
02-01-09	5	21	Updated Allendale County office PO Box zip code
02-01-09	Forms	-	Updated Authorization Agreement for Electronic Funds Transfer (EFT) form
02-01-09	Appendix 2	-	Updated list of carrier codes
01-01-09	1	8	Updated hyperlink for bulletin.scdhhs.gov
01-01-09	5	27	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	23, 25	Added EFT information to reflect Medicaid Bulletin

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
			dated August 26, 2008
10-01-08	3	27	Changed ECF field 1 to Prov/Xwalk ID
10-01-08	5	25, 29	• Updated address for Lake City • Updated phone number for Sumter County office
10-01-08	Forms	-	Revised ECF example to show update for field 1
10-01-08	Appendix 1	-	Updated edit codes 007, 059, 112, 219, 308, 339, 386, 403, 710, 722, 786, 798, 799, 843, 844, 845, 912, 914, 928, 941, 942, 943, 945, 952
09-01-08	5	22	Updated phone number for Berkeley County office
09-01-08	5	26	Updated phone number for Kershaw County office
09-01-08	Appendix 1	17	Added Edit Code 318
08-01-08	Appendix 1	3	Updated Edit Code 062
08-01-08	5	23	Deleted PO Box for Chester County
07-01-08	5	27	Deleted PO Box for Lancaster County
07-01-08	Managed Care Supplement	27	Replaced Web site address for BlueChoice
06-01-08	3	9, 16, 17, 19, 20, 24	Updated NPI policy and form instructions to reflect May 23, 2008, deadline requiring NPI only on claims for typical providers
06-01-08	5	28	Updated telephone number for Orangeburg county office
06-01-08	Appendix 1	30, 39, 42	• Added new edit code 529 • Deleted NPI warning edits 578, 579, 580, 581, 582, 583, 692
06-01-08	TPL Supplement	-	Updated Example Dental Claim Form Reporting Third-Party for Medicare Information to show NPI only; change/removed sample entries for fields 8, 15, 23, and 49; and added a tooth number to line 4

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
05-01-08	Appendix 1	3, 38 31	• Revised edit codes 062 and 569 • Added edit code 520
05-01-08	Managed Care Supplement	-	Revised supplement to include general policies and procedures effective May 1, 2008 and updated the SCDHHS-approved MCO contractors section
04-01-08	5	24	Updated address and phone number for Dorchester County office
04-01-08	Appendix 1	4, 13, 20, 33	Added edit codes 062, 219, 339, 528
04-01-08	TPL Supplement	2 3, 8, 15 12 29	• Updated reference to Medicaid card name • Changed references to location of forms from Section 5 to Forms section • Updated field numbers for occurrence codes on UB-04 • Replaced sample ADA forms with more attractive version
03-01-08	1	3-5 7	• Replaced sample Partners for Health Medicaid card with new Healthy Connections card and updated card information. • Deleted information about location of supervising entities – requirements will be included in Section 2 where applicable
03-01-08	3	9-20 All	• Updated NPI policy and form instructions to reflect March 1, 2008, deadline requiring NPI on claims on typical providers (with or without Medicaid legacy number). • Standardized formatting
03-01-08	Forms	-	Replaced Form 931 with new version dated January 2008
03-01-08	Appendix 1	59 70	• Added edit code 808 • Revised edit code 943 description and status (from warning to active)
03-01-08	TPL Supplement	9 21-22	• Added information on carrier code “CAS” for open casualty cases • Replaced Form 931 samples with new versions

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
02-01-08	3	12 31, 33 47	• Corrected instructions for field 10b • Standardized references to six-character legacy Medicaid provider number • Corrected mailing address for refunds
02-01-08	5	1	Removed "including Partners for Health" from first paragraph
02-01-08	Forms	-	Corrected mailing address for Medicaid Refunds Form 205
01-01-08	5	26	Updated address for Lancaster County office
01-01-08	Managed Care Supplement	1 3	• Removed PhyTrust from the list of MHNs • Added Carolina Crescent to the list of MCOs
11-01-07	5	25, 26	• Updated telephone numbers for Florence and Kershaw counties • Updated Horry County address to 1601 11th Ave., 1st Floor
11-01-07	Appendix 1	All	• Corrected ECF field numbers throughout edit codes resolution instructions • Added new edit code 107
11-01-07	Appendix 2	All	Updated list of carrier codes
10-01-07	1	1-2 3 4 12 15 25	• Removed PEP information • Added information about managed care enrollment broker and Managed Care Supplement • Removed managed care sample cards (cards and other information will appear in the new Managed Care Supplement). • Clarified that "days" refers to business days • Clarified which sections of manual may contain PA information • Expanded provider list under Program Integrity
10-01-07	3	14, 47	• Removed PEP information • Added 90-day time limit for reversing refunds
10-01-07	Appendix 1	26	• Corrected description for edit code 502

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		38-40, 43, 70	• Added NPI warning edits 578-583, 692, 943
10-01-07	-	-	Added Managed Care Supplement
10-01-07	TPL Supplement	15-17	• Added 90-day time limit for reversing refunds • Added information on Part B timely filing schedule to explain which claims are pulled into Retro Medicare
07-01-07	1	All	Revised policies and procedures throughout section
07-01-07	Forms	-	Updated DHHS Form 205
07-01-07	Appendix 2	-	Updated list of carrier codes
06-06-07	2	3	Clarified description of enrollment procedure
06-06-07	3	-	Removed Time Restricted Supplement
06-06-07	3	All	• Updated form completion instructions for new CMS-1500 and Form 130 versions • Updated ECF and RA descriptions • Added information about National Provider Identifier • Replaced Reference to Forms 110 and 120 with Form 115 • Clarified retroactive eligibility policy • Updated ECF correction instructions • Added CPT and HCPCS ordering information • Make minor editorial changes throughout section
06-06-07	5	5	Corrected Rock Hill zip code
06-01-07	2	- 13 13-14 17-19	• Replaced all Elderly/Disabled references with Community Choices • Added Nursing Home Transition Service and Appliances to Community Choices Waiver • Inserted additional services under Nursing Home Transition Service • Removed Nursing Home Transition Grant and SC Choice • Added Pervasive Developmental Disorder Waiver

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
06-01-07	4	2 -	• Added Pervasive Developmental Disorder Waiver • Added and removed procedure codes
06-01-07	5	3-4 - 20-22 26 -	• Revised "Procurement of Forms" to address new CMS-1500 version and updated vendor information • Updated CLTC regional offices • Add toll-free number for Berkeley, Charleston, and Dorchester county offices • Updated phone number for Oconee County • Split forms and exhibits from Section 5 to create separate Forms section
06-01-07	Forms	-	• Updated DHHS forms to add National Provider Identifier field • Updated sample claims to new CMS-1500 version • Updated ECF and remits to new versions • Updated 219-CLTCGC, 219-CLTCG-NC, 219-CLTCIC, 219-CLTCI-NC
06-01-07	Appendix 1	-	Updated list of edit codes
06-01-07	TPL Supplement	All	• Updated all sample forms and claims with new versions • Updated form completion instructions to match new form versions
05-01-07	Appendix 1	-	Updated list of edit codes
04-01-07	5	22	Updated phone number for Darlington county office
04-01-07	Appendix 1	-	Updated list of edit codes
04-01-07	Appendix 2	-	Updated list of carrier codes
04-01-07	Time Restricted Supplement	-	Updated date for mandatory use of revised CMS-1500
03-01-07	5	20	Updated Barnwell county office address

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
03-01-07	Time Restricted Supplement	All	Removed all references to NDC quantity and unit
03-01-07	Appendix 1	-	Updated list of edit codes
02-01-07	TPL Supplement	31-32	Updated ECF Samples to show third payer line
01-01-07	3	-	Added Time Restricted Supplement
01-01-07	5	-	Added line “03” to sample ECF for the third payer declaration
01-01-07	Appendix 1	9, 14	Added Edit Codes 202, 203, 204, 301
01-01-07	Appendix 2	-	Updated list of carrier codes
11-01-06	5	-	Updated county office addresses
10-01-06	5	-	Updated county office addresses
10-01-06	Appendix 2	-	Updated list of carrier codes
09-01-06	5	-	Updated county office addresses
09-01-06	Appendix 1	10,11,13 15,17,18 22, 23, 24 26, 27, 28 29, 30, 31 32, 35, 36 39, 40, 41 42, 46, 47 48, 49, 50 52, 58, 60 61, 62, 63 66, 67	• Updated CARCs for edit codes 504, 561, 562, 563, 636, 923, 940, 949 • Updated RARCs for edit codes 207, 208, 227, 234, 239, 263, 317, 369, 377, 421, 501, 504, 505, 507, 508, 515, 541, 545, 553, 564, 570, 672, 674, 709, 714, 719, 721, 722, 748, 749 • Updated resolutions for edit codes 761, 764, 765 768, 769, 771, 772, 773, 774 • Added new edit codes 518, 724 • Deleted edit code 777
08-01-06	-	-	Added TPL Supplement
08-01-06	5	-	Updated Reasonable Effort Documentation form
07-01-06	Appendix 1	23, 60, 61	Updated resolutions for edit codes 504, 923, 940

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
07-01-06	Appendix 2	-	Updated list of carrier codes
05-01-06	Appendix 1	52	Updated resolution for edit code 852
04-01-06	Appendix 1	43	Updated resolution for edit code 735
04-01-06	Appendix 2	-	Updated list of carrier codes
03-01-06	3	17, 18 19 25 25 40	• Changed the Trading Partner Agreement (TPA) and the Companion Guides Web site references to www.dhhs.state.sc.us • Changed the Internet Explorer version required for the Web Tool to 6.0 • Added TPL indicators to the ECF field 4 description • Added Injury Code indicators to the ECF field 5 description • Changed address name for refund checks (Form 205) from Division of Finance to Cash Receipts
03-01-06	Appendix 1	60	Changed resolution for edit code 925
02-01-06	Appendix 1	41	Changed resolution for edit code 721
01-01-06	1	4 & 5	Removed SILVERxCARD sample and program description
01-01-06	5	-	Updated Authorization Agreement for Electronic Funds Transfer
01-01-06	Appendix 1	67	Added edit code 935
01-01-06	Appendix 2	-	Updated list of carrier codes
12-01-05	Appendix 1	70	Added edit code 949
11-01-05	1	6, 7	Removed “HIPAA” from names of S.C. Medicaid Provider Outreach and S.C. Medicaid EDI Support Center
11-01-05	3	5	Changed verb tense under Procedural Coding

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
11-01-05	3	15	Removed requirement for entering whole numbers for day or units in field 24G
11-01-05	3	19, 34	Changed generic reference for the South Carolina Medicaid Web-based Claims Submission Tool from SCMWBCST to Web Tool
11-01-05	3	17, 18	Changed Web site from www.scdhhshipaa.org to www.scmedicaidprovider.org
11-01-05	5	19-28	Updated list of DHHS county offices
10-01-05	5	19-28	Updated list of DHHS county offices
10-01-05	Appendices	-	Made each appendix a separate file; moved Change Control Record out of appendices to a separate file
09-01-05	Appendix 1	38 & 64	Added edit codes 577 and 900
09-01-05	Appendix 2	All	Updated lists of carrier codes
08-01-05	Appendix 1	A1-62	Added edit code 868
07-01-05	3	2, 10, 12 19, 29, 30	• Added description of new Web Tool features • Removed instruction to attach EOB to paper claims • Change MIVS zip code to 29211-9804 (from 29201)
07-01-05	Appendix 2	All	Updated lists of carrier codes
05-03-05	2	13	Removed sentence under Home Delivered Meals: "Based on a physician's orders, meals may include standard diets or therapeutic and/or modified diets."
03-02-05	5	24 & 25	Changed incorrect area codes for county offices in Saluda and Union to (864)
03-01-05	Appendices	All	Added new edit codes and revised some resolutions
02-22-05	2	24	Added Adult Day Health Care Services description to MR/RD service list

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
02-11-05	5	4	Updated manual ordering information under Web Address header
01-24-05	5	19-25	Updated addresses for Allendale and Hampton county offices

SECTION 1

GENERAL INFORMATION AND ADMINISTRATION

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

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

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

ELIGIBILITY DETERMINATION

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

ELIGIBILITY DETERMINATION (CONT'D.)

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

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

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

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

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

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

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

ENROLLMENT COUNSELING SERVICES

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

MEDICARE / MEDICAID ELIGIBILITY

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

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

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

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

SOUTH CAROLINA HEALTHY CONNECTIONS MEDICAID CARD

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

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

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

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

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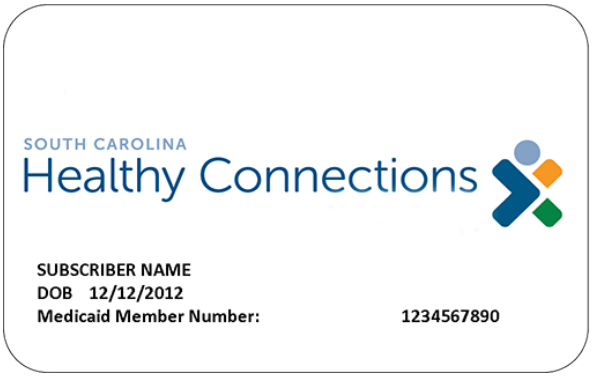
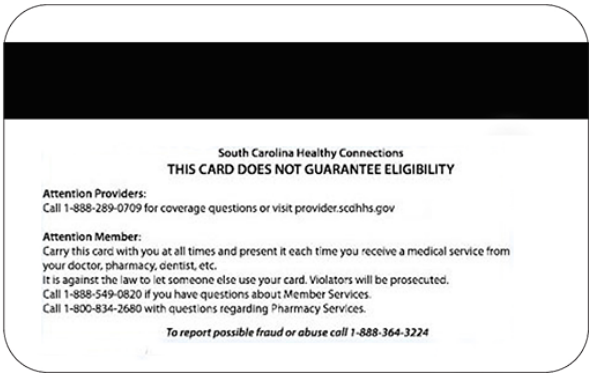
SOUTH CAROLINA MEDICAID PROGRAM





The back of the Healthy Connections Medicaid card includes:

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

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

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

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

Beneficiaries who are enrolled with a 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.

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

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

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

To learn more about this tool and how to access it, visit the SC Medicaid Provider Education 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 listing of training opportunities is also located on the Web site.

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

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SOUTH CAROLINA MEDICAID PROGRAM

SOUTH CAROLINA MEDICAID ALERTS, BULLETINS AND NEWSLETTERS

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

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

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SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

PROVIDER ENROLLMENT

PROVIDER PARTICIPATION

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

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

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

PROVIDER ENROLLMENT

PROVIDER PARTICIPATION (CONT'D.)

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

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

A provider must immediately report any change in enrollment or contractual information (*e.g.*, mailing or payment address, physical location, telephone number, specialty information, change in group affiliation, ownership, etc.) to SCDHHS 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. Provider Enrollment inquiries to South Carolina Medicaid should be directed as follows:

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

Extent of Provider Participation

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

PROVIDER ENROLLMENT

Extent of Provider Participation (Cont'd.)

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 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 with the MCO.

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

Non-Discrimination

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

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

PROVIDER ENROLLMENT

Non-Discrimination (Cont'd.)

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

Service Delivery

Freedom of Choice

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

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

Medical Necessity

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS/ DOCUMENTATION REQUIREMENTS

GENERAL INFORMATION

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

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

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

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS / DOCUMENTATION REQUIREMENTS

GENERAL INFORMATION (CONT'D.)

Records are considered to be maintained when:

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

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

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

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS / DOCUMENTATION REQUIREMENTS

General Information (Cont'd.)

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

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

Signature Policy

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

Handwritten Signature

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

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

Signature Log

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

Electronic Signatures

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS / DOCUMENTATION REQUIREMENTS

Electronic Signatures (Cont'd.)

Acceptable Electronic Signature Examples:

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

Date

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

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

Exceptions

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS / DOCUMENTATION REQUIREMENTS

Exceptions (Cont'd.)

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

DISCLOSURE OF INFORMATION BY PROVIDER

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

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

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS / DOCUMENTATION REQUIREMENTS

SAFEGUARDING BENEFICIARY INFORMATION

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

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

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

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

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

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS / DOCUMENTATION REQUIREMENTS

SAFEGUARDING BENEFICIARY INFORMATION (CONT'D.)

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

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

Confidentiality of Alcohol and Drug Abuse Case Records

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

SPECIAL / PRIOR AUTHORIZATION

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

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

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS / DOCUMENTATION REQUIREMENTS

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SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

CHARGE LIMITS

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

BROKEN, MISSED, OR CANCELLED APPOINTMENTS

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

NATIONAL CORRECT CODING INITIATIVE (NCCI)

The South Carolina Medicaid program utilizes 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 are to prevent improper payment when incorrect code combinations or units of service are reported exceeding what is normally considered to be medically necessary. NCCI edits identify procedures/services performed by the same provider for the same beneficiary on the same date of service.

NCCI consist of two types of edits:

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

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

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

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

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

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

The CMS web page http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems /National-Correct-Coding-Initiative.html provides overview information to providers on Medicaid's NCCI edits and links for additional information.

MEDICAID AS PAYMENT IN FULL

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

For beneficiaries enrolled in a Medicaid managed care option, the managed care entity must accept SCDHHS'

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

MEDICAID AS PAYMENT IN FULL (CONT'D.)

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

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

REASSIGNMENT OF CLAIMS (CONT'D.)

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

THIRD-PARTY LIABILITY

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

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

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

Health Insurance

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

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

Health Insurance (Cont'd.)

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

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

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

Premium Payment Project

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

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

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

Questions regarding the Premium Payment Project or referrals for beneficiary participation in this project should be directed to the Third Party Liability- Medicaid Insurance Verification Services (MIVS) department by calling (803) 264-6847.

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REIMBURSEMENT

Casualty Insurance

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

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

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

Provider Responsibilities – TPL

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

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

Provider Responsibilities – TPL (Cont'd.)

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

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

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

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

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TIME LIMIT FOR SUBMITTING CLAIMS

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

Medicare Cost Sharing Claims

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

Retroactive Eligibility

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

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

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

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

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REIMBURSEMENT

Retroactive Eligibility (Cont'd.)

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

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

Payment Information

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

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REIMBURSEMENT

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SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID PROGRAM INTEGRITY

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

PROGRAM INTEGRITY

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

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID PROGRAM INTEGRITY

PROGRAM INTEGRITY (CONT'D.)

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

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

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID PROGRAM INTEGRITY

PROGRAM INTEGRITY (CONT'D.)

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

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

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

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

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

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID PROGRAM INTEGRITY

PROGRAM INTEGRITY (CONT'D.)

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

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

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

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

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

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

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

PREPAYMENT REVIEW

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

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PREPAYMENT REVIEW (CONT'D.)

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

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

RECOVERY AUDIT CONTRACTOR

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

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MEDICAID PROGRAM INTEGRITY

RECOVERY AUDIT CONTRACTOR (CONT'D.)

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

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

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

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

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

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

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MEDICAID PROGRAM INTEGRITY

RECOVERY AUDIT CONTRACTOR (CONT'D.)

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

BENEFICIARY EXPLANATION OF MEDICAL BENEFITS PROGRAM

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

BENEFICIARY OVERSIGHT

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

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

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

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MEDICAID PROGRAM INTEGRITY

BENEFICIARY OVERSIGHT (CONT'D.)

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

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

MEDICAID BENEFICIARY LOCK-IN PROGRAM

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

DIVISION OF AUDITS

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

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MEDICAID PROGRAM INTEGRITY

DIVISION OF AUDITS (CONT'D.)

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

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

PAYMENT ERROR RATE MEASUREMENT

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

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

PAYMENT SUSPENSION

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

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

Suspension of Provider Payments for Credible Allegation of Fraud

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

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

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

Notice of Suspension

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

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

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

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

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

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

Referrals to the Medicaid Fraud Control Unit

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

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

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

- Law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation;
- Other available remedies implemented by SCDHHS will more effectively or quickly protect Medicaid funds;
- SCDHHS determines, based upon the submission of written evidence by the individual or entity that is the subject of the payment suspension, that the suspension should be removed;
- SCDHHS determines that beneficiary access to items or services would be jeopardized by a payment suspension for either of the following reasons:
  - An individual or entity is the sole community physician or the sole source of essential specialized services in a community;
  - The individual or entity serves a large number of 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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

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

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

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

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

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

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

PROVIDER EXCLUSIONS

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

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

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

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

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

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

PROVIDER EXCLUSIONS (CONT'D.)

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

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

The HHS-OIG maintains the LEIE (List of Excluded Individuals and Entities), a database accessible to the general public that provides information about parties excluded from participation in Medicare, Medicaid, and all other Federal health care programs. Visit the HHS-OIG 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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

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

ADMINISTRATIVE SANCTIONS (CONT'D.)

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

OTHER FINANCIAL PENALTIES

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

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

FAIR HEARINGS

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

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

REINSTATEMENT

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

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

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

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

REINSTATEMENT (CONT'D.)

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

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

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

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

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

APPEALS

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

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

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

Online: www.scdhhs.gov/appeals

By Fax: (803) 255-8206

By Mail to:

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

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

APPEALS

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SECTION 2 POLICIES AND PROCEDURES

PROGRAM OVERVIEW

COMMUNITY LONG-TERM CARE (CLTC)

The mission of Community Long-Term Care (CLTC) is to provide a cost-effective alternative to institutional placement for eligible clients with long-term care needs, if they choose, allowing them to remain in a community environment. The South Carolina Department of Health and Human Services (SCDHHS) Division of Community Long-Term Care operates several waiver programs, as well as two Department of Disabilities and Special Needs (DDSN) waivers. CLTC also administers the Palmetto SeniorCare program.

The following timeline denotes the services provided by the CLTC program and when they were enacted:

- In December 1984, the Centers for Medicare and Medicaid Services (CMS) approved South Carolina's request for a home- and community- based waiver for the elderly and disabled.
- In 1988, CMS authorized South Carolina to provide services under a Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) waiver to eligible persons with HIV/AIDS.
- In 1989, CMS authorized Palmetto SeniorCare. In 2003, this became a State Plan service.
- In January 1990, the Children's Personal Care Aide (PCA) service was approved as a part of the Medicaid State Plan to provide PCA to children under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program.
- In October 1991, CMS authorized South Carolina to provide services under a Mental Retardation/Related Disabilities (MR/RD) waiver to eligible persons.
- In December 1994, CMS authorized South Carolina to provide services under a Mechanical Ventilator Dependent waiver to eligible persons.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM OVERVIEW

COMMUNITY LONG-TERM CARE (CLTC) (CONT'D.)

- In April 1995, CMS authorized South Carolina to provide services to eligible persons with head and spinal cord injuries (HASCI).

.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

PROVIDER QUALIFICATIONS

All CLTC services have prerequisites for participation and require enrollment/contracts with SCDHHS. Certain licensing requirements may also exist. Please see Section 1 of this manual for general Medicaid enrollment and licensing requirements.

Enrollment

CLTC providers are required to complete and sign an individual enrollment form (DHHS 219-CLTCIC or CLTCI-NC) before submitting claims to Medicaid. Group providers must complete a separate form (DHHS 219-CLTCGC or CLTCG-NC). The Forms section of this manual contains copies of the enrollment forms.

Contracted Provider

Providers must have a contract with SCDHHS to provide CLTC Medicaid services requiring a contract.

Cost Reports

With the exception of respite care, all contracted providers are required to submit a final cost report for each service. The final cost report must cover the entire contract period and be filed no later than 90 days after the end of the reporting period. The cost report shall include the actual cost and service delivery information for the reporting period. If the provider fails to file the cost report within the specified time, all funds due the provider shall be withheld by SCDHHS until the report is filed. All cost reports should be mailed to:

Department of Health and Human Services
Division of Ancillary Reimbursements
Post Office Box 8206
Columbia, SC 29202-8206

If you have any questions regarding cost reports, contact the SCDHHS Medicaid Provider Service Center at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us.

Non-Contracted Provider

As a condition of participation and payment, CLTC non-contracted providers must complete and sign a Medicaid Enrollment Agreement with SCDHHS to provide CLTC Medicaid services.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Compliance Review

Before entering into any contractual arrangement with a provider, SCDHHS will have the Division of Community Long-Term Care conduct a compliance review of the prospective provider. The purpose of this review is to establish that the prospective provider meets the requirements outlined in the applicable Scope of Services. If the provider satisfactorily meets the precontractual compliance review requirements, the contract process will continue.

Compliance reviews are completed approximately 90 days after initiation of services with CLTC. Unannounced reviews are conducted thereafter. At the sole discretion of SCDHHS/CLTC, special reviews may be conducted at any time.

Field Service Representatives

After enrollment, visits are made to providers periodically and upon request. The purpose of each visit is to coordinate information concerning the Medicaid program and provide technical assistance as required.

Workshops are conducted on a periodic basis to acquaint providers with current Medicaid policy and regulations, changes, or amendments.

Requests for Field Service assistance and questions regarding manuals, bulletins, or workshops should be directed to the SCDHHS Medicaid Provider Service Center at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us.

COMMUNITY LONG-TERM CARE (CLTC) FUNCTIONS

Intake

The intake process in the CLTC area office ensures that all persons with perceived long-term care needs receive every opportunity for exposure to the CLTC program. The process identifies persons who may be eligible for the program and serves as an information and referral source for those who do not meet intake criteria.

Assessment

Assessment uses a comprehensive standard instrument to determine a client's current long-term care needs. Information obtained during the assessment process will assist staff in making a level-of-care decision and initiating a plan of service for discussion with the client and/or family.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Level-of-Care Determination

Level-of-care determination is the process of identifying the extent of a person's medical, psychobehavioral, and functional disability in keeping with the South Carolina Level-of-Care Criteria for Medicaid-Sponsored Long-Term Care. To be eligible for CLTC services, a person must be determined to meet either skilled or intermediate level-of-care criteria, or, in the case of persons with HIV/AIDS, be at risk for hospitalization. These criteria help determine a client's requirement for care.

Service Planning

Service planning encompasses a comprehensive review of the client's problems and strengths. Mutually agreed-upon goals are set based on identified needs. This service planning process allows for participation of the client and/or family, physician, service providers, and the CLTC case management team. Service planning provides involved persons with information necessary to make an informed choice regarding the location of care and services to be utilized. The outcome of this process is a written plan of service.

Service Authorization

A service authorization is a written document that enables contracted/enrolled service providers to initiate CLTC services for Medicaid-eligible clients. The service authorization is based on the CLTC plan of service for individual CLTC clients. With the exception of case management, prior authorizations are required for all CLTC services.

Case Management

CLTC case management is a vital part of the long-term care program that is provided for all waiver clients. (Case management for HASCI and MR/RD waiver clients is provided by DDSN.)

Case management ensures continued access to the long-term care program. It also enables case managers to advise, support, and assist clients and their families in coping with changing needs and in making decisions regarding long-term care.

Case management includes the following five activities: service counseling, service planning, service coordination, monitoring, and re-evaluating.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Prior Authorization of CLTC Services

Client Choice of Providers

CLTC clients are required to choose a service provider from a Client Choice of Provider(s) Form, which lists available providers of each service for the client's waiver of participation. The Client Choice of Provider(s) Form will identify the referring entity and CLTC provider(s) already involved in the care of the client. Any service requiring a referred provider to participate in a bid process is excluded from this policy. For bid process services, the provider submitting the lowest bid will be awarded the referral. If the provider submitting the lowest bid cannot provide the service, the referral will be awarded to the next lowest bidder.

Authorization of Services

Services must be pre-authorized by the CLTC case manager based on the client's plan of service. Authorization will be transmitted to the provider by the completion of a CLTC Service Provision Form (DHHS Form 175). (For an example of this form, please see the Forms section.) Accompanying the authorization will be a copy of the plan of service and, if appropriate, a copy of the physician's order.

Authorization Periods

Authorizations will be issued for all CLTC services indicating the beginning date of the service, the days of the week that the service will be provided, and the number of units of service to be provided. The hours of service will be indicated only if specific times are essential to meeting the client's service needs. For some services, the authorization will designate that the service is to be provided during the morning, afternoon, or evening. The authorization period ending date may or may not be indicated on the Service Provision Form. Authorizations without an ending date will be valid until a revised Service Provision Form is issued to the provider.

Changes in Services Within an Authorization Period

Should the client's needs change during an authorization period, a revised Service Provision Form will be sent to the provider. Changes in frequency of a particular service do not require a new physician's order.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Interruption of Services

Previously authorized Personal Care Aide (PCA) services will be interrupted if the client enters a hospital or institution for a temporary stay or temporarily chooses not to receive services. The interruption of PCA services does not require a revised Service Provision Form, unless the service is to be interrupted for an extended time.

Termination of Authorized Services

Service must be officially terminated whenever it is determined that the client no longer requires an authorized service or becomes either medically or financially ineligible. Both the client and the provider must be notified of the termination of services by personal contact. This verbal notification must be followed with a written confirmation of termination of the service.

DDSN SERVICE COORDINATION FUNCTIONS

Intake

The intake process at the local DDSN board ensures that all persons with perceived long-term care needs receive every opportunity for exposure to their programs. The process identifies persons who are eligible for programs and serves as an information and referral source for those who do not meet intake criteria. For all Head and Spinal Cord Injury client referrals, call 1-866-867-3864.

Assessment

Assessment is a method of determining a client's current long-term care needs. Information obtained during the assessment process will assist the service coordinator in initiating a plan of service for discussion with clients and/or their families.

Service Planning

Service planning encompasses a comprehensive review of the client's problems and strengths. Mutually agreed-upon goals are set based on identified needs. This service planning process allows for participation of the client and/or family, physician, service providers, and the service coordinator. Service planning provides information necessary to make an informed choice regarding the location of care and service to be used to the people involved. The outcome of this process is a written plan of service.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Service Coordination

Service coordination is a vital part of the DDSN programs and is provided for all service beneficiaries. This process ensures continued access to DDSN programs and enables service coordinators to continue advising, supporting, and assisting clients and their families in coping with changing needs and in making decisions regarding DDSN programs.

Service coordination includes the following five activities: service planning, coordinating service, service authorization, monitoring, and re-evaluating.

Prior Authorization of DDSN Services

Based on the client's plan of service, services will be authorized by DDSN's service coordinator and transmitted to the provider on an Authorization Form. Please see the Forms section for copies of MR/RD and HASCI Waiver authorization forms.

Authorization Periods

Authorizations shall be issued for all DDSN services indicating the beginning date and the number of units of service to be provided.

Changes in Services Within an Authorization Period

Should a client's needs change during an authorization period, a revised authorization form shall be sent to the provider.

Termination of Authorized Services

The service coordinator will terminate services when a client no longer requires an authorized service. Providers receive written notice of termination.

PRIOR AUTHORIZATION FOR HOSPICE PARTICIPANTS

In certain situations, Medicaid beneficiaries receiving the State Plan hospice benefit may receive waiver services. Prior authorization by the hospice provider is required in cases where waiver services are authorized for Medicaid hospice beneficiaries. The prior authorization number must be placed on the claim in order for the provider to receive reimbursement. The case manager obtains the prior authorization number from the hospice provider and gives it to the provider of the authorized service. Providers submitting hard copy CMS-1500 claims must place the prior authorization number in field 19. Providers submitting claims electronically by diskette or magnetic tapes will place the prior authorization number in field 10. Providers who receive the 976 edit (hospice beneficiary/service requires prior approval) may resolve

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

PRIOR AUTHORIZATION FOR HOSPICE PARTICIPANTS (CONT'D.)

the edit by submitting a new claim with the corrected information. See Section 3 of this manual for complete billing instructions.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

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SECTION 2 POLICIES AND PROCEDURES

CLTC WAIVER SUPPLY PROVIDERS

HOME AND COMMUNITY BASED WAIVER PROGRAMS

Home and Community Based Waivers (HCBW) are programs that allow individuals who meet an institutional level of care to receive items and services not covered through the South Carolina Medicaid State Plan. These items and services are allowed through the waiver programs to assist individuals in remaining in their own home or other community setting and avoiding institutional placement.

South Carolina currently administers seven waivers that allow for the provision of supplies. The Community Choices, HIV/AIDS, Mechanical Ventilation, and Medically Complex Children waivers are operated by the Department of Health and Human Services. Authorizations for these waivers will be made through the SCDHHS Phoenix web-based case management and authorization system. This system notifies the provider with an email directing the provider to a secure website. The provider will accept authorizations at this website. All providers requesting enrollment as a CLTC provider to distribute waiver supplies must be trained and utilize the Phoenix web-based case management and authorization system.

For waivers operated by the Department of Disabilities and Special Needs (DDSN), which include the Mental Retardation/Related Disability, the Head and Spinal Cord Injury and Community Supports waivers, all authorizations will be faxed to the provider.

Providers of waiver supplies must verify Medicaid eligibility of each participant prior to rendering services and at least one business day prior to transmitting the order. To verify Medicaid eligibility, the provider can, utilize the South Carolina Medicaid Web-Based Claim Submission Tool or by utilizing other point of sale devices.

SECTION 2 POLICIES AND PROCEDURES

CLTC WAIVER SUPPLY PROVIDERS

AUTHORIZATIONS FOR INCONTINENCE PRODUCTS

Providers must deliver products based on authorizations received from case managers/nurses and service coordinators/early interventionists working with participants. SCDHHS/SCDDSN will not authorize or pay for incontinence products for children under age 4.

The authorizations will provide the frequency of delivery and the participant information necessary to provide the incontinence products. Authorizations may provide for monthly, bi-monthly, or other frequency arrangements. However, incontinence products will not be delivered more frequently than monthly for each authorized participant. For authorizations that indicate an amount on a per case basis, the case quantity is as listed on the following table:

CURRENT REIMBURSEMENT RATES AND AUTHORIZATION AMOUNTS

Service	Rate	Maximum Frequency	Quantity Authorized	Procedure Code
Bariatric Diaper	$1.27/diaper	Monthly	96	T4543
ADULT x-large	$0.73/diaper	Monthly	96	T4524
Adult Large	$0.56/diaper	Monthly	96	T4523
Adult Medium	$0.46/diaper	Monthly	96	T4522
Adult Small	$0.47/diaper	Monthly	96	T4521
Pediatric Diaper Small	$0.45/diaper	Monthly	96	T4529
Pediatric Diaper Large	$0.45/diaper	Monthly	96	T4530
Pediatric Brief Small	$0.57/diaper	Monthly	80	T4531
Pediatric Brief Large	$0.57/diaper	Monthly	80	T4532
Youth Diaper	$0.47/diaper	Monthly	96	T4533
Adult Brief Extra Large (protective underwear)	$0.78/brief	Monthly	80	T4528
Adult Brief Large (protective underwear)	$0.60/brief	Monthly	80	T4527

SECTION 2 POLICIES AND PROCEDURES

CLTC WAIVER SUPPLY PROVIDERS

AUTHORIZATIONS FOR INCONTINENCE PRODUCTS (CONT'D.)

Service	Rate	Maximum Frequency	Quantity Authorized	Procedure Code
Adult Brief Medium (protective underwear)	$0.54/brief	Monthly	80	T4526
Adult Brief Small (protective underwear)	$0.57/brief	Monthly	80	T4525
Youth Brief (protective underwear)	$0.70/brief	Monthly	80	T4534
Incontinence Pads	$0.21/pad	Monthly	130	T4535
Under Pads	$30.56/case	Monthly	1	A4554
Wipes	$4.89/box	Monthly	70	T5999

All authorizations for incontinence products must utilize the codes established in the table above. The provider is expected to package these items in accordance with the quantity authorized in the table above, even if repackaging is required. After the initial delivery to the participant, future deliveries of the product to the participant must be at the same time of the month as the first delivery and at the frequency established by the authorization.

For any new initial authorizations, the supplies must be shipped within three business days of the provider receiving the authorization and must be received by the participant within one week of the provider's receipt of the authorization.

The provider shall not charge participants additional fees or surcharges; the unit rate reflected in the table above is the price reimbursed to Medicaid providers for incontinence products.

If the provider is unable to provide products as scheduled, the provider must contact the participant by telephone no less than five business days before the scheduled delivery

SECTION 2 POLICIES AND PROCEDURES

CLTC WAIVER SUPPLY PROVIDERS

AUTHORIZATIONS FOR INCONTINENCE PRODUCTS (CONT'D.)

date to inform him/her of the delay in shipment. The provider must offer the participant the option to wait on the product or choose another product that may be delivered on schedule.

- If the provider has made three unsuccessful attempts to contact the participant by telephone, the provider shall send a backorder notification to the participant. The backorder notification must give the participant the option to wait on the product or to choose an alternate product.
- If the provider attempts a delivery and the participant refuses to accept delivery, the provider will provide instructions to the participant on how to obtain the package. The provider must notify the Case Manager/Nurses/Service Coordinator/Early Interventionists if this becomes an issue.

Providers are allowed to ship more than a single months' worth of product to a participant. Providers electing to ship product in advance to a participant's place of residence may not ship more than a full quarters worth of product on any single delivery. Providers opting to ship in this manner accept the risk that the participant may lose Medicaid eligibility prior to the provider being able to bill for a second or third month of product. Authorizations from case managers and service coordinators will still reflect the normal shipment pattern that was originally authorized. The case manager and/or service coordinator will not add comments approving this shipment method. Providers must bill each month of product separately on the first day of the month if they elect to deliver multiple months of product in one shipment.

Incontinence products will be shipped or delivered to participants residing in community residential care facilities, community training homes, supervised living placements, and individual homes (houses, apartments, trailers, rental properties, etc.)

INCONTINENCE PRODUCT QUALITY

All products distributed to home and community based waiver (HCBW) participants must be latex-free and hypoallergenic. Products will not be kept in inventory long enough for the quality to degrade, i.e. adhesives drying out. No damaged or rejected products will be provided to

SECTION 2 POLICIES AND PROCEDURES

CLTC WAIVER SUPPLY PROVIDERS

INCONTINENCE PRODUCT QUALITY (CONT'D.)

(HCBW) participants. All products must not be shipped beyond their expiration date.

- All diapers/briefs must have a closure system, a wetness indicator that is visible to change, a polymer absorbent core in the middle of the product, a hydrophyllic top sheet and a waterproof backing. See the chart entitled, "Adult Briefs," for additional specifications. The provider's products must meet or exceed the requirements of the Standard Product and Universal Requirements.
- Protective underwear must have banding to indicate front and back, contain an absorbent polymer core, have elastic leg gatherings and tear away sides, and be embossed to help with the wicking of liquids away from the skin. See the chart entitled, "Protective Underwear," for additional specifications. The provider's products must meet or exceed the requirements of the Standard Product and Universal Requirements.
- All underpads must have a hydrophilic top sheet that allows fluid to pass quickly into an absorbent core and a polypropylene backsheet that protects against leakage. The underpads should help with wicking of liquid away from the skin.
- A case of medium size underpads must have a minimum count of 200 (minimum size 22"-23"), and a case of large size underpads must have a minimum count of 150 (minimum size 22"-35"). See the chart entitled, "Underpads," for additional specifications. The provider's products must meet or exceed the requirements of the Standard Product and Universal Requirements.
- Incontinence pads, inserts, shields, or liners must have a hydrophilic top sheet, absorbent core, and a waterproof polypropylene backing. The incontinence pad, insert, shield, or liner must be embossed to wick liquids away from the skin. See the chart entitled, "Pads, Inserts, Shields," for additional specifications. The provider's products must meet or exceed the requirements of the Category 2 product in this chart.

SECTION 2 POLICIES AND PROCEDURES

CLTC WAIVER SUPPLY PROVIDERS

INCONTINENCE PRODUCT QUALITY (CONT'D.)

- Disposable wipes must be at a minimum size of six inches by six inches, provided in at least a seventy-count tub, have a pre-moistened, alcohol-free formula, and be safe for use on the skin.
- All pediatric diapers/briefs and protective underwear must be quality premium brands by nationally recognized manufacturers Covidien (Kendall), First Quality, Kimberly Clark, Medline or Proctor and Gamble.

In addition to the other requirements stated above, the provider must:

- Maintain products in inventory for no longer than two months before being delivered to customers
- Maintain climate control measures in its storage facilities to ensure product quality

SCDHHS may perform an audit at any time. The audit may also include but is not limited to pricing and distribution of product adherence, responses to complaints, grievances, or inquiries. SCDHHS reserves the right to audit the provider's performance at any time.

SECTION 2 POLICIES AND PROCEDURES

CLTC WAIVER SUPPLY PROVIDERS

INCONTINENCE PRODUCT QUALITY (CONT'D.)

Adult Briefs

Recommendation:		Two protection levels - Standard and Premium, differentiated by lab performance.	
Product Specification	Size	Overall Length and Width; waist range is for reference only.	
	Performance	Use standard lab measurements as detailed in Attachment A and B	
		Rate of Acquisition (ROA) & Rewet	100 ml fluid add-on for Youth and Small
			200 ml for all others
		Capacity	As per ISO Method
Product Preparation:		Trim waist elastic and leg gathers, if present; fold under the front and back wing flaps	

Standard Brief				Product Performance [1]		
Size	Minimum Length[2]	Minimum Width[3]	Waist Range	ROA ≤	Rewet ≤	Capacity ≥
	inches	inches	inches	seconds	grams	grams
Youth	21.0	15.0	15 - 22"	65.0	4.0	900
Small	26.0	17.5	20 - 31"	65.0	4.0	1,100
Medium	31.0	24.0	32 - 44"	65.0	6.0	1,400
Regular	33.0	27.0	40 - 48"	65.0	6.0	1,400
Large	36.5	29.5	45 - 58"	65.0	6.0	1,700
Extra Large	38.0	31.0	56 - 64"	65.0	6.0	1,700
Extra Extra Large	38.0	33.5	62 - 67"	65.0	6.0	1,700

Premium Brief				Product Performance [1]		
Size	Minimum Length[2]	Minimum Width[3]	Waist Range	ROA ≤	Rewet ≤	Capacity ≥
	inches	inches	inches	seconds	grams	grams
Youth	21.0	15.0	15 - 22"	60.0	2.0	1,100
Small	26.0	17.5	20 - 31"	60.0	2.0	1,300
Medium	31.0	24.0	32 - 44"	60.0	2.5	1,800
Regular	33.0	27.0	40 - 48"	60.0	2.5	1,800
Large	36.5	29.5	45 - 58"	60.0	2.5	2,100
Extra Large	38.0	31.0	56 - 64"	60.0	2.5	2,100
Extra Extra Large	38.0	33.5	62 - 67"	60.0	2.5	2,100

Notes

[1] To qualify for inclusion on the formulary, products need to meet or exceed two of the three performance standards and be within 15% of the third standard

[2] Measured by cutting leg elastic and stretching flat

[3] Measured at non-tape end

Universal Requirements

1. Designed with wetness indicator visible on the outside of the brief
2. Designed with a side closure system (if tape tab, mimimum of 2 per sie and width ≥ 5/8")
3. Designed with multi-elastic leg gathers
4. Backing is waterproof

SECTION 2 POLICIES AND PROCEDURES

CLTC WAIVER SUPPLY PROVIDERS

INCONTINENCE PRODUCT QUALITY (CONT'D.)

PROTECTIVE UNDERWEAR

Recommendation		One protection level	
Product Specification	Dimension	Waist	Measure inside width fully stretched out under tension
		Length	Cut product at side seams
			Measure length fully stretched out under tension
	Performance	Rate of Acquisition & Rewet	100 ml fluid add-on for all products
		Total Capacity	As per ISO Method
	Product Preparation	Cut product at side seams Pin the product down so it lies flat	

Size	Minimum Inside Width [2]	Minimum Length [3]	Product Performance [1] ROA	Rewet	Capacity
			≤	≤	≥
	inches	inches	seconds	grams	grams
Small	18	23	60.0	2.0	900
Medium	22	28	60.0	2.0	1,000
Large	27	31	60.0	2.0	1,100
Extra Large	31	32	60.0	2.0	1,200

Universal Requirements

1. Designed with a continuous elasticized waistband and side panels.
2. Designed with multi-elastic leg gathers
3. Backing is waterproof

Notes

[1] To qualify for inclusion on the formulary, products need to meet or exceed two of the three performance standards and be within 15% of the third standard

[2] Measure inside width stretched out under full tension

[3] Measured by cutting product at side seams and fully stretching flat under tension.

SECTION 2 POLICIES AND PROCEDURES

CLTC WAIVER SUPPLY PROVIDERS

INCONTINENCE PRODUCT QUALITY (CONT'D.)

Underpads

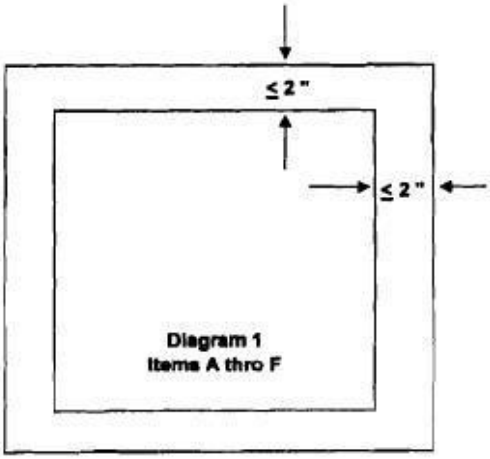
Recommendation: Seven sizes of Underpads in two protection levels
To ensure acceptable performance levels, minium absorbent core area is also specified.

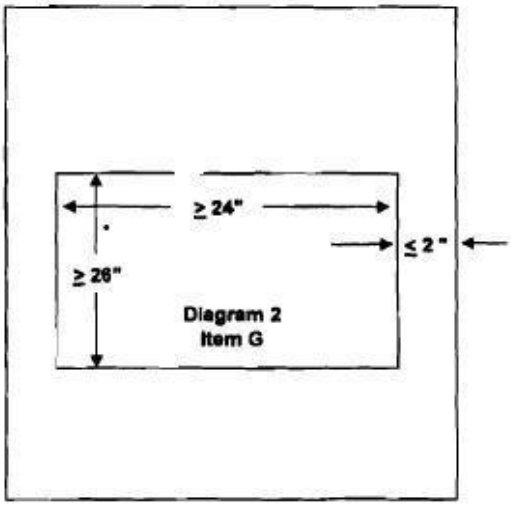
Performance: Determined by ISO Capacity Method.

	Size +/- 2 "	Minimum Mat Size	Product Performance Standard	Product Performance Premium
	inches	inches	≥ grams	≥ grams
A	17 x 24	See Diagram 1 below	200	500
B	23 x 23			
C	23 x 36		300	1,200
D	30 x 30			
E	30 x 36		700	1,700
F	36 x 36			
G	28 x 70	24 X 26		

Universal Requirements

1. Mat size should be large enough that the border (non absorbent area) is ≤ 2.0" (see diagrams)





SECTION 2 POLICIES AND PROCEDURES

CLTC WAIVER SUPPLY PROVIDERS

INCONTINENCE PRODUCT QUALITY (CONT'D.)

PADS, INSERTS, SHIELDS

Recommendation:		Three categories; based on capacity.	
Product Specification	Size	One size	
	Performance	Use standard lab measurements as detailed in Attachment A and B	
		Rate of Acquisition (ROA) & Rewet	100 ml fluid add-on
		Capacity	As per ISO Method
Product Preparation		Unfold; trim waist elastic and leg gathers, if present	

				Product Performance [1]		
		Width	Length	ROA	Rewet	Capacity
		inches	inches	≤	≤	≥
Category 1	Light	- na -	- na -	NA	NA	250
Category 2	Moderate	- na -	- na -	NA	NA	500
Category 3	Heavy	≥ 8.0	≥ 22.0	60	2.0	1,000

The products must have one of the following attributes:

1. Embossed or channeled absorbent mat
2. Elastic gathers
3. Super absorbent polymer
4. Waterproof backing

Notes:

[1] For category 3 only, to qualify for inclusion on the formulary, products need to meet or exceed two of the three performance standards and be within 15% of the third standard

SECTION 2 POLICIES AND PROCEDURES

CLTC WAIVER SUPPLY PROVIDERS

AUTHORIZATIONS FOR ORAL NUTRITIONAL SUPPLEMENTS

Providers must deliver products based on authorizations received from case managers/nurses and service coordinators/early interventionists working with participants. The authorizations will provide the frequency of delivery and the participant information necessary to provide the oral nutritional supplements, including the correct procedure code and amount to bill for DDSN participants. Each can of nutrient must have a minimum of 225 cals/250 ml and come in a 24-count case in order to qualify for Medicaid reimbursement.

AUTHORIZATIONS FOR MISCELLANEOUS SUPPLIES AND EQUIPMENT

Providers must deliver products based on authorizations received from case managers/nurses and service coordinators/early interventionists working with participants. The authorizations will provide the frequency of delivery and the participant information necessary to provide the supplies and equipment, including the correct procedure code and amount authorized to bill for DDSN participants. When billing for DDSN participants, all supplies and equipment delivered and authorized on the same date of service, under the miscellaneous procedure code should be combined and billed as a single line item when filing the claim for payment.

STAFFING AND OPERATING PROCEDURES

The provider shall employ staff to receive authorizations electronically via secure website, fax, or mail. The provider must maintain all authorizations for products on file for audit purposes. The provider must have adequate staff to:

- Contact participants to coordinate service delivery
- Package or repackage products to coordinate precisely with authorizations
- Handle complaints and grievances received from participants, case managers/nurses, and service coordinators/early interventionists
- Obtain authorizations from the secure website, fax, or mail
- Input product shipment and billing information into SCDHHS' Care Call system for the waivers operated by SCDHHS. For those waivers operated by SCDDSN product information and billing will be done via the South Carolina Medicaid Web-

SECTION 2 POLICIES AND PROCEDURES

CLTC WAIVER SUPPLY PROVIDERS

STAFFING AND OPERATING PROCEDURES (CONT'D.)

Based Submission Tool, tape, diskette, or hard copy.

Providers must fill orders from its own inventory, or must contract with other companies for the purchase of items necessary to fill the order. A provider must not contract with any entity currently excluded from any state or federal health care programs.

Providers must notify beneficiaries of warranty coverage and honor all warranties under applicable state law, and repair or replace free of charge Medicaid-covered items that are under warranty.

Providers cannot initiate telephone contact with participants, CLTC staff, or case management providers in order to solicit new business. The Provider shall not market directly to potential or current Medicaid waiver participants (including direct mail advertising, door-to-door, telephonic, or other "cold-call" marketing).

Cold-call marketing is any unsolicited personal contact by the Provider with a potential or current Medicaid waiver participant.

Marketing is any communication from the Provider to a potential or current participant that can reasonably be interpreted as intended to influence the participant to choose to receive services from the Provider or to not receive services from another Provider.

The Provider is prohibited from giving anything of value to a state employee or contract employee associated with the CLTC program. Providers may be suspended, terminated, or otherwise sanctioned for violating this requirement.

Providers must answer questions, respond to complaints from participants, and maintain documentation of contacts in response to complaints. Complaint records must include the name, address, telephone number, and Medicaid number of the participant, a summary of the complaint and any actions taken to resolve it.

Providers are responsible for delivery and must instruct beneficiaries on use of Medicaid-covered items, and maintain proof of delivery. Please see the section labeled documentation requirements for more information regarding proof of delivery.

SECTION 2 POLICIES AND PROCEDURES

CLTC WAIVER SUPPLY PROVIDERS

STAFFING AND OPERATING PROCEDURES (CONT'D.)

Providers must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the participant at the time it was fitted or sold) from participants.

Providers must disclose to SCDHHS any person having ownership, financial, or control interest in the agency. A provider must not convey or reassign a provider number (i.e., the provider may not sell or allow another entity to use its Medicaid billing number).

DOCUMENTATION REQUIREMENTS

Providers of waiver supplies are responsible for delivery. The provider may deliver directly to the participant or a designee. Noted the relationship of the designee to the beneficiary on the delivery slip and the signature should be legible. Providers, their employees, and others with a financial interest in the delivery of the item are prohibited from signing and accepting an item on behalf of the participant (i.e., acting as a designee on behalf of the participant).

Providers must maintain proof of the delivery of supplies (i.e., return receipt to include the participant's name, quantity delivered, detailed description of the delivered item, brand name, serial number) in their place of business for a minimum of five years. Proof of delivery documentation must be made available to Medicaid upon request. Any claims for services that do not have a documented proof of delivery from the supplier shall be denied and payments recovered.

Delivery confirmation slips must show ship dates, mailing dates, delivered dates, and addresses to which deliveries were made. The delivery confirmation slip must document if someone signed for the package, or if it was delivered without a signature, and where it was left for the participant.

Medical supply providers can access the delivery confirmation information maintained by the delivery companies online. Providers must keep delivery confirmation records for five years. Medicaid will not accept a tracking number without the follow-up delivery confirmation data.

SECTION 2 POLICIES AND PROCEDURES

CLTC WAIVER SUPPLY PROVIDERS

BILLING PROCEDURES AND SERVICE MONITORING

The provider must agree to participate in all components of SCDHHS' Care Call or Phoenix monitoring and payment system when providing services for participants of the Community Choices, HIV/AIDS, Mechanical Ventilation, and Medically Complex Children's waivers. The Care Call system is an automated system used for service documentation and Medicaid Management Information System (MMIS) billing. Phoenix is a system that is used for service monitoring, web-based reporting, and billing to MMIS. The provider will document its provision of incontinence products for all SCDHHS-operated waivers in the Phoenix system via a web-based claims submission process. Providers will be required to bill claims on this website in a timely manner. Claims, at a minimum, must be entered into the website within the quarter after the date of service. In all cases, services documented are compared with prior authorizations in the system to determine if the services were provided appropriately. Claims rejected for payment must be resubmitted through the local CLTC area office.

For monitoring of service delivery and reporting, real-time reports allow providers, case managers, and/or nurses to monitor participants more closely to ensure receipt of services. On a bi-weekly basis, Care Call generates electronic billing to MMIS for services provided. Only authorized services and the total units provided (up to the maximum authorization) are submitted to MMIS for payment. This billing ensures accuracy of claim processing.

For all instances in which a participant did not receive an authorized shipment for waivers operated by SCDHHS, the provider must indicate the reason why the shipment was not delivered on the Care Call website. For each month in which the delivery of the product was not provided, the provider must indicate the reason on the website by the close of business the following week.

The Mental Retardation/Related Disabilities, Community Supports, and Head and Spinal Cord Injury waiver currently do not require the use of the Care Call billing system and claims may be submitted electronically via the South Carolina Medicaid Web-based Claim Submission Tool, tape or diskette, or hard copy.

SECTION 2 POLICIES AND PROCEDURES

CLTC WAIVER SUPPLY PROVIDERS

BILLING PROCEDURES AND SERVICE MONITORING (CONT'D.)

SCDHHS reserves the right to perform on-site reviews during normal business hours to ensure compliance with policies and procedures.

MEDICAID POLICY ADHERENCE

Providers must comply with all South Carolina Medicaid policies and procedures as outlined by SCDHHS. The provider will use the Care Call system to bill claims by the end of the quarter following service delivery. For claims not using the Care Call system, the provider must submit edit-free claims for reimbursement to MMIS within one year from the date of service following up-to-date policies and procedures and in accordance with correct coding.

SECTION 2 POLICIES AND PROCEDURES

CLTC WAIVER SUPPLY PROVIDERS

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SECTION 2 POLICIES AND PROCEDURES

CLTC ENVIRONMENTAL MODIFICATION PROVIDERS

Environmental modification services provide pest control and physical adaptations or modifications to the home that are necessary to ensure the health, welfare, and safety of the client. Environmental modifications enable clients to function with greater independence in the home. An example of such a modification is the construction of a ramp. All environmental modification providers must have a residential or general contractor's license to provide services. In addition to this requirement providers must have general liability and workers compensation insurance.

GENERAL RAMP SPECIFICATIONS

These specifications are to be used as a guide to our providers. They will not be used to diminish in any way local, state, and national codes. These specifications are a summary of information gathered using the International Building Code (2010 Edition), ICC, ANSI A117.1 1998 and ADA Standards for Accessible Design.

General Notes:

- **Permits are the responsibility of the provider.**
- Ramps are to be firm, stable, slip resistant, and safe.
- Ramps and landings with drop offs will have a minimum 4" curb and railings.
- Ramps will be built using pressure (weather) treated lumber.
- **Please advise clients that ramps need to be treated/weatherproofed annually.**
- Ramps and landings are measured by the **clear** space provided, 56"x56" landings will not be counted as 5' x 5' landings and will be re-built.
- No toenailing of railings between posts is permitted.
- **All screws will be predrilled with pilot holes to prevent splitting.**

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

GENERAL RAMP SPECIFICATIONS (CONT'D.)

- There is only one type/ size of ramp, no more heavy duty**.**

General Materials:

- 4x4 posts
- 2x6 (min.) joists
- 2x6 or 5/4x6 decking
- 2x4 (min.) **curbing,** top, and top support rail
- **2x2 pickets**
- 1 ¼" galvanized pipes (fence top rails) are to be used as handrails with galvanized "C" clamps and PVC caps.
- 2x4x4" or 2x4x6 handrail spacers
- **3" ring-shanked exterior nails and 3" and 2 ½" decking screws**
- 2500 PSI cement

Foundations:

- Posts must be a minimum 4x4 CCA lumber
- Posts must be sunk a minimum **12"** into the ground and set in concrete (min. 25lbs)
- Exception – if post is set on cement walkway or driveway, post may be anchored with a post base attached to the cement, **and/or** cross- braced for stability.
- Foundation posts are to be set no more than 8' apart.
- **Set the final post back 8" from the end of the ramp.**

Floor Framing:

- Outside joists shall consist of 2x6 (min) lumber connected to the foundation posts.
- Inside joists shall be 2 x 6 (min) and shall be connected to the foundation posts using a header board and proper joist hangers.
- There shall be no more than 16" between joists.
- There shall be four total joists: (2) inside and (2) outside.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

GENERAL RAMP SPECIFICATIONS (CONT'D.)

- All framing will be attached with 3" ring-shanked nails or 3" decking screws.
- The 1st three decking boards at either end of the ramp must be attached with screws.

Slopes:

- All landings must be level (slope no greater than 1:50)
- All cross slopes must not exceed 1:50
- Ramps will have a maximum slope of 1:12 with few exceptions.
- In the RARE case a steeper slope is needed, the following will apply:
  - A 1:10 slope is permitted for no more than a 6" rise.
  - A 1:8 slope is permitted for no more than a 3" rise.

Ramps:

- Shall not rise more than 30" between landings.
- Shall lead to a firm stable landing, provider is responsible for the area at the end of a ramp.
- The ramp will be finished with concrete a minimum of 1" deep, 12" long, and the width of the ramp to aid in transition to the ground.
- Shall be level with a cross slope of no more than 1:50.
- Shall have a clear width of **41**".
- With a drop off of more than 2" shall have a minimum 4" curb.
- Shall allow for water to run off and not collect.
- Must be slip resistant (floor areas painted with a non- slip paint).
- Must use 2'x6" or 5/4"x6" as decking.
- Ramps are not to be built attached to the house unless necessary (2' spacing).
- Ramps for clients using stretchers should avoid turns and be angled if possible.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

GENERAL RAMP SPECIFICATIONS (CONT'D.)

The end of the ramp will be finished with concrete.

Landings (General):

- Must be level – slope less than 1:50, must be stable and slip resistant.
- Landing will have pickets.
- Landings must have top rail, **top support rail**, and curbing.
- Must be at least 60" x 60" **clear** space if the ramp changes direction.
- "Straight through" landings must be the width of the ramp and 5' long.
- "Switchback landings" will be at least 60"x 96" **clear** space.
- **Joists will be no more than 16" apart.**

Landings at Doorways:

- Shall have no more than a ½" beveled threshold between landing and interior floor.
- Must have a minimum 18" + of clear space past the latch side of the door (24" preferred).
- Will minimum have 60" x 60" clear space.
- Railings are required for drop offs of more than 2".
- Must not be positioned in such a way as to expose people to the danger of falling, (***i.e.*, railings blocking exposed steps).**

Handrails:

- **Will be made from 1 ¼" galvanized pipes (fence top rail) with support blocking every 5'.** Poles come in 10' lengths and are tapered to fit together.
- **Blocking will be screwed into the top rail.**
- **Shall be attached to blocking with galvanized "C" clamps and glued on PVC caps.**
- Shall run parallel to the floor of the landing or ramp.
- Shall be continuous on both sides.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

GENERAL RAMP SPECIFICATIONS (CONT'D.)

- **Shall extend 6" past the end of the last block, but not past the end of the ramp.**
- Shall have a 1 ½" clearance between handrail and top rail and any wall.
- Shall be between 34" and 38" high.
- Shall not rotate within its fittings, **drill a screw into galvanized pipes at every block.**
- Must be able to withstand **350 lbs.** of pressure.

Top rails, side rails, and curbing:

- **All lumber above the floor level is to be attached using decking screws.**
- Top rail must have a side support rail on the inside of the ramp.
- All rails shall be attached on the inside of the ramp to the 4x4 posts (no toe- nailing between posts).
- **2x2 pickets will be placed no more than 4" apart, will be pre-drilled and installed with a 2 ½" decking screw, a 2x4 will be substituted for the last picket at the end of the ramp.**
- **Pickets will be screwed into the top rail, curbing, and the ramp frame.** Brad nailing pickets into place before screwing can save time.
- Curbing shall be attached on the inside of the ramp to the 4x4 posts (no toe- nailing between posts) and be **2"** off the ramp.

Heavy Duty Ramps and Landings:

- Ramps and landings for clients above 250 lbs. shall be built to accommodate the extra weight.
- These ramps shall use: 2 x 6 decking boards; 2 x 8 joists every 16"; and be a minimum of 44" wide clear space.

CLTC STANDARDS FOR BATHROOM SAFETY PRODUCTS

Specs for Raised Toilet Seat with Steel Legs:

(3-in -1 Folding Steel Commode with Standard Seat Depth)

- Reimbursement – $100.00
- Minimum weight capacity – 350 lbs.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

CLTC STANDARDS FOR BATHROOM SAFETY PRODUCTS (CONT'D.)

- Seat width – 13.75"- 15"
- Seat depth – 13"- 14.5"
- Seat height – 15.5"- 21.5"
- Width between arms – 18"
- Overall width – 22.25"
- Locking
- Installation

Materials – Primary material is steel.

Warranty – Lifetime Limited Warranty

Specs for Bariatric Raised Toilet Seat with Steel Legs:

(Heavy Duty, Bariatric, Folding Commode – 650 lbs)

- Reimbursement – $195.00
- Minimum weight capacity – 650 lbs.
- Seat width – 13.75"- 15"
- Seat depth – 16.5"
- Seat height – 15.5"- 22"
- Width between arms – 24"
- Overall width – 31.75"
- Locking
- Installation

Materials – Primary material is steel.

Warranty – Lifetime Limited Warranty

Specs for Transfer Benches:

- Adjustable height from 17" to 23"
- Backrest
- Arm rail
- Seat depth – 18"
- Seat width – 33" minimum
- Maximum weight capacity – 350 lbs.
- Installation, assembly, and adjustment

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

CLTC STANDARDS FOR BATHROOM SAFETY PRODUCTS (CONT'D.)

Specs for Bariatric Shower Transfer Benches:

- Minimum weight capacity – 500 lbs.
- Backrest
- Seat depth – 16"
- Seat width – 28"
- Seat height – 16" minimum
- Installation

Specs for Shower Chair with Back:

- Back rest
- Maximum weight capacity – 300 lbs.
- Adjustable
- Seat height- 17" to 21"
- Seat width – 20"
- Seat depth – 18"
- Installation

Specs for Bariatric Shower Seat:

- Back rest
- Minimum weight capacity – 500 lbs.
- Seat height – 16" minimum
- Seat width – 17"
- Seat depth – 16"
- Installation

Specs for Hand-Held Showers:

- Minimum 6' hose
- Pause/shut off function
- Installation with Teflon tape

Specs for Oil Filled Space Heaters:

- Reimbursement – $61.75
- Minimum 1 year warranty
- Wheels/Casters
- 3 heat settings

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

CLTC STANDARDS FOR BATHROOM SAFETY PRODUCTS (CONT'D.)

- The oil filled space heaters must be delivered and set up.
- Accepted brands for oil filled space heaters: Honeywell (Walmart), Pelonis (Home Depot), DeLonghi (Lowes)

Alternative Space Heaters that may be shipped:

- Lasko2 heat tower electric space heater Model 6251 Item # 142570 (Available at Lowes)
- Warmwave 1500 watt ceramic portable tower heater Model HPQ15M (Available at Home Depot)

These products can be shipped to participants.

No substitutions are allowed unless prior approval is given in writing.

SANCTION PROCESS CLTC ENVIRONMENTAL MODIFICATION PROVIDERS

Community Long Term Care (CLTC) will review provider compliance with environmental modification program requirements on an ongoing basis. The department's environmental modification specialist will complete reviews. Failure to comply with the environmental modification requirements will result in the application of sanctions, either suspension and/or termination.

Suspension: The environmental modification provider is removed from the provider choice list. The provider will not be allowed to bid or be listed on the participant's choice list for the duration of the sanction. The minimum period of suspension is 1 month. Providers who are suspended must complete all outstanding jobs to the specifications indicated by the environmental modification specialist before being allowed to perform new work with CLTC.

Termination: The cancellation of your enrollment in the Medicaid (CLTC) program resulting in denial of Medicaid participation for a period of three (3) years. After two suspensions for any reason, a third suspension in a two (2) year period from July-June will lead to termination from Medicaid participation.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Compliance Issues Resulting in Suspension and/or Termination

Refusing to complete jobs that the provider has bid on and won: Providers are expected to complete any job where they are the winning bidder. If the winning bidder **accepts the job, then** refuses to complete the project the provider will be subject to the following sanctioning process.

First offense - Suspend one (1) month

Second offense- Suspend two (2) months (within 1 year of first offense)

Third offense - Termination (within 1 year of first offense)

Example: The provider bids and accepts jobs in several different areas. He or she gets to the jobsite and decides he or she has underbid the project and/or does not have the time or manpower to complete the job, and refuses to honor his bid. This action will result in sanctioning of the provider.

Failure to complete jobs timely as defined by the date on the environmental modification specialists bid notification in Phoenix: Providers are expected to complete work in a timely manner. If it is identified that there are three (3) occurrences of this type within a six (6) month time period of January through June and/or July through December the following sanctions will apply.

A) Suspension for two (2) months

B) Each subsequent occurrence - Suspension for two (2) months

Example: The provider accepts a project through Phoenix which has an expected date of completion on it; if the provider accepts the job he is accepting the completion time frame. If the environmental modification specialist discovers that the provider is not completing this project in the allotted time frame indicated on the bid in Phoenix this action will result in sanctioning of the provider indicated above.

SCDHHS environmental modification Inspector returning to jobsite due to poor workmanship: Providers are expected to comply with the standards set forth by the environmental modification inspector. If the SCDHHS inspector must return to the jobsite due to poor workmanship the following sanctioning process will occur.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Compliance Issues Resulting in Suspension and/or Termination (Cont'd.)

A) Three (3) substantiated returns in any quarter - Suspend two (2) months

B) Six (6) substantiated returns in any quarter - Terminate

Example: The provider accepts a project through Phoenix and completes the job. The environmental modification specialist will then review the work done. If the environmental modification specialist determines the project was not done to general contracting standards a letter will be sent to the provider indicating the corrections that need to be completed on the job. If this occurs sanctioning of the provider will occur on the schedule mentioned above.

Documenting in Phoenix that a job is complete and/or billing for services through Care Call prior to completion of job: Providers cannot bill Medicaid prior to the completion of an environmental modification project. If providers are found to have billed Medicaid or documented in Phoenix that the job was completed prior to job completion the following sanctioning process will apply:

Recoupment of inappropriate payment, if found job is not completed plus

A) First offense – Suspend for one (1) month

B) Second offense – Suspend two (2) months

C) Third offense- Termination

Example: The provider accepts a project through Phoenix and goes to work on the job. The crew tells the provider they have completed the job and the provider indicates this in the Phoenix system and/or bills for the job through Care Call. The environmental modification specialist and/or participant determine that project was not complete prior to indicating it in phoenix and/or billing through Care Call will result in the sanctioning of the provider on the schedule mentioned above.

Refusal or inability to complete job to the specifications set forth by the Environmental Modification inspector: Providers are expected to complete jobs within the standards set forth by the environmental modification specialist. Any job not completed to general contracting

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Compliance Issues Resulting in Suspension and/or Termination (Cont'd.)

specifications will receive a corrective action letter that must be followed. If the provider does not follow the corrective action letter and the deficiencies are not corrected within two (2) weeks all funds will be recouped and the provider will be automatically suspended from providing services to Medicaid participants until the job has been completed. The provider will be reinstated one month after the date of completion of the job.

A second offense of the type described above will result in being suspended for two months after the correction of the deficiencies and a third offense will result in automatic termination as a Medicaid provider.

Example: The provider accepts a project through Phoenix and completes the job. The environmental modification specialist will then review the work that was done. If the environmental modification specialist determines that the project was not done to general contracting standards a letter will be sent to the provider indicating the corrections that need to be completed on the job. If the provider does not correct the deficiencies within two weeks this will lead to the sanctioning process mentioned above.

Home and Community Based Waivers (HCBW) are programs that allow individuals who meet an institutional level of care to receive items and services not covered through the South Carolina Medicaid State Plan. These items and services are allowed through the waiver programs to assist individuals in remaining in their own home or other community setting and avoiding institutional placement.

PEST CONTROL STANDARDS FOR COMMUNITY LONG TERM CARE PARTICIPANTS

Conditions of Participation

All providers must verify participant's Medicaid eligibility upon acceptance of an authorization for pest control and any time services are rendered thereafter to ensure continued eligibility.

Agencies must utilize the automated systems mandated by CLTC to document and bill for the provision of services.

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Conditions of Participation (Cont'd.)

Providers must accept or decline referrals from CLTC or SCDDSN within two (2) working days. Failure to respond will result in the loss of the referral.

Conduct of Service

The Provider must obtain an authorization for pest control services from CLTC. The authorization will designate the amount, frequency and duration of service for participants. Pest control authorizations are for a maximum of once every other month. The Provider will receive new authorizations only when there is a change to the authorized service amount, frequency or duration.

All instructions on the authorization for service must be followed in order to be reimbursed for the pest control service. Pest control services must be completed by the provider within 14 days of acceptance of the CLTC authorization for service.

Pest Control treatments need to include both in-home and exterior treatment. All providers must go into the participants home to inspect and treat the residence and call in the service to Care Call. If a participant is not at the residence at the time of the treatment the provider will need to reschedule for a time when the participant will be present in the home.

Providers can only utilize a cell phone to call in claims if the participant does not have a home phone.

If for any reason a provider is not able to make the call for pest control the day of the treatment then the claim will need to be submitted via the Care Call website. Providers who are not routinely calling in claims for this service through the Care Call phone system will be terminated from South Carolina Medicaid.

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COMMUNITY CHOICES WAIVER

The Community Long-Term Care (CLTC) Community Choices Waiver is designed to serve Medicaid-eligible individuals who are age 18 or older and have long-term care needs. To avoid or delay costly nursing home admission, clients are able to access the services necessary to receive care at home through careful assessment, service planning, care coordination, and monitoring.

Covered Services

Adult Day Health Care Services

Based on the client's identified needs, Adult Day Health Care centers provide a range of health care and support services. The center provides planned therapeutic activities to stimulate mental activity, communication, and self-expression. The center staff provides meals and supervision of personal care. The center also transports clients to and from home, if they live within fifteen miles of the center. With special approval, the center may also provide additional services.

A limited number of skilled procedures are available to persons receiving Adult Day Health Care. A licensed nurse, as ordered by a physician, provides the skilled procedures in the Adult Day Health Care center. Nursing care is provided to:

- Monitor the client's vital signs and ability to function
- Supervise intake of medication and possible reactions
- Teach health care and self-care
- Oversee treatment in conjunction with a client's physician and case manager

The South Carolina Department of Health and Environmental Control (DHEC), or the equivalent licensing agency for out-of-state facilities, must license all adult day care centers. Furthermore, centers must have adequate procedures for medical emergencies and must meet the minimum staffing requirements as specified by the contract.

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Attendant Care Services

Attendant care services are provided by qualified individuals to help clients by offering support for activities of daily living and monitoring the medical condition of clients. The kinds of activities that an attendant provider performs include the following:

- Assistance with personal hygiene, feeding, bathing, and meal preparation
- Encouraging clients to adhere to specially prescribed diets
- General housekeeping duties
- Shopping assistance
- Assistance with communication
- Monitoring medication

Supervision may be furnished directly by the client when the client has been trained to perform this function, and when the safety and efficacy of client-provided supervision has been certified in writing by an RN or otherwise as provided within state law. This certification must be based on actual observation of the client and the specific attendant care provider during the actual provision of care.

Case Management

A qualified case manager provides CLTC case management for all waiver clients. The objective of case management is to counsel regarding services and support. Case management assists clients in coping with changing needs and in making decisions regarding long-term care. It also ensures continued access to appropriate and available services.

Companion

Companion services provide short-term relief for caregivers and supervision of clients.

Home Delivered Meals

Nutritionally sound meals are delivered to clients at their homes. All menus must be reviewed and approved by a registered dietitian and meals must be prepared and delivered according to the standards developed by CLTC.

Nursing Home Transition Services

The goal of Nursing Home Transition Services is to properly identify and transition current nursing home residents who desire to return to the community. The services assist elderly individuals with disabilities and

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Nursing Home Transition Services (Cont'd.)

clients with mental health conditions. The following one-time services are available for clients transitioning to a community waiver program from a nursing home:

- **Appliances:** This service is intended to provide necessary appliances.
- **Furniture procurement:** Funds are used to purchase minimal furnishings necessary to establish a home in the community.
- **Rent/utility assistance:** One-time rent/utility assistance is available for clients who need financial help to secure a community residence.

Personal Care II (PC II) Services

Personal Care II (PC II) services are designed to help clients with normal daily activities and monitor the medical conditions of functionally impaired/disabled clients. The kinds of activities that the PC II aide performs are comparable to those that family members would perform for the person in need. PC II aides provide assistance with walking, bathing, dressing, toileting, grooming, preparing meals, and feeding. The aide also helps to maintain the home environment, including light cleaning, laundry, shopping, and keeping the home safe. The client's vital signs, such as respiratory rate, pulse rate, and temperature, are observed. The aide may also remind the client to take prescribed medication(s) and, when necessary, transport and/or escort the client.

PC II aides work under the supervision of a registered nurse (RN) or a licensed practical nurse (LPN) in the client's home.

Under no circumstances may a PC II aide perform any type of skilled medical service.

Respite Care

Many clients with long-term care needs are cared for at home by family members or other caregivers. Respite care services are intended to provide temporary around-the-clock relief for caregivers by placing the client in an institutional setting for up to fourteen days per state fiscal year. The provider of respite care services must be licensed and certified by DHEC as a hospital, nursing home, or Intermediate Care Facility for People with Mental Retardation (ICF/MR). Out-of-state providers must be licensed by an equivalent agency of that state. They must also have a valid Medicaid contract with the SCDHHS.

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Respite Care in a Community Residential Care Facility

Respite care services may be provided for caregivers by placing the client in a community residential care facility for up to 28 days per state fiscal year. The facility must be licensed by DHEC and have a valid Medicaid contract with SCDHHS for these services.

HIV/AIDS WAIVER

The CLTC Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Waiver is designed to serve Medicaid-eligible HIV/AIDS clients, regardless of age, who choose to live at home but have long-term care needs and are at risk for hospitalization.

Covered Services

Attendant Care Services

Attendant care services are provided by qualified individuals to help clients by offering support for activities of daily living and monitoring the medical condition of clients. The kinds of activities that an attendant provider performs include the following:

- Assistance with personal hygiene, feeding, bathing, and meal preparation
- Encouraging clients to adhere to specially prescribed diets
- General housekeeping duties
- Shopping assistance
- Assistance with communication
- Monitoring medication

The client may directly supervise the attendant when the client has been trained to perform this function, and when the safety and efficacy of client-provided supervision has been certified in writing by an RN or otherwise as provided within state law. This certification must be based on actual observation of the client and the specific attendant care provider during the actual provision of care.

Case Management

A qualified case manager provides CLTC case management for all waiver clients. The objective of case management is to counsel clients regarding services and support. The case manager assists clients in coping with changing needs and in making decisions regarding long-term care. He or she also ensures continued access to appropriate and available services.

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Companion

Companion services provide supervision of clients and short-term relief for caregivers.

Environmental Modification

Environmental modification services provide pest control and physical adaptations or modifications to the home that are necessary to ensure the health, welfare, and safety of the client. Environmental modifications enable clients to function with greater independence in the home. An example of such a modification is the construction of a ramp.

Home Delivered Meals

Nutritionally sound meals are delivered to clients at their homes. Based on a physician's orders, meals may include standard diets or therapeutic and/or modified diets. All menus must be reviewed and approved by a registered dietitian and meals must be prepared and delivered according to the standards developed by CLTC.

Personal Care I (PC I) Services

Personal Care I (PC I) services are designed to help preserve a safe and sanitary home environment, provide short-term relief for caregivers, and assist clients with personal care. These services supplement, but do not replace, the care provided to clients. The kinds of services performed by the PC I aide include the following:

- Meal planning and preparation
- General housekeeping
- Assistance with shopping
- Companion or sitter services
- Assistance with financial matters, such as delivering payments to designated recipients on behalf of the client
- Assistance with communication
- Observing and reporting on the client's condition

Personal Care II (PC II) Services

Personal Care II (PC II) services are designed to help clients with normal daily activities and to monitor the medical conditions of functionally impaired/disabled clients. The kinds of activities that the PC II aide performs are comparable to those that family members would perform for the person in need. PC II aides provide assistance with walking, bathing, dressing, toileting, grooming, preparing meals, and feeding. The aide also

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Personal Care II (PC II) Services (Cont'd.)

helps to maintain the home environment, including light cleaning, laundry, shopping, and keeping the home safe. The client's vital signs, such as respiratory rate, pulse rate, and temperature, are observed. The aide may also remind the client to take prescribed medication(s) and, when necessary, transport and/or escort the client.

PC II aides work under the supervision of an RN or LPN in the client's home. Under no circumstances may a PC II aide perform any type of skilled medical service.

PC II aides who provide services to HIV/AIDS clients should be trained in infection control.The Centers for Disease Control and Prevention (CDC) precautions must be followed when rendering care to protect the client and the PC II aide.

Nursing Services

Nursing services provide skilled medical monitoring, direct care, and interventions that meet the medical needs of the client with HIV/AIDS at home. The client's condition may require 24-hour continuous care for a short duration due to an episodic condition.

PERVASIVE DEVELOPMENTAL DISORDER WAIVER

The Pervasive Developmental Disorder (PDD) waiver provides for early intensive behavioral intervention services (EIBI) to children who have been diagnosed with a pervasive developmental disorder, including autism and Asperger's Syndrome and who meet the ICF-MR level of care criteria. The Department of Disabilities and Special Needs operates the waiver with administrative oversight from SCDHHS. The waiver is for children who are ages three through ten. These services are provided in non-educational settings. The waiver develops the skills of children in the areas of cognition, behavior, communication, and social interaction. To learn more about the PDD waiver and DDSN services please visit http://www.state.sc.us/ddsn or call DDSN at 1-888-376-4636.

Covered Services

Case Management

Case managers assist participants in gaining access to needed waiver and other State plan services, as well as medical, social, educational, and other services, regardless of the funding source for the services to which access is gained.

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Case Management (Cont'd.)

The following minimum standards will apply for the provision of case management:

- Case managers will provide a monthly contact with the EIBI service provider and/or family.
- On a quarterly basis, there will be a review of the entire waiver plan of care, which includes the most recent EIBI service provider quarterly progress report and a contact with the participant's family.
- If progress toward established goals does not meet expectations, then consultation with DDSN will occur.
- On an annual basis, there will be a face-to-face contact with the family.

MECHANICAL VENTILATOR DEPENDENT PROGRAM

The Mechanical Ventilator Dependent Program is designed to serve Medicaid-eligible persons age 21 or older who are dependent on mechanical ventilation and have long-term care needs. Clients are able to receive services to supplement care in their home through careful assessment, service planning, and service coordination.

Covered Services

Environmental Modification

Environmental modification services provide pest control and physical adaptations or modifications to the home that are necessary to ensure the health, welfare, and safety of the client. Environmental modifications enable clients to function with greater independence in the home. Examples of modifications may include construction of ramps, installation of grab bars, widening of doorways, or installation of specialized electric and plumbing systems that are necessary to accommodate medical equipment.

Nursing Services

Nursing services provide skilled medical monitoring, direct care, and interventions that meet the medical needs of a client dependent upon mechanical ventilation at home.

Personal Care I (PC I) Services

Based on the client's assessed needs, PC I services provide general household activities, meal preparation, and routine household care.

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Personal Care II (PC II) Services

PC II services are designed to help clients with normal daily activities and to monitor the medical conditions of functionally impaired/disabled clients. The kinds of activities that the PC II aide performs are comparable to those that family members would perform for the person in need. PC II aides provide assistance with walking, bathing, dressing, toileting, grooming, preparing meals, and feeding. The aide also helps to maintain the home environment, including light cleaning, laundry, shopping, and keeping the home safe. The client's vital signs, such as respiratory rate, pulse rate, and temperature, are observed. The aide may also remind the client to take prescribed medication(s) and, when necessary, transport and/or escort the client.

PC II aides work under the supervision of an RN or LPN in the client's home. Under no circumstances may a PC II aide perform any type of skilled medical service.

Respite Care

Many clients with long-term care needs are cared for at home by family members or other caregivers. Respite care services are intended to provide temporary around-the-clock relief for caregivers by placing the client in an institutional setting for up to fourteen days per state fiscal year. The provider of respite care services must be licensed and certified by DHEC as a hospital, nursing home, or ICF/MR. Out-of-state providers must be licensed by an equivalent agency in that state. They must also have a valid Medicaid contract with SCDHHS.

Respite (In-Home)

In-home respite services provide temporary care in the home for mechanical ventilator dependent clients living at home and cared for by their families or other informal support systems. These services maintain clients and provide temporary relief for the primary caregivers.

CHILDREN'S PERSONAL CARE AIDE (PCA) SERVICES

Children's PCA services provide PC aide services in the community to Medicaid-eligible children under 21 years of age who meet established medical necessity criteria.

Covered Services

Personal Care II (PC II) Services

PC II services are designed to help clients with normal daily activities and to monitor the medical conditions of functionally impaired/disabled clients. The kinds of

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Personal Care II (PC II) Services (Cont'd.)

activities that the PC II aide performs are comparable to those that family members would perform for the person in need. PC II aides provide assistance with walking, bathing, dressing, toileting, grooming, preparing meals, and feeding. The aide also helps to maintain the home environment, including light cleaning, laundry, shopping, and keeping the home safe. The client's vital signs, such as respiratory rate, pulse rate, and temperature, are observed. The aide may also remind the client to take prescribed medication(s) and, when necessary, transport and/or escort the client.

PC II aides work under the supervision of an RN or LPN in the client's home. Under no circumstances may a PC II aide perform any type of skilled medical service.

PALMETTO SENIORCARE (PSC) PROGRAM

Palmetto SeniorCare (PSC) is a federal Medicaid and Medicare capitated program serving clients in the greater Columbia area (Richland and Lexington counties) who meet all of the following criteria:

- Are age 55 or older
- Meet nursing home level of care
- Wish to remain in the community
- Choose to participate in the program

Participants in Palmetto SeniorCare receive all services through PSC either directly from PSC staff health care professionals or through subcontracted health care entities. Many of the services provided are centered in the PSC Adult Day Health Centers.

HEAD AND SPINAL CORD INJURY (HASCI) WAIVER

In a joint effort, SCDHHS and the Department of Disabilities and Special Needs (DDSN) are providing a broad range of home- and community-based waiver services to Medicaid-eligible individuals with the most severe physical impairments involving head and spinal cord injuries. Head and Spinal Cord Injury (HASCI) Waivers are designed to help clients who would otherwise require services in a nursing facility or ICF/MR to remain independent in the community.

SCDHHS serves as an administrative oversight and monitoring entity to ensure the health, safety, and welfare of the waiver beneficiaries. SCDHHS is responsible for

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HEAD AND SPINAL CORD INJURY (HASCI) WAIVER (CONT'D.)

ensuring that a formal system is in place to periodically review clients' services and to ensure that those in place are consistent with identified needs of clients. DDSN has the primary responsibility for the daily operation of the HASCI program.

Covered Services

Attendant Care Services

Attendant care services assist with the performance of activities of daily living and personal care, which may include hands-on care, of both a medical and non-medical supportive nature, specific to the needs of a medically stable, physically handicapped individual. These services may include skilled medical care to the extent permitted by state law. Housekeeping and community access activities that are incidental to the performance of the client-based care may also be furnished as part of this activity.

Transportation may be provided as a component of the service when it is related to the performance of daily living skills. The cost of this transportation is included in the rate paid to the providers of attendant care services. These services may be conducted in a variety of settings as outlined in the DDSN plan of service. These services shall not duplicate any other service. An RN licensed to practice in the state must provide supervision. The frequency and intensity of supervision will be specified in the client's written plan of service by the DDSN service coordinator.

Supervision may be furnished directly by the client when the client has been trained to perform this function, and when the safety and efficacy of client-provided supervision has been certified in writing by an RN or otherwise as provided within state law. This certification must be based on actual observation of the client and the specific attendant care provider during the actual provision of care. Documentation of the certification will be maintained in the client's individual plan of service.

Environmental Modification, Specialized Supplies, and Adaptations

Environmental modification services provide physical adaptations to the home required by a client's plan of service necessary to ensure the health, welfare, and safety of the client. Environmental modifications are changes that enable clients to function with greater independence in the home and without which the client would require

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Environmental Modification, Specialized Supplies, and Adaptations (Cont'd.)

institutionalization. Under HASCI waivers, adaptations may include the following:

- Installation of ramps and grab bars
- Widening of doorways
- Modification of personal transportation, bathrooms, or kitchen facilities
- Fencing, when necessary for personal safety
- Installation of specialized electric and plumbing systems required to accommodate the medical equipment and supplies necessary for the welfare of clients

Excluded are those adaptations or improvements to the home that are of general utility and have no direct medical or remedial benefit to the client. Services must be provided for the client's benefit, not for the convenience of other occupants. Environmental modifications shall meet all applicable state and local building codes. In those counties without local building codes, all services shall be provided in accordance with standard building codes as set forth in the South Carolina Code of Laws § 6-9-10 *et seq*.

Habilitation Services (Day)

Day habilitation services provide assistance with the acquisition, retention, or improvement of self-help, socialization, and adaptive skills that take place in a non-residential setting, separate from the home or facility in which the client resides. Normally, these services are furnished four or more hours a day, on a regularly scheduled basis, for one or more days a week unless provided as an adjunct to another day activity included in the beneficiary's plan of service. Day habilitation services focus on enabling clients to attain or maintain their maximum functional level. They shall also be coordinated with any physical, occupational, or speech therapies listed in the plan of service. Additionally, day habilitation services reinforce skills or lessons taught in school, therapy, or other settings.

Habilitation Services (Prevocational)

Prevocational habilitation services are not available under a program funded under Section 110 of the Rehabilitations Act of 1973 or Section 602 (16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401 (16 and 17)). Activities included in this service are not directed at

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Habilitation Services (Prevocational) (Cont'd.)

teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the client's plan of service as directed to habilitative rather than explicit employment objectives. These services teach concepts such as compliance, attendance, task completion, problem solving, and safety, to prepare clients for paid and unpaid employment.

Excluding supported employment programs, prevocational habilitation services are provided to clients not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year. When compensated, individuals are paid less than 50 percent of minimum wage.

Documentation will be maintained in each client's file that the service is not otherwise available under the program funded under the Rehabilitation Act of 1973 or P.L. 94-142.

Habilitation Services (Residential)

Residential habilitation services include the care, skills training, and supervision provided to clients in a non-institutional setting. The degree and type of care, supervision, skills training, and support of clients will be based on the plan of service and the client's individual needs. Services include assistance with the following:

- The acquisition, retention, or improvement of skills related to activities of daily living, such as personal grooming and cleanliness
- Household chores and bed-making
- Eating and preparation of food
- Social and adaptive skills necessary to enable the individual to reside in a non-institutional setting

Other than costs that are for modifications or adaptations to a facility required to assure the health and safety of residents or meet the requirements of the applicable life safety codes, payments for residential habilitation are not made for the following:

- Room and board
- Costs of facility maintenance
- Upkeep

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Habilitation Services (Residential) (Cont'd.)

- Improvement

Payments for residential habilitation do not include those made, directly or indirectly, to members of the client's immediate family. Payments will not be made for the routine care and supervision provided by a family or group home provider or for activities or supervision covered by a source other than Medicaid.

Nursing Services

Nursing services provide skilled medical monitoring, direct care, and interventions that meet the medical needs of clients at home. Nursing services prevent institutionalization.

Respite Care Services

Respite care is provided for caregivers of clients unable to care for themselves; it is provided on a short-term basis as a response to the absence or need for relief of those persons normally providing the care. Respite services may be provided in clients' homes, licensed respite facilities, nursing facilities, ICF/MRs, or other facilities approved by the state. Such facilities may include the private residence of an Independent Respite Provider who meets the DDSN Standards for Respite Care Providers.

Respite Care in a Community Residential Care Facility

Respite care services may be provided for caregivers by placing the client in a community residential care facility for up to 28 days per state fiscal year. The facility must be licensed by DHEC and have a valid Medicaid contract with SCDHHS for these services.

Supported Employment Services

Supported employment services consist of paid employment for clients for whom competitive employment at or above minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported employment is conducted in a variety of settings, particularly work sites in which people without disabilities are employed. These services include activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. When supported employment services are provided at a work site where there are employees without disabilities, payment will be made only for the adaptation, supervision, and training required by clients receiving waiver services because of their disabilities. Payment for supervisory activities rendered as a normal part of the business setting are not included.

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Supported Employment Services (Cont'd.)

Supported employment services furnished under the waiver are not available under any programs funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in each client's file that it is not otherwise available under a program funded under the Rehabilitation Act of 1973 or P.L. 94-142.

Federal financial payments will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

- Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program
- Payments that are passed through to users of supported employment programs
- Payments for vocational training that is not directly related to an individual's supported employment program

MENTAL RETARDATION/ RELATED DISABILITIES (MR/RD) WAIVER

In a cooperative effort, SCDHHS and DDSN are providing a broad range of special home- and community-based waiver services to Medicaid-eligible individuals with mental retardation or related disabilities to help them live in the community rather than in an institution. DDSN has the primary responsibility for the daily operation of the MR/RD Waiver program.

SCDHHS serves as an administrative oversight and monitoring entity to ensure the health, safety, and welfare of the waiver beneficiaries. SCDHHS is responsible for ensuring that a formal system is in place to periodically review client services and ensure those in place are consistent with the client's identified needs.

Covered Services

Adult Day Health Care Services

Based on the client's identified needs, adult day health care centers provide a range of health care and support services. A center provides planned therapeutic activities to stimulate mental activity, communication, and self-expression. The center staff provides meals and supervision of personal care. The center also transports clients to and from home if they live within fifteen miles of the center. With special approval, the center may also provide additional services.

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Adult Day Health Care Services (Cont'd.)

A limited number of skilled procedures are available to participants receiving adult day health care. A licensed nurse, as ordered by a physician, provides the skilled procedures in the adult day health care center. Nursing care is provided to:

- Monitor the client's vital signs and ability to function
- Supervise intake of medication and possible reactions
- Teach health care and self-care
- Oversee treatment in conjunction with a client's physician and case manager

DHEC, or the equivalent licensing agency for out-of-state facilities, must license all adult day health care centers. Centers must have adequate procedures for medical emergencies and must meet the minimum staffing requirements as specified by the contract.

Personal Care I (PC I) Services

PC I services provide general household services for clients, such as meal preparation and routine household care as authorized in their plan of service by DDSN. Meal preparation includes planning meals, cooking, serving, and cleaning afterwards. Household care includes cleaning, laundry, and other activities as needed to properly maintain the client's residence.

Procedure codes for DDSN waiver services **must** be used when submitting claims for MR/RD waiver services.

Personal Care II (PC II) Services

Personal Care II (PC II) services are designed to help clients with normal daily activities and monitor the medical conditions of functionally impaired/disabled clients. The kinds of activities that the PC II aide performs are comparable to those that family members would perform for the person in need. PC II aides provide assistance with walking, bathing, dressing, toileting, grooming, preparing meals, and feeding. The aide also helps to maintain the home environment, including light cleaning, laundry, shopping, and keeping the home safe. The client's vital signs, such as respiratory rate, pulse rate, and temperature, are observed. The aide may also remind the client to take prescribed medication(s) and, when necessary, transport and/or escort the client.

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PROGRAM SERVICES

Personal Care II (PC II) Services (Cont'd.)

PC II aides work under the supervision of an RN. Prior authorization is required for PC II services, with an indication of the amount, frequency, duration, and type of services required.

The DDSN service coordinator shall obtain a physician's order requesting PC II services for individuals under the age of 21. A physician's order is not required for those MR/RD waiver beneficiaries over the age of 21.

Nursing Services

Nursing services provide skilled medical monitoring, direct care, and interventions that meet the medical needs of clients at home. Nursing services prevent institutionalization.

Habilitation Services (Day)

Day habilitation services provide assistance with the acquisition, retention, or improvement of self-help, socialization, and adaptive skills. These services take place in a non-residential setting, separate from the home or facility in which the client resides. Normally, these services are furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, unless provided as an adjunct to other day activities included in the beneficiary's plan of service. Day habilitation services focus on enabling clients to attain or maintain their maximum functional level. They shall also be coordinated with any physical, occupational, or speech therapies listed in the plan of service. Additionally, day habilitation services reinforce skills or lessons taught in school, therapy, or other settings.

Habilitation Services (Prevocational)

Prevocational habilitation services are not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or Section 602 (16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Activities included in this service are not directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the client's plan of service as directed to habilitation rather than explicit employment objectives. These services teach concepts such as compliance, attendance, task completion, problem solving, and safety, to prepare clients for paid and unpaid employment.

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Habilitation Services (Prevocational) (Cont'd.)

Excluding supported employment programs, prevocational habilitation services are provided to clients not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year. When compensated, individuals are paid less than 50 percent of minimum wage.

Documentation will be maintained in each client's file that the service is not otherwise available under the program funded under the Rehabilitation Act of 1973 or P.L. 94-142.

Habilitation Services (Residential)

Residential habilitation services include the care, skills training, and supervision provided to clients in a non-institutional setting. The degree and type of care, supervision, skills training, and support of clients will be based on the plan of service and the client's individual needs. Services include assistance with acquisition, retention, or improvement of skills related to activities of daily living, such as personal grooming and cleanliness; household chores and bed-making; eating and preparation of food; and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting.

Other than costs for modifications or adaptations to a facility required to assure the health and safety of residents or to meet the requirements of the applicable life safety codes, payments for residential habilitation are not made for the following:

- Room and board
- Costs of facility maintenance
- Upkeep
- Improvement

Payments for residential habilitation do not include those made, directly or indirectly, to members of the client's immediate family. Payments will not be made for the routine care and supervision provided by a family or group home provider or for activities or supervision covered by a source other than Medicaid.

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SECTION 3

BILLING PROCEDURES

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SECTION 3

BILLING PROCEDURES

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SECTION 3 BILLING PROCEDURES

GENERAL INFORMATION

The South Carolina Department of Health and Human Services (SCDHHS) strives to make billing as simple for providers as possible. This section is a "how-to" manual on billing procedures with information on how to file a claim, what to do with a rejected claim, etc. Also included is information concerning administrative procedures such as adjustments and refunds. This section will help with these issues, but may not answer all of your questions. You should direct any questions he 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.

REIMBURSEMENT

The Department of Health and Human Services will reimburse the CLTC provider for services agreed to in the contract, provided as authorized, and according to the rate specified in the contract.

USUAL AND CUSTOMARY RATES

Providers are required to bill their usual and customary rate when filing Medicaid claims. Charges to Medicaid cannot exceed charges to private patients, whether they are self-pay or covered by another carrier. Billing of covered procedures prior to the date of service is prohibited.

CLAIM FILING TIMELINESS

Medicaid policy requires that only "clean" claims received and entered into the claims processing system within one year from the date of service be considered for payment. A "clean" claim is free of errors and can be processed without obtaining additional information from the provider or another third party. Claims with an edit code of 509 or 510 on remittances, or CARC 29 on an electronic Remittance Advice, have not met these criteria. It is the provider's responsibility to follow up on claims in a timely manner to ensure that all claims are filed and corrected within Medicaid policy limits.

DUAL ELIGIBILITY

When a beneficiary has both Medicare and Medicaid, Medicare is considered to be the primary payer. Services rendered to persons who are certified dually eligible for Medicare/Medicaid must be billed to Medicare first.

SECTION 3 BILLING PROCEDURES

GENERAL INFORMATION

MEDICARE CROSSOVER CLAIMS FOR COINSURANCE AND DEDUCTIBLE

All claims not paid in full by Medicare must be filed directly to Medicaid as claims no longer cross over for automatic payment review.

MEDICARE PRIMARY CLAIM

Claims for payment when Medicare is primary must be received and entered into the claims processing system within two year from the date of service or discharge, or within six months following the date of Medicare payment, whichever is later.

RETROACTIVE ELIGIBILITY

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

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

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

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

Claims involving retroactive eligibility that are received more than three years from the date of service will be rejected with edit code 533 (date of service more than three years old) and CARC 29 (the time limit for filing has expired).

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

SECTION 3 BILLING PROCEDURES

GENERAL INFORMATION

BENEFICIARY COPAYMENTS

Section 1902(a)(14) of the Social Security Act permits states to require certain beneficiaries to share some of the costs of Medicaid by imposing copayments upon them. A copayment is the amount of money the beneficiary is expected to pay to the provider at the time services are received.

SC Medicaid has required a copayment from beneficiaries toward the cost of their care since March 2004. Medicaid beneficiaries may not be denied service if they are unable to pay the copayment at the time the service is rendered; however, this does not relieve the beneficiary of the responsibility for the copayment.

It is the provider's responsibility to collect the copayment from the beneficiary to receive full reimbursement for a service. The amount of the copayment will be deducted from the Medicaid payment for all claims involving copayments.

As of July 2011, SCDHHS revised the beneficiary copayment amounts for Medicaid Services. Please refer to Appendix 3 of this manual for the Copayment Schedule. Also, pursuant to this change, persons ages 19 and older who are enrolled in a waiver program through Community Long Term Care or the SC Department of Disabilities and Special Needs must make a copayment for their State Plan services according to established policy. Members of MCOs should contact their individual plan for information about copayments applicable in their plan.

Copayment Exclusions

Pursuant to federal regulations, the following beneficiaries are excluded from copayment requirements: children under the age of 19, pregnant women, institutionalized individuals (such as persons in a nursing facility or ICF/IID, members of a Federally Recognized Indian Tribe (for services rendered by the Catawbas Service Unit in Rock Hill, SC and when referred to a specialist or other medical provider by the Catawbas Service Unit) and members of the Health Opportunity Account (HOA) program. **Additionally, the following services are not subject to a copayment:** Medical equipment and supplies provided by DHEC; Orthodontic services provided by DHEC; Family Planning services, End Stage Renal Disease (ESRD) services, Infusion Center

SECTION 3 BILLING PROCEDURES

GENERAL INFORMATION

Copayment Exclusions (Cont'd.)

services, Emergency services in the hospital emergency room, Hospice benefits and Waiver services**.**

Claim Filing Information

The collection of copayment should not be entered in the Rsvd for NUCC use, field 30, on the CMS-1500 claim form; this would result in an additional reduction in payment.

When a beneficiary has Medicare or private insurance, the Medicaid copayment still applies per the policies outlined in this section. However, if the sum of the copayment and the Medicare/third party payment would exceed the Medicaid-allowed amount, the copayment should be adjusted or eliminated. In other words, though a provider may receive a primary insurance payment higher than what Medicaid would pay, the beneficiary's copayment should not contribute to the excess revenue.

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SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Providers may choose one or more of the following options for filing claims:

- Paper Claims
- Electronic Claims
  - SC Medicaid Web-based Claims Submission Tool
  - Tapes, Diskettes, CDs, and Zip Files
  - File Transfer Protocol (FTP)

PAPER CLAIMS SUBMISSIONS

Paper claims are mailed to Medicaid Claims Receipt at the following address:

Medicaid Claims Receipt
Post Office Box 1412
Columbia, SC 29202-1412

Care Call

Providers of services through the electronic monitoring system (Care Call) do not bill for services using any other billing method. In addition, rejected claims are only resubmitted through the local CLTC area office. The Care Call filing option is mandatory for certain long-term care services.

CMS-1500 Claim Form

Professional Medicaid claims must be filed on the CMS-1500 claim form (02/12 version). Alternate forms are not acceptable. “Super Bills” and Continuous Claims are not acceptable and will be returned to the provider for correction. Use only black or blue ink on the CMS-1500.

Each CMS-1500 submitted to SC Medicaid must show charges totaled. ONLY six lines can be processed on a hard copy CMS-1500 claim form. If more than six lines are submitted, only the first six lines will be processed for payment or the claim may be returned for corrective action.

SCDHHS does not supply the CMS-1500 (form) to providers. Providers should purchase the form in its approved format from the private vendor of their choice. A list of vendors who supply the form can be found in Section 5 of this manual. Examples of the CMS-1500 claim form can be found in the Forms section of this manual.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

CMS-1500 Claim Form (Cont'd.)

Providers using computer-generated forms are not exempt from Medicaid claims filing requirements. The SCDHHS data processing personnel should review your proposed format before it is finalized to ensure that it can be processed.

Procedural Coding

SC Medicaid requires that claims be submitted using codes from the current editions of the Healthcare Common Procedure Coding System (HCPCS) and the Current Procedural Terminology (CPT). Providers may also use supplemental codes as outlined in the various sections of this manual.

The Centers for Medicare and Medicaid Services revises the nomenclature within the HCPCS/CPT each quarter. When a HCPCS/CPT code is deleted, the SC Medicaid program discontinues coverage of the deleted code. SC Medicaid will not accept billing of discontinued codes for dates of service after the date on which the code is discontinued. When new codes are added, SCDHHS reviews the new codes to determine if the SC Medicaid program will cover them. Until the results of the review are published, SCDHHS does not guarantee coverage of the new codes.

Providers must adopt the new codes in their billing processes effective January 1 of each year and begin using them for services rendered on or after that time to assure prompt and accurate payment of claims.

The current editions of HCPCS/CPT may be ordered from:

Order Department
American Medical Association
Post Office Box 930876
Atlanta, GA 31193-0876

You may order online at http://www.amabookstore.com/ or call toll free 1-800-621-8335.

See Section 4 for procedure codes used for CLTC services.

Code Limitations

Certain procedures within the HCPCS/CPT may not be covered or may require additional documentation to establish their medical necessity or meet federal guidelines.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Diagnostic Codes

SC Medicaid requires that claims be submitted using the current edition of the *International Classification of Diseases, Clinical Modification* (ICD-CM). SC Medicaid will not accept billing of discontinued codes for dates of service after the date on which the code is discontinued. Physicians, practitioners, and suppliers must bill using the diagnosis code that is valid for that date of service. Providers must adopt the new codes for billing processes effective October 1 of each year and use for services rendered on or after that time to assure prompt and accurate payment of claims.

For dates of service on or before **September 30, 2015**, diagnosis codes must be full ICD-9-CM diagnosis codes. Valid diagnosis coding can only be obtained from the most current edition of the ICD-CM.

For dates of service on or after **October 1, 2015**, diagnosis codes must be full ICD-10-CM diagnosis codes. Valid diagnosis coding can only be obtained from the most current edition of the ICD-CM.

Supplementary Classification of External Causes of Injury and Poisoning (External Causes of Morbidity) codes are sub-classification codes and are not valid as first-listed or principal diagnosis.

A current edition of the ICD-CM may be ordered from:

Practice Management Information Corporation
4727 Wilshire Boulevard, Suite 300
Los Angeles, CA 90010

You may order online at http://www.pmiconline.com/ or call toll free 1-800-MED-SHOP.

Modifiers

Certain circumstances must be identified by the use of a two-character modifier that follows the procedure code. Failure to use these modifiers according to policy will slow turnaround time and may result in a rejected claim.

Only the first modifier entered is used to process the claim. Failure to use modifiers in the correct combination with the procedure code, or invalid use of modifiers, will result in a rejected claim.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Place of Service Key

Place of Service Codes

Code	Description
11	Office
12	Home
33	Custodial Care Facility
99	Other Unlisted Facility

Acceptable Signatures

Beneficiary signatures authorizing release of information regarding services provided will be accepted in the priority listed below:

1. Persons 18 years or older who are legally competent
2. Legal guardians signing on behalf of persons who have been judged incompetent
3. Signatures of case managers or public assistance technicians accompanying a patient who signs with an "X"
4. Parents or legal guardians signing on behalf of minors (under 18) (See 8 below.)
5. Case managers or public assistance technicians accompanying minors to a provider of services. In such cases, the case manager or public assistance technician should parenthetically indicate "accompanied" on the signature line of the individual claim form.
6. Foster parent(s) or a responsible party accompanying foster children for beneficiaries under 18 years of age. In either instance, relationship/ responsibility must be indicated.
7. A minor (including "X" signatures) in isolated areas where neither a parent, legal guardian, foster parent, or Department of Social Services representative is accompanying the minor, if a member of the provider's staff signs his or her name under the minor's signature as witness thereof

   Minors are allowed by law to sign on their own behalf in certain instances. Examples are:

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Acceptable Signatures (Cont'd.)

a) Abortion cases

b) Treatment of sexually transmitted diseases (STDs)

c) Family planning

d) A minor parent giving consent for his or her child to receive care or treatment

8. An emancipated minor who is the head of his or her own household. If the minor is a part of his or her parent's household budget when applying for assistance, the Department of Social Services has determined that he or she is not emancipated.

In lieu of having a beneficiary sign individual claim forms each time a service is rendered, the provider may elect to have the beneficiary sign an Authorization to Release Information statement. This statement must include the date signed and be maintained in the patient's record. This will effectively meet requirements as outlined in Section 1 under Enrollment. The phrase "Patient's Signature on File" may then be entered in the patient's signature block of the claim form.

Provider Signatures

Effective July 1, 1987, providers are no longer required to sign claims. Instead, providers are held personally liable for all claims submitted by them or on their behalf as evidenced by their endorsement of the Medicaid reimbursement check. Furthermore, the provider should understand in endorsing or depositing the Medicaid check that payment is from federal and state funds and any falsification or concealment of a material fact may be prosecuted under federal and state laws. (See Section 1 for more information.)

National Provider Identifier and Medicaid Provider Number

Providers who are covered entities under HIPAA are required to obtain a National Provider Identifier (NPI). These "typical" providers must apply for an NPI and share it with SC Medicaid. to obtain an NPI and taxonomy code, please visit http://www1.scdhhs.gov/openpublic/serviceproviders/npi%info.asp for more information on the application process.

When submitting claims to SC Medicaid, typical providers must use the NPI of the ordering/referring provider and the

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

National Provider Identifier and Medicaid Provider Number (Cont'd.)

NPI and taxonomy code for each rendering, pay-to, and billing provider.

Atypical providers (non-covered entities under HIPAA) identify themselves on claims submitted to SC Medicaid by using their six-character legacy Medicaid provider number.

CMS-1500 Form Completion Instructions

Effective on and after April 1, 2014, all claims, regardless of the date of service, must be submitted on the CMS 1500 claim form 02/12 version. Please use the instructions provided in this section to complete the form (see the Forms section of this manual for sample claims). Use only black or blue ink on the claim form.

Field	Description
*	Required for claim to process
**	Required if applicable (based upon the specific program area requirements)

1 Health Insurance Coverage

Show all types of coverage applicable to this claim by checking the appropriate box(es). If Group Health Plan is checked and the patient has only one primary health insurance policy, complete either block 9 (fields 9, 9a, and 9d) **or** block 11 (fields 11, 11b, and 11c). If the beneficiary has two policies, complete both blocks, one for each policy.

IMPORTANT: Check the **"MEDICAID"** field at the top of the form.

1a* Insured's ID Number

Enter the patient's Medicaid ID number, exactly as it appears on the South Carolina Healthy Connections Medicaid card (10 digits, no letters).

2 Patient's Name

Enter the patient's last name, first name, and middle initial.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

CMS-1500 Form Completion Instructions (Cont'd.)

Field	Description
*	Required for claim to process
**	Required if applicable (based upon the specific program area requirements)

3 Patient's Birth Date

Enter the date of birth of the patient written as month, day, and year.

Sex

Check "M" for male or "F" for female.

4 Insured's Name

Not applicable

5 Patient's Address

Enter the full address and telephone number of the patient.

6 Patient Relationship to Insured

Not applicable

7 Insured's Address

Not applicable

8 Reserved for NUCC Use

Not applicable

9 Other Insured's Name

When applicable, enter the name of the other insured.

If 11d is marked "YES," complete fields 9, 9a, and 9d.

9a Other Insured's Policy or Group Number**

When applicable, enter the policy or group number of the other insured.

9b Reserved for NUCC Use

When applicable, enter the date of birth of the other insured.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

CMS-1500 Form Completion Instructions (Cont'd.)

Field	Description
*	Required for claim to process
**	Required if applicable (based upon the specific program area requirements)

9c Reserved for NUCC Use**

If the insurance has paid, indicate the amount paid in this field. If the insurance has denied payment, enter "0.00" in this field.

9d Insurance Plan Name or Program Name**

When applicable, enter the three-character carrier code. A list of the carrier codes can be found in Appendix 2.

10a Is Patient's Condition Related to Employment?

Check "YES" or "NO."

10b Is Patient's Condition Related to an Auto Accident?

Check "YES" or "NO." If "YES," enter the two-character state postal code in the Place (State) field (*e.g.*, "SC").

10c Is Patient's Condition Related to an Other Accident?

Check "YES" or "NO."

10d Claim Codes (Designated by NUCC)**

When applicable, enter the appropriate TPL indicator for this claim. Valid indicators are as follows:

Code	Description
1	Insurance denied
6	Crime victim
8	Uncooperative beneficiary

11 Insured's Policy Group or FECA Number**

If the beneficiary is covered by health insurance, enter the insured's policy number.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

CMS-1500 Form Completion Instructions (Cont'd.)

Field	Description
*	Required for claim to process
**	Required if applicable (based upon the specific program area requirements)

11a Insured's Date of Birth

When applicable, enter the insured's date of birth.

Sex

Check "M" for male or "F" for female.

11b Other Claim ID (Designated by NUCC)**

If payment has been made by the patient's health insurance, indicate the payment in this field. If the health insurance has denied payment, enter "0.00" in this field. **The payment information should be entered on the right-hand side of the vertical, dotted line.**

11c Insurance Plan Name or Program Name**

When applicable, enter the three-character carrier code. A list of the carrier codes can be found in Appendix 2.

11d Is There Another Health Benefit Plan?

Check "YES" or "NO" to indicate whether or not there is another health insurance policy. If "YES," items 9, 9a, and 9d **or** 11, 11b, and 11c must be completed. (If there are two policies, complete both.)

12 Patient's or Authorized Person's Signature

"Signature on File" or patient's signature is required.

13 Insured's or Authorized Person's Signature

Not applicable

14 Date of Current Illness, Injury, or Pregnancy

Not applicable

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

CMS-1500 Form Completion Instructions (Cont'd.)

Field	Description
*	Required for claim to process
**	Required if applicable (based upon the specific program area requirements)

15 Other Date

Not applicable

16 Dates Patient Unable to Work in Current Occupation

Not applicable

Fields 17, 17a, and 17b are used to enter the referring, ordering, and/or supervising provider(s). Field values are a combination of a two-byte qualifier followed by the NPI of the applicable provider. Valid qualifiers are DN = Referring; DK = Ordering; DQ = Supervising.

17 Name of Referring Provider or Other Source**

Enter the two-byte qualifier to the left of the vertical, dotted line.

Enter the name of the referring, ordering, or supervising provider to the right of the vertical, dotted line.

17a Shaded**

Enter the provider's license number if applicable.

17b Unshaded**

NPI
Enter the NPI of the referring, ordering, or supervising provider listed in field 17.

18 Hospitalization Dates Related to Current Services

Complete this field when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

19 Additional Claim Information (Designated by NUCC)**

For beneficiaries participating in special programs

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

CMS-1500 Form Completion Instructions (Cont'd.)

Field	Description
*	Required for claim to process
**	Required if applicable (based upon the specific program area requirements)

(*i.e.*, CLTC, MCCW, Hospice, etc.), enter the primary care provider's referral number.

20 Outside Lab?

Not applicable

21* Diagnosis or Nature of Illness or Injury

ICD Ind.

The "ICD Indicator" identifies the ICD code set being reported. Enter the applicable 1-byte ICD indicator between the vertical, dotted lines in the upper right-hand portion of the field.

Indicator	Code Set
9	ICD-9-CM diagnosis
0	ICD-10-CM diagnosis

Diagnosis Codes

For dates of service on or before September 30, 2015, enter the diagnosis codes of the patient as indicated in the ICD-9-CM, Volume I. SC Medicaid requires full ICD-9-CM diagnosis codes. Enter the diagnosis codes in priority order (primary, then secondary condition). Only one diagnosis is necessary to process the claim.

For dates of services on or after October 1, 2015, enter the diagnosis codes of the patient as indicated in the ICD-10-CM. SC Medicaid requires full ICD-10-CM diagnosis codes. Enter the diagnosis codes in priority order (primary, then secondary condition). Only one diagnosis is necessary to process the claim.

22 Resubmission Code

Not applicable

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

CMS-1500 Form Completion Instructions (Cont'd.)

Field	Description
*	Required for claim to process
**	Required if applicable (based upon the specific program area requirements)

23** **Prior Authorization Number**

If applicable, enter the prior authorization number for this claim.

Fields 24A through 24J pertain to line item information. There are six billable lines on this claim. Each of the six lines contains a shaded and unshaded portion. The shaded portion of the line is used to report supplemental information.

24A** **Shaded**

NDC Qualifier/NDC Number

If applicable, enter the NDC qualifier of N4, followed by an 11-digit NDC. Do not enter a space between the qualifier and the NDC.

24A* **Unshaded**

Date(s) of Service

Enter the month, day, and year for each procedure, service, or supply that was provided.

24B* **Unshaded**

Place of Service

Enter the appropriate two-character place of service code. See "Place of Service Key" earlier in this section for a listing of place of service codes.

24C** **Unshaded**

EMG

If applicable, enter an "E" in this field to indicate that the service rendered was on an emergency basis.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

CMS-1500 Form Completion Instructions (Cont'd.)

Field	Description
*	Required for claim to process
**	Required if applicable (based upon the specific program area requirements)

24D* **Unshaded**

Procedures, Services, or Supplies

Enter the procedure code and, if applicable, the two-character modifier in the appropriate field. If two modifiers are entered, the first modifier entered will be used to process the claim. For unusual circumstances and for unlisted procedures, an attachment with a description of each procedure must be included with the claim.

When more than one service of the same kind is rendered to the **same** patient by the **same** provider on the **same** day, the second service must be billed with the 76 modifier (repeat procedure or service by same physician or other qualified health care professional). No more than two services for the same provider and date of service may be billed. Documentation to support billing of repeat procedures to the same patient by the same provider on the same day must be contained in the record.

24E **Diagnosis Pointer**

Not applicable

24F* **Unshaded**

Charges

Enter the charge for each listed service. Do not use dollar signs or commas when reporting dollar amounts. Enter "00" in the cents area if the amount is a whole number.

24G** **Unshaded**

Days or Units

If applicable, enter the number of days or units provided for each procedure listed.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

CMS-1500 Form Completion Instructions (Cont'd.)

Field	Description
*	Required for claim to process
**	Required if applicable (based upon the specific program area requirements)

24H** **Unshaded**

EPSDT/Family Plan

If applicable, if this claim is for EPSDT services or a referral from an EPSDT Screening, enter a "Y."

This field should be coded as follows:

N = No problems found during visit

1 = Well child care with treatment of an identified problem treated by the physician

2 = Well child care with a referral made for an identified problem to another provider

24I* **Shaded**

ID Qualifier

Typical Providers:

Enter ZZ for the taxonomy qualifier.

Atypical Providers:

Enter 1D for the Medicaid qualifier.

24J** **Shaded**

Rendering Provider ID #

Enter the six-character legacy Medicaid provider number or taxonomy code of the rendering provider/individual who performed the service(s).

Typical Providers:

Enter the provider's taxonomy code.

Atypical Providers:

Enter the six-character legacy Medicaid provider number.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

CMS-1500 Form Completion Instructions (Cont'd.)

Field	Description
*	Required for claim to process
**	Required if applicable (based upon the specific program area requirements)

24J** **Unshaded**

Rendering Provider ID #

Typical Providers:

Enter the NPI of the rendering individual provider. If the provider is billing as a member of a group, the rendering individual provider's 10-character NPI may be entered.

Atypical Providers:

Not applicable

25 **Federal Tax ID Number**

Enter the provider's federal tax ID number (Employer Identification Number) or Social Security Number.

26 **Patient's Account Number**

Enter the patient's account number as assigned by the provider. Only the first nine characters will be keyed. The account number is helpful in tracking the claim in case the beneficiary's Medicaid ID number is invalid. The patient's account number will be listed as the "Own Reference Number" on the Remittance Advice.

27 **Accept Assignment?**

Complete this field to indicate that the provider accepts assignment of Medicaid benefits. Submitting a claim to SC Medicaid automatically indicates the provider accepts assignment.

28* **Total Charge**

Enter the total charge for the services.

29** **Amount Paid**

If applicable, enter the total amount paid from all

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

CMS-1500 Form Completion Instructions (Cont'd.)

Field	Description
*	Required for claim to process
**	Required if applicable (based upon the specific program area requirements)

insurance sources on the submitted charges in item 28. This amount is the sum of 9c and 11b.

30* **Rsvd for NUCC Use**

Enter the balance due.

When a beneficiary has third party coverage, including Medicare, this is where the patient responsibility amount is entered. The third party payment plus the patient responsibility cannot exceed the amount the provider has agreed to accept as payment in full from the third-party payer, including Medicare.

31 **Signature of Physician or Supplier**

Not applicable

32** **Service Facility Location Information**

Note: Use field 32 only if the address is different from the address in field 33.

If applicable, enter the name, address and ZIP+4 code of the facility if the services were rendered in a facility other than the patient's home or provider's office.

32a** **Service Facility Location Information**

Typical Providers:

Enter the NPI of the service facility.

Atypical Providers:

Not applicable

32b** **Service Facility Location Information**

Typical Providers:

Enter the two-byte qualifier ZZ followed by the taxonomy code (no spaces).

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

CMS-1500 Form Completion Instructions (Cont'd.)

Field	Description
*	Required for claim to process
**	Required if applicable (based upon the specific program area requirements)

Atypical Providers:

Enter the two-byte qualifier 1D followed by the six-character legacy Medicaid provider number (no spaces).

33* Billing Provider Info & PH #

Enter the provider of service/supplier's billing name, address, ZIP+4 code, and telephone number.

Note: Do not use commas, periods, or other punctuation in the address. When entering a ZIP+4 code, include the hyphen. Do not use a hyphen or space as a separator within the telephone number. Claims will be paid to the provider number submitted in field 33 of the CMS-1500 form. This pay-to-provider number is indicated on the Remittance Advice and payment.

33a* Billing Provider Info

Typical Providers:

Enter the NPI of the billing provider or group. If the provider rendering the services is a member of a group, the 10-character NPI group/organization number must be entered. If not billing as a member of a group, enter the 10-character individual NPI in the field.

Atypical Providers:

Not applicable

33b* Billing Provider Info

Typical Providers:

Enter the two-byte qualifier ZZ followed by the taxonomy code (no spaces).

Atypical Providers:

Enter the two-byte qualifier 1D followed by the

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

CMS-1500 Form Completion Instructions (Cont'd.)

Field	Description
*	Required for claim to process
**	Required if applicable (based upon the specific program area requirements)
	six-character legacy Medicaid provider number (no spaces).

ELECTRONIC CLAIMS SUBMISSIONS

Trading Partner Agreement

SCDHHS encourages electronic claims submissions. All Medicaid providers who elect to submit or receive electronic transactions are required to complete a SC Medicaid Trading Partner Agreement (TPA) with SCDHHS. The TPA outlines the basic requirements for receiving and sending electronic transactions with SCDHHS. For specifications and instructions on electronic claims submission or to obtain a TPA, visit http://www1.scdhhs.gov/openpublic/hipaa/Trading%20Partner%20Enrollment.asp or contact the EDI Support Center via the SCDHHS Medicaid Provider Service Center at 1-888-289-0709.

Providers should return the completed and signed SC Medicaid TPA Enrollment Form by mail or fax to:

SC Medicaid TPA
Post Office Box 17
Columbia, SC 29202
Fax: (803) 870-9021

If a provider utilizes a billing agent and elects to have the billing agent access their electronic remittance advice, both the provider and the billing agent must have a TPA on file.

Note: SCDHHS distributes remittance advices electronically through the Web Tool. **All providers must complete a TPA in order to receive these transactions electronically.** Providers that currently use the Web Tool do not need to complete another TPA. Providers who have previously completed a TPA, but are not current users of the Web Tool, must register for a Web Tool User ID by contacting the EDI Support Center via the SCDHHS Medicaid Provider Service Center at 1-888-289-0709.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Companion Guides

Providers submitting electronic transactions must comply with all federal guidelines as contained in the HIPAA-required ANSI X-12 Implementation Guide, and with SCDHHS guidelines as contained in the SC Medicaid Companion Guides. The Companion Guides explain the situational and optional data required by SC Medicaid. Please visit the SC Medicaid Companion Guides webpage at http://www.scdhhs.gov/resource/sc-medicaid-companion-guides to download the Companion Guides. Information regarding placement of NPIs, taxonomy codes, and six-character legacy Medicaid provider numbers on electronic claims can also be found here.

Companion Guides are available for the following transactions:

- 837P Professional Health Care Claim
- 837I Institutional Health Care Claim
- 835 Claim Payment/Advice
- 276/277 Claim Status Inquiry/Response
- 270/271 Eligibility Verification Request/Response
- 278 Prior Authorization

Transmission Methods

An Electronic Data Interchange (EDI) transaction is the movement of data between two entities. EDI software enables providers to submit claims directly to SC Medicaid.

The following options may be used to submit claims electronically:

Tapes, Diskettes, CDs, and Zip Files

A biller using this option records transactions on the specified media and mails them to:

SC Medicaid Claims Control System
Post Office Box 2765
Columbia, SC 29202-2765

File Transfer Protocol

A biller using this option exchanges electronic transactions with SC Medicaid over the Internet.

SC Medicaid Web-based Claims Submission Tool

The SC Medicaid Web-based Claims Submission Tool is a free, online Web-based application for submitting HIPAA-compliant professional claims, institutional claims, and

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

SC Medicaid Web-based Claims Submission Tool

associated adjustments to SC Medicaid. The Web Tool offers the following features:

- Providers can attach supporting documentation to associated claims.
- The Lists feature allows users to develop their own list of frequently used information (*e.g.*, beneficiaries, procedure codes, diagnosis codes, etc.). During claims entry the user has the ability to select information from lists rather than repetitively keying, thus saving valuable time and increasing accuracy.
- Providers can check the status of claims.
- No additional software is required to use this application.
- Data is automatically archived.
- Providers can verify beneficiary eligibility online by entering Medicaid ID, Social Security Number, or a combination of name and date of birth.
- Providers can view, save and print their own remittance advices.
- Providers can change their own passwords.

The minimum requirements necessary for using the Web Tool are:

- Signed SC Medicaid Trading Partner Agreement (TPA) Enrollment Form
- Microsoft Internet Explorer (version 9.0, 10, 11); Firefox; Safari; or Google Chrome
- Internet Service Provider (ISP)
- Pentium series processor (recommended)
- Minimum of 1 gigabyte of memory
- Minimum of 20 gigabytes of hard drive storage

Note: In order to access the Web Tool, all users must have individual login Ids and passwords.

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CLAIM PROCESSING

REMITTANCE ADVICE

The Remittance Advice is an explanation of payments and actions taken on all processed claim forms and adjustments. The information on the Remittance Advice is drawn from the original claim submitted by the provider.

Processed claims and/or lines are assigned one of four statuses in field 10 on the Remittance Advice:

- **Status "P"** – Paid claims or lines
- **Status "S"** – Claims in process that require medical or technical review are suspended pending further action.
- **Status "R"** – Rejected claims or lines
- **Status "E"** – Encounter data (line contains service provided by the PCP). No action required.

Please refer to the Forms section of this manual for a sample Remittance Advice.

If a claim is rejected or suspended, the Remittance Advice will display the claim without payment. If some lines on the claim have paid and others are rejected, evaluate the reason for the rejection and file a new claim with the corrected information for the rejected lines only, if appropriate. For some rejected claims, it may also be necessary to attach applicable documentation to the new claim for review and consideration for payment.

Note: Corrections cannot be processed from the Remittance Advice.

SCDHHS generates electronic Remittance Advices every Friday for all providers who had claims processed during the previous week. Unless an adjustment has been made, a reimbursement payment equaling the sum total of all claims on the Remittance Advice with status P (paid) will be deposited by electronic funds transfer (EFT) into the provider's account. (See "Electronic Funds Transfer (EFT)" later in this section. **Providers must access their Remittance Advices electronically through the SC Medicaid Web-Based Claims Submission Tool (Web Tool).** Providers can view, save, and print their remittance advice(s), but not a Remittance Advice belonging to

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

REMITTANCE ADVICE (CONT'D.)

another provider. Remittance Advices for current and previous weeks are retrievable on the Web Tool.

Suspended Claims

Provider response is not required for resolution of suspended claims unless it is requested by SCDHHS. If the claim is not resolved within 30 days, check it for errors and refile. For information regarding your suspended claim, please contact the PSC or submit an online inquiry at http://scdhhs.gov/contact-us.

Rejected Claims

For a claim or line that is rejected, edit codes will be listed on the Remittance Advice under the Recipient Name column. The edit code sequence displayed in the column is a combination of an edit type (beginning with the letter "L" followed by "00" or "01," "02," etc.) and a three-digit edit code.

The following three types of edits will appear on the Remittance Advice:

Insurance Edits

These edit codes apply to third-party coverage information. They can stand alone ("L00") or include a claim line number ("L01," "L02," etc.). Always resolve insurance edit codes first.

Claim Edits

These edit codes apply to the body of the claim (not the line items) and have rejected the entire claim from payment. Such edits are prefaced by "L00."

Line Edits

These edit codes are line specific and are always prefaced by a claim line number ("L01," "L02," etc.). They apply to only the line indicated by the number.

The three-digit edit code has associated instructions to assist the providers in resolving their claims. Edit resolution instructions can be found in Appendix 1 of this manual.

If you are unable to resolve an unpaid line or claim, contact the PSC or submit an online inquiry at http://scdhhs.gov/contact-us for assistance before resubmitting another claim.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Rejected Claims (Cont'd.)

Note: Medicaid will pay claims that are up to one year old. If the date of service is greater than one year old, Medicaid will not make payment. The one-year time limit does not apply to **retroactive eligibility** for beneficiaries. Refer to "Retroactive Eligibility" earlier in this section for more information. Timeliness standards for the submission and resubmission of claims are also found in Section 1 of this manual.

Rejections for Duplicate Billing

When a claim or line is rejected for duplicate billing, the payment date of the original claim appears beside the duplicate edit code on the Remittance Advice under the Recipient Name column (*e.g.*, "L00 852 01/24/14"). This eliminates the need for contacting the PSC for the original reimbursement date.

Claim Reconsideration Policy — Fee-for-Service Medicaid

Effective January 1, 2015, SCDHHS will implement a Claim Reconsideration policy. The Claim Reconsideration process is an informal claim review, and is not a substitute for an appeal of a final agency decision. When requesting a reconsideration, providers must adhere to all applicable policies, timely filing limits, and must comply with the following procedures:

1. Submit a completed SCDHHS-CR Form within 30 days of receipt of the remittance advice reflecting the denial of the claim(s). The SCDHHS-CR Form is located in the Forms section of this provider manual.
2. Complete the SCDHHS-CR Form and attach all documentation in support of your request for reconsideration.

The provider will receive a written response from SCDHHS within 60 days notifying them of the decision of the reconsideration request provided the SCDHHS-CR Form has been fully completed and all supporting documentation was attached for review. If the denial is upheld as a result of the Claim Reconsideration review, the provider has 30 days from receipt of the decision to file an appeal in accordance with the Appeal policy in Section 1 of this provider manual.

Providers should submit Claim Reconsiderations to the following mailing address or fax number:

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CLAIM PROCESSING

Claim Reconsideration Policy — Fee-for-Service Medicaid (Cont'd.)

South Carolina Healthy Connections Medicaid
ATTN: Claim Reconsiderations
Post Office Box 8809
Columbia, SC 29202-8809

OR

Fax: 1-855-563-7086

Requests that **do not** qualify for SCDHHS claim reconsiderations:

1. Claim denials resulting from failure to submit documentation during the claim adjudication process do not qualify for a Claim Reconsideration. Providers should submit a new claim and attach documentation.
2. Providers who receive a denial of service for Prior Authorization (PA) through one of SCDHHS contracted agents (*e.g.*, KEPRO, LogistiCare, ICORE, Magellan, DentaQuest) will not qualify for a Claim Reconsideration. The provider must pursue a reconsideration or appeal request through the contracted agent, and if the denial is upheld the provider has the right to a SCDHHS formal Appeal of a final agency decision.
3. Providers who receive a denied claim or denial of service through one of SCDHHS' Managed Care Organizations (MCOs) must pursue a reconsideration or appeal through the MCO, and will not qualify for a Claim Reconsideration.
4. Claim payments suspended for a credible allegation of fraud and pending an investigation do not qualify for Claim Reconsideration.
5. Submission of a new claim with a Claim Reconsideration is not an acceptable method to correct claim disputes in the informal Claim Reconsideration review process, and will not be adjudicated or reviewed. For Claim Reconsideration requests that do not qualify for review, providers will be sent a written response notifying them that a Claim Reconsideration will not be conducted due to failure to meet Claim Reconsideration qualifications and/or procedures.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Claim Reconsideration Policy — Fee-for-Service Medicaid (Cont'd.)

If you have any questions regarding this process, please contact the PSC at 1-888-289-0709. For any Medicaid participants enrolled in a managed care plan, the member's MCO is responsible for claims payment and claims redetermination. Please refer all questions regarding claim payment and redeterminations to the Medicaid member's MCO.

EDI Remittance Advice - 835 Transactions

Providers who file electronically using EDI Software can elect to receive their Remittance Advice via the ASC X12 835 (005010X221A1) transaction set or a subsequent version. These electronic 835 EDI Remittance Advices contain Claim Adjustment Reason Codes (CARCs), broad definitions of why claims did not pay as billed, and Remittance Advice Remark Codes (RARCs), more detailed reasons for why claims did not pay as billed. (See Appendix 1 for a listing of CARCs and RARCs.) The electronic 835 EDI Remittance Advice will only report items that are returned with P (paid) or R (rejected) statuses.

Providers interested in utilizing this electronic transaction should contact the EDI Support Center via the SCDHHS Medicaid Provider Service Center at 1-888-289-0709.

Duplicate Remittance Advice

Providers must use the Remittance Advice Request Form located in the Forms Section of this manual to submit requests for duplicate remittance advices. Charges associated with these requests will be deducted from a future Remittance Advice and will appear as a debit adjustment. Please check the Web Tool for the availability of the remittance advice date before submitting your request.

Reimbursement Payment

SCDHHS no longer issues hard copy checks for Medicaid payments. Providers receive reimbursement from SC Medicaid via electronic funds transfer (EFT). (See "Electronic Funds Transfer" later in this section.)

The reimbursement payment is the sum total of all claims on the Remittance Advice with status P. If an adjustment request has been completed, it will appear on the Remittance Advice. (See "Claim Adjustments" later in this section.)

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Reimbursement Payment (Cont'd.)

Note: Newly enrolled providers will receive a hard copy check until the electronic funds transfer process is successfully completed.

Electronic Funds Transfer (EFT)

Upon enrollment, SC Medicaid providers must register for Electronic Funds Transfer (EFT) in order to receive reimbursement. SCDHHS will not provide any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside the United States.

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

Medicaid Provider Enrollment
Post Office Box 8809
Columbia, SC 29202-8809

The provider is required to submit a completed and signed EFT Authorization Agreement Form to confirm new and/or updated banking information. Refer to the Forms section for a copy of the EFT Authorization form.

All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any SC Medicaid direct deposits are made.

During the pre-certification period, the provider will receive reimbursement via hard copy checks.

If the bank account cannot be verified during the pre-certification period, the provider will be notified and will be required to submit an EFT form and bank account verification from their financial institution.

Upon completion of the pre-certification period, reimbursement payment will be deposited directly into the provider's bank account. The last four digits of the bank account are reflected on the Remittance Advice. Providers may view their Remittance Advice (RA) on the Web Tool for payment information.

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

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

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

verification from their financial institution.

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

Uncashed Medicaid Checks

SCDHHS may, under special circumstances, issue a hard copy reimbursement check. In instances where Medicaid checks to providers remain outstanding 180 days or longer from the date of check issue, SCDHHS is required by federal regulations to refund to the federal government the federal share of those Medicaid checks. Therefore, SCDHHS will have the bank return (or not honor) Medicaid checks presented for payments that are 180 days old or older.

THIRD-PARTY LIABILITY (TPL)

The SCDHHS Health Insurance Information Referral Form is used to document third-party insurance coverage, policy changes, beneficiary coverage changes, carrier changes, and policy lapse information. A copy of this form is included in the Forms section of this manual. Completed forms should be mailed or faxed directly to Medicaid Insurance Verification Services at the following address:

South Carolina Healthy Connections
Post Office Box 101110
Columbia, SC 29211-9804
Fax: (803) 252-0870

Cost Avoidance

Under the cost avoidance program, claims billed primary to Medicaid for many providers will automatically be rejected for those beneficiaries who have other resources available for payment that are responsible as the primary payer.

Providers should not submit claims to Medicaid until payment or notice of denial has been received from any liable third party. However, the time limit for filing claims cannot be extended on the basis of third-party liability requirements.

If a claim is rejected for primary payer(s), the Edit Correction Form will supply all information necessary for the provider to file with the third-party payer. This information is listed to the right of the Medicaid claims receipt address on the ECF under the heading "INSURANCE POLICY INFORMATION" and includes the insurance carrier code, the policy number, and the

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Cost Avoidance (Cont'd.)

name of the policyholder. Information about the carrier address and telephone number may be found in Appendix 2 of this manual. Providers can also view carrier codes on the Provider Information page at http://provider.scdhhs.gov/.

If a claim or line is rejected for primary payer(s) or failure to bill third-party coverage, providers should submit a new claim and include the insurance carrier code, the policy number, and the name of the policyholder found in third-party payer information on the Web Tool. Information about the insurance carrier address and telephone number may be found in Appendix 2 of this manual. Providers can also view carrier codes on the Provider Information page at http://provider.scdhhs.gov.

Reporting Third-Party Insurance On a CMS-1500 Claim Form

After the claim has been submitted to the third-party payer, and the third-party payer denies payment or the third-party payment is less than the Medicaid allowed amount, the provider may submit the claim to Medicaid. To indicate that a claim has been submitted to a third-party insurance carrier, include the carrier code, the policy number, and the amount paid. Instructions are provided earlier in this section on coding the CMS-1500 claim for third-party insurance information.

If the third party denies payment, the TPL indicator for "insurance denied" should be entered in the appropriate field on the CMS-1500 claim form. For the CMS-1500 the appropriate field for TPL coding is field 10d. The TPL indicators accepted are:

Code	Description
1	Insurance denied
6	Crime victim
8	Uncooperative beneficiary

If the third-party payment is equal to or greater than the SC Medicaid established rate, Medicaid will not reimburse the balance. The Medicaid beneficiary **is not liable** for the balance.

Third-Party Liability Exceptions

Providers may occasionally encounter difficulties in obtaining documentation and payment from third parties and beneficiaries. For example, the third-party insurer may

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Third-Party Liability Exceptions (Cont'd.)

refuse to send a written denial or explanation of benefits, or a beneficiary may be missing or uncooperative. In such cases it is the provider's responsibility to seek a solution to the problem.

Providers have many resources available to them for pursuing third party payments. Program areas will work with providers to explore these options.

As a final measure, providers may submit a reasonable effort document along with a claim filed as a denial. This document can be found in the Forms section of this manual. The reasonable effort document must demonstrate sustained efforts of claim submission and/or adequate follow-up to obtain the needed action from the insurance company or beneficiary. This document should be used only as a last resort, when all other attempts at contact and payment collection have failed.

The reasonable effort documentation process does not exempt providers from timely filing requirements for claims. Please refer to "Time Limit for Submitting Claims" in Section 1.

If the provider is filing a hard copy claim, the reasonable effort document should be attached to the claim form and returned to Medicaid Claims Receipt.

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

Dually Eligible Beneficiaries

When a dually eligible beneficiary also has a commercial payer, the provider should file to all payers before filing to Medicaid. If the provider chooses to submit a CMS-1500 claim form for consideration of payment, he or she must declare all payments and denials. If the combined payments of Medicare and the other payer add up to less than Medicaid's allowable, Medicaid will make an additional payment up to that allowable not to exceed the remaining patient responsibility. If the sum of Medicare and other payers is greater than Medicaid's allowable, the claim will reject with the 690 edit (payment from other sources is more than Medicaid allowable).

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

TPL Refunds

When reimbursed by both Medicaid and third-party insurance, the provider must refund the lesser of either the amount paid by Medicaid or the full amount paid by the insurance company. See "Claim Adjustments" and "Refunds" later in this section.

Medicaid Recovery Initiatives

Retro Health Insurance

Where SCDHHS discovers a primary payer for a claim Medicaid has already paid, SCDHHS will pursue recovery. Once an insurance policy is added to the TPL policy file, claims that have services in the current and prior calendar years are invoiced directly to the third party.

Retro Medicare

Every quarter, providers are notified by letter of claims Medicaid paid primary for beneficiaries with Medicare coverage (Retro Medicare). The letter provides the beneficiary's Medicare number to file the claim with Medicare. The Medicaid payments will be recouped within 30 days of the date of the letter. Please retain the letter for accurate accounting of the recoupment. Questions about this letter may be referred to Medicaid Insurance Verification Services (MIVS) at 1-888-289-0709 option 5.

Where claims have been pulled into retro Medicare and retro health for institutional providers, the provider should not attempt to refund the claim with a void or void/replacement claim. Should they do so, they will incur edits 561, 562, and 563.

Carrier Codes

All third-party payers are assigned a three-character code referred to as a carrier code. The appropriate carrier code must be entered on the CMS-1500 form when reporting third-party liability.

The list of carrier codes (Appendix 2) contained in this manual is categorized both alphabetically by the names of the insurance companies and numerically by the carrier code assigned to each company. These codes are current at the time of publication of this manual; however, they are subject to change.

If a particular carrier or carrier code cannot be found in this manual, providers should visit the Provider Information

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Carrier Codes (Cont'd.)

page on the SCDHHS Web site at http://provider.scdhhs.gov to view and/or download the most current carrier codes. Carrier codes are updated each quarter on the Web site.

If a particular carrier code is neither listed in the manual nor on the SCDHHS Web site, providers may use the generic carrier code 199 for billing purposes. Contact the PSC or submit an online inquiry for assistance should the Web Tool list a numerical code that cannot be located in the carrier codes either in this manual or online.

CLAIM ADJUSTMENTS

Adjustments can be made to paid claims only. A request may be initiated by the provider or SCDHHS. SCDHHS-initiated adjustments are used when the agency determines that an overpayment or underpayment has been made to a provider; SCDHHS will notify the provider when this occurs. Questions regarding an adjustment should be directed to the PSC or submit an online inquiry for assistance. It is important to note that discontinuation of participation in Medicaid will **NOT** eliminate an existing overpayment debt.

A **claim-level adjustment** is a **detail-level** Void (debit) or Void/Replacement that is used to correct both the payment history **and** the actual claim record. It is limited to one claim per adjustment request. A Void claim will always result in an account debit for the total amount of the original claim. A Void/Replacement claim will generate an account debit for the original claim and refile the claim with the corrected information.

A **gross-level adjustment** is defined as a **provider-level** adjustment that is a debit or credit that will affect the financial account history for the provider; however, the patient claim history in the Medicaid Management Information System (MMIS) will not be altered, and the Remittance Advice will not be able to provide claim-specific information.

Claim-Level Adjustments

All Medicaid providers are able to initiate claim-level adjustments. Please note: gross-level adjustments may still be used as discussed in "Gross-Level Adjustments." The process for claim-level adjustments gives providers the option of initiating their own corrections to individual claim records. This process allows providers to submit

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Claim-Level Adjustments (Cont'd.)

adjustments directly to SC Medicaid. Claim-level adjustments should only be submitted for claims that have been paid (status "P").

Claim-level adjustments should be initiated when:

- The provider has identified the need for a **Void/Replacement** of an original claim. This process should be used when the information reported on the original claim needs to be amended. **The original claim must have a date of service that is less than 12 months old.** (See "Claim Filing Timeliness" in this section for more information.)
- The provider has identified the need for a **Void Only** of a claim that was paid within the last 18 months. This process should be used when the provider wishes to withdraw the original claim entirely.

Claim-level adjustments can be submitted in several ways:

- Providers who submit claims using a HIPAA-compliant electronic claims submission format must use the void or replacement option provided by their system. (See "Void and Replacement Claims for HIPAA-Compliant Electronic Submissions" below.)
- Providers who submit claims on paper using CMS-1500, or Transportation forms can use the Claim Adjustment Form 130 (DHHS Form 130, revised 03-13-2007). They can also use the Web Tool to initiate claim-level adjustments in a HIPAA-compliant electronic format, even if they continue using paper forms for regular billing. See "Electronic Claims Submissions" in this section for more information about the Web Tool.

Providers who use an electronic format that is not compliant with HIPAA standards to submit CMS-1500 or Transportation claims can use DHHS Form 130; they may also use the Web Tool to submit adjustments.

Note: When submitting a Form 130 to void or void/replace a claim, it is not necessary for the provider to also submit a refund check.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Void and Replacement Claims (HIPAA-Compliant Electronic Submissions)

Providers may use a HIPAA-compliant electronic format to void a claim that has been filed in error, processed, and for which payment has been received. Submitting a **Void claim** with the original Claim Control Number will alert SCDHHS that claim payment has been made in error. The amount paid for the original claim will be deducted from the next Remittance Advice**.**

Alternatively, these providers may submit a **Replacement claim** to change information on a claim that has been filed, processed, and for which payment has been received. Submitting a Replacement claim automatically voids the original claim and processes the Replacement claim. The Void and Replacement claims must have the same beneficiary and provider numbers.

Void Only and Void/Replacement Claims

Providers who file claims on paper or who submit electronic claims that are not in a HIPAA-compliant electronic format may use DHHS Form 130 to submit claim-level adjustments. (A sample DHHS Form 130 can be found in the Forms section of this manual.) Once a provider has determined that a claim-level adjustment is warranted, there are two options:

- Submitting a **Void Only** claim will generate an account debit for the amount that was reimbursed. A Void Only claim should be used to retract a claim that was paid in error. To initiate a Void Only claim, complete DHHS Form 130 and attach a copy of the original Remittance Advice.
- Submitting a **Void/Replacement** claim will generate an account debit for the original claim and re-file the claim with the corrected information. A Void/Replacement claim should be used to:
  - Correct a keying or billing error on a paid claim
  - Add new or additional information to a claim
  - Add information about a third party insurer or payment

To initiate a Void/Replacement claim, complete DHHS Form 130 and attach a copy of the original Remittance Advice, as well as the new Replacement claim. Also attach any documentation relevant to the claim.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Form 130 Instructions

The completed DHHS Form 130 and any other documents specified above should be sent directly to SC Medicaid at the same address used for regular claims submission. All fields are required with the exception of field 13, "Comments."

1 Provider Name

Enter the provider's name.

2 Provider Address

Enter the provider's address.

3 Provider City, State, Zip

Enter the provider's city, state, and zip code.

4 Total amount paid on the original claim

Enter the total amount that was paid on the original claim that is to be voided or replaced.

5 Original CCN

Enter the Claim Control Number of the original claim you wish to Void or Void/Replace. The CCN is 17 characters long; the first 16 characters are numeric, and the 17th is alpha, indicating the claim type.

6 Provider ID/NPI

Enter the six-character Medicaid legacy provider number and/or NPI of the provider reimbursed on the original claim.

7 Recipient ID

Enter the beneficiary's Medicaid ID as submitted on the original claim.

8 Adjustment Type

Fill in the appropriate bubble to indicate Void or Void/Replace.

9 Originator

Fill in the "Provider" bubble.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Form 130 Instructions (Cont'd.)

10 Reason for Adjustment

Select only **one** reason for the adjustment and fill in the appropriate bubble.

11 Analyst ID

This field is for agency use only.

12 For Agency Use Only

These adjustment reasons are for agency use only.

13 Comments

Include any relevant comments in this field. Comments are not required.

14 Signature

The person completing the form must sign on this line.

15 Date

Enter the date the form was completed.

16 Phone

Enter the contact phone number of the person completing the form.

Visit Counts

Because visit counts are stored on the claim record for beneficiaries, the claim-level adjustment process can affect the visit count for services that have a limitation on the number of visits allowed within a specific time frame (typically the state fiscal year). Those services include Ambulatory, Home Health, and Chiropractic visits.

In the case of a **Void Only** adjustment, the visit count for a beneficiary will be restored by the same number and type of visits on the original claim. Once the Void Only adjustment has been processed, those allowed visits are returned to the beneficiary's record and are available for use.

In the case of a **Void/Replacement** adjustment, a new visit count will be applied to the beneficiary record after the replacement claim has completed processing.

There are two factors to note here:

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Visit Counts (Cont'd.)

- If the recalculated visit count exceeds that beneficiary's limits, reimbursement for the excess visits on the Replacement claim will be denied.
- There may be cases when a Void/Replacement adjustment is submitted, the Void of the old claim is processed, and the Replacement claim is suspended. In such cases, the allowable visits on the original claim are "held" until the suspension is resolved. If the resolution results in "Paid" status for the Replacement claim, the allowable visits are applied to it. However, if the Replacement claim is denied ("R" status), then those allowable visits again become active in the beneficiary's record and can be applied to other visits.

Gross-Level Adjustments

Gross-level adjustments will be initiated when:

- A claim is no longer in Medicaid's active history file (the claim payment date is more than 18 months old.)
- The adjustment request is not "claim-specific" (cost settlements, disproportionate share, etc.). SCDHHS will initiate this type of gross adjustment.
- A claim in TPL Recovery will not be taken back in full.

Provider requests for credit adjustments (where the provider can substantiate that additional reimbursement is appropriate) or debit adjustments (where the provider wishes to make a voluntary refund of an overpayment) should be directed to the Medicaid program manager within 90 days of receipt of payment. Requests for gross-level **credit** adjustments for dates of service that are more than one year old typically cannot be processed by SCDHHS without documentation justifying an exception. Providers may send TPL-related adjustments directly to Medicaid Insurance Verification Services (MIVS) at the following address:

South Carolina Healthy Connections
Post Office Box 101110
Columbia, SC 29211-9804

Fax: (803) 462-2582
Phone: 1-888-289-0709 option 5

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Gross-Level Adjustments (Cont'd.)

In the event of a debit adjustment, the provider should not send a check. Appropriate deductions will be made from the provider's account, if necessary. Providers may inquire directly to Medicaid Insurance Verification Services about debit or credit adjustments resulting from private health insurance or retroactive Medicare coverage.

To request a gross-level adjustment, the provider should submit a letter on letterhead stationery to the SCDHHS providing a brief description of the problem, the action that the provider wishes SCDHHS to take on the claim, and the amount of the adjustment, if known. If the problem involves an individual claim, the letter should also provide the beneficiary's name and Medicaid number, the date of service involved, and the procedure code for the service to be adjusted. The provider's authorized representative must sign the letter. For problems involving individual claims, copies of the pertinent Medicaid Remittance Advices with the beneficiary's name and Medicaid number, date of service, procedure code, and payment amount **highlighted** should also be included.

The provider will be notified of the adjustment via a letter or a copy of an Adjustment/Alternate Claim Form (DHHS Form 115). After it is processed by SCDHHS, the gross-level adjustment will appear on the last page of the provider's next Remittance Advice. Each adjustment will be assigned a unique identification number ("Own Reference Number" on the adjustment form), which will appear in the first column of the Remittance Advice. The identification number will be up to nine alphanumeric characters in length. A sample Remittance Advice can be found in the Forms section of this manual. Gross-level adjustments are shown on page 3 of the sample.

Adjustments on the Remittance Advice

If a Void claim and its Replacement process in the same payment cycle, they are reported together on the Remittance Advice along with other paid claims. The original Claim Control Number (CCN) and other claim details will appear on both the Void and the Replacement lines.

Void Only claim adjustments are reported on a separate page of the Remittance Advice; they will also show the original CCN and other claim details. If the Replacement claim for a Void/Replacement processes in a subsequent payment cycle, it will appear with other paid claims.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Adjustments on the Remittance Advice (Cont'd.)

Gross-level adjustments are reported on the last page of the Remittance Advice, and show only a reference number and debit/credit information.

A sample Remittance Advice that shows Void Only, Void/Replacement, and gross-level adjustments can be found in the Forms section of this manual.

Refund Checks

Providers who are instructed to send a refund check should complete the Form for Medicaid Refunds (DHHS Form 205) and send it along with the check to the following address:

South Carolina Healthy Connections
Cash Receipts
Post Office Box 8355
Columbia, SC 29202-8355

All refund checks should be made payable to the SC Department of Health and Human Services. A sample of the Form for Medicaid Refunds, along with instructions for its completion, can be found in the Forms section of this manual. SCDHHS must be able to identify the reason for the refund, the beneficiary's name and Medicaid number, the provider's number, and the date of service in order to post the refund correctly.

If you submit a refund to SCDHHS and subsequently discover that it was in error, SCDHHS must receive your credit adjustment request within 90 days of the refund.

SECTION 4

PROCEDURE CODES

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SECTION 4 PROCEDURE CODES

CLTC COMMUNITY CHOICES WAIVER SERVICES

Code	Service
LTC10	Adult Day Health Care
X0261	Attendant Care
G9001	Case Management — First Month
G9002	Case Management — Second Month
G9012	Case Management — Ongoing
X0273	Companion
S5165	Environmental Modification
X6860	Furniture
S5170	Standard/Modified Meals
X2045	Adult Health Care Nursing
S5130	Personal Care I
T1019	Personal Care II (PC II)
H0045	Respite Care
S5151	Respite Care in a CRCF
LTC24	Admission Processing
X0200	Pest Control I
X0201	Pest Control II
S5165	Environmental Modifications
X6855	Appliances
X6883	Chore Service
X6861	Security Deposits
X6862	Utility Deposits

SECTION 4 PROCEDURE CODES

CLTC HIV/AIDS WAIVER SERVICES

Code	Service
X0262	Attendant Care
G9001	Case Management — First Month
G9002	Case Management — Second Month
G9012	Case Management — Ongoing
X0274	Companion
S5165	Environmental Modification
S5170	Standard/Modified Meals
S5130	Personal Care I (PC I)
T1019	Personal Care II (PC II)
T1003	Nursing LPN
X0210	Pest Control I
X0211	Pest Control II
T1002	Nursing RN

PERVASIVE DEVELOPMENTAL DISORDER WAIVER

Code	Service
G9002	Case Management
H0031	One Time Yearly Assessment
H0032	Plan Implementation Code
G1077	Lead Therapy
H0046	Line Therapy

SECTION 4 PROCEDURE CODES

CLTC MECHANICAL VENTILATOR DEPENDENT WAIVER SERVICES

Code	Service
S5130	Personal Care I (PC I)
T1019	Personal Care II (PC II)
T1002	Nursing RN
T1003	Nursing LPN
X0227	In-Home Respite Care
H0045	Institutional Respite
X0233	Institutional Respite Adm. Processing
X0221	Pest Control I
X0222	Pest Control II
S5165	Environmental Modification

NON-WAIVER PERSONAL CARE AIDE SERVICE

Code	Service
T1019	Children's Personal Care
T1003	Children's Private Duty Nursing – LPN
T1002	Children's Private Duty Nursing – RN

PALMETTO SENIORCARE (PSC) CAPITATED PROGRAM

Code	Service
X1614	Palmetto Senior Care Capitated

SECTION 4 PROCEDURE CODES

HEAD AND SPINAL CORD INJURY (HASCI) WAIVER SERVICES

Code	Service
H0045	Respite — NF/Hosp
X7034	Respite Admission Processing
X7027	Respite — Daily
X7028	Respite — Hourly
S5151	Respite in a CRCF
H0045	Respite Care Not in Home
S5151	Unskilled Respite Care, Not Hospice Per Diem
X0241	Attendant Care (Agency)
X1000	Residential Habilitation — Daily
X1001	Prevocational Habilitation — Daily
X1002	Supported Employment — Hourly
X1003	Day Habilitation — Daily
X1922	Medical Supplies/Equipment
T1007	Alcohol and/or Drug Abuse Services
H0023	Behavioral Health Outreach Service
T1000	Private Duty/IND Nursing Service (Licensed, 15 min.)
S9123	Nursing — RN
S9124	Nursing — LPN
S5165	Home Modifications
G0114	Psychosocial Consultation
H0046	Psychological Services

SECTION 4 PROCEDURE CODES

MENTAL RETARDATION/ RELATED DISABILITIES (MR/RD) WAIVER SERVICES

Code	Service
S5130	Personal Care I (PC I)
X6987	Adult Day Health Care
S5165	Environmental Modifications
T1019	Personal Care II (PC II)
S9124	Nursing — LPN
S9123	Nursing — RN
X6974	Residential Habilitation — Hourly
X6975	Residential Habilitation — Daily
X6976	Supported Employment — Job Coach/Hr
X6984	Supported Employment Enclave/Daily
H0045	Respite Care Not in Home Per Diem
X6985	Non-facility Respite — Hourly
X6980	Non-facility Respite — Day
X6983	Prevocational Habilitation — Daily
X6986	Companion Care
H0046	Psychological Services
X9322	Vehicle Modifications
X6982	Day Habilitation
H0023	Behavior Support

SECTION 4 PROCEDURE CODES

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SECTION 5

ADMINISTRATIVE SERVICES

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SECTION 5 ADMINISTRATIVE SERVICES

GENERAL INFORMATION

ADMINISTRATION

The South Carolina Department of Health and Human Services (SCDHHS) administers the South Carolina Healthy Connections Medicaid Program. This section outlines the available resources for Medicaid providers, with CLTC regional offices telephone numbers and addresses.

CORRESPONDENCE AND INQUIRIES

All correspondence to South Carolina Healthy Connections Medicaid should be directed to the SCDHHS Provider Service Center (PSC) at 1-888-289-0709. In addition, providers may submit an online inquiry at https://www.scdhhs.gov/contact-us. Inquiries concerning specific claims should also be directed to the PSC, but only after all claims filing requirements have been met. **Allow 45 days from the submission date before requesting the status of the claim.**

BENEFICIARY ELIGIBILITY

Questions concerning beneficiary eligibility or identification numbers should be directed to the SCDHHS county office in the beneficiary's county of residence. Beneficiaries who have questions regarding specific coverage issues should be referred to the appropriate staff of their county SCDHHS office for assistance. The contact information for county offices is located on the SCDHHS website at https://www.scdhhs.gov/site-page/where-go-help.

Eligibility Status

To verify eligibility status, please use the South Carolina Medicaid Web-based Claims Submission Tool (Web Tool), which is available 24 hours a day/7 days a week. For information on the Web Tool, you may contact the PSC at 1-888-289-0709.

SECTION 5 ADMINISTRATIVE SERVICES

GENERAL INFORMATION

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SECTION 5 ADMINISTRATIVE SERVICES

PROCUREMENT OF FORMS

The South Carolina Department of Health and Human Services will not supply the CMS-1500 claim form to providers. Providers should purchase the form in its approved format from the private vendor of their choice. Examples of vendors who supply the form are listed below. This list should not be viewed as an endorsement of these vendors by SCDHHS.

REPRODUCIBLE NEGATIVES

Government Printing Office
(800) 512-1800

TFP Data Systems
(800) 482-9367 ext. 1770
1500form@tfpdata.com

SOFTWARE

Attn: Orders Department
American Medical Association
PO Box 930876
Atlanta, GA 31193-0876
(800) 621-8335
Fax: (312) 464-5600
https://commerce.ama-assn.org/store/

HARD COPY CLAIM FORMS

Government Printing Office
Superintendent of Documents
PO Box 979050
St. Louis, MO 63197-9000
(866) 512-1800 Toll Free
Fax: (202) 512-2104
https://bookstore.gpo.gov/

PRIVATE VENDORS

RR Donnelley
1210 Key Road
Columbia, SC 29201
(803) 576-1304
Fax: (803) 252-7748

SECTION 5 ADMINISTRATIVE SERVICES

PROCUREMENT OF FORMS

PRIVATE VENDORS (CONT'D.)

Physicians' Record Company
3000 S. Ridgeland Ave.
Berwyn, IL 60402-0724
(800) 323-9268 (toll free)
Fax: (708) 749-0171
orders@physiciansrecord.com

Standard Register Company
600 Albany Street
Dayton, OH 45417
(937) 221-1078
(800) 867-8465
Fax: (800) 473-3211

SCDHHS FORMS

Providers may order SCDHHS forms via email at forms@scdhhs.gov. Copies of forms, including program-specific forms, are also available in the Forms section of this manual.

WEB ADDRESS

Providers should visit the Provider Information page on the SCDHHS Web site at https://www.scdhhs.gov/provider for the most current version of this manual.

To order a paper version of this manual, please contact the SCDHHS Provider Service Center (PSC) at 1-888-289-0709. From the Main Menu, select the Provider Enrollment and Education option. Charges for printed manuals are based on actual costs of printing and mailing.

SECTION 5 ADMINISTRATIVE SERVICES

CLTC REGIONAL OFFICES

Area 1- Greenville-IMS
Area Administrator-Wilhelmina Smith
620 North Main Street, Suite 300
Greenville, South Carolina 29601
Telephone: (864) 242-2211 Fax (864) 242-2107
1-888-535-8523
Counties: Greenville, Pickens

Area 2-Spartanburg
Area Administrator-Karen Hubbard
945 East Main Street, Suite 3
Spartanburg, South Carolina 29302
Telephone: (864) 594-4964 Fax (864) 594-5152
1-888-551-3864
Counties: Cherokee, Spartanburg, Union

Area 3-Greenwood-IMS
Area Administrator-Pamela Jones
617 South Main Street¸ Suite 301
Greenwood, South Carolina 29648
Telephone: (864) 223-8622 Fax (864) 223-8607
1-800-628-3838
Counties: Abbeville, Edgefield, Greenwood, Laurens, McCormick, Saluda

Area 4-Rock Hill-IMS
Area Administrator-Virginia Crisp
454 South Anderson, Suite 11
Rock Hill, South Carolina 29730
Telephone: (803) 327-9061 Fax: (803) 327-9065
1-888-286-2078
Counties: Chester, Lancaster, York

Area 5-Columbia-IMS
Area Administrator-Vacant
7499 Parklane Road, Suite 164
Columbia, South Carolina 29223
Telephone: (803) 741-0826 Fax: (803) 741-0830
(843) 726-5113
Counties: Fairfield, Lexington, Newberry, Richland

Area 6-Orangeburg-IMS
Area Administrator-Jestine Sanders-Carter
191 Regional Parkway, Bldg. A
Orangeburg, South Carolina 29115
Telephone: (803) 536-0122 Fax: (803) 534-2358
Counties: Allendale, Bamberg, Calhoun, Orangeburg

Area 7-Sumter-IMS
Area Administrator- Gloria Farmer
30 Westmark Ct.
Sumter, South Carolina 29150
Telephone: (803) 905-1980 Fax: (803) 905-1987
1-888-761-5991
Counties: Clarendon, Kershaw, Lee, Sumter

Area 8-Florence-IMS
Area Administrator-Gloria Farmer
201 Dozier Boulevard
Florence, South Carolina 29501
Telephone: (843) 667-8718 Fax: (843) 667-9354
1-888-798-8995
Counties: Chesterfield, Darlington, Dillon, Florence, Marlboro

Area 9-Conway-IMS
Area Administrator-Vanessa Shalosky
1201 Creel Street
Conway, South Carolina 29526
Telephone: (843) 248-7249 Fax: (843) 248-3809
1-888-539-8796
Counties: Georgetown, Horry, Marion, Williamsburg

Area 10-Charleston-IMS
Area Administrator-Joann Nesbitt
4130 Faber Place Drive, Suite 303
North Charleston, South Carolina 29405
Telephone: (843) 529-0142 Fax: (843) 566-0171
1-888-805-4397
Counties: Berkeley, Charleston, Dorchester

SECTION 5 ADMINISTRATIVE SERVICES

CLTC REGIONAL OFFICES

Area 11-Anderson IMS
Area Administrator-Melville Harriss
3215 Martin Luther King Jr. Blvd., Suite H
Anderson, South Carolina 29625
Telephone: (864) 224-9452 Fax: (864) 225-0871
Counties: Anderson, Oconee

Aiken Satellite Office
Area Administrator-Jestine Sanders-Carter
6170 Woodside Executive Court
Aiken, South Carolina 29803
Telephone: (803) 641-7680 Fax: (803) 641-7682
1-888-364-3310
Counties: Aiken, Barnwell

Ridgeland Satellite Office-IMS
Area Administrator-Joanne Nesbitt
Satellite Supervisor-Tammy Davis
10175 South Jacob Smart Blvd.
Ridgeland, South Carolina 29936
Telephone: (843) 726-5353 Fax: (843) 726-5113
Beaufort Line: (843) 521-9191
1-800-262-3329
Counties: Beaufort, Colleton, Hampton, Jasper

SECTION 5 ADMINISTRATIVE SERVICES

LOCAL DISABILITIES & SPECIAL NEEDS BOARDS AND SERVICE ORGANIZATIONS

County	Names and Addresses
Abbeville	Emerald Center Board for Disabilities and Special Needs Post Office Box 3004 Greenwood, SC 29648 Phone: (864) 942-8900 Fax: (864) 942-8945 www.schsp.org/emeraldcenter Other services available in Edgefield, Greenwood, McCormick, and Saluda Counties. William H. O'Dell Center Ware Shoals 5 Griffin Dr. Ware Shoals, SC 29692 Phone: (864) 456-7426 Fax: (864) 456-3593
Aiken	Aiken County Board of Disabilities Post Office Box 698 Aiken, SC 29802 Phone: (803) 642-8800 Fax: (803) 642-8806 Email: Courtney@scescape.net www.aikenboard.org Tri-Development Center of Aiken County, Inc. Post Office Box 698 Aiken, SC 29802 Phone: (803) 642-8800 Fax: (803) 642-8806 www.aikentdc.org

SECTION 5 ADMINISTRATIVE SERVICES

LOCAL DISABILITIES & SPECIAL NEEDS BOARDS AND SERVICE ORGANIZATIONS

County	Names and Addresses
Allendale	Allendale/Barnwell Disabilities and Special Needs Board Post Office Box 556 Barnwell, SC 29812-0556 Phone: (803) 584-5050 (Allendale) (803) 259-7472 (Barnwell) Fax: (803) 584-7208 (Allendale) (803) 259-1351 (Barnwell) Email: bparker@barnwellsc.com
Anderson	Anderson Board of Disabilities and Special Needs 212 McGee Rd. Anderson, SC 29625 Phone: (864) 260-4515 Fax: (864) 260-5011
Bamberg	Bamberg Disabilities and Special Needs Board Post Office Box 333 Denmark, SC 29042 Phone: (803) 793-5003 Fax: (803) 793-3778 Email: gloriaj_59059@yahoo.com
Barnwell	Allendale/Barnwell Disabilities and Special Needs Board Post Office Box 556 Barnwell, SC 29812-0556 Phone: (803) 584-5050 (Allendale) (803) 259-7472 (Barnwell) Fax: (803) 584-7208 (Allendale) (803) 259-1351 (Barnwell) Email: bparker@barnwellsc.com
Beaufort	Beaufort Disabilities and Special Needs Board Post Office Box 129 Port Royal, SC 29935 Phone: (843) 525-7680 Fax: (843) 525-4073

SECTION 5 ADMINISTRATIVE SERVICES

LOCAL DISABILITIES & SPECIAL NEEDS BOARDS AND SERVICE ORGANIZATIONS

County	Names and Addresses
Berkeley	Berkeley Citizens, Inc. Post Office Drawer 429 Moncks Corner, SC 29461 Phone: (843) 761-0300 Fax: (843) 761-0303 Email: admin@bciservices.org www.berkeleycitizens.org
Calhoun	Calhoun Board of Disabilities and Special Needs Rte. 4, Box 79-B St. Matthews, SC 29135 Phone: (803) 874-2664 Fax: (803) 874-2660 Email: ljohnson@earthlink.com
Charleston	Disabilities Board of Charleston County 995 Morrison Dr. Charleston, SC 29413 Phone: (843) 805-5800 Fax: (843) 805-5805 Email: kelliott@dsncc.com
Cherokee	Cherokee Disabilities and Special Needs Board 959 East O'Neal St. Gaffney, SC 29340 Phone: (864) 487-4190 Fax: (864) 489-1384 Email: ccdsnb@aol.com Cherokee County ARC Post Office Box 397 Gaffney, SC 29342 Phone: (864) 489-4217

SECTION 5 ADMINISTRATIVE SERVICES

LOCAL DISABILITIES & SPECIAL NEEDS BOARDS AND SERVICE ORGANIZATIONS

County	Names and Addresses
Chester	Chester-Lancaster Disabilities and Special Needs Board Post Office Box 577 Lancaster, SC 29721 Phone: (803) 285-4368 Fax: (803) 286-5571
Chesterfield	Chesterfield Disabilities and Special Needs Board Post Office Drawer 151 Chesterfield, SC 29709 Phone: (843) 623-9016 Fax: (843) 623-3144 Email: CCBDN@infoave.net
Clarendon	Clarendon Disabilities and Special Needs Board Post Office Drawer 40 Manning, SC 29102 Phone: (803) 435-2330 Fax: (803) 435-8523
Colleton	Colleton Disabilities and Special Needs Board Post Office Box 1547 Walterboro, SC 29488 Phone: (843) 549-1732 Fax: (843) 549-2359
Darlington	Darlington Disabilities and Special Needs Board 201 N. Damascus Church Rd. Hartsville, SC 29550 Phone: (843) 332-7252 Fax: (843) 332-3168 Email: tmwitt@earthlink.net

SECTION 5 ADMINISTRATIVE SERVICES

LOCAL DISABILITIES & SPECIAL NEEDS BOARDS AND SERVICE ORGANIZATIONS

County	Names and Addresses
Dillon	Marion-Dillon Disabilities and Special Needs Board Post Office Box 2072 Dillon, SC 29536 Phone: (843) 774-6775 (Dillon) (843) 423-4484 (Marion) Fax: (843) 423-4541 (Dillon and Marion)
Dorchester	Dorchester Board of Disabilities and Special Needs Post Office Box 2950 Summerville, SC 29484 Phone: (843) 871-1285 Fax: (843) 871-2929
Edgefield	Emerald Center Board for Disabilities and Special Needs Post Office Box 3004 Greenwood, SC 29648 Phone: (864) 942-8900 Fax: (864) 942-8945 Other services available in Abbeville, Greenwood, McCormick, and Saluda Counties.
Fairfield	Fairfield-Newberry Disabilities and Special Needs Board Post Office Box 856 Newberry, SC 29108 Phone: (803) 635-1117 Fax: (803) 635 1964 Email: fndsnb@aol.com

SECTION 5 ADMINISTRATIVE SERVICES

LOCAL DISABILITIES & SPECIAL NEEDS BOARDS AND SERVICE ORGANIZATIONS

County	Names and Addresses
	Babcock Center, Inc. Post Office Box 3817 Columbia, SC 29230 Phone: (803) 799-1970 Fax: (803) 799-1238
	Bright Start 3202 Millwood Ave Columbia, SC 29205 Phone: (803) 929-1112 Fax: (803) 929-1418
Florence	Florence Disabilities and Special Needs Board Post Office Box 12810 Florence, SC 29504 Phone: (843) 667-5007 (Florence) (843) 394-3963 (Lake City) Fax: (843) 678-8573 (Florence) Email: hsdavised@yahoo.com
Georgetown	Georgetown Disabilities and Special Needs Board Post Office Box 1471 Georgetown, SC 29442 Phone: (843) 546-8228 Fax: (843) 546-1617 Email: rsg@sccoast.net

SECTION 5 ADMINISTRATIVE SERVICES

LOCAL DISABILITIES & SPECIAL NEEDS BOARDS AND SERVICE ORGANIZATIONS

County	Names and Addresses
Greenville	Greenville Disabilities and Special Needs Board Post Office Box 17467 Greenville, SC 29606-8467 Phone: (864) 288-1907 Fax: (864) 297-4990 Greenville Disabilities and Special Needs Board Peace Rehabilitation Center 651 S. Main St. Greenville, SC 29601 Phone: (864) 241-2613
Greenwood	Emerald Center Board for Disabilities and Special Needs Post Office Box 3004 Greenwood, SC 29648 Phone: (864) 942-8900 Fax: (864) 942-8945 Other services available in Abbeville, Edgefield, McCormick, and Saluda Counties.
Hampton	Hampton Disabilities and Special Needs Board Post Office Box 128 Hampton, SC 29924 Phone: (803) 943-4818 Fax: (803) 943-3322 Email: clalgood@internetx.net
Horry	Horry Disabilities and Special Needs Board 250 Victory Ln. Conway, SC 29526 Phone: (843) 347-3010 Fax: (843) 347-7308 Email: dsn@sccoast.net

SECTION 5 ADMINISTRATIVE SERVICES

LOCAL DISABILITIES & SPECIAL NEEDS BOARDS AND SERVICE ORGANIZATIONS

County	Names and Addresses
Jasper	Jasper Disabilities and Special Needs Board Post Office Box 747 Ridgeland, SC 29936 Phone: (843) 726-4499 Fax: (843) 726-4091 Email: myraz@hargay.com
Kershaw	Kershaw Board of Disabilities and Special Needs Post Office Box 310 Camden, SC 29020-0310 Phone: (803) 432-4841 (888) 246-7718 Fax: (803) 424-2280 Email: kcbdsn@camden.net
	Babcock Center, Inc. Post Office Box 3817 Columbia, SC 29230 Phone: (803) 799-1970 Fax: (803) 799-1238
	Bright Start 3202 Millwood Ave Columbia, SC 29205 Phone: (803) 929-1112 Fax: (803) 929-1418
Lancaster	Chester-Lancaster Disabilities and Special Needs Board Post Office Box 577 Lancaster, SC 29721 Phone: (803) 285-4368 Fax: (803) 286-5571

SECTION 5 ADMINISTRATIVE SERVICES

LOCAL DISABILITIES & SPECIAL NEEDS BOARDS AND SERVICE ORGANIZATIONS

County	Names and Addresses
Laurens	Laurens Disabilities and Special Needs Board Post Office Box 986 Laurens, SC 29360-0986 Phone: (864) 682-2314 Fax: (864) 682-2397 Email: vsinclair@lcdsnd.org
Lee	Lee Disabilities and Special Needs Board Post Office Box 468 Bishopville, SC 29010 Phone: (803) 484-9473 Fax: (803) 484-5710 Email: leedsn2@gte.net
Lexington	Richland/Lexington Disabilities and Special Needs Board Post Office Box 3817 Columbia, SC 29230 Phone: (803) 799-1970 Fax: (803) 799-8829 Email: mleitner@rldsn.state.sc.us Babcock Center, Inc. Post Office Box 3817 Columbia, SC 29230 Phone: (803) 799-1970 Fax: (803) 799-1238

SECTION 5 ADMINISTRATIVE SERVICES

LOCAL DISABILITIES & SPECIAL NEEDS BOARDS AND SERVICE ORGANIZATIONS

County	Names and Addresses
	Bright Start 3202 Millwood Ave Columbia, SC 29205 Phone: (803) 929-1112 Fax: (803) 929-1418
	Lexington County Recreation and Aging Commission 563 South Lake Dr. Lexington, SC 29072 Phone: (803) 359-0964 Fax: (803) 359-9092 (Administration) (803) 356-8990 (Aging Division) Email: lcrac@usit.net
Marion	Marion-Dillon Disabilities and Special Needs Board Post Office Box 2072 Dillon, SC 29536 Phone: (843) 774-6775 (Dillon) (843) 423-4484 (Marion) Fax: (843) 423-4541 (Dillon and Marion)
Marlboro	Marlboro Disabilities and Special Needs Board Post Office Box 1212 Bennettsville, SC 29512 Phone: (843) 479-1882 Fax: (843) 479-0655 Email: mcdsnb@flosc.net
McCormick	Emerald Center Board for Disabilities and Special Needs Post Office Box 3004 Greenwood, SC 29648 Phone: (864) 942-8900 Fax: (864) 942-8945 Other services available in Abbeville, Edgefield, Greenwood, and Saluda Counties.

SECTION 5 ADMINISTRATIVE SERVICES

LOCAL DISABILITIES & SPECIAL NEEDS BOARDS AND SERVICE ORGANIZATIONS

County	Names and Addresses
Newberry	Fairfield-Newberry Disabilities and Special Needs Board Post Office Box 856 Newberry, SC 29108 Phone: (803) 276-0078 Fax: (803) 276-0785 Steps provided by Emerald Center Disabilities and Special Needs Board.
Oconee	Oconee Disabilities and Special Needs Board 116 South Cove Rd. Seneca, SC 29672 Phone: (864) 885-6055 Fax: (864) 885-6058 Email: ocbd@innova.net
Orangeburg	Orangeburg Disabilities and Special Needs Board Post Office Box 1812 Orangeburg, SC 29116 Phone: (803) 536-1170 Fax: (803) 531-8317 Email: chucknorman@mindspring.com
Pickens	Pickens Board Of Disabilities and Special Needs Post Office Box 1308 Easley, SC 29641 Phone: (864) 859-5416 Fax: (864) 859-1157 Email: ethena@pcbdsn.org Respite provided by Anderson Disabilities and Special Needs Boards.

SECTION 5 ADMINISTRATIVE SERVICES

LOCAL DISABILITIES & SPECIAL NEEDS BOARDS AND SERVICE ORGANIZATIONS

County	Names and Addresses
Richland	Richland/Lexington Disabilities and Special Needs Board Post Office Box 3817 Columbia, SC 29230 Phone: (803) 799-1970 Fax: (803) 799-8829 Email: mleitner@rldsn.state.sc.us
	Babcock Center, Inc. Post Office Box 3817 Columbia, SC 29230 Phone: (803) 799-1970 Fax: (803) 799-1238 Email: ghendrix@babcock.org
	Bright Start 3202 Millwood Ave. Columbia, SC 29205 Phone: (803) 929-1112 Fax: (803) 929-1418
	Epworth Children's Home Post Office Box 50466 2900 Millwood Ave Columbia, SC 29250 V/Fax: (803) 256-7394
	Richland County Recreation Commission 5819 Shakespeare Rd. Columbia, SC 29223 Phone: (803) 754-7275 Fax: (803) 786-2028
Saluda	Emerald Center Board for Disabilities and Special Needs Post Office Box 3004 Greenwood, SC 29648 Phone: (864) 942-8900 Fax: (864) 942-8945 Other services available in Abbeville, Edgefield, Greenwood, and McCormick counties.

SECTION 5 ADMINISTRATIVE SERVICES

LOCAL DISABILITIES & SPECIAL NEEDS BOARDS AND SERVICE ORGANIZATIONS

County	Names and Addresses
Spartanburg	Spartanburg Disabilities and Special Needs Board 366 N. Church St., Suite 700 Spartanburg, SC 29303 Phone: (864) 596-3574 Fax: (864) 596-3018 Email: jblackwood@co.spartanburg.sc.us The Charles Lea Center 195 Burdette St. Spartanburg, SC 29307 Phone: (864) 585-0322 Fax: (864) 591-0780 Email: abrumfield@teleplex.net
Sumter	Sumter Disabilities and Special Needs Board Post Office Box 2847 Sumter, SC 29151-2847 Phone: (803) 778-1669 Fax: (803) 775-9184 Email: SCDSNB@FTC--1.net
Union	Union Disabilities and Special Needs Board Post Office Box 903 Union, SC 29379 Phone: (864) 427-7700 Fax: (864) 427-1777
Williamsburg	Williamsburg Disabilities and Special Needs Board 61 Greenlee St. Kingstree, SC 29556 Phone: (843) 355-5481 Fax: (843) 355-5483

SECTION 5 ADMINISTRATIVE SERVICES

LOCAL DISABILITIES & SPECIAL NEEDS BOARDS AND SERVICE ORGANIZATIONS

County	Names and Addresses
York	York Disabilities and Special Needs Board Post Office Box 30 Rock Hill, SC 29731 Phone: (803) 628-5999 Fax: (803) 324-7984 Email: jsmith@ycdbsn.org

SECTION 5 ADMINISTRATIVE SERVICES

LOCAL DISABILITIES & SPECIAL NEEDS BOARDS AND SERVICE ORGANIZATIONS

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SECTION 6

CLTC STANDARDS FOR WAIVER SERVICES

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SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

OVERVIEW

South Carolina Medicaid has established standards for providers who wish to render Community Long Term Care (CLTC) waiver services. This section describes the scope of waiver services administered by the Division of Community Long Term Care.

Provider should also visit the SCDHHS website at www.scdhhs.gov/organizations/long-term-care-behavioral-health-service for additional CLTC information.

MEDICAID ELIGIBILITY

Providers can verify Medicaid eligibility for CLTC participants in the Phoenix Provider Portal on their dashboard. Providers should also refer to Section 1 of this provider manual for additional information on eligibility determination.

PROVIDER PARTICIPATION

Enrollment

The enrollment process includes screening, licensure verification and site visits (if applicable), to ensure that all enrolling providers are in good standing and meet the requirements for which they are seeking enrollment. Refer to http://provider.scdhhs.gov for the eligible provider listing of SC Medicaid provider types and specialties.

Computer Requirements

Prior to the initiation of a contract, potential providers must have a computer, Internet access, and an email address to receive correspondences and authorizations from the Division of Community Long Term Care.

PROVIDER TRAINING

Mandatory Meeting

Providers interested in providing Adult Day Health Care, Case Management, Companion, Nursing, Personal Care I, and Personal Care II must attend a mandatory pre-contractual meeting, held monthly. A completed online enrollment application must be completed prior to being invited to attend one of the monthly meetings.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

OVERVIEW

In-Service Training

Providers of the following services must furnish in-service training in accordance with the SCDHHS-approved training list.

- Adult Care Home Services
- Companion Services
- Personal Care I
- Personal Care II

MANDATORY REPORTER

In accordance with S. C. Code of Laws, § 43-35-25, CLTC providers and their staff are mandatory reporters of abuse, neglect or exploitation of adults. Allegations must be reported to South Carolina Department of Social Services (SCDSS) within twenty-four (24) hours or within the next business day of receipt of the allegation or of witnessing the abuse, neglect or exploitation. Reports must be made in writing, or orally by telephone or otherwise.

CLTC providers and their staff are also mandatory reporters of abuse, neglect, or exploitation of children when in a professional capacity under S.C. Code of Laws, § 63-7-310. CLTC providers and their staff must report any information received that suggests the following:

- The reporter believes a child has been or may be abused or neglected as defined in § 63-7-20
- The reporter believes a child's physical or mental health or welfare has been or may be adversely affected by acts or omissions considered to be child abuse or neglect if committed by a responsible party (parent, guardian, or other person responsible for the child's welfare), but the acts or omission were committed by a person other than a responsible party

The reporter must notify the appropriate law enforcement agency. Reports of child abuse or neglect may be made orally by telephone or otherwise to the Department of Social Services county office or to a law enforcement agency in the county where the child resides or is found.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

STANDARDS FOR WAIVER SERVICES

Scopes of services for **Environmental Modification** and **Waiver Medical Supplies** are located in Section 2 of this manual.

MEDICAID HOME AND COMMUNITY-BASED WAIVER
SCOPE OF SERVICE
FOR
ADULT CARE HOME SERVICES

A. Objective

The objective is to provide assistance with activities of daily living in an alternative, less restrictive, home-like setting for elderly and physically disabled adults who wish to live in the community but who do not have other viable housing options due to physical, emotional, developmental or mental impairments. The service can be provided for a limited or indefinite time period based upon the needs of the participant.

B. Conditions of Participation

1. Agencies desiring to be a provider of Adult Care Home (ACH) Services must have demonstrated experience. An ACH Provider Agency (Provider) is any person or entity who has their own system of foster homes and experience facilitating the placement of individuals for the purposes of foster care or adoption. The adult care home provider agency shall recruit, assess, train and monitor individual ACHs to serve elderly and disabled adults. Experience must include at least three (3) years of administrative experience, one of which must be in the health care field.

2. The Provider must utilize the automated systems mandated by CLTC to document and bill for the provision of services.

3. The Provider must accept or decline referrals from CLTC within two (2) working days. Failure to respond will result in the loss of the referral.

4. The provider must verify the participant's Medicaid eligibility when it accepts an authorization and monthly thereafter to ensure continued eligibility.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

ADULT CARE HOME

Agencies can verify Medicaid eligibility for CLTC participants in the Phoenix Provider Portal on their dashboard. Providers should also refer to Section 1 of this provider manual for additional information on eligibility determination.

5. The Provider may use paperless filing systems. Provider must obtain approval from CLTC Central Office prior to initiating electronic documentation and/or filing systems. Electronic records must be made available upon request, and agencies must have a reliable back-up system in the event their computer system shuts down.

6. The Provider must agree to reserve a minimum of fifteen percent (15%) of any funds assigned to the Provider by the participant to allow participant to meet personal needs.

C. Definitions

1. Adult Care Home (ACH) – A home that meets the qualifications to have an elderly and/or disabled individual reside with them.

2. Adult Care Home Caregiver – An adult who resides in the ACH; who is unrelated by blood or marriage to the adult recipient of care; who is not legally responsible for the adult recipient of care; and who is the primary caregiver for the adult recipient.

3. Unit of Service – One (1) day in which services are provided in the adult care home by the adult care home caregiver for one adult resident. Room and board is not included as a component of this service.

D. Description of Services to be Provided

Services to be provided include:

1. Support for activities of daily living, e.g.:
   - Eating
   - Bathing (bed bath, bench shower, sink bath)
   - Personal grooming including dressing
   - Personal hygiene
   - Provide necessary skin care
   - Meal planning and preparation
   - Assisting participants in and out of bed
   - Repositioning participants as necessary
   - Assisting with ambulation/locomotion
   - Toileting and maintaining continence

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

ADULT CARE HOME

2. Home support, e.g.:
   - Cleaning
   - Laundry
   - Shopping
   - Home safety
   - Errands

3. Provide socialization and a home like environment

4. Monitoring of the participant's condition e.g., the type of monitoring that would be done by a family member such as monitoring temperature, checking pulse rate, observation of respiratory rate, and blood pressure.

5. Monitoring medication (for example, informing the participant that it is time to take medication as prescribed by his, or her, physician and as written directions on the box, or bottle, indicate). The caregiver is not responsible for giving the medicine; however, this does not preclude the caregiver from handing the medicine container to the participant.

6. Escort and transportation services when necessary

E. Staffing

1. The Provider must have staff members who provide oversight and monitoring to the caregiver and meet the following educational and training requirements:

   a. A registered nurse(s) (RN) or licensed practical nurse(s) (LPN) who meets the following requirements:

      i. Currently licensed by the S.C. State Board of Nursing or by a state that participates in the Nursing Compact.

      ii. At least one (1) year of experience as a RN or LPN in public health, hospital or long term care nursing.

      iii. Capable of evaluating the caregiver in terms of his or her ability to carry out assigned duties and his/her ability to relate to the participant.

      iv. Able to assume responsibility for in-service training for caregivers by individual instruction, group meetings or workshops.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

ADULT CARE HOME

b. Provider will verify nurse licensure at time of employment and ensure that the license remains active and in good standing at all times during employment. A copy of the current license must be maintained in the employee's personnel file. Nurse licensure can be verified at the State Board of nursing website:

http://www.llr.state.sc.us/pol.asp

2. The caregiver must:

a. Be at least 21 years of age, live in the home and have at least one (1) year of experience as a caregiver. Experience can include care of a relative, volunteer work as a caregiver or work in a Nursing Home (NH) or home setting providing similar care.

b. Demonstrate verbal and written communication skills sufficient to read, write, and communicate effectively with participant and supervisor.

c. Use the Care Call IVR system.

d. Aid in the activities of daily living to include the ability to lift and/or transfer the participant.

e. Follow the care plan with minimal supervision.

f. Have a valid driver's license if transporting participants. In addition, the caregiver must provide a copy of their driving record to the provider and must provide proof of insurance and current vehicle registration each year.

g. Complete required training(s).

h. Work cooperatively with CLTC, social agencies, medical agencies, Adult Protective Services and others involved with the participant(s).

i. Maintain required documentation of services provided.

j. Immediately notify the provider and CLTC case manager regarding a change in the participant's condition.

k. Pass competency testing or successfully complete a competency training and evaluation program performed by an RN or LPN prior to providing services to waiver participants. The competency evaluation

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

ADULT CARE HOME

must contain all elements of the ACH services in Article D. Description of Services in this Scope of Work, Including training on appropriate record keeping, ethics, and interpersonal relationships.

l. Complete a minimum of ten (10) hours relevant in-service training per calendar year. (The annual ten-hour requirement will be on a pro-rated basis during the caregiver's first year.) Documentation shall include topic, name and title of trainer, training objectives, outline of content, length of training, location, and outcome of training.

3. ACH Caregivers may be provided through subcontracting arrangements.

4. PPD Tuberculin Test

Please refer to SCDHEC website, Regulation 61-75 – Standards for Licensing page 11 of 36, section b. 1-6 for PPD Tuberculin test requirements.

http://www.scdhec.gov/health/licen/hladcinfo.htm

Providers needing additional information should contact the Tuberculosis Control Division, Department of Health and Environmental Control, 1751 Calhoun Street, Columbia, SC 29201, phone (803) 898-0558.

5. Individual records must be maintained by the Provider to document that each staff member has met all staffing requirements.

6. A criminal background check is required for all potential caregivers who will provide direct care to CLTC participants and Provider administrative/office employees. Office employees required to have background checks include: administrator, office manager, supervisor, and persons named on organizational chart in management positions. All criminal background checks must include all data for the individual with no less than a ten (10) year search. The criminal background check must include statewide (South Carolina) data. The statewide data must include South Carolina and any other state or states the worker has resided in within the prior ten (10) years. Potential caregivers and employees with felony convictions within the last ten (10) years cannot provide services to CLTC participants or work in an administrative/office position. Potential caregivers and employees with non-violent felonies dating back ten (10) or more years can provide services to CLTC participants under the following circumstances:

- Participant/responsible party must be notified of the caregiver's criminal background

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

ADULT CARE HOME

- Documentation signed by the participant/responsible party acknowledging awareness of the caregiver's criminal background and agreement to have the caregiver provide care must be placed in the participant record.

Potential administrative/office employees with non-violent felony convictions dating back ten (10) or more years can work in the Provider at the Provider's discretion.

Hiring of employees with misdemeanor convictions will be at the Provider's discretion.

Caregivers with misdemeanor convictions can be approved at the Provider's discretion.

7. The Providers must check the Certified Nursing Assistant (CNA) registry and the Office of Inspector General (OIG) exclusions list for all caregivers. A copy of the search results page must be maintained in each employee's personnel file. Anyone appearing on either of these lists is not allowed to provide services to Waiver participants or participate in any Medicaid funded programs. The website addresses are listed below:

   CNA Registry:
   https://www.asisvcs.com/services/registry/search_generic.asp?CPCat=0741NURSE

   OIG Exclusions List: http://www.oig.hhs.gov/fraud/exclusions.asp

F. Conduct of Service

The Provider must maintain documentation showing that it has complied with the requirements of this section.

1. The Provider must obtain a Service Plan and Authorization for ACH services from the CLTC case manager (CM). The CLTC Service Plan will designate the services to be provided to the participant. The Provider will receive an updated CLTC Service Plan from the CM yearly or more frequently as needed.

2. The Provider must adhere to those duties which are specified in the Service Plan in developing the caregiver task list. This caregiver task list must be developed by an RN or LPN. This documentation will be maintained in the participant files. No skilled services may be performed by a caregiver except

as allowed by the Nurse Practice Act and prior approved by a licensed physician.

3. As part of the conduct of service, Adult Care Home services must be provided under the supervision of an RN or LPN meeting all listed qualifications in Section D1.c and who will:

   a. Visit the Adult Care Home prior to or within one day of the participant's arrival at the home. This visit must be recorded in Care Call from the home at the time of the visit. The purpose of this visit is to:

      i. Review the Service Plan/Authorization and develop a task list for the caregiver,

      ii. Give the participant written information regarding advanced directives,

      iii. Inform participants of their right to complain about the quality of Adult Care Home services provided.

      The supervisor will give participants information about how to register a complaint.

   b. Be accessible by phone between the hours of 8:30 a.m. and 5:00 p.m. Monday through Friday.

   c. Provide and document supervision of, training for, and evaluation of caregivers.

   d. Make a supervisory visit to the ACH within thirty (30) days after the service is initiated.

   e. After the thirty (30) day supervisory visit, make a supervisory visit to the ACH at least every four (4) months. Four (4) month supervisory visit must be conducted by the end of the fourth month. Supervisory visits, including the initial visit, must be documented in the participant record and recorded in Care Call from the ACH at the time of the visit. The supervisor's report of the on-site visits must include, at a minimum:

      i. Documentation that services are being delivered consistent with the Service Plan/Authorization;

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

ADULT CARE HOME

ii. Documentation that the participant's needs are being met;

iii. Reference to any complaints that the participant has lodged;

iv. A brief statement regarding any changes in the participant's service needs; and,

v. Supervisor's original signature and date. Signature stamps are not acceptable.

f. Assist caregiver as necessary in providing services as outlined by the Service Plan/Authorization. Any supervision given must be documented in the individual participant's record and in Care Call.

4. Documentation of all supervisory visits must be filed in the participant's record within fifteen (15) days of the date of visit.

In addition to the every four (4) month supervisory visit requirement, supervisors must conduct visits in the following circumstances:

a. Indications of substandard performance

b. Complaints against caregiver

c. When injury to participant has occurred

d. When there are changes in participant's condition

5. The Provider must maintain an individual participant record which documents the following items:

a. The Provider will initiate services on the date negotiated with the CLTC CM and indicated on the Medicaid authorization. Services must not be provided prior to the authorized start date and must be provided according to the schedule as indicated on the Authorization.

b. The Provider will notify the CLTC CM within two (2) working days of the following:

i. Participant is institutionalized, dies or moves out of the adult care home

ii. Participant no longer wishes to receive services

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

ADULT CARE HOME

iii. Knowledge of the participant's Medicaid ineligibility or potential ineligibility

iv. Major change in participant's condition

v. Complaints

vi. Incidents such as falls, etc.

c. The Provider will maintain a record keeping system which documents:

i. The delivery of services in accordance with the CLTC Service Plan. The task sheet must be reviewed, signed, with original signature (signature stamps are not acceptable), and dated every two weeks by the supervisor. Task sheets must be filed in the participant's record within 30 days of service delivery.

ii. All active participant records must contain at least two (2) years of documentation to include task sheets, service plans, authorizations, supervisory visit documentation, any complaints, etc. Per Medicaid policy all records must be retained for at least five (5) years.

G. Provider Requirements

1. The Provider must have demonstrated experience in recruiting, training and monitoring caregivers or adult care home caregivers.

2. The Provider must enroll as a Medicaid provider.

3. The Provider must recruit adult care home caregivers, assess and approve the adult care home in accordance with the waiver standards.

4. The Provider must maintain a file for each adult care home.

5. The Provider must document compliance with standards established for ACHs.

6. The Provider must coordinate and/or provide orientation, competency training, testing and evaluation, and continuing education for approved adult care homes, staff and caregivers. The Provider must maintain documentation of training received including the dates and contents.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

ADULT CARE HOME

a. If Competency Training and Evaluation is performed by an LPN, the LPN must be supervised by an RN and report all competency evaluation results to the RN supervisor. The LPN and the supervising RN, as a confirmation of the delegation of this responsibility, must sign and date the form in addition to the LPN. All signatures must be original; signature stamps are not acceptable.

Proof of the competency evaluation must be recorded in the caregivers file within thirty (30) days of the date of the evaluation. The Division of CLTC has developed a form called "Competency Evaluation Documentation" form which can be used to document the competency evaluation.

b. Topics for specific in-service training that are not on the CLTC approved list may be mandated by CLTC. In-service training may be furnished by the supervisor while the caregiver is furnishing care to the participant. Additional training may be provided as deemed necessary by the Provider. All instructor led and self-study training programs, not on the prior approved list must be approved for content and credit hours by CLTC prior to being offered. Self-study training hours may not exceed six (6) of the ten (10) in-service annual training hours. The Provider shall submit proposed programs not on the prior approved list to the CLTC Central Office at least forty-five (45) days prior to the planned implementation. All approved training topics are at the SCDHHS agency website:

http://www1.scdhhs.gov/openpublic/insidedhhs/bureaus/BureauofLongTermCareServices/pc_2.asp

7. The Provider must monitor the adult care home for continued compliance with standards and monitor the placement of individuals in the home.

8. The Provider shall work with CLTC and adult care homes to match a participant with a caregiver. Prior to placement, CLTC will work with the Provider, and participant and/or responsible party to develop the participant's service plan.

9. The Provider must provide alternate placement when it has determined that the current placement is no longer available. When the caregiver is not in the home, there shall be an individual onsite who shall represent the caregiver, and be capable of assuming the responsibility of caregiver. This person must meet the same requirements as the caregiver.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

ADULT CARE HOME

10. The Provider may serve as the participant's representative payee if needed, maintain a separate account for the participant, and pay the caregiver room and board.

11. Provide on-going support for the participant and caregiver, and oversight and monitoring of the placement.

12. The Provider will maintain a copy of the caregivers driving record, annual proof of insurance and current vehicle registration in the caregiver's file.

H. Administrative Requirements

1. The Provider must inform CLTC of the Provider's organizational structure including the Provider personnel with authority and responsibility for employing qualified personnel, ensuring adequate staff education, in-service training and employee evaluations. The Provider shall notify SCDHHS within three (3) working days in the event of a change in or the extended absence of the personnel with the above listed authority.

2. The Provider must provide SCDHHS, upon request, a written document showing the organization, administrative control and lines of authority for the delegation of responsibility. The document should include an organizational chart including names of those currently in the positions. Revisions or modifications to this organizational document must be provided to SCDHHS.

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

4. In accordance with Article IX, Section E Proof of Insurance), the Provider shall provide a Certificate of Insurance listing SCDHHS as a certificate holder on all insurance policies required under Article IX, Section D. The address for SCDHHS as the Certificate Holder is Post Office Box 8206, Columbia, SC 29202-8206.

5. The Provider will develop and maintain a Policy and Procedure Manual that describes how activities will be performed in accordance with the terms of the requirements of the contract. The Policy and Procedure Manual shall be available during office hours for the guidance of the governing body and personnel and will be made available to SCDHHS upon request.

6. The Provider must comply with Article IX, Section Z of the Contract regarding safety precautions. The Provider must also have an on-going infectious disease program to prevent the spread of infectious diseases among its caregivers and employees.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

ADULT CARE HOME

7. The Provider shall ensure that key Provider staff are accessible during compliance review audits conducted by SCDHHS and/or its agents.

8. The Provider will ensure that its office is open and staffed by qualified personnel during the hours of 10:00 a.m. to 4:00 p.m., Monday through Friday. Outside of these hours, the Provider must be available by telephone from 8:30 a.m. to 5:00 p.m., Monday through Friday. The Provider must also have a contact number for emergencies occurring outside of these hours.

9. Participant, caregiver and personnel records must be maintained at the address indicated in the contract and must be made available, upon request, for review by SCDHHS.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

MEDICAID HOME AND COMMUNITY-BASED WAIVER SCOPE OF SERVICES FOR ADULT DAY HEALTH CARE SERVICES

A. Objective

The objective of Adult Day Health Care (ADHC) services is to restore, maintain, and promote the health status of Medicaid Home and Community-Based waiver participants through the provision of ambulatory health care and health-related supportive services in an ADHC center.

B. Conditions of Participation

1. The ADHC provider must maintain a current Adult Day Care license from the South Carolina Department of Health and Environmental Control (SCDHEC) or an equivalent licensing agency for an out-of-state provider.

2. Agencies must have certified evidence of not less than $10,000.00 operating capital. This capital is required so that the provider agency has the capability to operate for a minimum of 60 days in the event Medicaid reimbursement is delayed or withheld for any reason. Certified evidence of operating capital includes, but is not limited to, a written statement from an officer of a financial institution or a certified accountant; a copy of your most recent bank statement must be included. Operating capital will be verified prior to initiating a contract and periodically during the contract period.

3. Providers must use the automated systems mandated by Community Long Term Care (CLTC) to document and bill for the provision of services.

4. Providers must accept or decline referrals from SCDHHS or SCDDSN within two (2) working days. Failure to respond will result in the loss of the referral.

5. The provider will be responsible for verifying the participant's Medicaid eligibility when it has accepted a referral and monthly thereafter to ensure continued eligibility. Providers can verify Medicaid eligibility for CLTC participants in the Phoenix Provider Portal on their dashboard. Providers should also refer to Section 1 of this provider manual for additional information on eligibility determination.

6. Providers may use paperless filing systems. Provider must obtain approval from CLTC Central Office prior to initiating electronic documentation and/or filing systems. Electronic records must be made available upon request, and

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

ADULT DAY HEALTH CARE (ADHC) SERVICES

providers must have a reliable back-up system in the event their computer system shuts down.

C. Description of Services to Be Provided

1. The unit of service will be a participant day of ADHC services consisting of a minimum of five (5) hours in the care of the center. The five (5) hours does not include transportation time. The unit of service will be a minimum of four (4) hours when the participant has a scheduled medical appointment requiring him or her to leave early or arrive late. If a participant arrives late or leaves early due to a medical appointment, the provider must notify the CM/SC.

   Note: When a participant needs to be at the center for more than five (5) hours per day due to no one being at home to care for participant, the ADHC must allow the participant to remain at the center for up to eight (8) hours.

2. The ADHC center must operate at least eight (8) hours a day Monday through Friday. The hours of operation may be any eight (8) hours between 7:00 a.m. and 6:00 p.m. The provider understands and accepts that any deviation in hours or days of operation during the contract period requires notice to and approval by the Department Head of Provider Relations and Compliance, Division of CLTC Waiver Management in order for the services to be covered.

3. The number of days a participant attends each week is determined through the Medicaid Home and Community-Based waiver service plan and indicated on the current service authorization.

4. The provider must either provide directly, or make sub-contractual arrangements (only nurses can be sub-contracted), for some but not all of the following non-billable services which are included in the daily rate:

   a. Daily nursing services performed by an RN or under the supervision of an RN as permissible under State law to monitor vital signs as needed; to observe the functional level of the participant and note any changes in the physical condition of each participant; to supervise the administration of medications and observe for possible reactions; to teach positive health measures and encourage self-care; to coordinate treatment plans with the physician, therapist, and other involved service delivery agencies; to supervise the development and implementation of a care plan; to appropriately report to the participant's physician and/or the CM/SC any changes in the participant's condition. The RN must approve the documentation of the services provided.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES — PART I

ADULT DAY HEALTH CARE (ADHC) SERVICES

b. Supervision of, assistance with and training in personal care and activities of daily living including dressing, personal hygiene, grooming, bathing and clothing maintenance.

c. Daily planned therapeutic activities to stimulate mental activity, communication and self-expression. These include reality orientation exercises, crafts, music, educational and cultural programs, games, etc.

d. One meal and one snack per day with the meal meeting 1/3 of the daily recommended dietary allowances (RDA) for this age group as adopted by the United States Department of Agriculture. Special diets prescribed by the attending physician must be planned and prepared with consultation from a registered dietitian as needed.

5. The provider will incorporate in the center's operational procedures adequate safeguards to protect the health and safety of the participants in the event of a medical or other emergency.

D. Staffing

1. The minimum staffing requirements must be consistent with SCDHEC licensing requirements (i.e., one direct-care staff for every eight participants). In addition to the minimum staffing standards required by SCDHEC licensing, the following staffing standards for nurses and case managers apply whenever Home and Community-Based waiver participants are present. All nurse staffing and care must be provided in accordance with the South Carolina Nurse Practice Act. Should the RN position become vacant, the ADHC Provider must notify the local CLTC office no later than the next business day. The Director of the Division of CLTC must approve any deviations from these staffing patterns in writing.

For 1-44 Home and Community-Based waiver ADHC participants: one RN must be present as follows:

1 – 10 participants	2 hours minimum
11 – 20 participants	3 hours minimum
21 – 25 participants	4 hours minimum
26 – 35 participants	5 hours minimum
36 – 44 participants	6 hours minimum

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

ADULT DAY HEALTH CARE (ADHC) SERVICES

For 45 – 88 Home and Community-Cased waiver ADHC participants: one RN and one additional RN or LPN must be present for a minimum of five hours whenever Home and Community-Based waiver participants are present.

For 89 – 133 Home and Community-Based waiver ADHC participants:

a. one RN and two additional RNs or LPNs; or

b. one RN, one additional RN or LPN and one case manager.

Required nursing and case management staff must be present for a minimum of five (5) hours whenever Home and Community-Based waiver participants are present.

For 134 - or more Home and Community-Based waiver ADHC participants:

a. one RN and three additional RNs or LPNs; or,

b. one RN, and two additional RNs or LPNs and one case manager.

Required nursing and case management staff must be present for a minimum of five hours whenever Home and Community-Based waiver participants are present.

2. The provider must have a nursing supervisor on staff with the following qualifications:

a. A Registered Nurse (RN) currently licensed by the S.C. State Board of Nursing, by a state that participates in the Nursing Compact, or by an appropriate licensing authority of the state in which the ADHC provider is located for an out-of-state provider; and

b. A minimum of one year's experience in a related health or social services program; and

c. A minimum of one year's administrative or supervisory experience.

Provider will verify nurse licensure at time of employment and ensure that the license remains active and in good standing at all times during employment. A copy of the current license must be maintained in the employee's personnel file. Nurse licensure can be verified and printed at the State Board of nursing website:

http://www.llr.state.sc.us/pol.asp

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES — PART I

ADULT DAY HEALTH CARE (ADHC) SERVICES

3. For ADHC providers with 89 or more Home and Community-Based waiver participants who employ a case manager to meet staffing requirements of section D. 1, the case manager must have a bachelor's degree in health or social services.

4. Aides working at the ADHC center must meet minimum staffing requirements consistent with SCDHEC licensing requirements.

5. The provider must check the CNA abuse registry and the OIG exclusions lists periodically for all staff. A copy of the search results page must be maintained in each employee's personnel file. Anyone appearing on either of these lists is not allowed to provide services to waiver participants or participate in any Medicaid funded programs. The website addresses are listed below:

   CNA Registry: www.pearsonvue.com
   OIG Exclusions List: http://www.oig.hhs.gov/fraud/exclusions.asp

6. PPD Tuberculin Test

   Please refer to SCDHEC website, Regulation 61-75 – Standards for Licensing page 11 of 36 section b. 1-6 for PPD Tuberculin test requirements.

   http://www.scdhec.gov/health/licen/hladcinfo.htm

   Providers needing additional information should contact the Tuberculosis Control Division, Department of Health and Environmental Control, 1751 Calhoun Street, Columbia, SC 29201, phone (803) 898-0558.

7. A criminal background check is required for all potential employees to include employees who will provide direct care to SCDHHS/SCDDSN participants and all administrative/office employees (office employees required to have background checks include: administrator, office manager, nurse supervisor, and persons named on organizational chart in management positions). All criminal background checks must include all data for the individual with no less than a ten (10) year search. The criminal background check must include statewide data. The statewide data must include South Carolina and any other state or states the worker has resided in within the prior ten years. Potential employees with felony convictions within the last ten (10) years cannot provide services to SCDHHS/SCDDSN participants or work in an administrative/office position. Potential employees with non-violent felonies dating back ten (10) or more years can provide services to

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

ADULT DAY HEALTH CARE (ADHC) SERVICES

SCDHHS/SCDDSN participants under the following circumstances:

- Participant/responsible party must be notified of the employee's criminal background, i.e. felony conviction, year of conviction.
- Documentation signed by the participant/responsible party acknowledging awareness of the employee's criminal background and agreement to attend the center must be placed in the participant record.

Potential administrative/office employees with non-violent felony convictions dating back ten (10) or more years can work in the center at the provider's discretion.

Hiring of employees with misdemeanor convictions will be at the provider's discretion. Employees hired prior to July 1, 2007 and continuously employed since then will not be required to have a criminal background check.

8. Personnel Records

The provider must maintain personnel records, for each employee, including contracted personnel, which document the qualifications necessary to meet parts C.4 and D of this contract.

E. Conduct of Service

The provider must maintain documentation showing that it has complied with the requirements of this section.

1. The provider will be notified by the CM/SC of the pending referral.

2. The provider will obtain the DHHS form 122DC from the physician and notify the CM/SC of its receipt. The form must include recommendations regarding limitations of activities, special diet, and medications. The CM/SC will authorize the amount, duration and frequency of services for the participants in accordance with the participants' needs. Subsequent physical examinations or periodic health screening to determine the participant's ability to continue in the program will be required at least every two years. These must contain the same elements as the initial physical examination report. The ADHC provider is responsible for procuring the initial and all subsequent physical examination reports. A blank copy of this form can be obtained on the SCDHHS website:

http://www1.scdhhs.gov/openpublic/insidedhhs/bureaus/BureauofLongTermCareServices/BECOMINGAcltcPROVIDER.asp

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES — PART I

ADULT DAY HEALTH CARE (ADHC) SERVICES

3. For CLTC waiver participants, the provider's RN will prepare a care plan for the participant that is based on the CLTC service plan. When there is a change in the CLTC service plan that will affect the ADHC service, the provider's RN must update their care plan to reflect the change.

   For DDSN waiver participants, the Service Coordinators will submit a service authorization. The service authorization, in addition to DHHS Form 122DC obtained by the ADHC provider, should be used to develop a care plan.

4. The provider will initiate ADHC services on the date negotiated with the CM/SC and indicated on the service authorization. The CM/SC must be notified if services are not initiated on that date. Services provided prior to the authorized start date are not reimbursable.

5. The provider must have a daily schedule/activity plan that provides for the delivery of all required services to all participants.

6. The provider will develop and maintain a Policy and Procedure Manual, which describes how activities will be performed in accordance with the terms of the contract.

7. The provider will maintain a daily attendance log documenting the arrival and departure times of each participant. A separate log will be maintained indicating staff in attendance and their arrival and departure times.

8. The provider will notify the CM/SC within two (2) working days of the following participant changes:

   a. Participant's condition has changed or the participant no longer appears to need ADHC services.

   b. Participant is institutionalized, dies or moves out of service area.

   c. Participant no longer wishes to participate in ADHC services.

   d. Provider becomes aware of the participant's Medicaid ineligibility or potential ineligibility.

   e. Participant does not attend the day care on an authorized day and Provider has not been notified of reason for absence.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

ADULT DAY HEALTH CARE (ADHC) SERVICES

9. The provider will maintain a record keeping system which establishes a participant profile in support of the units of ADHC services delivered, based on the Medicaid Home and Community-Based waiver service authorization. Individual participant records must be maintained and contain the service authorization, the ADHC's care plan (which is approved and signed by the provider's RN), the Medicaid Home and Community-Based waiver CLTC Mode of Transportation form, the DHHS Form 122DC, and daily documentation of all care and services provided. Daily documentation must be made available to SCDHHS/SCDDSN upon request.

   For SCDHHS authorized services, the ADHC care plan must be based on the CLTC Service Plan. The CLTC Service Plan must be maintained in the participant file.

   For DDSN waiver participants, the ADHC care plan must be based on the service authorization and the DHHS Form 122DC. This information must be maintained in the participant file.

F. Overview of compliance review process

The Division of Long Term Care Waiver Management, Provider Compliance Department has developed this policy for clarification of the provider compliance process. The policy gives detailed information on how provider compliance sanctions are implemented. Provider reviews receive a score based on a sanctioning scale; review scores will determine if the provider will receive a sanction and if so, the level of the sanction. The sanction scoring process was developed to ensure that reviews are equitable and for providers to know what to expect when they are reviewed.

The following chart outlines how reviews are scored:

Sanction Level

- Provider compliance review questions in the Scope of Services are classified into three classes, based on (1) the significance of the question regarding to the services, and (2) the potential influences on providers and participants if the requirement was not met. See the example below:

Severity level: 1=less serious, 2 = serious, 3 = very serious

Client Service Questions	Possible Answers	Severity Level
Was supervisory visit made within 30 days after PC II services initiated?	Y, N, NA	3

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ADULT DAY HEALTH CARE (ADHC) SERVICES

Client Service Questions	Possible Answers	Severity Level
Was the initial supervisory visit documented in Care Call?	Y, N, NA	3
Does provider maintain individual client records?	Y, N	2
Did provider give participant written information regarding advanced directives?	Y, N, NA	1

There are five types of sanctions:

- Plan of Correction - This is the lowest sanction and indicates the provider is in substantial compliance with the contractual requirements. The provider will be required to submit a plan of correction outlining the deficiency (ies), the detailed plan to correct the deficiency and the effective date the plan will be implemented.

- 30-day suspension – At this level, new referrals are suspended for 30 days. The provider will also be required to submit a plan of correction. If the plan of correction is approved, the suspension is automatically lifted at the end of the 30-day period. If the corrective action plan is not approved, the Provider will be given an additional ten (10) business days to submit another corrective action plan for review and approval; the suspension will remain in place until an approved corrective action plan is received. If the second submitted corrective action plan is not approved, the provider contract will be terminated.

- 60-day suspension – At this level, new referrals are suspended for 60 days. The provider will also be required to submit a plan of correction. If the plan of correction is approved, the suspension is automatically lifted at the end of the 60-day period. If the corrective action plan is not approved, the Provider will be given an additional ten (10) business days to submit another corrective action plan for review and approval; the suspension will remain in place until an approved corrective action plan is received. If the second submitted corrective action plan is not approved, the provider contract will be terminated.

- 90-day suspension – Indicates serious and widespread deficiencies, new referrals are suspended for 90 days. The 90-day suspension of new referrals will only be lifted after an acceptable plan of correction is received. If the corrective action plan is not approved, the Provider will be given an additional ten (10) business days to submit another corrective action plan for review and approval; the suspension will remain in place until an approved corrective action plan is

received. If the second submitted corrective action plan is not approved, the provider contract will be terminated. In addition, an acceptable follow-up review visit may be conducted if warranted.

- Termination – Indicates a final review score of four hundred (400) or more points, very serious and widespread deficiencies, generally coupled with a history of bad reviews (3 consecutive reviews that receive suspension of new referrals).

  Providers who have two (2) consecutive reviews that result in suspension of new referrals, will be terminated if the third consecutive review has a final score that would result in a suspension of new referrals (100 and above).

  We have developed a system to score reviews based on the percentage of the identified deficiency and number of participants surveyed. Following is an outline of how reviews will be scored:

Calculating process

- The level of sanction will be decided based on the total score of the provider's current review and the provider's review history, which is converted from the deficiency percentage.

- Every 5% deficiency counts for 1 point in each class; the total score comes from the total points from each level.

Since each level has different severity, multiple points will be added on each class's score. Final score = level 3 = unweighted points x 3 + level 2 = unweighted basic points x 2+ level 1 = unweighted points x 1

Example:

Level	Deficiency percentage	Basic points	Final points
Level 1 (less serious)	28%	5	5x1=5
Level 2 (serious)	20%	4	4x2=8
Level3 (major)	35%	7	7x3=21
Final score			34

Based on the total score a sanction level is determined. If a provider has no deficiencies, they will not be subject to a sanction. Below is a chart that illustrates the sanction that will be imposed based on the final review score:

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ADULT DAY HEALTH CARE (ADHC) SERVICES

Score Scale & Sanction Level

Sanction Type	Final score	With Good History*
Correction Plans	0-99	0-149
30 Days Suspension	100-199	150-249
60 Days Suspension	200-299	250-349
90 Days Suspension	300-399	350-449
Termination	>400	>450

Good History is determined based on previous review scores. For example, if a provider's previous review had a total score of **50** and their current review has a score of **120**, the sanction for the current review will be corrective action rather than 30-day suspension based on the previous review score.

Scores are automatically calculated using a computer generated compliance review program.

Provider records will be reviewed periodically at the provider's office. Onsite visits are un-announced. If a reviewer (CLTC, Program Integrity or any other government entity) arrives at the provider's office to conduct a survey/visit and no one is there, the following sanctions will be imposed:

- First time – thirty (30) day suspension of new referrals
- Second time – ninety (90) day suspension of new referrals
- Third time – contract termination

G. Administrative Requirements

1. The provider must inform SCDHHS of the provider's organizational structure, including the provider personnel with authority and responsibility for employing qualified personnel, ensuring adequate staff education and employee evaluations. The provider agency shall notify SCDHHS within three (3) working days in the event of a change in the agency Administrator, address, phone number or an extended absence of the agency administrator.

2. The provider must provide SCDHHS a written document showing the organization administrative control and lines of authority for the delegation of responsibility down to the hands-on participant care level staff at contract implementation. The document should include an organizational chart

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ADULT DAY HEALTH CARE (ADHC) SERVICES

including names of those currently in the positions. Revisions or modifications to this organizational document must be provided to SCDHHS. It is recommended that this document be readily accessible to all staff.

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

4. The provider agency shall acquire and maintain during the life of the contract liability insurance and workers' compensation insurance as provided in Article IX, Section D of the Contract. The provider is required to list SCDHHS – CLTC as a Certificate Holder for informational purposes only on all insurance policies using the following address: Post Office Box 8206, Columbia, SC 29202-8206.

5. The provider must update their holidays in Phoenix annually. The provider will not be required to furnish services on their designated holidays. A copy of the scheduled holiday list must be posted in a visible location at the center.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

MEDICAID HOME AND COMMUNITY-BASED WAIVER
SCOPE OF SERVICES
FOR
ADULT DAY HEALTH CARE — NURSING

A. Adult Day Health Care (ADHC) Nursing services are available for those participants attending ADHC under authorization of a Medicaid Home and Community-Based waiver. This service must be ordered by a physician to meet the participant's care needs and must be prior authorized by the Medicaid Home and Community-Based waiver case manager. This service must be provided at the ADHC center by a licensed nurse, on a day the participant is attending Medicaid sponsored ADHC.

B. ADHC Nursing service procedures are limited to those skilled procedures listed below as ordered by a physician:

- Ostomy care
- Urinary catheter care
- Decubitus and/or wound care
- Tracheostomy care
- Tube feedings
- Nebulizer treatments that require medication

One Unit of ADHC Nursing consists of any combination of one or more of the listed ADHC Nursing service procedures listed above provided to a Medicaid Home and Community-Based waiver ADHC participant during one day's attendance at ADHC.

C. Authorization for ADHC Nursing will be separate from the ADHC authorization and will not be day specific unless so ordered by a physician.

D. Services provided prior to the Medicaid authorization date are not reimbursable.

E. The ADHC provider will obtain the physician's orders for the ADHC Nursing service from the physician using DHHS Form 122A.

Physician's orders must be updated at least every 90 days and maintained by the provider in the participant record.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

ADULT DAY HEALTH CARE — NURSING

A physician's order is required for any change in the type or frequency of ADHC Nursing services provided to the participant. Within three (3) working days of a physician's verbal order, the ADHC provider must obtain a written order from the physician, document the order in the participant record and communicate the order to the Home and Community-Based waiver case manager in writing using DHHS Form 122A.

The Home and Community-Based waiver case manager or DDSN service coordinator will review the participant's needs within three (3) working days of receipt of DHHS Form 122A and update the participant record making any necessary changes in the authorization.

F. All ADHC Nursing services must be provided within the scope of the South Carolina Nurse Practice Act or as otherwise provided within State law. Providers in bordering states must comply with all laws applicable to the provision of nursing services in that state.

G. The ADHC Nursing services provider must maintain a client record containing documentation, that supports services provided and billed.

H. Providers of ADHC Nursing services must utilize the automated systems mandated by SCDHHS to document and bill for the provision of services.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

ADULT DAY HEALTH CARE SERVICES— NURSING

Medicaid Home and Community-Based Waiver

ADULT DAY HEALTH CARE – NURSING

Physician's Orders

To: From:

Phone: Fax:

The client identified below participates in a Medicaid home and community-based waiver and has requested Adult Day Health Care-Nursing services. Please evaluate your patient's appropriateness for this service by completing and signing this form, noting any restrictions or special instructions. Please mail or fax this form to the above address. Thank you for your assistance in providing this service.

Participant: Medicaid ID:

ADHC – Nursing is limited to the following 6 skilled procedures:

1. [ ] **Ostomy Care**

Orders:

2. [ ] **Catheter Care**

Orders:

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

ADULT DAY HEALTH CARE — NURSING

3. [ ] **Decubitus/Wound Care** Orders:
4. [ ] **Tracheostomy Care** Orders:
5. [ ] **Tube Feedings** Orders:
6. [ ] **Nebulizer Treatment** Orders:
Physician Signature: Date:
ADHC Nurse Signature: Date:
Date mailed to MD: Date:

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

MEDICAID HOME AND COMMUNITY-BASED WAIVER SCOPE OF SERVICES FOR ADULT DAY HEALTH CARE — TRANSPORTATION

A. Adult Day Health Care (ADHC) Transportation service is available to participants authorized for the ADHC service through a Medicaid Home and Community-Based waiver who reside within fifteen (15) miles of the ADHC center. This service will be provided using the most direct route, door to door, from the center to the participant's place of residence or other location as agreed to by the provider and as indicated on the service authorization. The service must be prior authorized by the Medicaid Home and Community-Based waiver case manager/service coordinator.

B. ADHC Transportation service must be provided in an enclosed vehicle with adequate ventilation, heat and air conditioning, with provision for wheelchair bound and ambulatory participants as needed. ADHC Transportation does not include ambulance transportation, even when medically necessary.

C. Providers who are directly providing transportation to participants will provide assistance to the participant from the door of the participant's residence to the vehicle and from the vehicle to the door of the participant's residence or other location as agreed to by the provider and as indicated on the service authorization.

D. Transportation services are reimbursable only when provided to and/or from the ADHC center. For example, if the participant rides to the ADHC center with a family member and the ADHC center transports the participant home in the afternoon, reimbursement for transportation is allowed for one way.

E. Authorization for ADHC Transportation will be separate from the ADHC authorization.

F. Services provided prior to the Medicaid authorization date are not reimbursable.

G. The provider is required to complete a Mode of Transportation form indicating the number of miles the participant lives from the center. If it is determined that the participant is within fifteen (15) miles of the center, the provider is required to notify the case manager that an authorization is needed for ADHC Transportation.

The provider is required to maintain verification of the mileage to a participant's home in the participant's record, such as a MapQuest map stating the mileage.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

ADULT DAY HEALTH CARE — NURSING

The provider is required to report any changes in the participant's status that affect ADHC Transportation (e.g., Participant moves and no longer resides within 15 miles of the center; family member transports participant to and from the center, etc.) to the case manager/service coordinator immediately. If these types of changes occur, ADHC Transportation will no longer be reimbursable.

Drivers employed by the ADHC who transport Home and Community-Based waiver participants must have a valid driver's license and be certified in first aid.

H. The ADHC Transportation service provider must maintain a participant record containing documentation supporting services provided and billed.

I. Providers of ADHC Transportation service must use the automated systems mandated by SCDHHS to document and bill for the provision of services.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

MEDICAID HOME AND COMMUNITY-BASED WAIVER
SCOPE OF SERVICES
FOR
INDIVIDUAL ATTENDANT CARE PROVIDER STANDARDS AND DUTIES

A. Minimum Qualifications

1. Attendant Care providers, i.e., attendants, must meet the following minimum qualifications:

   a. Demonstrate an ability to read, write and speak English;

   b. Fully ambulatory;

   c. Capable of aiding in the activities of daily living; physically capable of performing duties which may require physical exertion such as lifting, transferring, etc. if necessary;

   d. Capable of following a service plan with participant and/or representative supervision;

   e. Be at least 18 years of age;

   f. Capable of following billing procedures and completing required paperwork;

   g. No known conviction for abuse, neglect, or exploitation of adults (as defined in the Omnibus Adult Protection Act, S.C. Code Ann. Title 43, Chapter 35) or of children (as defined in the Children's Code, S.C. Code Ann. Title 63, Chapter 7);

   h. No known conviction for any crime against another person;

   i. No known felony conviction of any kind;

   j. No known conviction of any kind concerning the misuse or abuse of any public assistance program (including, but not limited to, fraudulently obtaining benefits, engaging in fraudulent billing practices, and embezzling or otherwise misusing public assistance funds in any manner);

   k. No exclusion from the Medicare or Medicaid Programs;

   l. Upon request will provide references to the participant and/or representative;

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

ATTENDANT CARE

m. All Attendants shall submit the results of a PPD tuberculin (TB) skin test that was administered within one year prior to the Attendants Medicaid enrollment date. All attendants whose PPD skin test is over a year old at the time of actual enrollment must have a new PPD skin test to remain enrolled and to be eligible to serve participants as an attendant. The two-step procedure is advisable for initial testing in order to establish a reliable baseline. (If the reaction to the first test is classified as negative, a second test should be given a week later. If the second test is classified as negative, the person is considered as being uninfected. A positive reaction to a third test (with an increase of more than 10mm) in such a person within the next few years is likely to represent the occurrence of infection with M. Tuberculosis in the interval. If the reaction to the second of the initial two tests is positive, this probably represents a boosted reaction, and the person should be considered as being infected).

Attendants with reactions of 10mm and over to the pre-enrollment tuberculin test, those with newly converted skin tests, and those with symptoms suggestive of tuberculosis (e.g., cough, weight loss, night sweats, fever, etc.) regardless of skin test status, shall be given a chest radiograph to determine whether tuberculosis disease is present. If tuberculosis is diagnosed, appropriate treatment should be given, and the person must not be allowed to work until declared noncontagious by a licensed physician.

Routine chest radiographs are not required on attendants who are asymptomatic with negative tuberculin skin tests.

Attendants with negative tuberculin skin tests shall have an annual tuberculin skin test. Forty-five (45) days prior to the expiration date, USC-CDR will notify active enrolled attendants of the expiration of their TB test results. If the attendant has not submitted the required information by the expiration date, USC-CDR will notify the CLTC Central Office. Current services of the attendant will be terminated after reasonable notice (2 weeks) to participants has been given so participants can find replacement services. The CLTC Compliance Office will suspend new referrals to the attendant effective on the date suspension is submitted.

New attendants who have a history of a positive TB skin test shall send a copy of their most recent chest x-ray and complete a signs and symptoms questionnaire, or have certification by a licensed physician or local health department TB staff prior to enrollment as a Medicaid

provider that they are not contagious. Attendants who are known or suspected to have tuberculosis shall be required to be evaluated by a licensed physician or local health department TB staff, and must not return to work until they have been declared noncontagious.

Preventative treatment should be considered for all infected attendants having direct participant contact who have positive skin tests but show no symptoms of tuberculosis. Routine annual chest radiographs are not a substitute for preventative treatment. Attendants who complete treatment, either for disease or infection, may be exempt from further routine radiographic screening unless they develop symptoms of tuberculosis. Attendants with a history of a positive TB skin test will be required to complete a tuberculosis signs and symptoms questionnaire to assess for Tuberculosis annually.

Post exposure skin test should be obtained for tuberculin negative attendants within 12 weeks after termination of contact to a documented case of infection.

Attendants needing additional information should contact the Tuberculosis Control Division, Department of Health and Environmental Control, 2600 Bull Street, Columbia, SC 29201, phone (803) 898-0558.

B. MinimumTraining Requirements

The following are the minimum training requirements for attendants:

1. Prior to the first authorization being issued, all attendants who have been matched with their first participant are required to attend Care Call/billing training in the CLTC office which covers the geographical area where the participant resides.

2. Training may be furnished by the licensed nurse of USC-CDR while the attendant is furnishing care to the participant. USC-CDR may also identify additional training needs and assist the attendant with locating training to address those needs. Participant-specific training for the attendant and/or participant/ representative may be provided as deemed necessary based on the professional judgment of the licensed nurse of USC-CDR or when the participant/representative or attendant requests assistance with training related to specific tasks.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

ATTENDANT CARE

C. Supervision

The attendant will be supervised by the participant or representative for whom the safety and efficacy of participant/representative supervision has been certified by the licensed nurse of USC-CDR. The licensed nurse of USC-CDR will determine when a participant or representative is no longer certified to provide supervision for the attendant.

D. Infection Control

The attendant must adhere to basic infection control procedures at all times while providing attendant care services.

E. Description of Services to be Provided

1. The Unit of Service is authorized in one (1) hour increments and will consist of direct Attendant Care services provided in the participant's home (except when services such as laundry, shopping or escort must be done off-site). The amount of time authorized does not include the attendant's transportation time to and from the participant's home.

2. The number of units and service provided to each participant is dependent upon the individual participant's needs as set forth in the participant's approved Service Plan. Services must be participant specific and for the direct benefit of the participant.

3. Attendant Care services include:

   a. Support for activities of daily living e.g., assistance with bathing, dressing, feeding, personal grooming, personal hygiene, transferring and mobility

   b. Meal or snack preparation, planning and serving, cleaning up afterwards, following specially prescribed diets as necessary and encouraging participants to adhere to any specially prescribed diets

   c. General housekeeping includes cleaning, laundry, and other activities as needed to maintain the participant in a safe and sanitary environment; Housekeeping only includes areas specific to the participant such as the participant's bedroom, bathroom, etc.

   d. Assistance with communication which includes, but is not limited to, placing a phone within participant's reach and physically assisting participant with use of the phone, and orientation to daily events

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

ATTENDANT CARE

e. Monitoring medication, e.g., the type that would consist of informing the participant that it is time to take medication as prescribed by his or her physician and as written directions on the box or bottle indicate. It does not mean that the attendant is responsible for giving the medicine; however, it does not preclude the attendant from handing the medicine container or medicines already set up in daily containers to the participant

F. Record Keeping

The attendant shall maintain an individual participant record for each participant. This participant record is subject to the confidentiality rules for all Medicaid providers and shall be made available to CLTC upon request. This record shall include the following:

1. Current and historical Service Provision Forms specifying units and services/duties to be provided;

2. The CLTC participant's Service Plan;

3 The attendant will complete a daily log reflecting the attendant care services provided for the participant and must submit the logs to the appropriate entity at appropriate times for review

and

4. A copy of the participant's back-up plan for service provision when the primary attendant is unable to provide services. (The participant/representative must make prior arrangements with family members, other formal or informal supports or another enrolled attendant for care provision in the absence of the primary attendant).

G. Conduct of Services

1. The attendant will initiate attendant care services on the date agreed upon by the participant/representative, attendant and the case manager. This date will be the start date on the written authorization for services. Services provided prior to the authorized start date as stated on the Service Provision Form will not be reimbursed.

2. The case manager will authorize attendant care services by designating the authorized units of services in accordance with the participant's Service Plan.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

ATTENDANT CARE

The attendant must adhere to those duties. The participant and/or representative will self-direct the provision of care and coordinate with the attendant for the time for service delivery and specific tasks to be performed. The amount of time authorized does not include transportation time to and from the participant's home.

3. If the attendant or the participant/representative identify attendant care duties that would be beneficial to the participant's care but are not specified in the CLTC service plan, the attendant or participant/representative must contact the case manager to discuss the possibility of having these duties included in the service plan. The decision to modify the duties to be performed by the attendant is the responsibility of the case manager.

4. The attendant will notify the case manager immediately of the following participant changes:

   a. Participant's condition has changed and the Service Plan no longer meets participant's need or the participant no longer appears to need attendant care services.

   b. Participant/representative no longer appears capable of providing supervision for the attendant.

   c. Participant/representative no longer wants to serve as Employer of Record/ representative.

   d. Participant dies or moves out of the service area.

   e. Participant/representative no longer wishes to receive attendant care services.

   f. Knowledge of the participant's Medicaid ineligibility or potential ineligibility.

5. The attendant will notify Adult Protective Services if he/she has knowledge of, or reason to believe that the participant has been or is likely to be abused, neglected or exploited.

6. The participant must have an effective back-up service provision plan in place to ensure that the participant receives services in the absence of the primary attendant. However, if/when the attendant determines that services cannot be provided by the attendant as authorized, the attendant must immediately notify the case manager and the participant/representative by telephone.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

ATTENDANT CARE

7. When two consecutive attempted visits occur, the local CLTC office must be notified immediately. An attempted visit is when the attendant arrives at the home and is unable to provide the assigned tasks because the participant is not at home or refuses services.

8. For all participants the attendant is responsible for verifying the participant's Medicaid eligibility each month.

9. The attendant will notify the case manager immediately if the attendant wishes to terminate as the provider.

10. The attendant is responsible for giving participants a written description of the state law concerning advance directives in accordance with the Patient Self-Determination Act. USC-CDR will assist attendants in meeting this requirement.

11. The attendant shall adhere to all SCDHHS policies, procedures and Medicaid provider manuals including policies regarding billing, claims adjustments, Fiscal Intermediary requirements, etc.

12. The attendant must comply with all Care Call requirements for all participants.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

MEDICAID HOME AND COMMUNITY-BASED WAIVER SCOPE OF SERVICES FOR CASE MANAGEMENT SERVICES

A. Objective

The objective of Case Management Services is to assist Participants in gaining access to needed waiver and other State plan services; as well as medical, social, educational, and other services, regardless of the funding source for those services. Case Managers are responsible for the ongoing monitoring and coordination of the provision of services included in the participant's person-centered service plan.

B. Provider Conditions of Participation

1. The Provider must have demonstrated experience providing Case Management in a health and human services setting.

2. The Provider must be licensed to operate a business in the State of South Carolina and be in good standing with the State and counties served.

3. Upon application, the provider must demonstrate knowledge of the SC long-term care continuum and community resources.

4. The Provider must have four (4) or more employees, two (2) of which must be a licensed Social Worker; or have a Bachelor's degree or Master's degree with at least two years of assessment and care planning experience with clients. Independent providers contracted prior to September 1, 2016, may continue to provide case management activities to participants served under this waiver.

5. The Provider must be capable of providing case management services in the entire geographical area of at least one (1) CLTC Regional Office. The Provider must not refuse to accept cases within its area of service based on geographical location.

6. The Provider and its staff must be independent of the service delivery system and not a provider of services that could be incorporated into a CLTC participant's plan of care ("conflict free case management"). These services include, but are not limited to, CLTC waiver services, home health services, and hospice services. CLTC is the final decision authority regarding questions concerning conflict free case management.

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7. The Provider must provide all supplies, tools, equipment, and technology necessary for its Case Managers and Case Management Supervisors to carry out case management functions. SCDHHS will post equipment requirements in the "Help" section of Phoenix.

8. The Provider will ensure that Case Managers and Case Management Supervisors do not serve members of their own families.

9. The Provider must ensure that its Case Managers and Case Management Supervisors meet all conditions in the Conduct of Service.

C. Conduct of Service

1. The Provider must ensure that its Case Managers are available by telephone to SCDHHS staff Monday through Friday, 8:30 a.m. to 5:00 p.m.

2. The Provider must ensure that its Case Managers are available to Participants from 8:30 a.m. to 5:00 p.m., Monday through Friday, and as required by Participant needs.

3. The Provider must ensure that if a Case Manager has other employment, it does not prevent the case manager from performing case management activities between 8:30 a.m. and 5:00 p.m., Monday through Friday, and as required by Participant needs. The Provider must ensure that any Case Manager hired after August 1, 2014, does not have other employment for more than four (4) hours between 8:30 a.m. and 5:00 p.m., Monday through Friday. The Provider must also ensure that its Case Managers hired before August 1, 2014, do not accept additional employment that will exceed this rule if they are not currently employed beyond this requirement. The Provider must ensure accessibility of its Case Managers to CLTC program staff, service providers, and participants.

4. The Provider must ensure that its Case Managers are available to meet with SCDHHS staff in area offices or by phone as required for case management activities. These activities include, but are not limited to:

   a. Discussing quality assurance findings,

   b. Participating in team staffing of existing and new cases,

   c. Attending training and meetings on policy updates (off-site as required),

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d. Conducting case transfers , and

5. The Provider must ensure that its Case Managers check voice mail and respond appropriately at least twice daily, Monday through Friday, excluding state holidays.

6. The Provider must ensure that its Case Managers return calls related to participant care in a timely manner. Calls received by the Case Manager before noon must be returned by 5:00 p.m. that day; calls received after noon must be returned by noon on the next business day.

7. The Provider must ensure the secure and accurate maintenance of all electronic and hard-copy participant records assigned to its Case Managers,

8. All hardcopy records will be housed in the participant's assigned Area Office. Records removed from the Area Office must be signed out and returned per CLTC office policy.

9. The Provider must ensure that its Case Managers adhere to the documentation policy posted in the "Help" section of Phoenix.

10. The Provider must ensure that it's Case Managers check and respond to email daily, Monday through Friday.

11. The Provider must ensure that its Case Managers use the Electronic Visit Verification System (EVV). Documentation must be completed according to the current policy. For home visits, the EVV must be utilized while in the Participant's home.

12. The Provider must ensure that each of its Case Managers and Case Management Supervisors providing Case Management services uses the Phoenix System and/or other systems as designated by SCDHHS for all case management activities, including but not limited to, re-evaluations, service planning, documentation, and verification of continued financial eligibility.

13. The Provider must have an effective, written back-up service provision plan in place to ensure that participants receive case management services as authorized when the assigned Case Manager is not available to provide services.

    The plan must include:

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a. The name of the Case Manager(s) who will cover the cases while the regular Case Managers is away,

b. (For Independent Case Managers only) A signed agreement between the assigned Case Manager and the back-up Case Manager who will cover the cases during the period when the assigned Case Manager is away,

c. The procedure for notifying the Participant when the back-up plan will be used,

d. The procedure for transferring cases to the back-up Case Manager in Phoenix, and

e. The procedure for notifying the Area Administrator/Lead Team Case Manager when the back-up plan is initiated.

If the Provider determines that services cannot be provided as authorized, the Area Administrator/Lead Team Case Manager must be notified by telephone immediately.

14. The Provider must ensure that each Case Manager meets the Training Requirements in Article F of this document.

15. The Provider must ensure that its Case Managers serve a maximum of two CLTC Area Offices unless approved by Central Office. Case Managers serving two Area Offices must designate one CLTC Area Office as the primary office for training and meetings.

16. Violations of the Conduct of Service will result in sanctions. See Sanction Guidelines posted in the "Help" section of Phoenix.

C. Description of Services to Be Provided

1. The unit of service will be specified in the approved waiver document.

2. The Provider must ensure that its Case Managers use professional judgment in allotting an appropriate amount of time to complete each participant-related activity for which billing is submitted. These activities include Case Management Contacts and Initial, Quarterly, and Re-evaluation Visits. If the amount of time spent to complete the billed activities for a particular day does not meet CLTC's expectations of the time necessary to complete those

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activities, then CLTC SCDHHS, in its sole discretion, may conduct an investigation and impose sanctions.

3. SCDHHS sets minimum and maximum limits on caseload sizes. The Provider must ensure that its Case Managers abide by these limits, which are available in the "Help" section of Phoenix. Once a case is accepted, it must be retained by the Provider and assigned Case Manager for ninety (90) days unless otherwise requested by the participant. The maximum caseload limit takes into consideration all participants assigned to a Case Manager/Case Management Supervisor in a given month, including assignments for a partial month

4. The Provider must ensure that cases are maintained through an entire month unless otherwise requested by the Participant. Central Office and Area Office(s) should be notified as soon as possible of any pending cases to be relinquished. The Provider must justify any notification that is provided less than fourteen days prior to the end of the month. The Provider must immediately notify Central Office when an employee with access to Phoenix separates from the case management Provider.

1. D. Case ManagementCases are referred to Providers in accordance with the Participant's choice. In no case shall a Provider solicit any waiver Participant. If a Case Manager leaves the Provider, that Case Manager may not solicit the Participant to follow him/her. Solicitation is cause for immediate termination.

2. The Provider must notify SCDHHS within two (2) business days to accept or decline a referral for Participant service. Once a Participant is accepted, team staffing must occur within two (2) business days.

3. Case Management services include the following:

   a. Regularly contacting the Participant during initial visits, monthly contacts, quarterly visits, and re-evaluation visits. The Provider must ensure that At least one of these case management activities and all of its necessary components are completed every month and documented appropriately

   b. In conjunction with the Participant, developing and monitoring needs and personal goals. ongoing evaluation of the service plan to include team staffing.

   c. Completing authorizations for waiver services (including initial authorization, changes, and terminations).

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d. Resource assessment and development, with referrals to other agencies as needed.

e. Service coordination, to include coordination of community-based support and participation in interagency case staffing.

f. Ongoing Case monitoring and problem solving to address participant's needs throughout the month.

g. Re-evaluation activities including but not limited to team staffing with designated reviewers.

h. Service counseling with participant and families.

i. Case termination and transfer.

4. The Provider must ensure that Case Management services and other related activities provided by its Case Managers and Case Management Supervisors are provided in accordance with the CLTC Services Provider manual, CLTC program policies and procedures, any applicable SCDHHS policies and procedures, the SCDHHS Case Management contract, and any applicable federal and state statutes and regulations. All of the foregoing provisions, policies, procedures, statutes, and regulations (together with any subsequent amendments) are hereby incorporated as an integral part of this Scope of Service.

5. When a case has been relinquished or transferred to another provider, the Provider must cease any contact with the Participant and/or primary contact.

E. Staffing

The Provider must adhere to the following provisions related to staffing:

Case Manager and Case Management Supervisor

1. Case Management Providers must **employ** Case Managers and Case Management Supervisors. Sub-contracting arrangements between Providers and individuals to provide case management services are not permitted. Case Managers and Case Management Supervisors must not be employed by multiple CLTC Case Management Providers.

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2. Case Management Providers must employ a Supervisor(s) who meets the qualifications of a Case Manager and who will provide technical assistance, perform quality assurance, and provide training to all Case Managers employed by the agency. Case Management Supervisors must attend and complete initial CLTC training for supervisors and pass a competency exam prior to assuming supervisory duties. A Case Management Supervisor who previously served as a CLTC Case Manager may request an exemption. Supervisors must also attend ongoing training as presented by CLTC.

3. Requirements for ratio of Case Management Supervisors to Participants and/or Case Managers is published in the Help section of Phoenix.

4. The Provider must ensure that Case Managers and Case Management Supervisors do not have a felony conviction of any kind. A national background check must be completed and maintained in the personnel record for all case managers and Case Management Supervisors and made available to CLTC upon request. A new background check must be completed every five years. Hiring of employees with misdemeanor convictions will be at the discretion of the Provider.

5. Providers must check the Office of Inspector General (OIG) exclusions list at least once a year for all staff. A copy of the search results page must be maintained in each employee's personnel file. Anyone appearing on the list will not be allowed to provide services to Waiver participants or participate in any Medicaid -funded programs. The website address is listed below:–

   OIG Exclusions List: http://www.oig.hhs.gov/fraud/exclusions.asp

6. The Provider must ensure that each Case Manager and Case Manager Supervisor has a current, valid driver's license. The Provider must obtain a copy of the case Manager's driving record and verify that the license is valid at the time of hiring and then again every five years. Copies of the driving records must be maintained in the employee's file and provided to SCDHHS upon request.

7. The Provider must ensure that its Case Managers and Case Management Supervisors have demonstrated skills in computer hardware/software access and usage.

8. The Provider must ensure that, when serving Participants, its Case Managers and Case Management Supervisors display a photo identification badge identifying the Provider and the employee.

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9. The Provider must ensure that its Case Managers record a voice mail greeting that clearly identifies the name of the Case Manager and the Provider.

10. The Provider must ensure that Routine ongoing Case Management activities are conducted by one of the following:

    a. Social Workers licensed by the state of South Carolina,

    b. Individuals with a Bachelor's or Master's degree in a health or human services field from an accredited college or university, who have at least two (2) years of assessment and care planning experience with clients (experience cannot include more than six (6) months of internship),

    c. Registered nurses currently licensed by the state of South Carolina or by a state that participates in the Nursing Compact,

    d. Certified Geriatric Care Managers with two (2) years of assessment and care planning experience with clients,

    e. Certified Case Managers with two (2) years of assessment and care planning experience with clients. All Case Managers who have professional licenses must comply with the continuing education requirements necessary for their specific licensure,

    f. Any Case Managers/Supervisors who do not have professional licenses must have a minimum of ten (10) hours relevant in-service training per calendar year. The annual ten-hour requirement will be on a pro-rated basis during the first year of employment. Documentation of training must include topic, name and title of trainer, training objectives, and outline of content and length of training, location, and outcome of training. Topics for specific in-service training may be mandated by SCDHHS.

    g. The Provider must ensure that its Case Managers and Case Management Supervisors are aware that they are mandated reporters of Abuse, Neglect and Exploitation (ANE). Failure to report ANE will result in immediate action up to and including termination of serving CLTC participants and the Case Manager/Supervisor being reported to the appropriate authority.

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11. PPD Tuberculin Test

The Provider must comply with the PPD Tuberculin test requirements found on the Department of Health and Environmental Control website, Regulation 61-75 Standards for Licensing at:

www.scdhec.gov/health/licen/hladcinfo.htm

If Provider requires additional information, Provider should contact the Tuberculosis Control Division, Department of Health and Environmental Control, 1751 Calhoun Street, Columbia, SC 29201, phone (803) 898-0558.

12. Personnel folders: Individual records will be maintained to document that each member of the staff has met the above requirements. When requested by SCDHHS, documents will be uploaded to Phoenix.

F. Case Management Training

1. Case Management Providers will be responsible for training employees as required by SCDHHS. This training will be in conjunction with any training directly provided by SCDHHS.

2. Case Management providers will be responsible for training costs and attending training required by SCDHHS. SCDHHS will not reimburse expenses for Case Managers, Case Management Supervisors, or other Provider staff associated with attending required SCDHHS training.

3. All new Case Managers and Case Management Supervisors must complete the SCDHHS CLTC Training curriculum to include home visits with SCDHHS staff.

4. Case Managers and Case Management Supervisors must obtain passing scores on all tests administered by SCDHHS. Case Managers and Case Management Supervisors who do not obtain a passing score on any test given during SCDHHS initial training will not be assigned any cases and must repeat the training and retake any required tests. If he/she fails on the second attempt, he/she will not be allowed to provide case management for CLTC participants. If a Case Management Supervisor does not pass required tests, he/she cannot be designated nor act as a supervisor.

5. After passing all initial tests and attending CLTC Area office(s) orientation, Case Managers and Case Management Supervisors will be eligible to be assigned cases based on participant choice. Case Managers and Case

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Management Supervisors must take an additional competency test after having cases for ninety (90) days. If the Case Manager or Case Management Supervisor fails this test, he/she will be allowed to retake it once. If he/she fails on the second attempt, he/she will not be allowed to provide Case management services to CLTC participants.

6. The types and number of Case assignments during the first ninety (90) days must be coordinated with a regional trainer to ensure adequate case coverage, with no assignments of re-evaluations to any new employee without prior approval. Caseloads may not exceed approved levels during the training cycle.

7. The Provider must ensure that its Case Managers and Case Management Supervisors have business cards available to give to Participants no later than their first scheduled home visit after completion of training and on an ongoing basis thereafter.

8. The Provider must ensure that any of its Case Managers or Case Management Supervisors who are identified by quality reviews as needing remedial training attend that training and obtain passing scores on all required competency tests.

G. Compliance

Quality Assurance and case management reviews are performed randomly and when failures to comply with contract or scope requirements are detected. CLTC can also conduct unscheduled compliance visits during regular office hours.

Following is the sanction process for Case Management Providers that will apply when minimum standards as set forth by CLTC are not adhered to by Providers and Case Managers. CLTC will review the provider's compliance with Case Management program requirements on an ongoing basis. Failure to comply with the program requirements will result in the application of sanctions against the Provider. Case Manager, and/or Case Management Supervisor as follows:

1. Strike: Case Managers and Case Management Supervisors will receive strikes for actions that are out of compliance with policy. Case Managers and Case Management Supervisors can receive up to six (6) strikes per year. After the sixth strike, recoupment will occur for any additional instances of non-compliance. All Strikes are removed annually on the Case Manager's hire date.

2. Recoupment: Case Management services that have been billed but are out of compliance with policy and procedures may be recouped from the Provider.

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3. Caseload reductions: The caseload of the Case Manager or Case Management Supervisor will be reduced by a minimum of 10 percent (10%) for a minimum of ninety (90) days. Case managers and Case Management Supervisors must comply with corrective action plans before any cases are reassigned.

4. At its discretion, SCDHHS may require that a Provider's Case Manager or Case Management Supervisor can no longer work with CLTC Participants.

5. Suspension: The Case Management provider is removed from the provider choice list for the duration of the sanction. The minimum period of suspension is one (1) month. Providers who are suspended must complete an acceptable corrective action plan before the suspension is lifted. Suspension will be for all geographic areas the Provider covers.

6. Termination: The cancellation of the Provider's enrollment in the Medicaid CLTC program resulting in the denial of Medicaid participation for a period of three (3) years. After two (2) suspensions for any reason, a third suspension in a two (2) year period will result in termination. Termination will also occur if the provider is substantially out of compliance with contractual requirements. See compliance guideline sheet for specifics on sanctions based on Provider/Case Manager actions.

H. Administrative Requirements

1. The Provider must use the Phoenix system to enter a list of regularly scheduled holidays, on which it will not be required to furnish services. The Provider must not be closed for more than two (2) consecutive days, except when a holiday falls in conjunction with a weekend. If a holiday falls in conjunction with a weekend, the Provider may be closed for not more than four (4) consecutive days.

2. The Provider will specify in Phoenix's Provider Portal the hours of operation.

3. The Provider must maintain an up-to-date organizational chart that is available to each employee.

4. The Provider must maintain written bylaws or the equivalent for governing the Provider's operations.

5. The Provider must maintain a written employee handbook that contains a Fragrance -Free Policy and a dress code requiring business casual attire when conducting SCDHHS business.

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6. The Provider must assure SCDHHS that a governing body or person(s) so functioning shall assume full legal authority for the operation of the provider agency.

7. The Provider shall acquire and maintain, during the life of the contract, general liability insurance and worker's compensation insurance as required in the SCDHHS contract. The Provider is required to list SCDHHS-CLTC as certificate holder for notice purposes on all insurance policies using the following address: Post Office Box 8206, Columbia, SC 29202-8206.

8. Upon request by SCDHHS, the Provider will be responsible for appropriate participation in the SCDHHS Appeals and Hearings process with respect to appeals of any action involving the Provider.

9. The Provider is subject to recoupment for payments made for all waiver services as a result of authorizations issued by provider staff not consistent with CLTC policies and procedures and in accordance with the CLTC Case Management Recoupment Guidelines.

10. The Provider must disclose to SCDHHS the names and relationships of any relatives of the Provider or its staff who provide items or services to Medicaid Participants. For purposes of this Contract, the Provider means all owners, partners, managing employees, directors and any other person involved in the direct management and/or control of the business of the Provider. The Provider's staff includes everyone who works for or with the Provider, including independent contractors, in the provision of or billing for services described in this Contract. Relative means persons connected to the Provider by blood or marriage.

    The Provider must disclose all such relationships via email to provider-distribution@scdhhs.gov within two (2) days of learning of the relationship. The Provider, in executing this Contract, certifies that it has in place policies, procedures or other mechanisms acceptable to SCDHHS to identify and report these relationships. Failure to report a relationship timely or to have the appropriate policies and procedures in place may result in sanctions by SCDHHS up to and including termination of this Contract for cause.

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CLTC Case Management Compliance Guidelines

1. Late Level of Care/Re-evaluation (without an approved reason)
   a. If late recoup for every month late from appropriate entity
   b. If completed within the month but out of compliance, recoup for the month
   c. If level of care date is inaccurate, recoup
   d. Late Initial Visit (without approved reason) – Recoup

2. No Case Activity or Inappropriate Case Activity
   a. Recoup if CM service has been billed but record reflects no case activity
   b. If Narrative & Checklist are incomplete, the CM will be considered out of compliance – CM will receive one strike per incident, after 6th strike any additional instances of this type will be recouped
   c. No activity and not billed – strike

      **** Exception: If adequate documentation is noted that CM (throughout the month) was unable to reach participant/ family/Provider to complete contact, then a CLTC Notification (10-day notice) need to be sent and annotated in the narrative.**
   d. Quarterly due; however Monthly Contact was completed without a valid reason narrated – strike **and** recoup for each month the quarterly is not completed

3. Closed Cases
   a. If authorizations are not terminated at case closure resulting in provider payment for services – Strike **and** recoup
   b. Failure to notify provider by phone or Phoenix conversation of service termination – Strike
   c. Failure to send CLTC notification with Appeal Notice to participant/family at case closure – Strike **and** recoup

4. Billing prior to Service Delivery
   a. Recoup if Care Call reports indicate Case Management Service billing occurred before monthly activity was performed

5. Timeliness
   a. If documentation is completed outside of timeliness standards – Strike

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b. If documentation is recorded late in the Service Plan or left blank in the Service Plan – Recoup. Recoup for each month the Service Plan was not completed.

6. Overlap Claims

a. If a pattern of overlapped claims is identified and substantiated, the provider will be informed that the case manager will no longer be allowed to manage waiver participants; independent case manager's contract will be terminated.

7. Monitoring APS cases

a. Failure to follow-up monthly on APS case/referral

1st action – A reminder will be sent via email to Case Manager, Provider Agency, and AA/LTCM by CLTC Central Office QA staff with notification of the email sent in the complaint form. The email will include a reminder for the CM/Provider Agency to contact the AA/LTCM for assistance with contacting APS if needed (refer to APS Policy-Chapter 5). ****If no response/documentation from CM within five (5) working days of the email, move to 2nd action.**

2nd action – A letter will be sent to the Case Manager and Provider Agency by CLTC Central Office Provider Compliance staff with notification of the letter sent in the complaint form. **** CM or Provider Agency has five (5) working days from the date letter sent to document contact/follow-up with APS staff before 3rd action is taken.**

3rd action – A Case Manager and Provider Agency will not receive new referrals for sixty (60) days.

b. Failure to file a complaint in Phoenix

1st offense – A letter will be sent to the Case Manager and Provider Agency by Central Office staff after area office staff sends in a complaint on the Case manager.

2nd offense – A Case Manager and Provider Agency will not receive new referrals for sixty (60) days.

c. Failure to make APS referral **(we are mandated reporters)**

i. If mandatory reporter who has actual knowledge of the abuse, neglect or exploitation of a vulnerable adult fails to report, he or she can be charged with a misdemeanor. If convicted, he or she may be fined up to $2,500 or sentenced to not more than one (1) year in prison.

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ii. Failure to report abuse, neglect, or exploitation of a vulnerable adult may jeopardize the Provider's professional license.

8. Other Compliance issues

All of the following compliance issues will result in the CM's agency being contacted to address and correct the issue (Independent CM's will be addressed directly by CLTC staff). If the behavior continues and/or a pattern of the behavior is established, CLTC will no longer allow the worker to provide services for waiver participants. The Independent CM will be terminated.

a. Failing to timely (within 24 hours) follow-up on participant's issues, concerns, requests, Care Call issues, etc.

b. Failure to attend scheduled monthly training/policy update meetings without receiving an excused absence

c. Failure to respond to emails in a timely manner per Scope of Services (daily)

d. Failure to return phone calls to CLTC staff

Note: New Case Managers will have a sixty (60) day grace period after Phoenix registration date; the CM will not receive any strikes or recoupments during the grace period. All strikes will be accumulated to total six (6) occurrences. All occurrences after the sixth strike will be subject to recoupment. The strike period will be one (1) year and will go back to zero on the worker's Phoenix registration anniversary date.

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MEDICAID HOME AND COMMUNITY-BASED WAIVER
SCOPE OF SERVICES
FOR
COMPANION SERVICES

A. Objectives

The objectives of Companion services are to provide short-term relief for caregivers and to provide needed supervision of Medicaid Home and Community-Based waiver participants.

B. Conditions of Participation

1. Agencies must utilize the automated systems mandated by Community Long Term Care (CLTC) Division to document and bill for the provision of services.

2. Agencies must have certified evidence of not less than $10,000.00 operating capital. This capital is required so that the provider agency has the capability to operate for a minimum of 60 days in the event Medicaid reimbursement is delayed or withheld for any reason. Certified evidence of operating capital includes, but is not limited to, a written statement from an officer of a financial institution or a certified accountant; a copy of your most recent bank statement must be included. Operating capital will be verified prior to initiating a contract and periodically during the contract period.

3. Pursuant to enactment and implementation of S.C. § Code 44-70-10 all providers of personal care services will require a license to provide personal care services. Providers who are not licensed by the South Carolina Department of Health and Environmental Control will not be allowed to enroll as a Medicaid provider for these services.

4. Provider agencies must be housed in an office that is in a commercial zone. Any agency not housed within a commercial location must be prior approved by SCDHHS to enroll as a personal care provider. Requirements for agencies not in commercial locations include all of the following:

   a. Has a county/municipal zoning permit to operate a business in a residential setting if required

   b. Holds appropriate business licenses

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c. Meets applicable county/municipal, mixed-use zoning guidelines for a home-based business in a primarily residential neighborhood

d. Has a business entrance door which is separate from a residential living area

e. Uses office space devoted entirely for the business; space must be enclosed and have a locking door which uses a different key from other locks in the home

f. Has an outside business sign conforming to county/municipal sign and zoning codes for its neighborhood

5. Providers must accept or decline referrals from CLTC within two (2) working days. Failure to respond will result in the loss of the referral.

6. The provider will be responsible for verifying the participant's Medicaid eligibility when it has accepted a referral and monthly thereafter to ensure continued eligibility. Providers can verify Medicaid eligibility for CLTC participants in the Phoenix Provider Portal on their dashboard. Providers should also refer to Section 1 of this provider manual for additional information on eligibility determination.

7. Providers may use paperless filing systems. Provider must obtain approval from CLTC Central Office prior to initiating electronic documentation and/or filing systems. Electronic records must be made available upon request, and providers must have a reliable back-up system in the event their computer system shuts down.

C. Description of Services to be provided

1. The unit of service is one (1) hour of direct services provided in the participant's residence or away from the participant's residence for shopping, laundry services, other offsite services or escort services. The amount of time authorized does not include the companion's transportation time to and from the participant's residence.

2. The number of units and services provided to each participant is dependent upon the participant's needs as set forth in the participant's Service Plan.

3. Services to be provided include:

a. Socialization - Reading, conversation, assistance with mail and other interaction with participant as appropriate

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b. Assistance with or supervision of meal/snack preparation

c. Assistance with or supervision of participant laundry (washing clothes and linens)

d. Assistance with or supervision of participant's shopping

e. Incidental light housekeeping (dusting, sweeping or other light chores to maintain participant in a safe clean environment)

f. Sitting service focusing on the participant including supervision, orientation, making appropriate contact in case of emergency

D. Staffing

The Provider must maintain individual records for all employees.

1. The Provider must maintain the following (supervisory positions may be sub-contracted):

a. A supervisor who meets the following requirements:

i. High school diploma or equivalent;

ii. Capable of evaluating companions in terms of their ability to carry out assigned duties and their ability to relate to the participant; and

iii. Able to assume responsibility for in-service training for companions.

b. Companions who meet the following minimum qualifications:

i. Able to read, write and communicate effectively with participant and supervisor;

ii. Able to use the Care Call IVR system;

iii. Capable of following a care plan with minimal supervision; and

iv. At least 18 years of age.

c. Companions must complete four (4) hours of relevant in service training per calendar year in the following areas:

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i. Maintaining a safe, clean environment and utilizing proper infection control techniques;

ii. Following written instructions;

iii. Ethics and interpersonal relationships;

iv. Documenting services provided; and

v. Other areas of training as appropriate.

The annual four-hour requirement will be on a pro-rated basis during the companion's first year of employment.

2. Agency staff may be related to participants served by the agency within limits allowed by the South Carolina Family Caregiver Policy. The following family members cannot be a paid caregiver:

a. The spouse of a Medicaid participant

b. A parent of a minor Medicaid participant

c. A step parent of a minor Medicaid participant

d. A foster parent of a minor Medicaid participant

e. Any other legally responsible guardian of a Medicaid participant

Qualified family members can be reimbursed for their provision of Companion services.

3. PPD Tuberculin Test

Please refer to Department of Health and Environmental Control (DHEC) website, Regulation 61-75 – Standards for Licensing for PPD Tuberculin test requirements.

http://www.scdhec.gov/health/licen/hladcinfo.htm

Providers needing additional information should contact the Tuberculosis Control Division, Department of Health and Environmental Control, 1751 Calhoun Street, Columbia, SC 29201, phone (803) 898-0558.

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4. A criminal background check will be required for all potential employees to include employees who will provide direct care to CLTC participants and all administrative/office employees (office employees required to have background checks include: administrator, office manager, supervisor, and persons named on organizational chart in management positions). All criminal background checks must include all data for the individual with no less than a ten (10) year timeframe being searched. The criminal background check must include statewide (South Carolina) data. The statewide data must include South Carolina and any other state or states the worker has resided in within the prior ten years. Potential employees with felony convictions within the last ten (10) years cannot provide services for CLTC participants or work in an administrative/office position. Potential employees with non-violent felonies dating back ten (10) or more years can provide services to CLTC participants under the following circumstances:

   - Participant/responsible party must be notified of the aide's criminal background, and

   - Documentation must be placed in the participant's record and signed by the participant/responsible party acknowledging awareness of the aide's criminal background and agreement to have the aide provide care.

Potential administrative/office employees with non-violent felony convictions dating back ten (10) or more years can work in the agency at the Provider's discretion.

Hiring of employees with misdemeanor convictions will be at the Provider's discretion.

E. Conduct of Service

The Provider must maintain documentation showing that it has complied with the requirements of this section.

1. The Provider must obtain the Service Plan and authorization from the case manager prior to the provision of services. The authorization will designate the amount, frequency and duration of service for participants in accordance with the participant's Service Plan/Authorization which will have been developed in consultation with the participant and others involved in the participant's care. The provider will receive new authorizations only when there is a change to the authorized service. The Provider must adhere to those duties which are specified in the authorization in developing the provider task list. The provider task list must be developed by the supervisor. If the provider identifies Companion duties that would be beneficial to the participant's care but are not specified in the authorization, the Provider must contact the case manager to discuss the possibility of having these duties included in the Authorization. **Under no**

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COMPANION SERVICES

circumstances will any type of skilled medical service or hands on care be performed by a companion. The case manager will make the decision as to whether the CLTC Service Plan should be amended to include the additional duty. This documentation will be maintained in the participant files.

2. The supervisor of Companion services must:

   a. Perform an initial visit to the participant's home within 90 days of the start of services and provide on-site supervision at least once every 365 days thereafter for each participant and phone contact with the participant or responsible party as needed.

   b. Each supervisory visit, including the initial visit, will be documented in the participant's file and recorded in Care Call. In the event the participant is inaccessible during the time the visit would have normally been made, the review must be completed within five (5) working days of the resumption of Companion services. The Supervisor's report of the on-site visits must include, at a minimum:

      i. Documentation that services are being delivered consistent with the Service Plan/Authorization;

      ii. Documentation that the participant's needs are being met;

      iii. Reference to any complaints which the participant or family member/responsible party has lodged; and,

      iv. A brief statement regarding any changes in the participant's service needs.

   c. Supervisors will provide assistance to companions as necessary.

   d. Supervisors will be immediately accessible by phone and/or beeper during any hours services are being provided under this contract. If the supervisor position becomes vacant, SCDHHS must be notified within two (2) business days.

   e. If there is a break in service which lasts more than sixty (60) days, the supervisor must conduct a visit within ninety (90) days of the resumption of services.

5. In addition, the Provider must maintain an individual participant record that documents the following items:

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a. The Provider will initiate Companion services on the date negotiated with the CM and indicated on the authorization. Services must not be provided prior to the authorized start date and must be provided according to the schedule as indicated on the authorization.

b. The Provider will notify the CM within two (2) working days of the following participant changes:

   i. Participant's condition has changed and the Service Plan/Authorization no longer meets participant's needs or the participant no longer appears to need Companion services.

   ii. Participant dies, is institutionalized, or moves out of the service area.

   iii. Participant no longer wishes to participate in a program of Companion services.

   iv. Provider becomes aware of the participant's Medicaid ineligibility or potential ineligibility.

c. The Provider will maintain a record keeping system which documents the delivery of services in accordance with the Service Plan. The Provider shall not ask the participant/responsible person to sign any log or task sheet. Task sheets must be reviewed, signed, with original signature (rubber signature stamps are not acceptable), and dated every two (2) weeks by the supervisor. Task sheets must be filed in the participant's record within thirty (30) days of service delivery.

d. Whenever two consecutive attempted visits occur, the local CLTC office must be notified. An attempted visit is when the companion arrives at the home and is unable to provide the assigned tasks because the participant is not at home or refuses services.

f. The Provider will inform participants of their right to complain about the quality of Companion services provided and will give participants information about how to register a complaint. Complaints which are made against companions will be assessed for appropriateness and for investigation by the Provider. All complaints which are to be investigated will be referred to the supervisor who will take any appropriate action.

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F. Compliance Review Process

The Division of Long Term Care Waiver Management, Provider Compliance Department has developed this policy for clarification of the provider compliance process. The policy gives detailed information on how provider compliance sanctions are implemented. Provider reviews receive a score based on a sanctioning scale; review scores will determine if the Provider will receive a sanction and if so, the level of the sanction. The sanction scoring process was developed to ensure that reviews are equitable and for providers to know what to expect when they are reviewed.

The following chart outlines how reviews are scored:

Sanction Level

- Provider compliance review questions in the Scope of Services are classified into three classes, based on (1) the significance of the question regarding to the services, and (2) the potential influences on providers and participants if the requirement was not met. See the example below:

Severity level: 1=less serious, 2 = serious, 3 = very serious

Client Service Questions	Possible Answers	Severity Level
Was supervisory visit made within 30 days after PC II services initiated?	Y, N, NA	3
Was the initial supervisory visit documented in Care Call?	Y, N, NA	3
Does provider maintain individual client records?	Y, N	2
Did provider give participant written information regarding advanced directives?	Y, N, NA	1

There are five types of sanctions:

- Plan of Correction – This is the lowest sanction and indicates the provider is in substantial compliance with the contractual requirements. The Provider will be required to submit a plan of correction outlining the deficiency (ies), the detailed plan to correct the deficiency and the effective date the plan will be implemented.

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- 30-day suspension – At this level, new referrals are suspended for 30 days. The Provider will also be required to submit a plan of correction. If the plan of correction is approved, the suspension is automatically lifted at the end of the 30-day period. If the corrective action plan is not approved, the Provider will be given an additional ten (10) business days to submit another corrective action plan for review and approval; the suspension will remain in place until an approved corrective action plan is received. If the second submitted corrective action plan is not approved, the provider contract will be terminated.

- 60-day suspension – At this level, new referrals are suspended for sixty (60) days. The Provider will also be required to submit a plan of correction. If the plan of correction is approved, the suspension is automatically lifted at the end of the 60-day period. If the corrective action plan is not approved, the Provider will be given an additional ten (10) business days to submit another corrective action plan for review and approval; the suspension will remain in place until an approved corrective action plan is received. If the second submitted corrective action plan is not approved, the provider contract will be terminated.

- 90-day suspension – Indicates serious and widespread deficiencies, new referrals are suspended for 90 days. The 90-day suspension of new referrals will only be lifted after an acceptable plan of correction is received. If the corrective action plan is not approved, the Provider will be given an additional ten (10) business days to submit another corrective action plan for review and approval; the suspension will remain in place until an approved corrective action plan is received. If the second submitted corrective action plan is not approved, the provider contract will be terminated. In addition, an acceptable follow-up review visit may be conducted if warranted.

- Termination – Indicates a final review score of four hundred (400) or more points, very serious and widespread deficiencies, generally coupled with a history of bad reviews (3 consecutive reviews that receive suspension of new referrals)

Providers who have two (2) consecutive reviews that result in suspension of new referrals, will be terminated if the third consecutive review has a final score that would result in a suspension of new referrals (100 and above).

We have developed a system to score reviews based on the percentage of the identified deficiency and number of participants surveyed. Following is an outline of how reviews will be scored:

<u>Calculating process</u>

- The level of sanction will be decided based on the total score of the provider‘s current review and the provider’s review history, which is converted from the deficiency percentage.

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- Every 5% deficiency counts for 1 point in each class; the total score comes from the total points from each level.
- Since each level has different severity, multiple points will be added on each class's score. Final score = level 3 = unweighted points x 3 + level 2 = unweighted basic points x 2+ level 1 = unweighted points x 1

Example:

Level	Deficiency percentage	Basic points	Final points
Level 1 (less serious)	28%	5	5x1=5
Level 2 (serious)	20%	4	4x2=8
Level3 (major)	35%	7	7x3=21
Final score			34

Based on the total score a sanction level is determined. If a provider has no deficiencies, they will not be subject to a sanction. Below is a chart that illustrates the sanction that will be imposed based on the final review score:

Score Scale & Sanction Level

Sanction Type	Final score	With Good History*
Correction Plans	0-99	0-149
30 Days Suspension	100-199	150-249
60 Days Suspension	200-299	250-349
90 Days Suspension	300-399	350-449
Termination	>400	>450

Good History is determined based on previous review scores. For example, if a provider's previous review had a total score of **50** and their current review has a score of **120**, the sanction for the current review will be corrective action rather than 30-day suspension based on the previous review score.

Scores are automatically calculated using a computer generated compliance review program.

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Provider records will be reviewed periodically at the Provider's office. Onsite visits are unannounced. If the reviewer (CLTC, Program Integrity or other Government Entity) arrives at the provider's office to conduct a survey and no one is there, the following sanctions will be imposed:

- First time – thirty (30) day suspension of new referrals
- Second time – ninety (90) day suspension of new referrals
- Third time – contract termination

G. Administrative Requirements

1. The Provider must inform CLTC of the provider's organizational structure, including the provider personnel with authority and responsibility for employing qualified personnel, ensuring adequate staff education, in-service training, and employee evaluations. The Provider shall notify SCDHHS within three (3) working days in the event of a change in or the extended absence of the personnel with the above listed authority.

2. The Provider must provide SCDHHS a written document showing the organization administrative control and lines of authority for the delegation of responsibility down to the hands-on participant care level staff at contract implementation. The document should include an organizational chart including names of those currently in the positions. Revisions or modifications to this organizational document must be provided to SCDHHS. It is recommended that this document be readily accessible to all staff.

3. Administrative and supervisory functions shall not be delegated to another organization.

4. The Provider shall acquire and maintain for the duration of the contract liability insurance and workers' compensation insurance as provided in Article IX, Section D of the Contract. The Provider is required to list SCDHHS – CLTC as a Certificate Holder for informational purposes only on all insurance policies using the following address: Post Office Box 8206, Columbia, SC 29202-8206.

5. The Provider will develop and maintain a Policy and Procedure Manual that describes how activities will be performed in accordance with the terms of the requirements of the contract. The Policy and Procedure Manual shall be available during office hours for the guidance of the governing body, personnel and will be made available to SCDHHS upon request.

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COMPANION SERVICES

6. The Provider agency shall ensure that key agency staff is accessible in person, by telephone, or by beeper during compliance review audits conducted by SCDHHS.

7. The Provider shall update holidays in Phoenix; the Provider is not required to furnish services on those days. The Companion provider agency must not be closed for more than two (2) consecutive days at a time, except when a holiday falls in conjunction with a weekend. If a holiday falls in conjunction with a weekend, a Companion provider agency may be closed for not more than four (4) consecutive days.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

MEDICAID HOME AND COMMUNITY-BASED WAIVER SCOPE OF SERVICES FOR MEDICAID HOME DELIVERED MEALS

A. Objective

The objective of Home Delivered Meal Services is to provide at least one nutritionally sound meal per day to persons unable to care for their nutritional needs because of a functional disability/dependency and who require nutrition assistance to remain in the community.

B. Condition of Participation

1. Agencies desiring to be a provider of Home Delivered Meals (HDM) Services must have demonstrated experience. Experience to include no less than one year in food service meal planning and preparation.

2. Agencies must have certified evidence of not less than $10,000.00 operating capital. This capital is required so that the provider agency has the capability to operate for a minimum of 60 days in the event Medicaid reimbursement is delayed or withheld for any reason. Certified evidence of operating capital includes, but is not limited to, a written statement from an officer of a financial institution or a certified accountant; a copy of your most recent bank statement must be included. Operating capital will be verified prior to initiating a contract and periodically during the contract period.

3. Providers must use the automated systems mandated by CLTC to document and bill for the provision of services.

4. Providers must accept or decline referrals from CLTC or SCDDSN within two (2) working days. Failure to respond will result in the loss of the referral.

5. The provider will be responsible for verifying the participant's Medicaid eligibility when it has accepted a referral and monthly thereafter to ensure continued eligibility. Providers can verify Medicaid eligibility for CLTC participants in the Phoenix Provider Portal on their dashboard. Providers should also refer to Section 1 of this provider manual for additional information on eligibility determination.

6. Providers may use paperless filing systems. Provider must obtain approval from CLTC Central Office prior to initiating any electronic documentation and/or filing systems. Electronic records must be made available upon request, and providers

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

HOME DELIVERED MEALS

must have a reliable back-up system in the event their computer system shuts down.

C. Description of Services

1. The Unit of Service is one meal delivered to a participant's residence, or other location, as agreed to by the provider and as indicated on the service authorization. Each meal must provide a minimum of one-third of the current recommended dietary allowance (RDA) for the age group as adopted by the United States Department of Agriculture. The number of units of service provided to each participant is determined by the participant's service plan, which is established by the case manager in consultation with the participant.

2. Modified Diet menus must be developed using Dietary Guidelines for Americans and must be reviewed and approved by a registered dietitian. The provider must have procedures in place to assure that each participant requiring a modified meal receives only the meal ordered for that individual.

3. Home delivered meals are made available at a minimum Monday through Friday.

D. Conduct of Service

1. The provider must obtain the authorization from the CLTC Case Manager prior to the provision of services. The authorization will designate the amount, frequency and duration of service for participants in accordance with the participant's service plan which will be developed in consultation with the participant and/or responsible party. More than one meal for each day's consumption may be delivered if authorized by CLTC. The authorization will indicate if the person requires a modified diet due to diabetes or some other condition.

2. The provider will initiate home delivered meals on the date negotiated with the case manager and indicated on the service authorization. Services must not be provided prior to the authorized start date as stated on the service authorization.

3. Each provider must offer one hot meal per day, five or more days each week, and any additional authorized meals may be hot or cold. Shelf stable meals may be provided if authorized by the Case Manager and the participant or responsible party requests this type of meal. A hot meal, for the purposes of this program, is one in which the main food item is hot at the time of serving. A blast-frozen meal, if authorized, meets the hot meal requirement for this standard. (If the participant or responsible party agrees and/or requests shelf stable meals, we will allow this option in lieu of hot or frozen meals.)

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HOME DELIVERED MEALS

4. No home-canned or home-prepared food shall be used in the preparation and service of the meals.

5. The facility at which the meals are prepared and/or packaged, as well as the manner of handling, transporting, serving and delivery of these meals must meet all applicable health, fire safety and sanitation regulations.

6. Only single service covered aluminum foil or styrofoam divided containers can be used for hot food. Each tray compartment must be large enough to contain the required portions without spillover.

7. Unless providing a blast frozen meal or shelf stable meal, hot and cold food shall be portioned and packed separately to ensure retention of heat or cold and shall be transported in approved insulated carriers which will maintain the required hot (130 degrees Fahrenheit or above) and cold (45 degrees Fahrenheit or below) temperatures until the time of delivery to the participant. Blast frozen meals must be transported in approved insulated carriers which will maintain the meals in a frozen state until the time of delivery to the participant.

8. Delivery routes must be clearly established. No more than three (3) hours shall elapse between the time of packaging and the time of delivery of the last hot meal on the route. Delivery of a cold meal beyond the three (3) hour limit for a participant who lives too far away may be made upon written approval of the Head of the Provider Relations and Compliance Department, CLTC Division of Waiver Management.

9. Meals must be received, in hand, by an individual at the participant's door or at another location as agreed to by the provider and as indicated on the service authorization.

10. The provider shall give initial and on-going training in the proper service, handling, and delivery of food to all staff, both volunteer and paid.

11. The provider will maintain a record keeping system which establishes an eligible participant profile in support of units of Home Delivered Meal service provided, based on the service authorization**.**

12. The provider shall regularly observe, or at a minimum inquire about, the participant's condition and will confirm at least monthly that the participant continues to reside in the home and is available to receive the meals. The provider will notify the case manager as soon as possible, but no more than two (2) working days, after the provider becomes aware of the following participant changes:

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

HOME DELIVERED MEALS

a. Participant's condition has changed or participant no longer appears to need home delivered meal services; or**,**

b. Participant is institutionalized**,** dies or moves out of service area; or,

c. Participant no longer wishes to receive home delivered meal services; or,

d. Knowledge of the participant's Medicaid ineligibility or potential ineligibility.

E. Administrative Requirements

1. The provider must inform CLTC of the Provider's organizational structure, including the provider personnel with authority and responsibility for employing qualified personnel, ensuring adequate staff education, in-service training and employee evaluations. The provider shall notify SCDHHS within three (3) working days in the event of a change in or the extended absence of the personnel with the above listed authority.

2. The provider must provide SCDHHS a written document showing the organization administrative control and lines of authority for the delegation of responsibility down to the hands-on participant care level staff at contract implementation. The document should include an organizational chart including names of those currently in the positions. Revisions or modifications to this organizational document must be provided to SCDHHS. It is recommended that this document be readily accessible to all staff.

3. Administrative and supervisory functions must not be delegated to another agency or organization.

4. The provider agency must acquire and maintain for the duration of the contract liability insurance and worker's compensation insurance as provided in Article IX, Section D of the Contract. The provider is required to list SCDHHS – CLTC as a Certificate Holder for informational purposes only on all insurance policies using the following address: Post Office Box 8206, Columbia, SC 29202-8206.

5. The provider must update their holidays in Phoenix. The provider is not required to furnish services on those days.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

MEDICAID HOME AND COMMUNITY-BASED WAIVER
SCOPE OF SERVICES
FOR
INDIVIDUAL COMPANION PROVIDERS STANDARDS AND DUTIES

A. Minimum Qualifications

Individual companions must meet the following minimum qualifications:

1. Demonstrate an ability to read, write and speak English;

2. Fully ambulatory;

3. Capable of performing all companion care duties;

4. Capable of following a service plan with participant and/or representative supervision;

5. Be at least 18 years of age;

6. Capable of following billing procedures and completing required paperwork;

7. No known conviction of abuse, neglect, or exploitation of adults (as defined in the Omnibus Adult Protection Act, S.C. Code Ann. Title 43, Chapter 35) or of children (as defined in the Children's Code, S.C. Ann. Title 63, Chapter 7);

8. No known conviction for any crime against another person;

9. No known felony conviction of any kind;

10. No known conviction of any kind concerning the misuse or abuse of any public assistance program (including, but not limited to, fraudulently obtaining benefits, engaging in fraudulent billing practices, and embezzling or otherwise misusing public assistance funds in any manner);

11. No record of exclusion or suspension from the Medicare or Medicaid Programs;

12. Upon request will provide references to the participant and/or representative;

13. All Companions shall submit the results of a PPD tuberculin (TB) skin test that was administered within one year prior to the Companions Medicaid enrollment date. All Companions whose PPD skin test is over a year old at the time of actual

enrollment must have a new PPD skin test to remain enrolled and to be eligible to serve participants as a companion. The two-step procedure is advisable for initial testing in order to establish a reliable baseline. (If the reaction to the first test is classified as negative, a second test should be given a week later. If the second test is classified as negative, the person is considered as being uninfected. A positive reaction to a third test (with an increase of more than 10 mm) in such a person within the next few years is likely to represent the occurrence of infection with M. Tuberculosis in the interval. If the reaction to the second of the initial two tests is positive, this probably represents a boosted reaction, and the person should be considered as being infected). Companions with reactions of 10mm and over to the pre-enrollment tuberculin test, those with newly converted skin tests, and those with symptoms suggestive of tuberculosis (e.g., cough, weight loss, night sweats, fever, etc.) regardless of skin test status, shall be given a chest radiograph to determine whether tuberculosis disease is present. If tuberculosis is diagnosed, appropriate treatment should be given, and the person must not be allowed to work until declared noncontagious by a licensed physician.

Routine chest radiographs are not required on companions who are asymptomatic with negative tuberculin skin tests.

Companions with negative tuberculin skin tests shall have an annual tuberculin skin test. Forty- five (45) days prior to the expiration date, USC-CDR will notify active enrolled companions of the expiration of their TB test results. If the companion has not submitted the required information by the expiration date, USC-CDR will notify the CLTC Central Office. Current services of the companion will be terminated after reasonable notice (2 weeks) to participants has been given so participants can find replacement services. The CLTC Compliance Office will suspend new referrals to companions effective on the date suspension is submitted. If the companion has not submitted the information within six (6) months of the suspension date, USC-CDR will notify CLTC Central Office to initiate steps to terminate the companion's enrollment in the Medicaid Program.

New companions who have a history of positive TB skin test shall send a copy of their most recent chest x-ray and complete a signs and symptoms questionnaire, or have certification by a licensed physician or local health department TB staff prior to enrollment as a Medicaid provider that they are not contagious. Companions who are known or suspected to have tuberculosis shall be required to be evaluated by a licensed physician or local health department TB staff, and must not return to work until they have been declared noncontagious.

Preventative treatment should be considered for all infected companions having direct participant contact who have positive skin tests but show no symptoms of tuberculosis. Routine annual chest radiographs are not a substitute for

preventative treatment. Companions who complete treatment, either for disease or infection, may be exempt from further routine radiographic screening unless they develop symptoms of tuberculosis. Companions with a history of a positive TB skin test will be required to complete a tuberculosis signs and symptoms questionnaire to assess for Tuberculosis annually.

Post exposure skin test should be obtained for tuberculin negative companions within 12 weeks after termination of contact to a documented case of infection.

Companions needing additional information should contact the Tuberculosis Control Division, Department of Health and Environmental Control, 2600 Bull Street, Columbia, SC 29201, phone 803-898-0558.

14. The companion must adhere to basic infection control procedures at all times when providing companion services.

15. All new companion providers must complete companion/Care Call training in the CLTC area office prior to or during the first week of authorized companion services.

B. Conduct of Service

1. The companion will begin services on the date agreed upon by the participant/representative, companion and case manager. This date will be the start date on the written authorization for services. Services provided prior to the authorized start date as stated on the Service Provision Form will not be reimbursed.

2. The case manager will authorize companion services by designating the authorized units of service in accordance with the participant's Service Plan. The companion must adhere to those duties. The participant/representative will self-direct the provision of care and coordinate with the companion regarding the time for service delivery and specific tasks to be performed. Services must be participant specific and for the direct benefit of the participant.

3. The unit of service is authorized in one (1) hour increments and will consist of companion service provided in the participant's home or other setting as may be appropriate to support the duties preformed. The amount of time authorized does not include transportation time to and from the participant's home.

4. If the companion or the participant/representative identify companion duties that could be beneficial to the participant's care but are not specified on the CLTC Service Plan, the companion or participant/representative must contact the case

manager to discuss the possibility of having these duties included on a new service provision form and the Service Plan. Under no circumstances will any type of skilled medical services be performed by a companion. The decision to modify the duties to be performed by the companion is the responsibility of the case manager.

5. The companion will notify the case manager immediately of the following participant changes:

   a. Participant's condition has changed and the Service Provision form no longer meets the participant's needs or the participant no longer appears to need companion services.

   b. Participant/representative no longer appears capable of providing supervision for the companion services.

   c. Participant/representative no longer wants to serve as Employer of Record/representative.

   d. Participant dies or moves out of the service area.

   e. Participant/representative no longer wants to receive companion services.

   f. Participant becomes Medicaid ineligible or potentially ineligible for Medicaid.

6. The companion will notify Adult Protective Services if he/she has knowledge of or reason to believe that the participant has been or is likely to be abused, neglected or exploited.

7. If/when the companion determines that services cannot be provided as authorized, the companion must immediately notify the case manager and the participant/representative by telephone.

8. When two consecutive attempted visits occur, the companion must contact the local CLTC office. An attempted visit is when the companion arrives at the home and is unable to provide the assigned duties because the participant is not at home or refuses services.

9. The companion is responsible for verifying the participant's Medicaid eligibility each month.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

INDIVIDUAL COMPANION

10. The companion will notify the case manager or USC-CDR immediately if the companion wishes to terminate as the provider.

11. The companion is responsible for giving participants a written description of the state law concerning advance directive in accordance with the Patient Self Determination Act. USC-CDR will assist companions in meeting this requirement.

12. The companion shall adhere to all SCDHHS policies, procedures and Medicaid provider manuals including policies regarding billing, claims adjustments, Fiscal Intermediary requirements, etc.

13. The companion must comply with all Care Call requirements.

C. Record Keeping

The companion shall maintain an individual participant record for each participant. The participant record is subject to the confidentiality rules for all Medicaid providers and shall be made available to CLTC upon request. This record shall include the following:

1. Current and historical Service Provision/Termination Forms specifying units and duties to be provided.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

MEDICAID HOME AND COMMUNITY-BASED WAIVER
SCOPE OF SERVICES
FOR
NURSING SERVICES

A. Objective

The objective of nursing services is to provide skilled medical monitoring, direct care, and intervention to maintain the participant through home support. This service is necessary to avoid institutionalization.

B. Conditions of Participation

1. Agencies desiring to be a provider of Medicaid Nursing services must have demonstrated experience in providing Nursing services or a similar service. Experience must include at least three (3) years of health care experience, one of which must be in administration.

2. Agencies must have certified evidence of not less than $10,000.00 operating capital. This capital is required so that the provider agency has the capability to operate for a minimum of 60 days in the event Medicaid reimbursement is delayed or withheld for any reason. Certified evidence of operating capital includes, but is not limited to, a written statement from an officer of a financial institution or a certified accountant; a copy of your most recent bank statement must be included. Operating capital will be verified prior to initiating a contract and periodically during the contract period.

3. Provider agencies must be housed in an office that is in a commercial zone. Any agency not housed within a commercial location must be prior approved by SCDHHS to enroll as a personal care provider. Requirements for agencies not in commercial locations include all of the following:

   a. Has a county/municipal zoning permit to operate a business in a residential setting if required

   b. Holds appropriate business licenses

   c. Meets applicable county/municipal, mixed-use zoning guidelines for a home-based business in a primarily residential neighborhood

   d. Has a business entrance door which is separate from a residential living area

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

NURSING

e. Uses office space devoted entirely for the business; space must be enclosed and have a locking door which uses a different key from other locks in the home

f. Has an outside business sign conforming to county/municipal sign and zoning codes for its neighborhood

4. Agencies must utilize the automated systems mandated by SCDHHS to document and bill for the provision of services.

5. Providers must accept or decline referrals from SCDHHS or SCDDSN within two (2) working days. Failure to respond will result in the loss of the referral.

6. The provider must verify the participant's Medicaid eligibility when it accepts an authorization and monthly thereafter to ensure continued eligibility. Agencies can verify Medicaid eligibility for CLTC participants in the Phoenix Provider Portal on their dashboard. Providers should also refer to Section 1 of this provider manual for additional information on eligibility determination.

7. Providers may use paperless filing systems. Provider must obtain approval from CLTC Central Office prior to initiating electronic documentation and/or filing systems. Electronic records must be made available upon request, and providers must have a reliable back-up system in the event their computer system shuts down.

C. Description of Services to be Provided

1. The unit of service is one (1) hour of direct nursing care provided to the participant in the participant's place of residence. Services are not allowable when the participant is in an institutional setting. The amount of time authorized does not include travel time. Services provided without a current, valid authorization are not reimbursable.

2. The number of units and services provided to each participant are determined by the individual participant's needs as set forth in the Service Plan/Authorization.

3. Nursing services providers will provide skilled nursing services as ordered by the physician performed by a registered nurse (RN) or licensed practical nurse (LPN) in accordance with state law. In addition, providers will assist with/perform ADL's as needed.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

NURSING

D. Staffing

1. The provider must maintain individual records for all employees.

2. The provider must employ an RN or LPN that meets the following requirements:

   a. Supervised by an RN

   b. Licensed to practice nursing by the State of South Carolina

   c. Has at least one year of experience in public health, hospital, or long term care nursing; and

   d. Has a minimum of six (6) hours relevant in-service training per calendar year (The annual six-hour requirement will be pro-rated during the nurse's first year of employment with the provider)

   e. Ensure that nurses serving pediatric participants have at least one year of pediatric nursing experience in a clinical setting

   f. Ensure that nurses serving pediatric participants are additionally trained in caring for children with a tracheostomy, mechanical ventilation, gastric or jejeunostomy tubes, and indwelling catheters

3. PPD Tuberculin Test

   Please refer to Department of Health and Environmental Control (DHEC) website, Regulation 61-75 – Standards for Licensing page 11 of 36 section b. 1-6 for PPD Tuberculin test requirements.

   http://www.scdhec.gov/health/licen/hladcinfo.htm

   Providers needing additional information should contact the Tuberculosis Control Division, Department of Health and Environmental Control, 1751 Calhoun Street, Columbia, SC 29201, phone (803) 898-0558.

4. The provider must conduct a criminal background check for all potential employees to include employees who will provide direct care to SCDHHS/SCDDSN participants and all administrative/office employees. All criminal background checks must include all data for the individual with no less than a ten (10) year timeframe being searched. The criminal background check must include statewide (South Carolina) data. The statewide data must include South Carolina and any other state or states the worker has resided in within the

prior ten years. Potential employees with felony convictions within the last ten (10) years cannot provide services to SCDHHS/SCDDSN participants or work in an administrative/office position. Potential employees with non-violent felonies dating back ten (10) or more years can provide services to SCDHHS/SCDDSN participants under the following circumstances:

- Participant/responsible party must be notified of the nurse's criminal background.
- Provider must obtain a written statement, signed by the participant/responsible party acknowledging awareness of the nurse's criminal background and agreement to have the nurse provide care; this statement must be placed in the participant record.

Potential administrative/office employees with non-violent felony convictions dating back ten (10) or more years can work in the agency at the discretion of the provider.

Hiring of employees with misdemeanor convictions will be at the discretion of the provider.

5. The provider must check the Office of Inspector General (OIG) exclusions list for all staff. A copy of the search results page must be maintained in each employee's personnel file. Anyone appearing on this list is not allowed to provide services to waiver participants or participate in any Medicaid funded programs.
The website address is:

OIG Exclusions List - http://www.oig.hhs.gov/fraud/exclusions.asp

The provider must verify nurse licensure and license status at the State Board of Nursing website. http://www.llr.state.sc.us/pol.asp. A copy of the current license must be maintained in the employee's personnel file. The provider must periodically verify that the nurse license is active and in good standing.

6. Each September the provider must submit a statement certifying that all professional staff are appropriately and currently licensed.

7. In addition, services must also adhere to the following:

   a. The RN supervisor must be accessible via beeper/phone at all times the RN or LPN is on duty; and,

   b. The RN supervisor must decide the frequency of supervisory visits based on his/her professional knowledge of the participant's situation and health status; however, this may be no less frequently than every ninety (90) days

for LPNs and every 180 days for RNs. In the event the participant is inaccessible during the time the visit would have normally been made, the visit must be completed within five (5) working days of the resumption of Nursing services. These visits will include a re-evaluation of the participant's condition as well as updating of the plan of care.

E. Conduct of Service

The provider must maintain documentation showing that it has complied with the requirements of this section. An individual participant record must be maintained.

1. The provider must obtain the Plan of Service/Authorization from the SCDHHS/SCDDSN prior to the provision of services. The authorization will designate the amount, frequency, and duration of service for participants in accordance with the participant's Plan of Service. This documentation must be maintained in the participant's file.

2. Prior to the initiation of nursing services, the provider must conduct an assessment and develop a plan of care. This must be done by an RN. If services are to be provided by an LPN, the plan of care must be developed by the RN supervisor. The provider must maintain the initial and subsequent care plans in the participant's record. If applicable, recommendations to change the service schedule from the initial authorization may be sent to SCDHHS/SCDDSN.
For SCDHHS Participants: This visit must be recorded in Care Call.

3. If there is a break in service which lasts more than sixty (60) days, the supervisor is required to conduct a new initial visit and subsequent visits as indicated above.

4. The provider is responsible for procuring the direct care skilled nursing orders from the physician. The orders must specify the skilled needs of the participant and include the medication administration record (MAR). The provider must communicate with the participant's physician(s) in order to maintain current physician orders. The physician's orders must be updated no less than every ninety (90) days. Participant records must be maintained by the provider and made available to the nurse providing care.

5. Nursing services must begin on the date negotiated by SCDHHS/SCDDSN and the Nursing services provider. Payment will not be made for nursing services provided prior to the authorized start date.

6. The provider must notify SCDHHS/SCDDSN within two (2) working days of the following participant changes:

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a. Participant's condition has changed, and the Plan of Service no longer meets the participant's needs, or the participant no longer needs nursing services;

b. Participant is institutionalized, dies or moves out of the service area;

c. Participant no longer wishes to receive the Nursing services; or

d. Knowledge of the participant's Medicaid ineligibility or potential ineligibility.

7. The provider must maintain a record keeping system which documents:

a. **For SCDHHS participants:** The delivery of services in accordance with the SCDHHS Service Plan. The provider will maintain daily notes including MAR that reflect the nursing services provided to the participants. The provider shall not ask the participant/responsible party to sign any nursing notes. The nurse's note must be reviewed, signed, with original signature (rubber signature stamps are not acceptable), and dated every two weeks by the supervisor. Nursing notes must be filed in the participant's record within thirty (30) days of service delivery

b. **For SCDDSN participants:** The delivery of services and units provided in accordance with the service authorization. The provider will maintain daily notes including MAR that reflect the Nursing services provided by the nurse for the participants and the actual amount of time expended for the service. The daily logs must be signed weekly by the participant or family member. The nurse's note must be reviewed, signed with original signature (rubber signature stamps are not acceptable) and dated every two weeks by the Supervisor. Nursing notes must be filed in the participant's record within thirty (30) days of service delivery.

c. All active participant records must contain at least two (2) years of documentation to include nurse's notes, service plans, authorizations, supervisory visit documentation, etc. Per Medicaid policy, all records must be retained for a period of at least five (5) years. Daily logs must be made available to SCDHHS/SCDDSN upon request.

8. A summary of services provided must be sent to SCDHHS/SCDDSN monthly. This summary must be documented on the monthly summary form. Documentation of supervisory visits must be sent to SCDHHS/SCDDSN quarterly on the supervisory visit form and maintained in the participant record. Providers serving pediatric participants must document on the Pediatric Monthly

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Summary and Pediatric Supervisory Visit forms. All of these forms can be obtained on the SCDHHS website:

http://www1.scdhhs.gov/openpublic/insidedhhs/bureaus/BureauofLongTermCareServices/nursing.asp

F. Overview of compliance review process

The Division of Long Term Care Waiver Management, Provider Compliance Department has developed this policy for clarification of the provider compliance process. The policy gives detailed information on how provider compliance sanctions are implemented. Provider reviews receive a score based on a sanctioning scale; review scores will determine if the provider will receive a sanction and if so, the level of the sanction. The sanction scoring process was developed to ensure that reviews are equitable and for providers to know what to expect when they are reviewed.

Following is a chart that outlines how reviews are scored:

Sanction Level

- Provider compliance review questions in the Scope of Services are classified into three classes, based on (1) the significance of the question regarding to the services, and (2) the potential influences on providers and participants if the requirement was not met. See the example below:

Severity level: 1=less serious, 2 = serious, 3 = very serious

Client Service Questions	Possible Answers	Severity Level
Was supervisory visit made within 30 days after PC II services initiated?	Y, N, NA	3
Was the initial supervisory visit documented in Care Call?	Y, N, NA	3
Does provider maintain individual client records?	Y, N	2
Did provider give participant written information regarding advanced directives?	Y, N, NA	1

There are five types of sanctions:

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- Plan of Correction – This is the lowest sanction and indicates the provider is in substantial compliance with the contractual requirements. The provider will be required to submit a plan of correction outlining the deficiency (ies), the detailed plan to correct the deficiency and the effective date the plan will be implemented.

- 30-day suspension – At this level, new referrals are suspended for thirty (30) days. The provider will also be required to submit a plan of correction. If the plan of correction is approved, the suspension is automatically lifted at the end of the 30-day period. If the corrective action plan is not approved, the Provider will be given an additional ten (10) business days to submit another corrective action plan for review and approval; the suspension will remain in place until an approved corrective action plan is received. If the second submitted corrective action plan is not approved, the provider contract will be terminated.

- 60-day suspension – At this level, new referrals are suspended for sixty (60) days. The provider will also be required to submit a plan of correction. If the plan of correction is approved, the suspension is automatically lifted at the end of the 60-day period. If the corrective action plan is not approved, the Provider will be given an additional ten (10) business days to submit another corrective action plan for review and approval; the suspension will remain in place until an approved corrective action plan is received. If the second submitted corrective action plan is not approved, the provider contract will be terminated.

- 90-day suspension – Indicates serious and widespread deficiencies, new referrals are suspended for ninety (90) days. The 90-day suspension of new referrals will only be lifted after an acceptable plan of correction is received. If the corrective action plan is not approved, the Provider will be given an additional ten (10) business days to submit another corrective action plan for review and approval; the suspension will remain in place until an approved corrective action plan is received. If the second submitted corrective action plan is not approved, the provider contract will be terminated. In addition, an acceptable follow-up review visit may be conducted if warranted.

- Termination – Indicates a final review score of four hundred (400) or more points, very serious and widespread deficiencies, generally coupled with a history of bad reviews (3 consecutive reviews that receive suspension of new referrals).

  Providers who have two (2) consecutive reviews that result in suspension of new referrals, will be terminated if the third consecutive review has a final score that would result in a suspension of new referrals (100 and above).

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We have developed a system to score reviews based on the percentage of the identified deficiency and number of participants surveyed. Following is an outline of how reviews will be scored:

Calculating process

- The level of sanction will be decided based on the total score of the provider's current review and the provider's review history, which is converted from the deficiency percentage.
- Every 5% deficiency counts for 1 point in each class; the total score comes from the total points from each level.
- Since each level has different severity, multiple points will be added on each class's score. Final score = level 3 = unweighted points x 3 + level 2 = unweighted basic points x 2+ level 1 = unweighted points x 1

Example:

Level	Deficiency percentage	Basic points	Final points
Level 1 (less serious)	28%	5	5x1=5
Level 2 (serious)	20%	4	4x2=8
Level3 (major)	35%	7	7x3=21
Final score			34

Based on the total score a sanction level is determined. If a provider has no deficiencies, they will not be subject to a sanction. Below is a chart that illustrates the sanction that will be imposed based on the final review score:

Score Scale & Sanction Level

Sanction Type	Final score	With Good History*
Correction Plans	0-99	0-149
30 Days Suspension	100-199	150-249
60 Days Suspension	200-299	250-349
90 Days Suspension	300-399	350-449
Termination	>400	>450

Good History is determined based on previous review scores. For example, if a provider's previous review had a total score of **50** and their current review has a score of **120**, the sanction for the current review will be corrective action rather than 30-day suspension based on the previous review score.

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Scores are automatically calculated using a computer generated compliance review program.

Provider records will be reviewed periodically at the provider's office. Onsite visits are un-announced. If the reviewer (CLTC, Program Integrity or other government entity) arrives at the provider's office to conduct a survey and no one is there, the following sanctions will be imposed:

- First time – thirty (30) day suspension of new referrals
- Second time – ninety (90) day suspension of new referrals
- Third time – contract termination

G. Administrative Requirements

1. The provider must inform SCDHHS of the provider's organizational structure, including the provider personnel with authority and responsibility for employing qualified personnel, ensuring adequate staff education, in-service training, and employee evaluations. The provider shall notify SCDHHS within three (3) working days in the event of a change in or the extended absence of the personnel with the above listed authority.

2. The provider must provide SCDHHS with a written document showing the organization, administrative control and lines of authority for the delegation of responsibility down to the hands-on participant care level staff at contract implementation. The document shall include an organizational chart including names of those currently in the positions. Revisions or modifications to this organizational document must be provided to SCDHHS. It is recommended that this document be readily accessible to all staff.

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

4. The provider agency must acquire and maintain for the duration of the contract liability insurance and worker's compensation insurance as provided in Article IX, Section D of the Contract. The provider is required to list – SCDHHS as a Certificate Holder for informational purposes only on all insurance policies using the following address: Post Office Box 8206, Columbia, SC 29202-8206.

5. The provider will ensure that its office is staffed by qualified personnel during the hours of 10:00 a.m. to 4:00 p.m. Outside of these hours; the provider agency must

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be available by telephone during normal business hours, 8:30 a.m. to 5:00 p.m., Monday through Friday. Failure to maintain an open and staffed office as indicated will result in sanctions as outlined in section F, last paragraph. The provider must also have a number for emergencies outside of normal business hours. Participant and personnel records must be maintained at the address indicated in the contract and must be made available, upon request, for review by SCDHHS.

6. The provider must develop and maintain a policy and procedure manual which describes how it will perform its activities in accordance with the terms of the contract. The Policy and Procedure Manual shall be available during office hours for the guidance of the governing body, personnel and will be made available to SCDHHS upon request.

7. The provider must have an effective written back-up service provision plan in place to ensure that the participant receives the nursing services as authorized. Whenever the provider determines that services cannot be provided as authorized, the SCDHHS/SCDDSN must be notified by telephone immediately.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

NURSING

MEDICAID HOME AND COMMUNITY-BASED WAIVER
SCOPE OF SERVICES
FOR
NURSING SERVICES

ADDENDUM

Nursing Services to High Risk/High Tech Children:

The Department of Health and Human Services has established a separate classification and compensation plan for Registered Nurses (RN) and Licensed Practical Nurses (LPN) who provide services to medically fragile children under the age of 21 who are ventilator dependent, respirator dependent, intubated and require parental feeding or any combination of these conditions.

In addition to the staffing requirements outlined in Section D.1, the RN or LPN must have documented experience to care for these children that is over and above normal home care or school based nurses.

If the above requirements are met, the provider will be paid an enhanced rate for High Risk/High Tech RN and LPN services as indicated on the rate sheet included in the contract.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

MEDICALLY COMPLEX CHILDREN'S WAIVER
SCOPE OF SERVICES
FOR
PEDIATRIC MEDICAL DAY CARE

A. Objective

The purpose of Pediatric Medical Day Care (PMDC) is to provide physician ordered, comprehensive nursing care services in a licensed day care center to waiver Participants who have medically complex needs in accordance with the Participant's approved Care Coordination Plan.

B. Description of Services to Be Provided

PMDC, which must be provided in accordance with the Treatment Plan, MCC waiver, MCC policy and procedure, SCDHHS policies and procedures and applicable federal and state statutes and regulations, includes the following services:

1. Three meal and at least one snack per day, including formula or enteral nutrition, either provided by the PMDC or the participant's parent or legal guardian.

2. Daily planned therapeutic activities to promote developmentally age appropriate mental stimulation, communication and self-expression. These activities may include exercises, crafts, music, educational programs, and games, which address cognitive, motor, speech, and emotional needs of children.

3. PMDC services must be coordinated with the participant's waiver Care Plan, which is under the direction of the Care Coordinator and a Treatment Plan must be kept on file, which must include:

    a. Patient contact information

    b. History and physical from the child's primary care physician

    c. Specific medical treatment plan which outlines doctor's orders specific to the child's needs

4. The daily physician prescribed nursing services provided in the PMDC performed by or under the supervision of a registered nurse (RN) as permissible under State law must comply with the MCC Policy and Procedure Manual.

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PEDIATRIC MEDICAL DAY CARE

5. When medically necessary, the provider will contact the waiver participant's physician.

C. Staffing

1. The Provider must employ:

a. A Nursing Supervisor who:

i. Hires qualified personnel,

ii. Ensures adequate staff education,

iii. Conducts employee evaluations,

iv. Has the following qualifications:

a. Is a RN currently licensed by an appropriate licensing authority of the state in which the PMDC is located;

b. Has a minimum of three (3) years of experience in pediatric nursing care or three (3) years of social services experience involving the pediatric population; and

c. Has a minimum of one (1) year of administrative or supervisory experience.

b. Nurses who:

i. Are licensed by the State of South Carolina, the State of Georgia, or by a state that participates in the Nursing Compact as an RN or Licensed Practical Nurse (LPN);

ii. Have two (2) years of pediatric experience with medically complex or chronically ill children unless otherwise approved by SCDHHS;

iii. Attend all mandatory SCDHHS training programs and adhere to the training requirements; and

iv. Provide skilled nursing services within the scope of the respective State Nurse Practice Act.

c. Direct Care staff that are:

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

PEDIATRIC MEDICAL DAY CARE

i. RNs, LPNs, Certified Nursing Assistants (CNAs), Nursing Aides, or teaching assistants who:

a. Must be present in a ratio of one (1) for every three (3) participants in the PMDC at any given time.

b. Must have a minimum of one (1) year of pediatric experience or six (6) months of pediatric experience in a hospital setting (other than nurses**).**

2. There must be one (1) RN in the PMDC at all times when MCC participants are present. The supervisor may be the one (1) RN required.

3. The PMDC must maintain a ratio of one (1) RN or LPN for every six (6) participants.

4. Should the provider find itself unable to meet the staffing requirements outlined in this section due to vacancies or for any other reason, the provider must notify SCDHHS immediately. Any deviation from the staffing ratios and requirements must be approved in writing by the SCDHHS MCC waiver administrator.

5. All direct care staff must be trained regarding specific or singular needs of the medically complex participants supervised by the RN on staff. Orientation must be accomplished by observing direct hands on care with specific procedures documented for the employee record.

D. Conditions of Participation

1. The provider must maintain a current day care license through the South Carolina Department of Social Services or their state's respective day care licensing body.

2. The PMDC must be able to accommodate handicapped participants.

3. The PMDC must be equipped with medical equipment appropriate to address the needs of the MCC waiver participants.

4. **The provider must participate in the Care Call monitoring and payment system.**

a. Care Call billing activity must be completed at the time the service is rendered.

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PEDIATRIC MEDICAL DAY CARE

b. For units of service, the Care Call documentation should be completed immediately upon assuming care of the Participant.

5. The provider shall not delegate administrative and supervisory functions to another agency or organization.

6. The provider shall not enter into any subcontract to provide any services or functions covered under this Contract without prior written approval from SCDHHS.

7. The provider must comply with the South Carolina Child Protection Reform Act (S.C. Code Ann. §63-7-10 et seq. (Supp. 2008)), which requires the reporting of any suspected abuse, neglect or exploitation of a child age 17 and under as defined in the Act or the respective state's child protection laws..

8. The provider must maintain a business continuity plan, which will be made available to SCDHHS upon request.

9. The provider must maintain a personnel file for each staff member and document that she/he has met all requirements set forth herein.

10. The provider must conduct a criminal background check for all potential employees to include employees who will provide direct care to participants and all administrative/office employees. All criminal background checks must include all data for the individual with no less than a ten (10) year timeframe being searched. The criminal background check must include statewide data. The statewide data must include South Carolina and any other state or states the worker has resided in within the prior ten years. Potential employees with felony convictions within the last ten (10) years cannot provide services to participants or work in an administrative/office position. Potential employees with non-violent felonies dating back ten (10) or more years can provide services to participants under the following circumstances;

    a. Participant/responsible party must be notified of the nurse's criminal background.

    b. Provider must obtain a written statement, signed by the Participant/responsible party acknowledging awareness of the nurse's criminal background and agreement to have the nurse provide care; this statement must be placed in the Participant record.

    Potential administrative/office employees with non-violent felony convictions dating back ten (10) or more years can work in the agency at the discretion of the Provider.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

PEDIATRIC MEDICAL DAY CARE

Hiring of employees with misdemeanor convictions will be at the discretion of the Provider.

11. The Provider must verify nurse licensure and license status at the State Board of Nursing website:

    http://www.llr.state.sc.us/pol.asp.

    A copy of the current license must be maintained in the employee's personnel file.

12. Provider will verify nurse licensure at time of employment and will ensure that the license remains active and in good standing at all times during employment. Provider must maintain a copy of the current license in the employee's personnel file. Nurse licensure can be verified at the State Board of nursing website.

    http://www.llr.state.sc.us/pol.asp

13. PPD Tuberculin Test

    Please refer to South Carolina Department of Health and Environmental Control (SCDHEC) website, Regulation 61-75 – Standards for Licensing page 11 of 36 section b. 1-6 for PPD Tuberculin test requirements.

    http://www.scdhec.gov/health/licen/hladcinfo.htm

    Providers needing additional information should contact the Tuberculosis Control Division, South Carolina Department of Health and Environmental Control, 1751 Calhoun Street, Columbia, SC 29201, phone (803) 898-0558.

14. All staff employed must hold Basic Life Support Certification, which includes Adult, Infant, and Child CPR with First Aid. Copies of the certification must be maintained at the p.m.

E. Administrative Requirements

1. The provider will maintain current licensure information in each employee's personnel file.

2. The provider shall ensure that key organization staff, including the administrator, is accessible during compliance review audits conducted by SCDHHS and/or its agents.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

PEDIATRIC MEDICAL DAY CARE

3. The provider must provide all necessary documentation, data and support, including witness testimony, if required, for the SCDHHS Appeals and Hearings process with respect to appeals of any action involving the Provider within the scope of this Contract.

4. The provider must incorporate in the operation procedures of the PMDC adequate safeguards to the health and safety of the participants in the event of a medical or other emergency.

5. The provider shall notify SCDHHS within three (3) business days in the event of a change in the administrator, the administrator's extended absence or a change in the provider's address, telephone or fax number.

6. SCDHHS shall be given a point of contact for the provider which has legal authority.

7. The provider must develop and maintain a Policy and Procedure Manual that describes how activities will be performed in accordance with the requirements of the Contract. The Policy and Procedure Manual shall be available during office hours and will be made available to SCDHHS upon request.

8. The provider will ensure that its office is staffed by qualified personnel during hours of operation. The provider must also have an emergency contact number for emergencies occurring outside of normal business hours. Participant and personnel records must be maintained at the address indicated in the Contract and must be made available, upon request, for review by SCDHHS or its designee.

9. The provider shall provide SCDHHS a list of regularly scheduled holidays for the coming calendar year each September. The provider is not required to furnish services on regularly scheduled holidays. The provider must not be closed for more than two (2) consecutive days, except when a holiday falls in conjunction with a weekend. In that case, the provider may be closed for not more than four (4) consecutive days.

10. The PMDC must be open Monday through Friday at least six (6) hours a day.

11. The provider shall conform to applicable federal, state, and local health and safety rules and regulations, and have an on-going program to prevent the spread of infectious diseases among its employees.

12. The provider must adhere to any other criteria as established by SCDHHS.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

MEDICAID HOME AND COMMUNITY-BASED WAIVER
SCOPE OF SERVICES
FOR
PERSONAL CARE I (PC I) SERVICES

A. Objectives

The objectives of PC I Services are to preserve a safe and sanitary home environment, assist participants with home care management duties and to provide needed supervision of Medicaid Home and Community-Based waiver participants.

B. Conditions of Participation

1. Agencies desiring to be a provider of PC I services must have demonstrated experience in providing home care management.

2. Agencies must have certified evidence of not less than $10,000.00 operating capital. This capital is required so that the provider agency has the capability to operate for a minimum of 60 days in the event Medicaid reimbursement is delayed or withheld for any reason. Certified evidence of operating capital includes, but is not limited to, a written statement from an officer of a financial institution or a certified accountant; a copy of your most recent bank statement must be included. Operating capital will be verified prior to initiating a contract and periodically during the contract period.

3. Pursuant to enactment and implementation of S.C. § Code 44-70-10 all providers of personal care services will require a license to provide personal care services. Providers who are not licensed by the South Carolina Department of Health and Environmental Control will not be allowed to enroll as a Medicaid provider for these services.

4. Provider agencies must be housed in an office that is in a commercial zone. Any agency not housed within a commercial location must be prior approved by SCDHHS to enroll as a personal care provider. Requirements for agencies not in commercial locations include all of the following:

   a. Has a county/municipal zoning permit to operate a business in a residential setting if required

   b. Holds appropriate business licenses

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PERSONAL CARE I

c. Meets applicable county/municipal, mixed-use zoning guidelines for a home-based business in a primarily residential neighborhood

d. Has a business entrance door which is separate from a residential living area.

e. Uses office space devoted entirely for the business; space must be enclosed and have a locking door which uses a different key from other locks in the home

f. Has an outside business sign conforming to county/municipal sign and zoning codes for its neighborhood

5. Providers must utilize the automated systems mandated by CLTC to document and bill for the provision of services.

6. Providers must accept or decline referrals from South Carolina Department of Health and Human Services (SCDHHS) or SCDDSN within two (2) working days. Failure to respond will result in the loss of the referral.

7. The provider must verify the participant's Medicaid eligibility when it accepts an authorization and monthly thereafter to ensure continued eligibility. Agencies can verify Medicaid eligibility for CLTC participants in the Phoenix Provider Portal on their dashboard. Providers should also refer to Section 1 of this provider manual for additional information on eligibility determination.

8. Providers may use paperless filing systems. Provider must obtain approval from CLTC Central Office prior to initiating electronic documentation and/or filing systems. Electronic records must be made available upon request, and providers must have a reliable back-up system in the event their computer system shuts down.

C. Description of Services To Be Provided

1. The Unit of Service is one (1) hour of direct services provided in the participant's residence for shopping, laundry services, other off-site services or escort services. The amount of time authorized does not include the aide's transportation time to and from the participant's residence.

2. The number of units and services provided to each participant are determined by the individual participant's needs as set forth in the participant's Service Plan/Authorization.

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PERSONAL CARE I

3. Under no circumstances will a PC I furnish any type of skilled medical service.

4. Services to be provided include:

   a. Meal planning and preparation:
      - Cleaning
      - Laundry
      - Shopping
      - Home safety
      - Errands
      - Escort services

   b. Limited assistance with financial matters, such as delivering payments to designated recipients on behalf of the participant. Receipts for payment should be returned to the participant.

   c. Assistance with communication which includes, but is not limited to, placing phone within participant's reach and physically assisting participant with use of the phone, and orientation to daily events.

   d. Observing and reporting on participant's condition.

D. Staffing

The provider must maintain individual records for all employees.

The provider must maintain all of the following (supervisory positions can be sub-contracted):

1. A supervisor who meets the following requirements:

   a. High school diploma or equivalent

   b. Capable of evaluating aides in terms of their ability to carry out assigned duties and their ability to relate to the participant

   c. Able to assume responsibility for in-service training for aides by individual instruction, group meetings, or workshops

2. Aides who meet the following minimum qualifications:

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

PERSONAL CARE I

a. Able to read, write and communicate effectively with participant and supervisor

b. Able to use the Care Call IVR system

c. Capable of following a care plan with minimal supervision

d. Be at least 18 years of age

e. Have documented record of having completed six (6) hours of training in the areas indicated in Section D.2.f, prior to providing services or documentation of personal, volunteer or paid experience in the care of adults, families and/or the disabled, home management, household duties, preparation of food, and be able to communicate observations verbally and in writing

f. Complete at least six (6) hours in-service training per calendar year in the following areas:

   i. Maintaining a safe, clean environment and utilizing proper infection control techniques;

   ii. Following written instructions;

   iii. Providing care including individual safety, laundry, meal planning, preparation and serving, and household management;

   iv. First aid;

   v. Ethics and interpersonal relationships;

   vi. Documenting services provided;

   vii. Home support:
   - Cleaning
   - Laundry
   - Shopping
   - Home safety
   - Errands

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- Observing and reporting the participant's condition

The annual six (6) hour requirement will be on a pro-rated basis during the aide's first year of employment.

3. Agency staff may be related to participants served by the agency within limits allowed by the South Carolina Family Caregiver Policy. The following family members cannot be a paid caregiver:

   a. The spouse of a Medicaid participant

   b. A parent of a minor Medicaid participant

   c. A step parent of a minor Medicaid participant

   d A foster parent of a minor Medicaid participant

   e. Any other legally responsible guardian of a Medicaid participant

   Family members who are primary caregivers will not be reimbursed for HASCI respite services. All other qualified family members can be reimbursed for their provision of PCI services.

4. PPD Tuberculin Test

   Please refer to Department of Health and Environmental Control (DHEC) website, Regulation 61-75 – Standards for Licensing page 11 of 36 section b. 1-6 for PPD Tuberculin test requirements.

   http://www.scdhec.gov/health/licen/hladcinfo.htm

   Providers needing additional information should contact the Tuberculosis Control Division, Department of Health and Environmental Control, 1751 Calhoun Street, Columbia, SC 29201, phone (803) 898-0558.

5. A criminal background check is required for all potential employees to include employees who will provide direct care to SCDHHS/SCDDSN participants and all administrative/office employees (office employees required to have background checks include: administrator, office manager, nurse supervisor, and persons named on organizational chart in management positions). All criminal background checks must include all data for the individual with no less than a ten (10) year timeframe being searched. The criminal background check must include statewide data. The statewide data must include South Carolina and any other state or states the worker has resided in within the prior ten years. Potential

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employees with felony convictions within the last ten (10) years cannot provide services to SCDHHS/SCDDSN participants or work in an administrative/office position. Potential employees with non-violent felonies dating back ten (10) or more years can provide services to SCDHHS/SCDDSN participants under the following circumstances:

- Notification of participant/responsible party of aide's criminal background
- Provider must obtain a written statement, signed by the participant/responsible party acknowledging awareness of the aide's criminal background and agreement to have the aide provide care; this statement must be placed in the participant record.

Potential administrative/office employees with non-violent felony convictions dating back ten (10) or more years can work in the agency at the discretion of the provider.

Hiring of employees with misdemeanor convictions will be at the discretion of the provider.

E. Conduct of Service

The provider must maintain documentation showing that it has complied with the requirements of this section.

1. The provider must obtain the Service Plan/Authorization from the Case Manager/Service Coordinator prior to the provision of services. The authorization will designate the amount, frequency and duration of service for participants in accordance with the participant's SCDHHS (CLTC) Service Plan/SCDDSN Authorization which will have been developed in consultation with the participant and others involved in the participant's care. The provider will receive new authorizations only when there is a change to the authorized service amount, frequency or duration. The provider must adhere to those duties which are specified in the SCDHHS (CLTC) Service Plan/SCDDSN Authorization in developing the Provider task list. This provider task list must be developed by the supervisor. If the provider identifies PC I duties that would be beneficial to the participant's care but are not specified in the SCDHHS (CLTC) Service Plan/SCDDSN Authorization, the Provider must contact the Case Manager/Service Coordinator to discuss the possibility of having these duties included in the SCDHHS (CLTC) Service Plan/SCDDSN Authorization. **Under no circumstances will any type of skilled medical service be performed by an aide.** The Case Manager/Service Coordinator will make the decision as to whether the SCDHHS (CLTC) Service Plan/DDSN Authorization should be amended to include the additional duty. This documentation will be maintained in the participant files.

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2. As part of the conduct of service, the supervisor of PC I services must:

   a. Provide an initial visit prior to the start of PC I services for the purpose of reviewing SCDHHS CLTC plan of care, developing a task list for the aide, **(this task list must be developed prior to the provision of any PC I services)**, giving the participant written information regarding advanced directives and informing participants of their right to complain about the quality of PC I services provided. The supervisor must give participants information about how to register a complaint. Complaints against aides must be investigated by the Provider and appropriate action taken. Documentation must be maintained in the participant and the aide's file.

   b. Provide on-site supervision at least once every 365 days for each participant and phone and/or on-site contact with the participant at least once every 120 days. Supervisors must make phone contacts or conduct on-site supervision more frequently if warranted by complaints or indications of substandard performance by the aide.

   c. Each supervisory visit, including the initial visit, must be documented in the participant's file and recorded in Care Call. The Supervisor's report of the on-site visits must include, at a minimum:

      i. Documentation that services are being delivered consistent with the SCDHHS CLTC Service Plan/SCDDSN Authorization

      ii. Documentation that the participant's needs are being met

      iii. Reference to any complaints which the participant or family member/responsible party has lodged:

         - A brief statement regarding any changes in the participant's service needs; and

         - Supervisor's original signature and date. Rubber signature stamps are not acceptable.

         - Documentation of all supervisory visits must be filed in the participant's record within thirty (30) days of the date of the visit.

   c. Supervisors must provide assistance to aides as necessary.

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e. Supervisors must be accessible by phone and/or beeper during any hours services are being provided under this contract. If the PC I supervisory position becomes vacant, SCDHHS must be notified no later than the next business day.

f. If there is a break in service which lasts more than sixty (60) days, the supervisor will be required to complete a new initial visit.

3. In addition, the provider must maintain an individual participant record that documents the following items:

a. Initiation of PC I services on the date negotiated with the Case Manager/Service Coordinator and indicated on the Medicaid Home and Community-Based waiver authorization. Services must not be provided prior to the authorized start date and must be provided according to the schedule as indicated on the SCDHHS CLTC Service Plan/SCDDSN Authorization.

b. Notification to the Case Manager/Service Coordinator within two (2) working days of the following participant changes:

i. Participant's condition has changed and the SCDHHS CLTC Service Plan/SCDDSN Authorization no longer meets participant's needs or the participant no longer appears to need PC I services.

ii. Participant dies, is institutionalized or moves out of the service area.

iii. Participant no longer wishes to participate in a program of PC I services.

iv. Knowledge of the participant's Medicaid ineligibility or potential ineligibility.

c. The provider will maintain a record keeping system that document:

i. **For SCDHHS participants:** The delivery of services in accordance with the SCDHHS CLTC Service Plan. The provider shall not ask the participant/responsible person to sign any log or task sheet. Task sheets must be reviewed, signed, with original signature (rubber signature stamps are not acceptable), and dated, every two (2) weeks by the supervisor. Task sheets must be filed in the participant’s file within thirty (30) days of service delivery.

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ii. **For SCDDSN participants:** The delivery of services and units provided in accordance with the service authorization. The provider will maintain daily logs reflecting the PCI services provided by the aides for the participants and the actual amount of time expended for the service. The daily logs must be initialed daily by the participant/family member and the aide, and must be signed weekly by the participant/family member and signed, with original signature (rubber signature stamps are not acceptable), and dated by the Supervisor at least once every two weeks. Daily logs must be filed in the participant's file within thirty (30) days of service delivery.

All documentation must be made available to SCDHHS/SCDDSN upon request.

d. **For SCDHHS participants only:** For all instances in which a participant did not receive an authorized daily service, providers must indicate on the Care Call web site the reason why the service was not delivered. The provider must do this both when the provider was unable to complete the visit and when the participant was not available to receive the visit. For each week in which there are missed visits, the provider must indicate the reason on the web site by the close of business the following week. A missed visit report is not required for SCDDSN participants.

e. Whenever two consecutive attempted visits occur, the local SCDHHS/SCDDSN office must be notified. An attempted visit is when the aide arrives at the home and is unable to provide the assigned tasks because the participant is not at home or refuses services.

F. Overview of Compliance Review Process

The Division of Long Term Care Waiver Management, Provider Compliance Department has developed this policy for clarification of the provider compliance process. The policy gives detailed information on how provider compliance sanctions are implemented. Provider reviews receive a score based on a sanctioning scale; review scores will determine if the provider will receive a sanction and if so, the level of the sanction. The sanction scoring process was developed to ensure that reviews are equitable and for providers to know what to expect when they are reviewed.

Following is a chart that outlines how reviews are scored:

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Sanction Level

- Provider compliance review questions in the Scope of Services are classified into three classes, based on (1) the significance of the question regarding to the services, and (2) the potential influences on providers and participants if the requirement was not met. See the example below:

Severity Level: 1=less serious, 2 = serious, 3 = very serious

Client Service Questions	Possible Answers	Severity Level
Was supervisory visit made within 30 days after PC II services initiated?	Y, N, NA	3
Was the initial supervisory visit documented in Care Call?	Y, N, NA	3
Does provider maintain individual client records?	Y, N	2
Did provider give participant written information regarding advanced directives?	Y, N, NA	1

There are five types of sanctions:

- Plan of Correction – This is the lowest sanction and indicates the provider is in substantial compliance with the contractual requirements. The provider will be required to submit a plan of correction outlining the deficiency (ies), the detailed plan to correct the deficiency and the effective date the plan will be implemented.

- 30-day suspension – At this level, new referrals are suspended for 30 days. The provider will also be required to submit a plan of correction. If the plan of correction is approved, the suspension is automatically lifted at the end of the 30-day period. If the corrective action plan is not approved, the Provider will be given an additional ten (10) business days to submit another corrective action plan for review and approval; the suspension will remain in place until an approved corrective action plan is received. If the second submitted corrective action plan is not approved, the provider contract will be terminated.

- 60-day suspension – At this level, new referrals are suspended for 60 days. The provider will also be required to submit a plan of correction. If the plan of correction

is approved, the suspension is automatically lifted at the end of the 60-day period. If the corrective action plan is not approved, the Provider will be given an additional ten (10) business days to submit another corrective action plan for review and approval; the suspension will remain in place until an approved corrective action plan is received. If the second submitted corrective action plan is not approved, the provider contract will be terminated.

- 90-day suspension – Indicates serious and widespread deficiencies, new referrals are suspended for 90 days. The 90-day suspension of new referrals will only be lifted after an acceptable plan of correction is received. If the corrective action plan is not approved, the Provider will be given an additional ten (10) business days to submit another corrective action plan for review and approval; the suspension will remain in place until an approved corrective action plan is received. If the second submitted corrective action plan is not approved, the provider contract will be terminated. In addition, an acceptable follow-up review visit may be conducted if warranted.

- Termination – Indicates a final review score of four hundred (400) or more points, very serious and widespread deficiencies, generally coupled with a history of bad reviews (3 consecutive reviews that receive suspension of new referrals).

Providers who have two (2) consecutive reviews that result in suspension of new referrals, will be terminated if the third consecutive review has a final score that would result in a suspension of new referrals (100 and above).

We have developed a system to score reviews based on the percentage of the identified deficiency and number of participants surveyed. Following is an outline of how reviews will be scored:

<u>Calculating process</u>

- The level of sanction will be decided based on the total score of the provider‘s current review and the provider’s review history, which is converted from the deficiency percentage.

- Every 5% deficiency counts for 1 point in each class; the total score comes from the total points from each level.

- Since each level has different severity, multiple points will be added on each class’s score. Final score = level 3 = unweighted points x 3 + level 2 = unweighted basic points x 2+ level 1 = unweighted points x 1

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Example:

Level	Deficiency percentage	Basic points	Final points
Level 1 (less serious)	28%	5	5x1=5
Level 2 (serious)	20%	4	4x2=8
Level3 (major)	35%	7	7x3=21
Final score			34

Based on the total score a sanction level is determined. If a provider has no deficiencies, they will not be subject to a sanction. Below is a chart that illustrates the sanction that will be imposed based on the final review score:

Score Scale & Sanction Level

Sanction Type	Final score	With Good History*
Correction Plans	0-99	0-149
30 Days Suspension	100-199	150-249
60 Days Suspension	200-299	250-349
90 Days Suspension	300-399	350-449
Termination	>400	>450

Good History is determined based on previous review scores. For example, if a provider's previous review had a total score of **50** and their current review has a score of **120**, the sanction for the current review will be corrective action rather than 30-day suspension based on the previous review score.

Scores are automatically calculated using a computer generated compliance review program.

Provider records will be reviewed periodically at the provider's office. Onsite visits are un-announced. If the reviewer (CLTC, Program Integrity or other government entity) arrives at the provider's office to conduct a survey and no one is there, the following sanctions will be imposed:

- First time – thirty (30) day suspension of new referrals
- Second time – ninety (90) day suspension of new referrals
- Third time – contract termination

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G. Administrative Requirements

1. The provider must inform SCDHHS of the Provider's organizational structure, including the provider personnel with authority and responsibility for employing qualified personnel, ensuring adequate staff education, in-service training, and employee evaluations. The provider shall notify SCDHHS within three (3) working days in the event of a change in or the extended absence of the personnel with the above listed authority.

2. The provider must provide SCDHHS with a written document showing the organization, administrative control and lines of authority for the delegation of responsibility down to the hands-on participant care level staff at contract implementation. The document should include an organizational chart including names of those currently in the positions. Revisions or modifications to this organizational document must be provided to SCDHHS. It is recommended that this document be readily accessible to all staff.

3. Administrative and supervisory functions shall not be delegated to another organization.

4. The provider shall acquire and maintain for the duration of the contract liability insurance and worker's compensation insurance as provided in Article IX, Section D of the Contract. The provider is required to list SCDHHS – CLTC as a Certificate Holder for informational purposes only on all insurance policies using the following address: Post Office Box 8206, Columbia, SC 29202-8206.

5. The provider will develop and maintain a Policy and Procedure Manual that describes how activities will be performed in accordance with the terms of the requirements of the contract. The Policy and Procedure Manual shall be available during office hours for the guidance of the governing body, personnel and will be made available to SCDHHS upon request.

6. The provider must comply with Article IX, Section Z of the Contract regarding safety precautions. The provider must also have an on-going infectious disease program to prevent the spread of infectious diseases among its employees.

7. The provider agency shall ensure that key agency staff are accessible in person, by telephone, or by beeper during compliance review audits conducted by SCDHHS and/or its agents.

8. The provider will ensure that its office is staffed by qualified personnel during the hours of 10:00 a.m. to 4:00 p.m., Monday through Friday. Outside of these hours, the Provider agency must be available by telephone during normal business hours,

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8:30 a.m. to 5:00 p.m., Monday through Friday. Failure to maintain an open and staffed office as indicated will result in sanctions as outlined in section F, last paragraph. The provider must also have a number for emergencies outside of normal business hours. Participant and personnel records must be maintained at the address indicated in the contract and must be made available, upon request, for review by SCDHHS.

9. The provider shall update holidays in Phoenix; the provider is not required to furnish services on those days. The PC I provider agency may not be closed for more than two (2) consecutive days except when a holiday falls in conjunction with a weekend. If a holiday falls in conjunction with a weekend, a PC I provider agency may be closed for not more than four (4) consecutive days.

10. The provider must have an effective written back-up service provision plan in place to ensure that the participant receives the PC I services as authorized. Whenever the provider determines that services cannot be provided as authorized, the Case Manager/Service Coordinator must be notified by telephone immediately.

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MEDICAID
SCOPE OF SERVICES
FOR
PERSONAL CARE II (PC II), HASCI ATTENDANT CARE,
HASCI RESPITE and MEDICALLY COMPLEX CHILDREN (MCC)
RESPITE SERVICES

A. Objectives

The objectives of the PC II/HASCI Attendant and HASCI Respite services are to restore, maintain, and promote the health status of Medicaid Home and Community-Based waiver participants through home support, medical monitoring, escort/transportation services, and assistance with activities of daily living**.**

FOR MCC Respite: Services may be provided in the home setting and/or natural environment.

B. Conditions of Participation

1. Agencies desiring to be a provider of PC II/HASCI Attendant and HASCI Respite services must have demonstrated experience in in-home personal care services or a similar service. For providers contracting after July 1, 2011, the owner or administrator of the agency must have at least three (3) years of administrative experience in the health care field. If the owner will also be the administrator, he/she is required to have at least three (3) years of administrative experience in the health care field.

2. Agencies must have certified evidence of not less than $10,000.00 operating capital. This capital is required so that the provider agency has the capability to operate for a minimum of 60 days in the event Medicaid reimbursement is delayed or withheld for any reason. Certified evidence of operating capital includes, but is not limited to, a written statement from an officer of a financial institution or a certified accountant; a copy of your most recent bank statement must be included. Operating capital will be verified prior to initiating a contract and periodically during the contract period.

3. Pursuant to enactment and implementation of S.C. § Code 44-70-10 all providers of personal care services will require a license to provide personal care services. Providers who are not licensed by the South Carolina Department of Health and Environmental Control will not be allowed to enroll as a Medicaid provider for these services.

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PERSONAL CARE II, HASCI ATTENDANT CARE, HASCI RESPITE, AND MEDICALLY COMPLEX CHILDREN (MCC) RESPITE SERVICES

4. Provider agencies must be housed in an office that is in a commercial zone. Any agency not housed within a commercial location must be prior approved by SCDHHS to enroll as a personal care provider. Requirements for agencies not in commercial locations include all of the following:

   a. Has a county/municipal zoning permit to operate a business in a residential setting if required

   b. Holds appropriate business licenses·

   c. Meets applicable county/municipal, mixed-use zoning guidelines for a home-based business in a primarily residential neighborhood

   d. Has a business entrance door which is separate from a residential living area

   e. Uses office space devoted entirely for the business; space must be enclosed and have a locking door which uses a different key from other locks in the home

   f. Has an outside business sign conforming to county/municipal sign and zoning codes for its neighborhood

   g. Providers who are out of compliance with these requirements will have thirty (30) days to come into compliance. Failure to do so will result in contract termination.

5. Agencies must utilize the automated systems mandated by South Carolina Department of Health and Human Services (SCDHHS) Community Long Term Care (CLTC) Division to document and bill for the provision of services.

6. Providers must accept or decline referrals from SCDHHS or South Carolina Department of Disabilities and Special Needs (SCDDSN) within two (2) working days. Failure to respond will result in the loss of the referral.

7. The provider must verify the participant's Medicaid eligibility when it accepts an authorization and monthly thereafter to ensure continued eligibility. Agencies can verify Medicaid eligibility for CLTC participants in the Phoenix Provider Portal on their dashboard. Providers should also refer to Section 1 of this provider manual for additional information on eligibility determination.

8. Providers may use paperless filing systems. Provider must obtain approval from CLTC Central Office prior to initiating electronic documentation and/or filing

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systems. Electronic records must be made available upon request, and providers must have a reliable back-up system in the event their computer system shuts down.

9. The provider must agree to use any Competency Test provided by CLTC.

C. Description of Services to be Provided

1. The unit of service is one (1) hour of direct PC II/HASCI Attendant care service/HASCI Respite provided in the participant's place of residence and/or natural environment for MCC participants. PC II/HASCI Attendant, and/or HASCI Respite may be provided in other locations when the participant's record documents the need and when prior approved by the Case Manager/Service Coordinator (CM/SC). Services are not allowed when the participant is in an institutional setting and/or ADHC setting. The amount of time authorized does not include provider transportation time to and from the participant. Services provided without a current, valid authorization are not reimbursable.

2. The number of units and services provided to each participant are dependent upon the individual participant's needs as set forth in the participant's Service Plan/Authorization. If it is determined that a participant requires more than one aide for lifting, transfers, etc., this must be prior approved by SCDHHS/SCDDSN.

3. When services are authorized for more than one SCDHHS/SCDDSN participant in the same home, the provider must document and deliver the total amount of hours authorized for each participant. For example if both participants are authorized for two (2) hours of PCII per day; the aide must provide a total of four (4) hours per day in the home or natural environment for MCC.

4. **Under no circumstances will any type of skilled medical service be performed by an aide.** HASCI Attendants and/or HASCI Respite caregivers may provide skilled services as authorized by the county DSN Board Service Coordinator. All skilled needs for HASCI services are determined by RN delegation.

5. Services to be provided include:

   a. Support for activities of daily living, e.g.,
      - eating
      - bathing (bed bath, bench shower, sink bath)
      - personal grooming including dressing
      - personal hygiene

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- provide skin care (applying lotion, oil, etc.)
- meal planning and preparation
- assisting participants in and out of bed
- repositioning participants as necessary
- assisting with ambulation
- toileting and maintaining continence

b. Home support, e.g.,
-cleaning
-laundry
-shopping
-home safety
-errands

c. Monitoring of the participant's condition e.g., the type of monitoring that would be done by a family member such as monitoring temperature, checking pulse rate and observation of respiratory rate.

d. Monitoring medication (for example, informing the participant that it is time to take medication as prescribed by his, or her, physician and as written directions on the box, or bottle, indicate). **The aide cannot administer the medicine**; however, this does not preclude the aide from handing the medicine container to the participant.

e. Escort services when necessary. Transportation may be provided when necessary and included in the participant's Service Plan/Authorization. The provision of transportation is optional and will depend on the provider's policy in this regard.

f. Strength and balance training.

D. Staffing

1. The provider must provide all of the following staff members; supervisory nurses may be provided through subcontracting arrangements:

   a. A registered nurse(s) (RN) or licensed practical nurse(s) (LPN) who meets the following requirements:

      i. Currently licensed by the S.C. State Board of Nursing

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PERSONAL CARE II, HASCI ATTENDANT CARE, HASCI RESPITE, AND MEDICALLY COMPLEX CHILDREN (MCC) RESPITE SERVICES

ii. Capable of evaluating the aide's competency in terms of his or her ability to carry out assigned duties and his/her ability to relate to the participant

iii. Able to assume responsibility for in-service training for aides by individual instruction, group meetings or workshops

iv. Must have had background and/or training on the complex treatment issues regarding the care of the head and spinal cord injured

v. Provider will verify nurse licensure at time of employment and will ensure that the license remains active and in good standing at all times during employment. Provider must maintain a copy of the current license in the employee's personnel file. Nurse licensure can be verified at the State Board of nursing website

http://www.llr.state.sc.us/pol.asp

b. Aides who meet the following minimum qualifications:

i. Able to read, write, and communicate effectively with participant and supervisor

ii. Able to use the Care Call IVR system

iii. Capable of assisting with the activities of daily living

iv. Capable of following a care plan with minimal supervision.

v. Have a valid driver's license if transporting participants. The provider must ensure the employee's license is valid while transporting any participants by verifying the official highway department driving record of the employed individual initially and every two (2) years during employment. Copies of the initial and subsequent driving records must be maintained in the employee's personnel file.

vi. Are at least 18 years of age

vii. Have passed competency testing or successfully completed a competency training and evaluation program performed by an RN

or LPN prior to providing services to Home and Community-Based waiver participants. The competency evaluation must contain all elements of the PC II services in the Description of Services listed above. The competency training should also include training on appropriate record keeping and ethics and interpersonal relationships.

If an LPN performs the competency evaluation, the LPN must be supervised by an RN and report all competency evaluation results to the RN supervisor. The LPN and the supervising RN, as a confirmation of the delegation of this responsibility, must sign and date the form. All signatures must be original, signature stamps are not acceptable.

Proof of the competency evaluation must be recorded and filed in the personnel record prior to the aide providing care to waiver participants. The Division of CLTC has developed a form called "Competency Evaluation Documentation" form which must be used to document the competency evaluation results. The CLTC form may be obtained from the CLTC Central Office or on our website at:

http://www1.scdhhs.gov/openpublic/insidedhhs/bureaus/BureauofLongTermCareServices/pc_2.asp

All aides including those who are Certified Nursing Assistant's (CNA), are required to complete the competency testing or training and evaluation outlined above.

viii. Have a minimum of ten (10) hours relevant in-service training per calendar year (The annual ten-hour requirement will be on a pro-rated basis during the aide's first year of employment). Documentation shall include topic, name and title of trainer, training objectives, outline of content, length of training, list of trainees, and location. This documentation will be maintained in an annual in-service manual for all employees. In addition, each staff member's personnel file must contain a summary of their in-service training for the year.

The summary must include the date of the training, the subject or title of the training and the total number of in-service hours earned. Topics for specific in-service training may be mandated by

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SCDHHS CLTC Division. In-service training may be furnished by the nurse supervisor while the aide is furnishing care to the participant. Additional training may be provided as deemed necessary by the Provider. All instructor- led and self- study training programs, not on the prior approved list must be approved for content and credit hours by SCDHHS prior to being offered. Self-study training hours may not exceed six of the ten in-service annual training hours. The Provider shall submit proposed programs not on the prior approved list to the SCDHHS CLTC Central Office at least forty-five (45) days prior to the planned implementation. All approved training topics are at the SCDHHS agency website:

http://www1.scdhhs.gov/openpublic/insidedhhs/bureaus/BureauofLongTermCareServices/pc_2.asp

ix. Aides must complete a training program in the following areas:

- Confidentiality, accountability and prevention of abuse and neglect
- Fire safety/disaster preparedness related to the specific location of services
- First aid for emergencies, monitoring medications, and basic recognition of medical problems
- Documentation and record keeping
- Ethics and interpersonal relationships
- Orientation to traumatic brain injury, spinal cord injury and similar disability
- Training in lifting and transfers

2. Agency staff may be related to participants served by the agency within limits allowed by the South Carolina Family Caregiver Policy. The following family members cannot be a paid caregiver:

   a. The spouse of a Medicaid participant;

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b. A parent of a minor Medicaid participant;

c. A step parent of a minor Medicaid participant;

d. A foster parent of a minor Medicaid participant;

e. Any other legally responsible guardian of a Medicaid participant

Family members who are primary caregivers will not be reimbursed for HASCI Respite and MCC Respite services. All other qualified family members can be reimbursed for their provision of PCI, PCII and HASCI Attendant Care.

3. PPD Tuberculin Test

Please refer to Department of Health and Environmental Control (DHEC) website, Regulation 61-75 – Standards for Licensing page 11 of 36 section b. 1-6 for PPD Tuberculin test requirements.

http://www.scdhec.gov/health/licen/hladcinfo.htm

Providers needing additional information should contact the Tuberculosis Control Division, Department of Health and Environmental Control, 1751 Calhoun Street, Columbia, SC 29201, phone (803) 898-0558.

4. Individual records must be maintained that document that each staff member has met all staffing requirements.

5. A criminal background check is required for all potential employees to include employees who will provide direct care to SCDHHS/SCDDSN participants and all administrative/office employees (office employees required to have background checks include: administrator, office manager, nurse supervisor, and persons named on organizational chart in management positions). All criminal background checks must include all data for the individual with no less than a ten (10) year timeframe being searched. The criminal background check must include statewide data. The statewide data must include South Carolina and any other state or states the worker has resided in within the prior ten years. Potential employees with felony convictions within the last ten (10) years cannot provide services to SCDHHS/SCDDSN participants or work in an administrative/office position. Potential employees with non-violent felonies dating back ten (10) or more years can provide services to SCDHHS/SCDDSN participants under the following circumstances:

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- Participant/responsible party must be notified of the aide's criminal background, i.e., felony conviction, and year of conviction;

- Provider must obtain a written statement, signed by the participant/responsible party acknowledging awareness of the aide's criminal background and agreement to have the aide provide care; this statement must be placed in the participant record.

Potential administrative/office employees with non-violent felony convictions dating back ten (10) or more years can work in the agency at the provider's discretion.

Hiring of employees with misdemeanor convictions will be at the provider's discretion. Employees hired prior to July 1, 2007 and continuously employed since then will not be required to have a criminal background check.

6. Providers will be required to check the CNA registry and the Office of Inspector General (OIG) exclusions list periodically for all staff. A copy of the search results page must be maintained in each employee's personnel file. Anyone appearing on either of these lists is not allowed to provide services to Waiver participants or participate in any Medicaid funded programs. The website addresses are listed below:

   CNA Registry - www.pearsonvue.com
   OIG Exclusions List - http://www.oig.hhs.gov/fraud/exclusions.asp

E. Conduct of Service

The provider must maintain documentation showing that it has complied with the requirements of this section.

1. The provider must obtain a Service Plan/Authorization for PCII/HASCI Attendant care, HASCI Respite or MCC Respite services from the CM/SC or CC. The authorization will designate the amount, frequency and duration of service for participants in accordance with the participant's Service Plan/Authorization. The provider must obtain an updated SCDHHS CLTC Service Plan from the case manager yearly. CLTC Service plans are updated in Phoenix and available on the provider's dashboard; the current and annual service plans must be printed and placed in the participant's record. The provider will receive new authorizations only when there is a change to the authorized service amount, frequency or duration. The provider must adhere to those duties which are specified in the Service Plan/SCDDSN/HASCI/MCC Authorization in developing the provider

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task list. This provider task list must be developed by an RN or LPN. If the provider identifies PC II/HASCI Attendant HASCI Respite, or MCC Respite service duties that would be beneficial to the participant's care but are not specified in the Service Plan/SCDDSN/HASCI/MCC Authorization, the provider must contact the CM/SC or CC to discuss the possibility of having these duties included in the Service Plan/SCDDSN/HASCI/MCC Authorization. The CM/SC or CC will make the decision as to whether the Service Plan/Authorization should be amended to include the additional service duty. This documentation will be maintained in the participant files. For CLTC, SCDDSN and MCC participants, no skilled services may be performed by an aide except as allowed by the Nurse Practice Act and prior approved by a licensed physician. For HASCI participants, skilled services may be performed if authorized by the Service Coordinator and overseen by RN or LPN delegation.

2. As part of the conduct of service, PC II/HASCI Attendant, HASCI Respite, and/or MCC Respite services must be provided under the supervision of an RN or LPN who meets the requirements as stated in this Scope and who will:

   a. Visit the participant’s home prior to the start of PC II/HASCI Attendant, HASCI Respite and/or MCC Respite services. This visit by the provider’s nurse must be recorded in Care Call from the participant’s home at the time of the visit and documented in the record. If the participant has already been receiving another similar service (i.e. personal care I) a new initial visit is required prior to the start date of personal care II service. The purpose of this visit is to:

      i. Review the Service Plan/Authorization and develop a task list for the aide. (This task list must be developed prior to the provision of PC II/HASCI Attendant, HASCI Respite or MCC Respite services.)

      ii. Give the participant written information regarding advanced directives; the participant is required to sign and date a statement that they have received this information; the nurse supervisor is also required to sign and date the statement.

      vii. Inform participants of their right to complain about the quality of PC II/HASCI Attendant, HASCI Respite or MCC Respite services provided; the participant is required to sign and date a statement that they have received this information; the nurse supervisor is also required to sign and date the statement.

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The nurse supervisor will give participants information about how to register a complaint. Complaints against aides must be investigated by the provider and appropriate action taken. Documentation must be maintained in the participant and aide's file.

b. Nurse supervisors and/or aides may not discuss services authorized by SCDHHS or SCDDSN with the participant. If participants of any waiver ask about either the level of service they are receiving or the different services offered in one of the waivers the nurse supervisor and/or aide must refer that participant back to their case manager/service coordinator for additional information.

c. Be accessible by phone and/or beeper during any hours services are being provided under this contract. If the nurse supervisor position becomes vacant, SCDHHS must be notified no later than the next business day.

d. Provide and document supervision of, training for, and evaluation of aides.

e. Make a supervisory visit to the participant's place of residence within thirty (30) days after the PC II/HASCI Attendant service is initiated.

f. After the thirty (30) day supervisory visit, make a supervisory visit to the participant's place of residence at least once every four months for each participant. Four (4) month supervisory visits must be conducted by the end of the fourth month. The aide must be present during at least one of the supervisory visits during each 12 month period. For the HASCI Attendant care service, all supervisory visits scheduled will be arranged in consultation with the DSN Board Service Coordinator and documented in the participant record. For SCDHHS/SCDDSN participants, supervisory visits, including the initial visit, must be documented in the participant record and recorded in Care Call, for CLTC only, from the participant's home at the time of the visit. In the event the participant is inaccessible during the time the supervisory visit would have normally been made, the visit must be completed within five (5) working days of the resumption of PC II/HASCI Attendant services. The supervisor's report of the on-site visits must include, at a minimum:

i. Documentation that services are being delivered consistent with the Service Plan/Authorization;

ii. Documentation that the participant's needs are being met;

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iii. Reference to any complaints which the participant or family member/responsible party has lodged;

iv. A brief statement regarding any changes in the participant's service needs; and,

v. Supervisor's original signature and date. Signature stamps are not acceptable.

g. Assist aides as necessary as they provide individual personal care services as outlined by the Service Plan/Authorization. Any supervision given must be documented in the individual participant's record.

3. Documentation of all supervisory visits must be filed in the participant's record within thirty (30) days of the date of visit.

Supervisory visits should be conducted as necessary if there are indications of substandard performance by the aide.

If there is a break in service which lasts more than sixty (60) days, the supervisor must complete a new initial visit when services are resumed. If the participant's condition changes enough to warrant a new service plan, the supervisor must update the task sheet to reflect the new duties.

4. The provider must maintain an individual participant record which documents the following:

a. The provider will initiate PC II/HASCI Attendant, HASCI Respite and/or MCC Respite services on the date negotiated with the CM/SC or CC and indicated on the Medicaid authorization. Services must not be provided prior to the authorized start date and must be provided according to the schedule as indicated on the Service Plan/Authorization.

b. The provider will notify the CM/SC or CC within two (2) working days of the following:

i. Participant's condition has changed and the Service Plan/Authorization no longer meets participant's needs or the participant no longer appears to need PC II/HASCI Attendant, HASCI Respite or MCC Respite services.

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ii. Participant is institutionalized, dies or moves out of the service area.

iii. Participant no longer wishes to receive PC II/HASCI Attendant, HASCI Respite or MCC Respite services.

iv. Knowledge of the participant's Medicaid ineligibility or potential ineligibility.

c. The provider will maintain a record keeping system which documents:

i. **For SCDHHS (CLTC) and MCC participants:** The delivery of services in accordance with the SCDHHS CLTC Service Plan. The provider shall not ask the participant/responsible party to sign any log or task sheet. The task sheet must be reviewed, signed, with original signature (signature stamps are not acceptable), and dated every two weeks by the supervisor. Task sheets must be filed in the participant's record within 30 days of service delivery.

Services provided by the personal care aide must also be documented in Care Call at check out.

ii. Task sheets/Daily logs can include multiple services on the same sheet as long as the services can be easily identified and tasks performed can be distinguished. For example if a participant receives PCII and PCI services, both can be documented on the same sheet as long as each service can be easily identified.

iii. **For SCDDSN participants:** The delivery of services and units provided must be in accordance with the Authorization. The provider will maintain daily logs reflecting the PCII/HASCI Attendant and/or HASCI Respite services provided by the aides for the participants and the actual amount of time expended for the service. The daily logs must be initialed daily by the participant or family member and the aide, and must be signed weekly by the participant or family member and signed with original signature (signature stamps are not acceptable), and dated by the supervisor at least once every two weeks. Daily logs must be filed in the participant's record within 30 days of service delivery. Daily logs must be made available to SCDHHS/SCDDSN upon request.

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iv. All active participant records must contain at least two (2) years of documentation to include task sheets, service plans, supervisory visit documentation, any complaints, etc. Per Medicaid policy all records must be retained for at least five (5) years. Active records must contain **all** authorizations.

d. **For SCDHHS (CLTC) and MCC participants:** For all instances in which a participant did not receive an authorized daily service, providers must indicate on the Care Call web site the reason why the service was not delivered. The provider must do this both when the provider was unable to complete the visit and when the participant was not available to receive the visit. For each week in which there are missed visits, the provider must indicate the reason on the web site by the close of business the following week. A missed visit report is not required for SCDDSN/HASCI/MCC participants.

e. Whenever two consecutive attempted or missed visits occur, the local SCDHHS/SCDDSN office must be notified. An attempted visit is when the aide arrives at the home and is unable to provide the assigned tasks because the participant is not at home or refuses services. A missed visit is when the provider is unable to provide the authorized service. These instances must be documented in the participant record as well as in Care Call.

5. Providers must adhere to all Care Call and Phoenix policies and procedures as indicated in the Phoenix IVR Provider User Guidelines, which can be obtained from the Phoenix Provider portal (https://providers.phoenix.scdhhs.gov) in the Help section.

F. Children's Personal Care Requirements

The requirements listed in this section are in addition to the requirements as listed in this scope for PCII services. Children's PC services are reimbursable when the following conditions are met:

1. Child is under age 21

2. Provided in the participant's place of residence

3. Authorized by SCDHHS/SCDDSN

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The CM/SC will determine the need for personal care services and develop a service plan that outlines the child's needs. This service plan will only be updated as needed.

Children's Personal Care services must be supervised by a Registered Nurse (RN).

G. Compliance Review Process

The SCDHHS Division of Long Term Care Waiver Management, Provider Compliance Department has developed this policy for clarification of the provider compliance process. The policy gives detailed information on how provider compliance sanctions are implemented. Provider reviews receive a score based on a sanctioning scale; review scores will determine if the provider will receive a sanction and if so, the level of the sanction. The sanction scoring process was developed to ensure that reviews are equitable and for providers to know what to expect when they are reviewed.

The following chart outlines how reviews are scored:

Sanction Level

- Provider compliance review questions in the Scope of Services are classified into three classes, based on (1) the significance of the question regarding to the services, and (2) the potential influences on providers and participants if the requirement was not met. See the example below:

Severity Level: 1=less serious, 2 = serious, 3 = very serious

Client Service Questions	Possible Answers	Severity Level
Was supervisory visit made within 30 days after PC II services initiated?	Y, N, NA	3
Was the initial supervisory visit documented in Care Call?	Y, N, NA	3
Does provider maintain individual client records?	Y, N	2
Did provider give participant written information regarding advanced directives?	Y, N, NA	1

There are five types of sanctions:

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- Plan of Correction – This is the lowest sanction and indicates the provider is in substantial compliance with the contractual requirements. The provider will be required to submit a plan of correction outlining the deficiency (ies), the detailed plan to correct the deficiency and the effective date the plan will be implemented.

- 30-day suspension – At this level, new referrals are suspended for thirty (30) days. The provider will also be required to submit a plan of correction. If the plan of correction is approved, the suspension is automatically lifted at the end of the 30-day period. If the corrective action plan is not approved, the Provider will be given an additional ten (10) business days to submit another corrective action plan for review and approval; the suspension will remain in place until an approved corrective action plan is received. If the second submitted corrective action plan is not approved, the provider contract will be terminated.

- 60-day suspension – At this level, new referrals are suspended for sixty (60) days. The provider will also be required to submit a plan of correction. If the plan of correction is approved, the suspension is automatically lifted at the end of the 60-day period. If the corrective action plan is not approved, the Provider will be given an additional ten (10) business days to submit another corrective action plan for review and approval; the suspension will remain in place until an approved corrective action plan is received. If the second submitted corrective action plan is not approved, the provider contract will be terminated.

- 90-day suspension – Indicates serious and widespread deficiencies, new referrals are suspended for ninety (90) days. The 90-day suspension of new referrals will only be lifted after an acceptable plan of correction is received. If the corrective action plan is not approved, the Provider will be given an additional ten (10) business days to submit another corrective action plan for review and approval; the suspension will remain in place until an approved corrective action plan is received. If the second submitted corrective action plan is not approved, the provider contract will be terminated. In addition, an acceptable follow-up review visit may be conducted if warranted.

- Termination – Indicates a final review score of four hundred (400) or more points, very serious and widespread deficiencies, generally coupled with a history of bad reviews three (3) consecutive reviews that receive suspension of new referrals)

Providers who have two (2) consecutive reviews that result in suspension of new referrals, will be terminated if the third consecutive review has a final score that would result in a suspension of new referrals (100 and above).

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We have developed a system to score reviews based on the percentage of the identified deficiency and number of participants surveyed. Following is an outline of how reviews will be scored:

Calculating process

- The level of sanction will be decided based on the total score of the provider's current review and the provider's review history, which is converted from the deficiency percentage.

- Every 5% deficiency counts for 1 point in each class; the total score comes from the total points from each level.

- Since each level has different severity, multiple points will be added on each class's score. Final score = level 3 = unweighted points x 3 + level 2 = unweighted basic points x 2+ level 1 = unweighted points x 1

Example:

Level	Deficiency percentage	Basic points	Final points
Level 1 (less serious)	28%	5	5x1=5
Level 2 (serious)	20%	4	4x2=8
Level 3 (major)	35%	7	7x3=21
Final Score			34

Based on the total score a sanction level is determined. If a provider has no deficiencies, they will not be subject to a sanction. Below is a chart that illustrates the sanction that will be imposed based on the final review score:

Score Scale & Sanction Level

Sanction Type	Final score	With Good History*
Correction Plans	0-99	0-149
30 Days Suspension	100-199	150-249
60 Days Suspension	200-299	250-349
90 Days Suspension	300-399	350-449
Termination	>400	>450

Good History is determined based on previous review scores. For example, if a provider's previous review had a total score of **50** and their current review has a score of **120**, the sanction for the current review will be corrective action rather than 30-day suspension based on the previous review score.

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Scores are automatically calculated using a computer generated compliance review program.

Provider records will be reviewed periodically at the provider's office. Onsite visits are un-announced. If the reviewer (CLTC, Program Integrity or other government entity) arrives at the provider's office to conduct a survey and no one is there, the following sanctions will be imposed:

- First time – thirty (30) day suspension of new referrals
- Second time – ninety (90) day suspension of new referrals
- Third time – contract termination

G. Administrative Requirements

1. The provider must inform SCDHHS of the provider's organizational structure including the Provider personnel with authority and responsibility for employing qualified personnel, ensuring adequate staff education, in-service training and employee evaluations. The provider agency shall notify SCDHHS within three (3) working days in the event of a change in the agency administrator, address, phone number or an extended absence of the agency administrator.

2. The provider must provide SCDHHS with a written document showing the organization, administrative control and lines of authority for the delegation of responsibility down to the hands-on participant care level staff at contract implementation. The document should include an organizational chart including names of those currently in the positions. Revisions or modifications to this organizational document must be provided to SCDHHS. It is recommended that this document be readily accessible to all staff.

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

4. The provider agency shall acquire and maintain for the duration of the contract liability insurance and worker's compensation insurance as provided in Article IX, Section D of the Contract. The provider is required to list SCDHHS – CLTC as a Certificate Holder for informational purposes only on all insurance policies using the following address: Post Office Box 8206, Columbia, SC 29202-8206.

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PERSONAL CARE II, HASCI ATTENDANT CARE, HASCI RESPITE, AND MEDICALLY COMPLEX CHILDREN (MCC) RESPITE SERVICES

5. The provider will develop and maintain a Policy and Procedure Manual that describes how activities will be performed in accordance with the terms of the requirements of the contract. The Policy and Procedure Manual shall be available during office hours for the guidance of the governing body and personnel and will be made available to SCDHHS upon request.

6. The provider must comply with Article IX, Section Z of the Contract regarding safety precautions. The provider must also have an on-going infectious disease program to prevent the spread of infectious diseases among its employees.

7. The provider shall ensure that key agency staff is accessible in person, by phone, or by beeper during compliance review audits conducted by SCDHHS and/or its agents.

8. The provider will ensure that its office is open and staffed by qualified personnel during the hours of 10:00 a.m. to 4:00 p.m., Monday through Friday. Outside of these hours, the Provider agency must be available by telephone during normal business hours, 8:30 a.m. to 5:00 p.m., Monday through Friday. Failure to maintain an open and staffed office as indicated will result in sanctions as outlined in section G, last paragraph. The provider must also have a number for emergencies outside of normal business hours. Participant and personnel records must be maintained at the address indicated in the contract and must be made available, upon request, for review by SCDHHS.

9. The provider must have an effective written back-up service provision plan in place to ensure that the participant receives the PC II/HASCI Attendant services as authorized. Whenever the provider determines that services cannot be provided as authorized, the CM/SC must be notified by telephone immediately.

10. The provider shall update holidays in Phoenix; the provider is not required to furnish services on those days. The PC II/HASCI Attendant, HASCI Respite and/or MCC Respite provider agency must not be closed for more than two (2) consecutive days at a time, except when a holiday falls in conjunction with a weekend. If a holiday falls in conjunction with a weekend, a PC II/HASCI Attendant, HASCI Respite and/or MCC Respite provider agency may be closed for not more than four (4) consecutive days.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

MEDICAID HOME AND COMMUNITY-BASED WAIVER SCOPE OF SERVICES FOR PERSONAL EMERGENCY RESPONSE (PERS) SERVICES

A. Objectives

The objective of Personal Emergency Response Service (PERS) is to provide Medicaid Home and Community-Based waiver Participants with twenty-four (24) hour monitoring and live telephone contact in case of emergency or urgent concern. The service must provide the ability to initiate alerts for safety and emergencies both automatically and manually twenty-four (24) hours per day.

B. Conditions of Participation

1. Provider must have a unit that meets the following requirements:

   a. FCC Part 68 – telecom terminal equipment approval

   b. UL (Underwriters Laboratories) and/or ETL (Equipment Testing Laboratories) approved as a "health care signaling product

   c. The product has to be registered with the FDA as a medical device under the classification "powered environments control signaling product"

2. The unit must have three components:

   a. A small radio transmitter (a help button carried or worn by the user)

   b. A console when emergency help (medical, fire, or police) is needed

   c. Emergency Response Center to determine the nature of the calls

3. Providers must utilize the automated systems mandated by SCDHHS to document and bill for the provision of services.

4. Provider must accept or decline referrals from Community Long Term Care (CLTC) or South Carolina Department of Disabilities and Special Needs (SCDDSN) within two (2) working days. Failure to respond will result in the loss of the referral.

5. The provider must verify the participant's Medicaid eligibility when it accepts an authorization and monthly thereafter to ensure continued eligibility. Agencies can verify Medicaid eligibility for CLTC participants in the Phoenix Provider Portal

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PERSONAL EMERGENCY RESPONSE SERVICES (PERS)

on their dashboard. Providers should also refer to Section 1 of this provider manual for additional information on eligibility determination.

6. Provider may use paperless filing systems Provider must obtain approval from CLTC Central Office prior to initiating electronic documentation and/or filing systems. Electronic records must be made available upon request, and Provider must have a reliable back-up system in the event its computer system shuts down.

7. Provider must have qualified technicians for the installation of the PERS units, as explained in Section D.4 hereof.

8. Provider must have at least one (1) year of experience or otherwise demonstrated competency in the provision of the PERS service.

C. Description of Services to Be Provided

When emergency help is needed, the PERS user presses the transmitter help button. It sends a radio signal to the console. The console automatically dials one or more pre-selected emergency telephone numbers. The system must be able to dial even if the telephone is off the hook or in use. The PERS unit should be programmed to telephone the response center where the caller is identified. The center will determine the nature of the emergency and contact the appropriate person. The contact will include calling a primary and back-up number in emergency cases. Within two (2) working days, the Provider shall report through the Phoenix System operated by CLTC all contacts made to the Participant indicating the nature of the contact.

Reimbursement for the PERS service includes a one-time installation and monthly monitoring. These reimbursements are inclusive of all equipment installation, and training on its use and care while the equipment is in the Participant's home. These reimbursements also include all, visits or calls made to the home to follow up with Participants and/or caregivers, telephone calls made that are necessary while the Participant is receiving the PERS service and equipment removal when the service is no longer authorized for the Participant.

The Provider shall provide the PERS service seven (7) days per week for all authorized time periods.

D. Staffing

1. The Response center staff must be able to monitor the PERS unit twenty-four (24) hours a day, seven (7) days a week.

2. Response center staff must be trained to perform duties related to monitoring the PERS unit.

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PERSONAL EMERGENCY RESPONSE SERVICES (PERS)

3. Response center staff must be able to test the PERS unit in the home monthly.

4. Technicians that install equipment must meet the following requirements:

   a. Qualified as a technician to install PERS equipment.

   b. Capable of evaluating whether or not the equipment is functioning properly.

   c. Able to assume responsibility for training Participants and/or caregivers in the use of PERS equipment.

5. A criminal background check is required for all potential employees including technicians, response center staff and administrative/office employees (office employees required to have background checks include: administrator, office manager, supervisor, and persons named on organizational chart in management positions). All criminal background checks must include all data for the individual with not less than a ten (10) year search. The criminal background check must include statewide (South Carolina) data. The statewide data must include South Carolina and any other state or states the worker has resided in within the prior ten years. Potential employees with felony convictions within the last ten (10) years cannot provide services to Participants or work in an administrative/office position.

   Potential employees with non-violent felony convictions dating back ten (10) or more years can work at the Provider's discretion.

   Hiring of employees with misdemeanor convictions shall be at the Provider's discretion.

6. Personnel folders: Individual records shall be maintained to document that each member of the staff has met the above requirements.

E. Conduct of Service

The Provider must maintain documentation showing that it has complied with the requirements of this section.

The Provider must obtain the authorization from the case manager/service coordinator (CM/SC) prior to the provision of services. The authorization will designate the amount, frequency and duration of service for Participants in accordance with the Participant's CLTC/SCDDSN Authorization which will have been developed in consultation with the

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PERSONAL EMERGENCY RESPONSE SERVICES (PERS)

Participant and others involved in the Participant's care.

Participants and/or caregivers shall choose among qualified providers of the PERS service, once Provider has been chosen by the Participant and/or caregiver, the PERS provider shall receive a referral that will have information on the condition of the Participant. PERS providers must accept or decline referrals from SCDHHS within two (2) working days. Failure to respond shall result in the loss of the referral.

The Provider shall initiate PERS services on the date negotiated with the CM/SC and indicated on the Medicaid Home and Community-Based waiver service authorization. The CM/SC must be notified if services are not initiated on that date. Services provided prior to the service authorization date are not reimbursable.

The CM/SC shall notify the provider immediately if services to a Participant are to be terminated. However, the Provider should refer to the language in the CLTC Services Provider Manual in Section 1, General Information and Administration, regarding the Provider's responsibility in checking the Participant's Medicaid eligibility status.

The Provider must maintain an individual Participant record which documents the following items:

1. The Provider will initiate PERS on the date negotiated with the CM/SC and indicated on the Medicaid authorization. Services must not be provided prior to the authorized start date and must be provided according to the schedule as indicated on the authorization.

2. **For SCDDSN:** The Provider must document all contacts made to the Participant. This documentation must include the nature of the contact, all actions taken and the outcome. Documentation of the contact must be filed in the participant’s record within two (2) working days of the contact.

3. **For CLTC:** The Provider must report through Phoenix all contacts made to the Participant indicating the nature of the contact, the action taken and the outcome within two (2) working days.

4. The Provider will notify the CM/SC within two (2) working days of the following:

    a. Participant is institutionalized, dies or moves out of the service area.

    b. Participant no longer wishes to receive PERS services.

    c. Knowledge of the Participant's Medicaid ineligibility or potential ineligibility.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

PERSONAL EMERGENCY RESPONSE SERVICES (PERS)

d. All active Participant records must contain the lesser of two (2) years or the complete record of documentation to include authorizations, documentation of PERS installation, monitoring records, any complaints, etc. All records must be retained for at least five (5) years. Records must contain **all** authorizations in the Participant's active record.

F. Administrative Requirements

1. The Provider must inform SCDHHS of the Provider's organizational structure, including the Provider personnel with authority and responsibility for employing qualified personnel, ensuring adequate staff education, and employee evaluations. The Provider shall notify SCDHHS within three (3) working days in the event of a change in or the extended absence of the personnel with the above listed authority.

2. The Provider must provide SCDHHS with a written document showing the organization, administrative control and lines of authority for the delegation of responsibility down to the technical staff at contract implementation. The document should include an organizational chart including names of those currently in the positions. Revisions or modifications to this organizational document must be provided to SCDHHS. It is recommended that this document be readily accessible to all staff.

3. Administrative and supervisory functions shall not be delegated to another organization.

4. The Provider shall acquire and maintain for the duration of the contract liability insurance as provided in Article IX, Section D of the Contract. The Provider is required to list SCDHHS – CLTC as a Certificate Holder for informational purposes only on all insurance policies using the following address: Post Office Box 8206, Columbia, SC 29202-8206.

5. The Provider will develop and maintain a Policy and Procedure Manual that describes how activities will be performed in accordance with the terms of the requirements of the contract. The Policy and Procedure Manual shall be available during office hours for the guidance of the governing body, personnel and will be made available to SCDHHS upon request.

6. The Provider agency shall ensure that key agency staff are accessible during compliance review audits conducted by SCDHHS and/or its agents.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

MEDICAID
THE SCOPE OF SERVICES
FOR
RESIDENTIAL PERSONAL CARE II

A. Objectives

The objective of the Residential Personal Care II (RPC II) services are to restore, maintain, and promote the health status of Medicaid Home and Community Based waiver participants who choose to transition from their homes into the residential facilities or for individuals who wish to remain in the community residential care facilities and meet the intermediate nursing home level of care.

B. Conditions of Participation

1. The Provider of RPC II services in a CRCF must meet all SCDHEC standards for licensure and must comply with all requirements of this Scope of Services.

2. The Provider must have demonstrated experience in personal care services. The Provider's administrator must have at least three (3) years of administrative experience in the health care field.

3. The Provider shall accept or decline referrals from Community Long Term Care (CLTC) within two (2) working days. Failure to respond within this timeframe will result in the loss of the referral.

4. The Provider will be responsible for verifying the Participant's Medicaid eligibility when it has accepted a referral and monthly thereafter to ensure continued eligibility. The Provider shall refer to the OSS Provider Manual for instructions on how to verify Medicaid eligibility.

5. The Provider shall not be at risk of classification as a Resident Case Mix. The OSCAP facility that is licensed for more than sixteen (16) beds or is part of a larger entity that exceeds sixteen (16) beds shall not admit or maintain a census of more than 45% of residents whose current need for placement as determined by SCDHHS is due to a mental illness. The policies and procedures outlining the process for determining the CRCF's risk for resident case mix are located in the OSS Provider Manual.

6. The Provider shall utilize the automated systems mandated by SCDHHS CLTC Division to document and bill for the provision of services.

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7. The Provider may use paperless filing systems. When using electronic filing systems any documentation requiring signatures must be signed prior to scanning. Electronic records must be made available upon request, and providers must have a reliable back-up system in the event their computer system shuts down.

8. The Provider shall submit upon execution of the Contract and as requested by SCDHHS thereafter evidence of working capital that will show that the Provider has the capability to operate for a minimum of sixty (60) days in the event Medicaid reimbursement is delayed or withheld for any reason. This evidence shall be a certified written statement from an officer of a financial institution or a certified accountant.

   The minimum working capital levels are:

   - 4-10 Beds – $2,500
   - 11-25 Beds – $5,000
   - 26 and above – $10,000

C. Description of Services to be provided

1. The Provider shall ensure that the facility meet specific basic requirements of the Americans with Disabilities Act, as outlined in the OSS Provider Manual (as amended).

2. The unit of service will be a patient day which is defined as a twenty-four (24) hour period, including the day of admission and excluding the day of discharge. The per diem rate will include all those items and supplies associated with patient care, except prescribed drugs and personal items. These items cannot be billed to Medicaid.

3. The number of units and services provided to each Participant are dependent upon the individual Participant's needs as set forth in the Participant's Service Plan.

4. Under no circumstances will any type of skilled medical service be performed in a CRCF.

5. Services to be provided in a CRCF include:

   a. Support for activities of daily living which include:
      - Eating
      - Bathing (bed bath, bench shower, sink bath)

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- Personal grooming including dressing
- Personal hygiene
- Provide necessary skin care
- Assisting participants in and out of bed
- Repositioning participants as necessary
- Assisting with ambulation
- Toileting and maintaining continence

b. Monitoring of the Participant's condition, *e.g.*, the type of monitoring that would be done by a family member such as monitoring temperature, checking pulse rate, observation of respiratory rate, and blood pressure.

D. Staffing

1. The Provider shall maintain staffing accordance with the OSS Provider Manual.

2. The Provider's staff may have a familiar relationship to a participant served by the Provider within limits allowed by the South Carolina Family Caregiver Policy. The following family members cannot be a paid caregiver:

   a. The spouse of a Medicaid participant;

   b. A parent of a minor Medicaid participant;

   c. A step parent of a minor Medicaid participant;

   d. A foster parent of a minor Medicaid participant;

   e. Any other legally responsible guardian of a Medicaid participant.

3. PPD Tuberculin Test

   Please refer to Department of Health and Environmental Control (DHEC) website, Regulation 61-84 – Standards for Licensing page 11 of 36 section b. 1-6 for PPD Tuberculin test requirements.

   http://www.scdhec.gov/health/licen/hladcinfo.htm

   Providers needing additional information should contact the Tuberculosis Control Division, Department of Health and Environmental Control, 1751 Calhoun Street, Columbia, SC 29201, phone (803) 898-0558.

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4. Individual records must be maintained that document that each staff member has met all staffing requirements.

5. A criminal background check is required for all potential employees to include employees who will provide direct care to SCDHHS participants and all administrative/office employees (office employees required to have background checks include: administrator, office manager, nurse supervisor, and persons named on organizational chart in management positions). All criminal background checks must include all data for the individual with no limit on the timeframe being searched. Criminal background checks that cover a specific time period such as seven or ten year searches are not acceptable. The criminal background check must include statewide (South Carolina) data. Potential employees with felony convictions within the last ten (10) years cannot provide services to SCDHHS/SCDDSN participants or work in an administrative/office position. Potential employees with non-violent felonies dating back ten (10) or more years can provide services to SCDHHS/SCDDSN participants under the following circumstances:

   a. Participant/responsible party must be notified of the aide's criminal background, i.e. felony conviction, and year of conviction;

   b. Provider must obtain a written statement, signed by the participant/responsible party acknowledging awareness of the aide's criminal background and agreement to have the aide provide care; this statement must be placed in the participant record.

   Potential administrative/office employees with non-violent felony convictions dating back ten (10) or more years can work in the agency at the provider's discretion.

   Hiring of employees with misdemeanor convictions will be at the provider's discretion. Employees hired prior to July 1, 2007 and continuously employed since then will not be required to have a criminal background check.

6. Providers will be required to check the CNA registry and the Office of Inspector General (OIG) exclusions list periodically for all staff. A copy of the search results page must be maintained in each employee's personnel file. Anyone appearing on either of these lists is not allowed to provide services to Waiver participants or participate in any Medicaid funded programs. The website addresses are listed below:

   CNA Registry - www.pearsonvue.com

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RESIDENTIAL PERSONAL CARE II

OIG Exclusions List - http://www.oig.hhs.gov/fraud/exclusions.asp

E. Conduct of Service

The Provider must maintain documentation showing that it has complied with the requirements of this section.

1. The Provider must obtain a Service Plan for RPC II services from the CM. The authorization will designate the amount, frequency and duration of service for Participants in accordance with the Participant's Service Plan. The Provider must obtain an updated SCDHHS CLTC Service Plan from the case manager yearly. The Provider will receive new authorizations only when there is a change to the authorized service amount, frequency or duration. The Provider must adhere to those duties which are specified in the Service Plan in developing the provider task list. This provider task list must be developed by an RN or LPN. No direct care staff or nurse will perform any job/task related to OSCAP 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, the Bureau of Long Term Care Certification, and the Attorney General office

2. As part of the conduct of service, the PRC II services must be under the supervision of an RN or LPN who meets the requirements as stated in the scope of services and who will:

   a. Develop an Individual Care Plan (ICP) for each Participant receiving OSCAP services. The ICP for current Participants will be updated to reflect the Participant's status in OSCAP. The ICP is to be developed with participation by the Participant, administrator (or designee), the responsible party when appropriate, and the facility's nurse within seven (7) days of admission or within seven (7) days of the change to OSCAP.

      i. The initial ICP will be developed utilizing information from the SCDHHS nurse's assessment and Service Plan, along with any other relevant Participant information obtained from the Provider's staff, the Participant, and if appropriate, the party responsible for the Participant. The ICP is to direct the services provided to the Participant and the resident care log.

      ii. The ICP must be reviewed by the Participant, facility administrator, and responsible party, when appropriate, every six (6) months or after being reviewed and/or revised by the facility's

nurse. The ICP must be signed and dated by the Participant, facility administrator, responsible party when appropriate, and the facility's Nurse. The revisions signed and dated by the CRCF registered nurse must be maintained in the resident's record.

iii. All ICP's must be maintained in the Participant's permanent record, and should be available for a SCDHHS representative to review upon request.

b. Not discuss services authorized by SCDHHS with the Participant. If Participants of any waiver ask about either the level of service they are receiving or the different services offered in one of the waivers, the nurse supervisor and/or aide must refer that Participant back to their CM for additional information.

c. Be accessible by telephone during any hours services are being provided under this Contract.

d. Provide and document supervision of, training for, and evaluation of aides.

e. Assist aides as necessary as they provide individual personal care services as outlined by the Service Plan. Any supervision given must be documented in the individual Participant's record.

3. If the nurse supervisor position becomes vacant, SCDHHS must be notified no later than the ten (10) business day**.**

4. Documentation of all supervision must be filed in the Participant's record within thirty (30) days of the date of the contact.

Supervisory contacts should be conducted as necessary if there are indications of substandard performance by the aide.

If there is a break in service which lasts more than sixty (60) days, the supervisor must develop a new IPC when services are resumed. If the participant's condition changes enough to warrant a new service plan, the supervisor must update the task sheet to reflect the new duties.

5. The Provider must maintain an individual Participant record which documents the following:

a. The Provider will initiate RPC II services on the date negotiated with the CM and indicated on the Medicaid authorization. Services must not be provided prior to the authorized start date and must be provided according

to the schedule as indicated on the Service Plan

b. The Provider will notify the CM within two (2) working days of the following:

i. If Participant's condition has changed and the Service Plan/Authorization no longer meets Participant's needs or the Participant no longer appears to need – RPC II

ii. If Participant is institutionalized, dies or moves out of the service area

iii. If Participant no longer wishes to receive RPC II

iv. Knowledge of the Participant's Medicaid ineligibility or potential ineligibility

c. The Provider will maintain a record keeping system which documents the delivery of services in accordance with the Service Plan. The Provider shall not ask the Participant/responsible party to sign any log or task sheet. The task sheet must be reviewed, signed, with original signature (signature stamps are not acceptable), and dated every two weeks by the supervisor. Task sheets must be filed in the Participant's record within 30 days of service delivery.

d. For all instances in which a Participant did not receive an authorized daily service, the Provider must indicate on the Care Call web site the reason why the service was not delivered. The Provider must do this both when the Provider was unable to complete the visit and when the Participant was not available to receive the visit. For each week in which there are missed visits, the Provider must indicate the reason on the web site by the close of business the following week.

e. Whenever two consecutive attempted or missed visits occur, the local SCDHHS office must be notified. An attempted visit is when the aide is unable to provide the assigned tasks because the participant is not at the facility or refuses services. A missed visit is when the Provider is unable to provide the authorized service. These instances must be documented in the participant record as well as in Care Call.

5. Providers must adhere to all Care Call and Phoenix policies and procedures as indicated in the Phoenix IVR Provider User Guidelines, which can be obtained from

the Phoenix Provider portal (https://providers.phoenix.scdhhs.gov) in the Help section.

F. Compliance Review Process

The compliance review and sanction scoring process is located in the OSS Provider Manual (as amended) and is designed to ensure that reviews are fair and the Provider know what to expect when reviewed.

SCDHHS reserves the right to perform on-site compliance reviews during normal business hours. The Provider must permit SCDHHS staff to conduct unannounced on-site inspections of any and all of Provider's locations. At the sole discretion of SCDHHS, reviews may be conducted at any time. Failing to permit access for on-site visits may result in termination of the OSCAP Contract.

Sanctions

SCDHHS may use three types of sanctions under this Contract:

- Corrective Action Plan (CAP) – The Provider who is in substantial compliance with the Contract but has some minor compliance issues may be required to submit a corrective action plan within thirty (30) days of notice of the deficiencies detailing how and when deficiencies will be corrected (or have been corrected) and how the Provider will avoid future deficiencies. If the Provider fails to submit the CAP within thirty (30) days, the Provider may be subject to suspension as provided herein. This sanction will be imposed until the Provider develops and adheres to a corrective action plan to adequately address any concerns.

- Suspension – SCDHHS may suspend the Provider for moderate deficiencies, failure to submit a required CAP within thirty (30) days, or failure to comply with the Contract. SCDHHS shall notify the Provider of the deficiencies and the suspension of new referrals/admissions for a minimum of thirty (30) days. The Provider must submit a written CAP addressing the deficiencies to SCDHHS within fifteen (15) days from the institution of the suspension. SCDHHS has fifteen (15) days to review the CAP to determine whether the response is acceptable. If the CAP is not acceptable, SCDHHS will request clarification or additional information. The suspension will be lifted fifteen (15) days from SCDHHS' acceptance of the CAP. A suspension lasting more than ninety (90) days will result in termination.

- Termination – Indicates very serious and/or widespread deficiencies, generally coupled with a history of bad reviews.

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RESIDENTIAL PERSONAL CARE II

- Substantiated finding of failure to follow policy for the administration of the participant's personal needs accounts.

G. Administrative Requirements

1. The Provider must inform SCDHHS of the Provider's organizational structure including the Provider personnel with authority and responsibility for employing qualified personnel, ensuring adequate staff education, in-service training and employee evaluations during the enrollment process. The Provider shall notify SCDHHS within three (3) working days in the event of a change in the agency administrator, address, phone number or an extended absence of the agency administrator.

2. The Provider must provide SCDHHS with a written document showing the organization, administrative control and lines of authority for the delegation of responsibility down to the hands-on participant care level staff at contract implementation.

3. The Provider shall not delegate administrative and supervisory functions to another agency or organization.

4. The Provider will develop and maintain a Policy and Procedure Manual that describes how activities will be performed in accordance with the terms of the requirements of the Contract. The Policy and Procedure Manual shall be available during office hours for the guidance of the governing body and personnel and will be made available to SCDHHS upon request.

5. The Provider shall ensure that key agency staffs are accessible in person or by telephone during compliance review audits conducted by SCDHHS and/or its agents.

6. The Provider will ensure that its office is open and staffed by qualified personnel during normal business hours. Participant and personnel records must be maintained at the address indicated in the Contract and must be made available, upon request, for review by SCDHHS.

7. The Provider must have an effective written back-up service provision plan in place to ensure that the Participant receives the RPC II services as authorized. Whenever the Provider determines that services cannot be provided as authorized, the CM must be notified by telephone immediately.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

MECHANICAL VENTILATOR DEPENDENT WAIVER
SCOPE OF SERVICES
FOR
IN-HOME RESPITE

A. Objective

The objective of In-home Respite Services is to provide temporary care in the home for mechanical ventilator dependent participants who live at home and are cared for by their families or other informal support systems. This service will provide temporary relief for the primary caregivers and maintain the participant at home. This service is necessary to avoid institutionalization.

B. Description of Services to be Provided

1. The unit of service will be a twenty-four hour period.

2. The number of units and services provided to each participant will be dependent upon the individual participant's needs as established or approved by the Case Manager and set forth in the participant's Service Plan. In-home respite services may be provided for a period not to exceed fourteen (14) days per State fiscal year (July 1-June 30) in accordance with the provider contracting period.

3. In-home respite services will provide skilled medical services as ordered by the physician and will be performed by a Registered Nurse, or Licensed Practical Nurse, who will perform their duties in compliance with the Nurse Practice Act and S. C. Code of Laws, Regulations, Chapter 91, State Board of Nursing.

4. In-home respite services will include, but are not limited to, any household care, meal preparation and personal care services as needed by the participant during the in-home respite period. All other waiver services will be discontinued during the in-home respite period.

5. Agencies must utilize the automated systems mandated by CLTC to document and bill for the provision of services.

6. Providers must accept or decline referrals from CLTC or SCDDSN within two (2) working days. Failure to respond will result in the loss of the referral.

7. The provider must verify the participant’s Medicaid eligibility when it accepts an authorization and monthly thereafter to ensure continued eligibility. Agencies can

verify Medicaid eligibility for CLTC participants in the Phoenix Provider Portal on their dashboard. Providers should also refer to Section 1 of this provider manual for additional information on eligibility determination.

8. Providers may use paperless filing systems. Provider must obtain approval from CLTC Central Office prior to initiating electronic documentation and/or filing systems. Electronic records must be made available upon request, and providers must have a reliable back-up system in the event their computer system shuts down.

C. Staffing

1. A licensed practical nurse or registered nurse who meets the following requirements:

   a. Currently licensed by the state of South Carolina.

   b. At least one year experience in public health, hospital, or long term care nursing.

   c. Please refer to Department of Health and Environmental Control (DHEC) website, Regulation 61-75 – Standards for Licensing for PPD Tuberculin test requirements.

      http://www.scdhec.gov/health/licen/hladcinfo.htm

      Providers needing additional information should contact the Tuberculosis Control Division, Department of Health and Environmental Control, 1751 Calhoun Street, Columbia, S.C. 29201, phone (803) 898-0558.

2. Minimum training for registered nurses:

   a. The provider assures CLTC that the nurse has adequate experience and expertise to perform the skilled services ordered by the physician including the care required by individuals requiring mechanical ventilator assistance.

   b. The provider will provide a minimum of six (6) hours relevant in-service training per year (based on date of employment) for each nurse.

D. Conduct of Service

1. The name of a designated person(s) and telephone number(s) will be furnished to CLTC in order to provide CLTC seven (7) day twenty-four (24) hour accessibility.

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RESPITE CARE

2. An individual participant record must be maintained. The record must include the following:

   a. CLTC authorization

   b. Skilled nursing orders signed and dated by the physician

   c. Plan of Care

   d. Documentation of daily care and services provided

3. The provider will be responsible for procuring the skilled nursing orders from the physician.

4. In-home Respite Services must begin on the date negotiated by the case manager and the provider.

5. The provider must send a plan of care to the case manager which includes goals, after completion of the first in-home respite nursing visit. If applicable, recommendations to change the service schedule from that on the initial Service Provision Form may be sent to the Case Manager at that time.

6. The In-home Respite Service must not be provided prior to the authorized start date as stated on the Service Provision Form.

7. The provider will notify the Case Manager within two (2) working days of the following participant changes:

   a. Participant's condition has changed and the Service Plan no longer meets the participant's needs or the participant no longer needs In-home Respite Services.

   b. Participant dies or moves out of the Service area.

   c. Participant no longer wishes to receive the In-home Respite Service.

   d. Knowledge of the participant's Medicaid ineligibility or potential ineligibility.

8. A record keeping system will be maintained which establishes an eligible participant profile in support of units of In-home Respite Services. A daily log will reflect the services provided by the nurse and the time expended for this service.

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RESPITE CARE

9. The provider must develop and maintain a state approved Policy and Procedure Manual which describes how it will perform its activities in accordance with the terms of the contract.

10. The case manager will authorize In-home Respite Services by designating the amount, frequency, and duration of service for participants in accordance with the participant's Service Plan. This documentation will be maintained in the participant's file.

11. The case manager will obtain the initial physician's order for In-home Respite Services. A copy will be sent to the provider to be placed in the participant's file.

12. The provider will be responsible for procuring the direct care physician's orders.

13. The case manager will review the participant's Service Plan within three (3) days of receipt of the provider's request to modify the plan.

14. The case manager or CLTC will notify the provider immediately if a participant becomes medically ineligible for CLTC services.

E. Administrative Requirements

1. The provider must inform CLTC of the provider's organizational structure, including the provider personnel with authority and responsibility for employing qualified personnel, ensuring adequate staff education, in-service training, and employee evaluations. The provider shall notify SCDHHS within three (3) working days in the event of a change in or the extended absence of the personnel with the above listed authority.

2. The provider must provide SCDHHS with a written document showing the organization, administrative control and lines of authority for the delegation of responsibility down to the hands-on participant care level staff at contract implementation. The document shall include an organizational chart including names of those currently in the positions. Revisions or modifications to this organizational document must be provided to SCDHHS. It is recommended that this document be readily accessible to all staff.

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

4. The provider agency must acquire and maintain for the duration of the contract liability insurance and worker's compensation insurance as provided in Article IX, Section D of the Contract. The provider is required to list SCDHHS – CLTC

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RESPITE CARE

as a Certificate Holder for informational purposes only on all insurance policies using the following address: Post Office Box 8206, Columbia, SC 29202-8206.

5. The provider will ensure that its office is staffed by qualified personnel during the hours of 10:00 a.m. to 4:00 p.m. Outside of these hours, the provider agency must be available by telephone during normal business hours, 8:30 a.m. to 5:00 p.m., Monday through Friday. The provider must also have a number for emergencies outside of normal business hours. Participant and personnel records must be maintained at the address indicated in the contract and must be made available, upon request, for review by SCDHHS.

6. The provider must develop and maintain a policy and procedure manual which describes how it will perform its activities in accordance with the terms of the contract. The Policy and Procedure Manual shall be available during office hours for the guidance of the governing body, personnel and will be made available to SCDHHS upon request.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

RESPITE CARE

MEDICAID HOME AND COMMUNITY-BASED WAIVER
SCOPE OF SERVICES
FOR
RESPITE CARE IN A COMMUNITY RESIDENTIAL CARE FACILITY

A. Objective

The objective of Respite Care services in a Community Residential Care Facility (CRCF) is to provide temporary care for Medicaid waiver participants who live at home and are cared for by their families or other informal support systems.

B. Conditions of Participation

Providers of Respite Care services in a CRCF must meet all SCDHEC standards for licensure and must comply with all requirements of this Scope of Services.

Providers must accept or decline referrals from CLTC or DDSN within two (2) working days. Failure to respond will result in the loss of the referral.

The provider will be responsible for verifying the participant's Medicaid eligibility when it has accepted a referral and monthly thereafter to ensure continued eligibility. Providers can verify Medicaid eligibility for CLTC participants in the Phoenix Provider Portal on their dashboard. Providers should also refer to Section 1 of this provider manual for additional information on eligibility determination.

Providers may use paperless filing systems. When using electronic filing systems any documentation requiring signatures must be signed prior to scanning. Electronic records must be made available upon request, and providers must have a reliable back-up system in the event their computer system shuts down.

C. Description of Services to be Provided

1. Respite care will be provided in a licensed CRCF which is contracted with SCDHHS to provide Respite Care services to Medicaid waiver participants.

2. The facility must be wheelchair accessible as well as equipped with a handicapped bathroom.

3. The unit of service will be a patient day which is defined as a twenty-four (24) hour period, including the day of admission and excluding the day of discharge.

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RESPITE CARE

4. Total patient days allowed per fiscal year (July 1 – June 30) is twenty-eight (28). This includes any Institutional Respite days, if applicable.

5. The number of units of service provided to each participant is dependent upon the individual participant's needs as set forth in the participant's service plan, which is established or approved by the CM/SC. Services will be based on physician's orders.

6. The per diem rate will include all those items and supplies associated with patient care, except prescribed drugs and personal items. These items cannot be billed to Medicaid or the participant by the Respite Care provider.

   An example of items included in the per diem rate is: non-durable medical equipment, such as diapers and underpads.

   Items that are to be supplied by the participant and/or the responsible party are prescription and non-prescription medications and personal care items such as soap, mouthwash, deodorant, shampoo, and clothing.

7. Respite Care services will not be authorized for: (1) participants who are dependent upon oxygen or on a mechanical ventilator; (2) Participants who require tube feedings; (3) Participants who are diagnosed with either dementia or traumatic brain injury and have a history of wandering, unless there is documentation that appropriate safety measures are in place and have been reviewed and approved by the CLTC/SCDDSN state office prior to admission; or (4) participants who meet the Medicaid Nursing Facility skilled level of care (LOC) unless it is determined by the CLTC/SCDDSN state office prior to admission, that the participants do not require the daily attention of a nurse.

D. Staffing

The facility must be staffed by alert, oriented and appropriately dressed staff when a Medicaid Home and Community–Based waiver participant is in the facility. At a minimum, a certified nursing assistant must be on duty at all times when a Medicaid Home and Community-Based waiver participant is in the facility.

E. Conduct of Service

1. The CM/SC will authorize Respite care services by designating the amount, frequency and duration of the services for the participant in accordance with the participant's service plan. Services must not be provided prior to the authorized start date as stated on the service authorization form.

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RESPITE CARE

Upon request of the CM/SC for Respite care services, the provider will secure a prior admission agreement with the primary caregiver or responsible party. This agreement will set forth the scheduled period of placement, specifying admission and discharge dates, and will include a statement of understanding for the responsible party to resume care of the participant after the authorized respite period.

2. The CM/SC will use the SCDHHS Form 122RC to obtain the physician's order for Respite Care, which includes the participant's medical history and a report of a physical examination that occurred no more than thirty (30) days prior to admission. SCDHHS Form 122RC will be sent to the provider prior to or at the time of the participant's admission to Respite care.

3. Upon request of the CM/SC for Respite care services, the provider will secure a prior admission agreement with the primary caregiver or responsible party. This agreement will set forth the scheduled period of placement, specifying admission and discharge dates, and will include a statement of understanding for the primary caregiver or responsible party to resume care of the participant after the authorized respite period.

4. The provider will establish a participant file, which includes the physician's respite orders, the prior admission agreement, the Home and Community-Based waiver authorization, the facility's plan of care and documentation of all care and services provided.

5. The Provider will notify the CM/SC within twenty-four (24) hours if the participant is admitted to the hospital, dies, returns home or no longer requires Respite care services.

F. Administrative Requirements

1. The Provider must inform CLTC of the provider's organizational structure, including the provider personnel with authority and responsibility for employing qualified personnel, ensuring adequate staff education, in-service training, and employee evaluations. The Provider shall notify SCDHHS within three (3) working days in the event of a change in or the extended absence of the personnel with the above listed authority.

2. The Provider must provide SCDHHS with a written document showing the organization, administrative control and lines of authority for the delegation of responsibility down to the hands-on participant care level staff at contract implementation. The document should include an organizational chart including names of those currently in the positions. Revisions or modifications to this

organizational document must be provided to SCDHHS. It is recommended that this document be readily accessible to all staff.

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

4. The provider agency must acquire and maintain for the duration of the contract liability insurance and worker's compensation insurance as provided in Article IX, Section D of the Contract. The Provider is required to list SCDHHS – CLTC as a Certificate Holder for informational purposes only on all insurance policies using the following address: Post Office Box 8206, Columbia, SC 29202-8206.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

RESPITE CARE

MEDICAID HOME AND COMMUNITY-BASED WAIVER
SCOPE OF SERVICES
FOR
INSTITUTIONAL RESPITE CARE

A. Objective

The objective of Institutional Respite Care Services is to provide temporary institutional care for Medicaid waiver clients who live at home and are cared for by their families or other informal support systems.

B. Conditions of Participation

1. The Institutional Respite Care Provider must maintain a current license from SCDHEC or an equivalent licensing agency for an out-of-state provider.

2. Providers must accept or decline referrals from CLTC or SCDDSN within two (2) working days. Failure to respond will result in the loss of the referral.

3. The provider will be responsible for verifying the participant's Medicaid eligibility when it has accepted a referral and monthly thereafter to ensure continued eligibility. Providers can verify Medicaid eligibility for CLTC participants in the Phoenix Provider Portal on their dashboard. Providers should also refer to Section 1 of this provider manual for additional information on eligibility determination.

4. Providers may use paperless filing systems. When using electronic filing systems any documentation requiring signatures must be signed prior to scanning. Electronic records must be made available upon request, and providers must have a reliable back-up system in the event their computer system shuts down.

C. Description of Services to be Provided

1. Respite care will be provided in a hospital, nursing facility (NF), or an Intermediate Care Facility for People with Mental Retardation (ICF/MR) that has been approved by the state and is not a private residence.

2. The unit of service will be a patient day. A patient day is defined as a twenty-four (24) hour period, including the day of admission and excluding the day of discharge.

3. Total patient days allowed per fiscal year (July 1 – June 30) is fourteen (14). This includes any Community Residential Care Facility Respite days, if applicable.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

RESPITE CARE

The 14-day limit does not apply to DDSN waiver participants.

4. The number of units of service provided to each participant is dependent upon the individual participant's needs as set forth in the participant's service plan, which is established or approved by the CM/SC.

5. The per diem rate will include all those items and supplies associated with patient care, except prescribed drugs and personal items. These items cannot be billed by the Provider to Medicaid or the participant.

   Examples of items included in the per diem rate are: durable medical equipment, nonprescription drugs, underpads, suctioning equipment and supplies, and NG tube equipment and feeding supplies. Other examples include supplies necessary for dressing changes, ostomy catheters, and tracheostomy care items.

   Examples of personal care items are soap, mouthwash, deodorant, shampoo, and clothing.

6. Respite Care Services will be based on the Physician's orders.

D. Conduct of Service

1. The CM/SC will authorize Institutional Respite Care Services by designating the amount, frequency and duration of the services for the participant in accordance with the participant's service plan. Services must not be provided prior to the authorized start date as stated on the service authorization form.

2. Prior to the time of admission to Institutional Respite Care , the CM/SC will send the provider the Respite services form (SCDHHS Form 122RC) which includes the physician's admission order, the participant's medical history, a physical examination report that is not over five (5) days old and the participant's service plan. If it is not possible to obtain the SCDHHS Form 122RC prior to admission, the CM/SC will send a copy of the medical information from the Medicaid waiver assessment form in lieu of the medical history and the provider must obtain a physical examination report within forty eight (48) hours of admission.

3. Upon request of the CM/SC for Institutional Respite Care services, the provider will secure a prior admission agreement with the primary care giver or responsible party. This agreement will set forth the scheduled period of placement, specifying admission and discharge dates, and will include a statement of understanding and agreement for the responsible party to resume care of the participant after the authorized respite period.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

RESPITE CARE

4. The provider will establish a participant file, which includes the physician's respite orders (SCDHHS Form 122RC), the Home and Community-Based waiver service authorization, the facility plan of care and documentation of all care and services provided.

5. The provider will notify the CM/SC within twenty-four (24) hours if the participant is admitted to the hospital, dies, returns home or no longer requires Institutional Respite Care services.

6. For DDSN waiver participants, institutional respite services may not be billed in conjunction with the residential habilitation service.

E. Administrative Requirements

1. The provider must inform CLTC of the provider's organizational structure, including the provider personnel with authority and responsibility for employing qualified personnel, ensuring adequate staff education, in-service training, and employee evaluations. The provider shall notify SCDHHS within three (3) working days in the event of a change in or the extended absence of the personnel with the above listed authority.

2. The provider must provide SCDHHS with a written document showing the organization, administrative control and lines of authority for the delegation of responsibility down to the hands-on participant care level staff at contract implementation. The document should include an organizational chart including names of those currently in the positions. Revisions or modifications to this organizational document must be provided to SCDHHS. It is recommended that this document be readily accessible to all staff.

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

4. The provider agency must acquire and maintain for the duration of the contract liability insurance and worker's compensation insurance as provided in Article IX, Section D of the Contract. The provider is required to list SCDHHS – CLTC as a Certificate Holder for informational purposes only on all insurance policies using the following address: Post Office Box 8206, Columbia, SC 29202-8206.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

MEDICALLY COMPLEX CHILDREN'S WAIVER
SCOPE OF SERVICES
FOR
SKILLED RESPITE

A. Objective

The objective of Skilled Respite services is to provide temporary care in the home for Medically Complex Children's (MCC) waiver Participants. This service will provide temporary relief for the primary caregivers to help maintain the participant at home and/or Natural Environment.

B. Conditions of Participation

1. The Provider must agree to participate in the Care Call monitoring and payment system.

   a. Care Call billing activity should be completed upon arrival at and departure from the participant's home.

2. The Provider must utilize any other automated systems mandated by CLTC to document and bill for the provision of services.

C. Description of Services to be Provided

1. The unit of service will be in one (1) hour increments, with a minimum of four (4) hours authorized at a time.

2. The number of units of service authorized to each participant will be dependent upon the participant's needs as established and set forth in the participant's Care Plan. Skilled Respite services may be provided for a specific period as stated in policy.

3. Skilled Respite services will provide skilled medical care as ordered by a physician, and performed by a Registered Nurse or Licensed Practical Nurse with pediatric experience in compliance with the Nurse Practice Act and S. C. Code of Laws, Regulations, Chapter 91, State Board of Nursing.

4. Skilled Respite services will include, but are not limited to, meal preparation and personal care services as needed by the participant during the respite period.

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D. Staffing

1. The provider must have staff that meets the following requirements:

   a. Currently licensed by the State of South Carolina to practice nursing.

   b. At least two (2) years of experience with the pediatric population in a public health, hospital, or long term care setting; as evidenced by work experience documented and maintained in the employee personnel file.

   c. Provider will verify nurse licensure at time of employment and will ensure that the license remains active and in good standing at all times during employment. Provider must maintain a copy of the current license in the employee's personnel file. Nurse licensure can be verified at the State Board of nursing website.

http://www.llr.state.sc.us/pol.asp

E. Conditions for Qualification for Service

1. A criminal background check is required for all potential employees to include employees who will provide direct care to SCDHHS/SCDDSN participants and all administrative/office employees (office employees required to have background checks include: administrator, office manager, nurse supervisor, and persons named on organizational chart in management positions). All criminal background checks must include all data for the individual with no less than a ten (10) year timeframe being searched. The criminal background check must include statewide data. The statewide data must include South Carolina and any other state or states the worker has resided in within the prior ten years. Potential employees with felony convictions within the last ten (10) years cannot provide services to SCDHHS/SCDDSN participants or work in an administrative/office position. Potential employees with non-violent felonies dating back ten (10) or more years can provide services to SCDHHS/SCDDSN participants under the following circumstances:

   - Participant/responsible party must be notified of the aide's criminal background, i.e. felony conviction, and year of conviction;

   - Provider must obtain a written statement, signed by the participant/responsible party acknowledging awareness of the aide's criminal background and agreement to have the aide provide care; this statement must be placed in the participant record.

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- Potential administrative/office employees with non-violent felony convictions dating back ten (10) or more years can work in the agency at the provider's discretion.

- Hiring of employees with misdemeanor convictions will be at the provider's discretion. Employees hired prior to July 1, 2007, and continuously employed since then will not be required to have a criminal background check.
- Providers will be required to check the CNA registry and the Office of Inspector General (OIG) exclusions list periodically for all staff. A copy of the search results page must be maintained in each employee's personnel file. Anyone appearing on either of these lists is not allowed to provide services to Waiver participants or participate in any Medicaid funded programs. The website addresses are listed below:

  CNA Registry - http://www.pearsonvue.com
  OIG Exclusions List - http://www.oig.hhs.gov/fraud/exclusions.asp

2. PPD Tuberculin Test

   Please refer to South Carolina Department of Health and Environmental Control (SCDHEC) website, Regulation 61-75 – Standards for Licensing page 11 of 36 section b. 1-6 for PPD Tuberculin test requirements.

   http:/www.scdhec.gov/health/licen/hladcinfo.htm

   Providers needing additional information should contact the Tuberculosis Control Division, South Carolina Department of Health and Environmental Control, 1751 Calhoun Street, Columbia, SC 29201, phone (803) 898-0558.

3. The provider must maintain a personnel file for each staff member and document that they have met the above requirements.

4. Minimum training for Licensed Practical Nurses and Registered Nurses:

   a. The provider assures SCDHHS that the nurse has adequate experience and expertise to perform the skilled services ordered by the physician that may include the skills necessary to care for a Participant who requires but is not limited to mechanical ventilator assistance, gastrostomy or jejeunostomy tubes, and indwelling catheters.

   b. The provider will provide for a minimum of six (6) hours relevant in-service training per year (based on date of employment) for each nurse.

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RESPITE CARE

F. Conduct of Service

1. The provider shall provide SCDHHS a list of regularly scheduled holidays for the coming calendar year each September. The Provider is not required to furnish services on regularly scheduled holidays. The Provider must not be closed for more than two (2) consecutive days, except when a holiday falls in conjunction with a weekend. In that case, the Provider may be closed for not more than four (4) consecutive days.

2. The provider must have a written back-up service provision plan in place to ensure that the Participant receives the authorized respite services. Whenever the Provider determines that services cannot be provided as authorized, SCDHHS must be notified immediately by telephone.

3. The provider must adhere to any other criteria as established and disseminated by SCDHHS.

4. An individual participant record must be maintained.

5. The provider will be responsible for procuring the direct care orders from the physician.

6. Skilled Respite services must begin on the date and time negotiated by the Care Coordinator and the provider in accordance with the family's requests.

7. The provider must send a treatment plan to the Care Coordinator which includes treatment goals, after completion of the first respite visit. If applicable, recommendations to change the service schedule from that of the initial Service Authorization Form may be sent to the Care Coordinator at that time.

8. The provider must comply with the South Carolina Child Protection Reform Act (S.C. Code Ann. § 63-7-10 et seq. (Supp. 2008)), which requires the reporting of any suspected abuse, neglect or exploitation of a child age 17 and under as defined in the Act.

9. The Skilled Respite service must not be provided prior to the authorized start date as stated on the Service Authorization Form.

10. The provider will notify the Care Coordinator within two (2) working days of the following participant changes:

    a. Participant's condition has changed and the Care Plan no longer meets the participant's needs or the participant no longer needs Skilled Respite services.

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b. Participant dies or moves out of the State.

c. Participant no longer wishes to receive the Skilled Respite service.

d. Knowledge of the participant's Medicaid ineligibility or potential ineligibility.

11. The Care Coordinator will authorize Skilled Respite services by designating the amount, frequency, and duration of service for participants in accordance with the participant's Care Plan. This documentation will be maintained in the participant's file.

12. The Care Coordinator will notify the provider immediately if a participant becomes medically ineligible for Medicaid services. It is the provider's responsibility to verify the participant's Medicaid eligibility.

G. Compliance Review Process

The SCDHHS Division of Long Term Care Waiver Management, Provider Compliance Department has developed this policy for clarification of the provider compliance process. The policy gives detailed information on how provider compliance sanctions are implemented. Provider reviews receive a score based on a sanctioning scale; review scores will determine if the provider will receive a sanction and if so, the level of the sanction. The sanction scoring process was developed to ensure that reviews are equitable and for providers to know what to expect when they are reviewed.

The following chart outlines how reviews are scored:

Sanction Level

- Provider compliance review questions in the Scope of Services are classified into three classes, based on (1) the significance of the question regarding to the services, and (2) the potential influences on providers and participants if the requirement was not met. See the example below:

Severity Level: 1=less serious, 2 = serious, 3 = very serious

Client Service Questions	Possible Answers	Severity Level
Was supervisory visit made within 30 days after PC II services initiated?	Y, N, NA	3

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Client Service Questions	Possible Answers	Severity Level
Was the initial supervisory visit documented in Care Call?	Y, N, NA	3
Does provider maintain individual client records?	Y, N	2
Did provider give participant written information regarding advanced directives?	Y, N, NA	1

There are five types of sanctions:

- Plan of Correction – This is the lowest sanction and indicates the provider is in substantial compliance with the contractual requirements. The provider will be required to submit a plan of correction outlining the deficiency (ies), the detailed plan to correct the deficiency and the effective date the plan will be implemented.

- 30-day suspension – At this level, new referrals are suspended for 30 days. The provider will also be required to submit a plan of correction. If the plan of correction is approved, the suspension is automatically lifted at the end of the 30-day period. If the corrective action plan is not approved, the Provider will be given an additional ten (10) business days to submit another corrective action plan for review and approval; the suspension will remain in place until an approved corrective action plan is received. If the second submitted corrective action plan is not approved, the provider contract will be terminated.

- 60-day suspension – At this level, new referrals are suspended for 60 days. The provider will also be required to submit a plan of correction. If the plan of correction is approved, the suspension is automatically lifted at the end of the 60-day period. If the corrective action plan is not approved, the Provider will be given an additional ten (10) business days to submit another corrective action plan for review and approval; the suspension will remain in place until an approved corrective action plan is received. If the second submitted corrective action plan is not approved, the provider contract will be terminated.

- 90-day suspension – Indicates serious and widespread deficiencies, new referrals are suspended for 90 days. The 90-day suspension of new referrals will only be lifted after an acceptable plan of correction is received. If the corrective action plan is not approved, the Provider will be given an additional ten (10) business days to submit another corrective action plan for review and approval; the suspension will remain in place until an approved corrective action plan is received. If the second submitted

corrective action plan is not approved, the provider contract will be terminated. In addition, an acceptable follow-up review visit may be conducted if warranted.

- Termination – Indicates a final review score of four hundred (400) or more points, very serious and widespread deficiencies, generally coupled with a history of bad reviews (3 consecutive reviews that receive suspension of new referrals)

Providers who have two (2) consecutive reviews that result in suspension of new referrals, will be terminated if the third consecutive review has a final score that would result in a suspension of new referrals (100 and above).

We have developed a system to score reviews based on the percentage of the identified deficiency and number of participants surveyed. Following is an outline of how reviews will be scored:

Calculating process:

- The level of sanction will be decided based on the total score of the provider's current review and the provider's review history, which is converted from the deficiency percentage.

- Every 5% deficiency counts for 1 point in each class; the total score comes from the total points from each level.

- Since each level has different severity, multiple points will be added on each class' score. Final score = level 3 = unweighted points x 3 + level 2 = unweighted basic points x 2+ level 1 = unweighted points x 1

Example:

Level	Deficiency percentage	Basic points	Final points
Level 1 (less serious)	28%	5	5x1=5
Level 2 (serious)	20%	4	4x2=8
Level 3 (major)	35%	7	7x3=21
Final score			34

Based on the total score a sanction level is determined. If a provider has no deficiencies, they will not be subject to a sanction. Below is a chart that illustrates the sanction that will be imposed based on the final review score:

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Score Scale & Sanction Level

Sanction Type	Final score	With Good History*
Correction Plans	0-99	0-149
30 Days Suspension	100-199	150-249
60 Days Suspension	200-299	250-349
90 Days Suspension	300-399	350-449
Termination	>400	>450

Good History is determined based on previous review scores. For example, if a provider's previous review had a total score of 50 and their current review has a score of 120, the sanction for the current review will be corrective action rather than 30-day suspension based on the previous review score. Scores are automatically calculated using a computer generated compliance review program.

Provider records will be reviewed periodically at the provider's office. Onsite visits are un-announced. If the reviewer (CLTC, Program Integrity or other government) arrives at the provider's office to conduct a survey and no one is there, the following sanctions will be imposed:

- First time – thirty (30) day suspension of new referrals
- Second time – ninety (90) day suspension of new referrals
- Third time – contract termination

H. Administrative Requirements

1. The provider must inform SCDHHS of the provider's organizational structure including the Provider personnel with authority and responsibility for employing qualified personnel, ensuring adequate staff education, in-service training and employee evaluations. The provider agency shall notify SCDHHS within three (3) working days in the event of a change in the agency administrator, address, phone number or an extended absence of the agency administrator.

2. The provider must provide SCDHHS with a written document showing the organization, administrative control and lines of authority for the delegation of responsibility down to the hands-on participant care level staff at contract implementation. The document should include an organizational chart including names of those currently in the positions. Revisions or modifications to this organizational document must be provided to SCDHHS. It is recommended that this document be readily accessible to all staff.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

RESPITE CARE

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

4. The provider agency shall acquire and maintain for the duration of the contract liability insurance and worker's compensation insurance as provided in Article IX, Section D of the Contract. The provider is required to list SCDHHS – CLTC as a Certificate Holder for informational purposes only on all insurance policies using the following address: Post Office Box 8206, Columbia, SC 29202-8206.

5. The provider will develop and maintain a Policy and Procedure Manual that describes how activities will be performed in accordance with the terms of the requirements of the contract. The Policy and Procedure Manual shall be available during office hours for the guidance of the governing body and personnel and will be made available to SCDHHS upon request.

6. The provider must comply with Article IX, Section Z of the Contract regarding safety precautions. The provider must also have an on-going infectious disease program to prevent the spread of infectious diseases among its employees.

7. The provider shall ensure that key agency staff is accessible in person, by phone, or by beeper during compliance review audits conducted by SCDHHS and/or its agents.

8. The provider will ensure that its office is open and staffed by qualified personnel during the hours of 10:00 a.m. to 4:00 p.m., Monday through Friday. Outside of these hours, the Provider agency must be available by telephone during normal business hours, 8:30 a.m. to 5:00 p.m., Monday through Friday. Failure to maintain an open and staffed office as indicated will result in sanctions as outlined in section G, last paragraph. The provider must also have a number for emergencies outside of normal business hours. Participant and personnel records must be maintained at the address indicated in the contract and must be made available, upon request, for review by SCDHHS.

9. The provider must have an effective written back-up service provision plan in place to ensure that the participant receives the services as authorized. Whenever the provider determines that services cannot be provided as authorized, the CC or CS must be notified by telephone immediately.

10. The provider shall update holidays in Phoenix; the provider is not required to furnish services on those days. The provider agency must not be closed for more than two (2) consecutive days at a time, except when a holiday falls in conjunction with a weekend. If a holiday falls in conjunction with a weekend, the provider agency may be closed for not more than four (4) consecutive days.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

MEDICAID HOME AGAIN PROGRAM
SCOPE OF SERVICE
FOR
TRANSITION COORDINATION SERVICE

A. Objective

The objective of Transition Coordination is to provide assistance with the transition process to Home Again participants. The Transition Coordination service will support the participants in order to make a successful transition into the community. The Transition Coordination service will also ensure continued access to appropriate and available services for participants to remain in the community.

B. Conditions of Participation

1. The Provider and provider staff delivering Transition Coordination Service must be one of the following: Licensed Baccalaureate Social Worker (LBSW), Licensed Master Social Worker (LMSW), Case Manager Certified (CMC), Registered Nurse (RN), or individuals with a Bachelor's degree in a health or human services field from an accredited college or university.

2. The license and certification must be in the state of South Carolina and in good standing, if applicable.

3. The Provider must have demonstrated at least two (2) years of case management experience with one (1) of the Home Again target populations; either older adults or people with physical disabilities.

4. The Provider must be able to provide the specified geographical area (counties) in which they will deliver the Transition Coordination service. Transition Coordinators servicing multiple area offices must designate a CLTC office for training and meetings.

5. The Provider will be responsible for provision of all supplies and tools necessary to carry out Transition Coordinator Functions. The Provider will be responsible for assuring each Transition Coordinator has a laptop computer meeting South Carolina Department of Health and Human Services (SCDHHS) specifications.

6. The Provider will ensure that Transition Coordinator does not service members of his/her own immediate family.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

TRANSITION COORDINATION SERVICE

7. The Provider should be available by telephone to participants and SCDHHS staff Monday through Friday, 8:30 a.m. to 5:00 p.m., and, if there is other employment, it shall not prevent the Transition Coordinator from performing Transition Coordination during these hours. The Provider will guarantee accessibility to participants and the program staff.

8. The Provider must also be available to meet with SCDHHS staff by either face-to-face or by phone.

9. The Provider must check voice mail at least twice daily Monday through Friday, excluding state holidays.

10. The Provider must sync with the Phoenix System prior to any field activity to verify services and daily if any work has been performed.

11. The Provider is responsible for secure and accurate maintenance of all participant records.

12. The Provider must scan into Phoenix all consumer specific documents received from outside sources. All hardcopy records shall remain in the participant's assigned Area Office.

13. The Provider must check and respond to e-mails daily, Monday through Friday.

14. The Provider must return calls related to participant care within 24 hours.

15. The Provider will ensure that each Transition Coordinator utilizes the Care Call System. Care Call documentation must be completed upon each transition coordination visit and transition coordination contact. For home visits, the call to the Care Call System must be completed while in the Participant's home.

16. The Provider will ensure that each Transition Coordinator providing Transition Coordination services uses the Phoenix System to document all Transition Coordination activities, as specified in Section G.

17. The Provider must complete documentation in the Phoenix System within 48 hours after the visit and contact.

18. The Provider will ensure that each Transition Coordinator meets the Training Requirements set out in Article F of this document.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

TRANSITION COORDINATION SERVICE

C. Description of Services to be Provided

1. The Provider must use the Phoenix System to enter a list of regularly scheduled holidays; the Provider shall not be required to furnish services on those days. The Provider must not be closed for more than two consecutive days at a time, except when a holiday falls in conjunction with a weekend. If a holiday falls in conjunction with a weekend, the Provider may be closed for not more than four consecutive days.

2. The Provider must make provisions for coverage during times when the Provider is unavailable. Providers must have an office location.

3. Transition Coordination services must be performed as set forth in the CLTC Area Office Home Again Policy.

4. The Transition Coordinator must use professional judgment in allotting a sufficient amount of time to complete activities, including all visits and contacts. Following is the minimum visit and contact schedule that the Provider must conduct:

   a. Pre-transition planning: The Provider must complete an initial visit to the potential participant in a skilled nursing facility. A home visit is also required once housing is identified in the community.

   b. The Provider must be present either at the facility or at home in the community on the transition date.

   c. During the first two (2) months, there must be two (2) face-to-face visits and two (2) telephone calls per month.

   d. During months 3-12, the Providers will perform one (1) face-to-face visit every other month and one (1) monthly telephone call.

   e. Additional visits and contact may be required as needed or if the transition is in jeopardy. If Care Call reflects that the amount of time spent to complete the billed activities for a particular day does not meet Home Again staff's expectations of the time necessary to complete those activities, then at SCDHHS's sole discretion, Home Again staff may conduct an investigation and may recoup payments for those activities from the Provider.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

TRANSITION COORDINATION SERVICE

D. Transition Coordination

1. Cases will be assigned in accordance with the Participant's choice.

2. Provider must notify SCDHHS within two (2) working days of its intent to accept or decline a referral for Participant service.

3. The Transition Coordination service includes the following but is not limited to:

   a. Initial visit to a skill nursing facility and a home in the community to determine transition possibility

   b. Conducting comprehensive assessment to identify the participant's needs

   c. Developing and monitoring transition plan with a participant and assist the transition process

   d. Assist the participant with housing needs and ensure that the participant is moving into a qualified "Home and Community based residence"

   e. Consult with Case Manager II in the CLTC Area Office for setting up Service Plan, provider choices, referrals, and authorizations prior to the transitioning

   f. Ongoing problem solving to address participant's needs

   g. Maintain a 24/7 backup plan for critical services, as is requirement to be a provider.

   h. Evaluate needs for Expanded and Goods and Services and submit filled out Home Again Sales Quotation form to Home Again staff, if needed

   i. Case termination and transferring

   j. Any additional work required by Home Again staff and which is amended to the scope of service

4. The Provider must provide Transition Coordination services in accordance with Home Again policies and procedures, applicable SCDHHS policies and procedures, and applicable federal and state statutes and regulations. All of the foregoing provisions, policies, procedures, statutes and regulations (together with

any subsequent amendments) are hereby incorporated as an integral part of this Scope of Service.

5. Once a case has been relinquished or transferred to another provider, Provider must cease any contact with the Participant and/or primary contact.

E. Staffing

Provider must adhere to the following provisions related to staffing:

1. Transition Coordinators cannot simultaneously be working as a Medicaid Waiver Case Manager with the same participant.

2. Transition Coordinators must have a current valid driver's license.

3. When servicing Participants, Transition Coordinators must display a picture identification badge identifying agency/organization or independent status.

4. Transition Coordinators must comply with the continuing education requirements necessary for their licensure/certificate.

5. Transition Coordinators must have demonstrated skills in computer hardware/ software access and usage.

6. Transition Coordinators must agree to accept a minimum of one (1) case and cannot carry a caseload of over fifteen (15) cases at the same time without the approval of the Home Again staff.

7. PPD Tuberculin Test

The Provider must comply with the PPD Tuberculin test requirements found on the Department of Health and Environmental Control website, Regulation 61-75 Standards for Licensing at:

http://www.scdhec.gov/health/licen/hladcinfo.htm

If Provider requires additional information, Provider should contact the Tuberculosis Control Division, Department of Health and Environmental Control, 1751 Calhoun Street, Columbia, SC 29201, phone (803) 898-0558.

8. Personnel folders: Individual records will be maintained to document that each member of the staff has met the above requirements.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

TRANSITION COORDINATION SERVICE

F. Transition Coordination Training

1. Transition Coordinators must attend Medicaid sponsored Transition Coordination training, either in person or via online prior to be enrolled as the provider in Phoenix.

2. All new Transition Coordinators must meet or do conference call with Transition Coordination Manager prior to take the first case.

G. Transition Coordination Activities and Rates

1. The provider will be paid based on each milestone: a) pre-transition planning, b) transitioning, c) six month milestone from transition date, and d) one year milestone from transition date. See appendix A for the rates.

2. Providers have a responsibility to notify Home Again staff once each milestone has been met. The provider must complete the activities below in order to request the payments.

   Pre-transition planning

   a. Make initial visit to a nursing facility to meet with the potential participant

   b. Conduct the Risk Assessment to determine transition safety and possibility

   c. Document all visits and contacts into Phoenix System

   d. Conduct a visit to the participant's home in the community and determine home modification needs

   e. Complete Quality of Life survey 3 weeks prior to transitioning

   f. Discuss possible waiver services for the participant with CLTC Case Manager II in the Area Office and follow up on the case to make appropriate referrals and authorizations

   g. Ensure participants recurring income is transferred from nursing facilities to the participants

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

TRANSITION COORDINATION SERVICE

h. Complete all pre-transition planning checklist up to "1-2 days prior to move" tab in Phoenix System

i. Make sure medications and/or prescriptions are acquired prior to the discharge date

Note: The Provider will be paid $200 if the transition is deemed unsafe and the case terminated

Transitioning

a. Be present at the nursing facility or at the participant's home on the transition date

b. Document all visits and contacts into Phoenix System

c. Explain to the participant all services the person will be receiving, including Home Again demonstration program, waiver services, and any additional community services

d. Ensure each waiver authorization has a service start date

e. Monitor if the necessary Home Modifications are completed and identify if house set up is completed

f. Complete activities on the "Day of Move" tab in Phoenix System

g. Report Home Again staff and make a narrative in Phoenix if any Critical Incident occurs. Critical Incidents include hospitalizations, deaths due to abuse/neglect, deaths, contact with the criminal justice System, and medication errors.

Six month milestone from transition date

a. Comply with minimum visit/contact schedule as followed:

- Month 1-2: two (2) face-to-face visits and two (2) telephone calls
- Month 3-12: one (1) face-to-face visit every other month and one (1) telephone call each month

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

TRANSITION COORDINATION SERVICE

b. Document all visits/contacts into Phoenix System.

c. Complete activities on the "1st Week after Move" and "1st Month after Move" tabs in Phoenix System

d. Report Home Again staff and make a narrative in Phoenix if any Critical Incident occurs

One year milestone from transition date

a. Comply with visit/contact schedule, at least one face-to-face visit every other month and one (1) telephone call each month.

b. Document all visits/contacts into Phoenix System.

c. Complete activities on the "11 Months after Move" tab in Phoenix System.

d. Conduct new Quality of Life survey in 11th month from the transition date.

e. Follow case transferring policy and procedures after 365 days from the transition date.

f. Report Home Again staff and make a narrative in Phoenix if any Critical Incident occurs.

H. Administrative Requirements

1. The Provider must maintain an up-to-date organizational chart that is available to each employee.

2. The Provider must maintain written bylaws (or the equivalent) for governing the Provider's operations.

3. The Provider must assure SCDHHS that a governing body or person(s) so functioning shall assume full legal authority for the operation of the provider agency.

4. The Provider shall acquire and maintain, during the life of the contract, general liability insurance and worker's compensation insurance. The Provider is required to list SCDHHS-Home Again as certificate holder for notice purposes on all

insurance policies using the following address: Post Office Box 8206, Columbia, South Carolina, 29202-8206.

5. The Provider must have an effective written back-up service provision plan in place to ensure that the participant receives the Transition Coordination services. Whenever the Provider determines that services cannot be provided as authorized, the Provider shall immediately notify Home Again Transition Coordination Manager and the waiver Case Manager by telephone.

6. The Provider will be responsible for continuing Transition Coordination activity for all cases in the Provider's caseload. Should the Provider be unable to cover a case(s), the Provider shall immediately notify Transition Coordination Manager by telephone.

7. Upon request by SCDHHS, the Provider will be responsible for appropriate participation in the SCDHHS Appeals and Hearings process with respect to appeals of any action involving the Provider.

8. The Provider is subject to recoupment for payments made for services as a result of authorizations issued by provider staff not consistent with Home Again policies and procedures and in accordance with the Transition Coordination Scope of Service.

9. The Provider must disclose to SCDHHS the names and relationships of any relatives of the Provider or its staff who provide items or services to Medicaid Participants. For purposes of this Contract, the Provider means all owners, partners, managing employees, directors and any other person involved in the direct management and/or control of the business of the Provider. The Provider's staff includes everyone who works for or with the Provider, including independent contractors, in the provision of or billing for services described in this Contract. Relative means persons connected to the Provider by blood or marriage.

   The Provider must disclose all such relationships in writing to Home Again, SCDHHS, within two (2) days of learning of the relationship. The Provider, in executing this Contract, certifies that it has in place policies, procedures or other mechanisms acceptable to SCDHHS to identify and report these relationships.

   Failure to report a relationship timely or to have the appropriate policies and procedures in place may result in sanctions by SCDHHS up to and including termination of this Contract for cause.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

MEDICAID HOME AGAIN PROGRAM
SCOPE OF SERVICE
FOR
TELEMONITORING SERVICE

A. Objectives

The objectives of the Telemonitoring service are to maintain and promote the health status of Medicaid home and community-based waiver participants through medical telemonitoring of body weight, blood pressure, oxygen saturation, blood glucose levels, and basic heart rate information.

B. Conditions of Participation – Providers

1. Providers must have equipment that records at a minimum the participant's body weight, blood pressure, oxygen saturation, blood glucose levels, and basic heart rate information. All agencies must also have nursing personnel and health care professionals able to carry out the duties of the service described below.

2. Agencies must have certified evidence of not less than $10,000.00 operating capital. This capital is required so that the provider agency has the capability to operate for a minimum of sixty (60) days in the event Medicaid reimbursement is delayed or withheld for any reason. Certified evidence of operating capital includes, but is not limited to, a written statement from an officer of a financial institution or a certified accountant; a copy of your most recent bank statement must be included. Operating capital will be verified prior to initiating a contract and periodically during the contract period.

3. Providers must agree to participate in all components of the Care Call payment system and have the capability to receive and respond to authorizations for service in an electronic format.

4. Providers must have at least one (1) year of experience or otherwise demonstrate competency in the provision of this service.

C. Conditions of Participation – Community Choices Waiver Participants

Community Choices waiver participants must meet the following criteria in order to be considered for the Telemonitoring service:

1. Have a primary diagnosis of Insulin Dependent Diabetes Mellitus, Hypertension, Chronic Obstructive Pulmonary Disease, and/or Congestive Heart Failure; and

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

TELEMONITORING SERVICE

2. Have a history of at least two hospitalizations and/or emergency room visits in the past twelve (12) months; and

3. Have a primary care physician that approves the use of the telemonitoring service and is solely responsible for receiving and acting upon the information received via the telemonitoring service; and

4. Be capable of using the telemonitoring equipment and transmitting the necessary data or have an individual available to them that is capable of utilizing the telemonitoring equipment and transmitting data to the telemonitoring provider.

At a minimum, South Carolina Department of Health and Human Services (SCDHHS) shall perform a reassessment of the telemonitoring service need at re-evaluation of level of care. The reassessment by SCDHHS shall be done to assess whether or not any of the above conditions have changed and to assess the continuing need for the service.

D. Description of Services to be Provided

2. The Unit of Service is one (1) day of direct telemonitoring provided to/for a participant in the participant's place of residence.

3. Home telemonitoring equipment must record, at a minimum, body weight, blood pressure, oxygen saturation, blood glucose, and basic heart rate information. The data must be transmitted electronically, and any transmission costs shall be incurred by the provider of the telemonitoring service. Medical professionals shall receive the data and determine if readings are within normal limits based upon guidelines provided by the physician.

4. The daily reimbursement rate for the Telemonitoring service is inclusive of monitoring of data, charting data from the monthly monitoring, visits or calls made to the home to follow up with participants and/or caregiver, phone calls made to primary care physician(s) that are necessary while the participant is receiving the telemonitoring service, all installation of the equipment in the home, and training on the equipment’s use and care while it is in the participant’s home. This also includes equipment removal when the service is no longer authorized for the participant.

4. The Provider shall provide the Telemonitoring service seven (7) days per week for all authorized time periods.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

TELEMONITORING SERVICE

E. Staffing

The provider must provide all of the following (some, but not all of which, may be provided through subcontracts):

1. A registered nurse (RN) who meets the following requirements:

   a. Currently licensed by the S.C. State Board of Nursing or by a state that participates in the Nursing Compact

   b. At least one (1) year of experience as a RN in public health, hospital or long term care nursing

   c. Capable of evaluating and monitoring vital signs and physiological data transmitted from the participant's residence

   d. Able to assume responsibility for monitoring and training participants and/or caregivers in the use of telemonitoring equipment

   e. Able to use the Care Call IVR system

2. Technicians that install telemonitoring equipment must meet the following requirements:

   a. Qualified as a technician to install telemonitoring equipment

   b. Capable of evaluating whether or not the telemonitoring equipment is functioning properly

   c. Able to assume responsibility for training participants and/or caregivers in the use of telemonitoring equipment

   d. Able to use the Care Call IVR system

3. Agency staff may be related to participants served by the agency within limits allowed by the South Carolina Family Caregiver Policy. Copies of this policy are available upon request.

4. A criminal background check is required for all potential employees to include employees who shall provide direct care to SCDHHS participants and all administrative/office employees (office employees required to have background checks include: administrator, office manager, nurse supervisor, and persons

named on organizational chart in management positions). All criminal background checks must include all data for the individual with no less than a ten (10) year search. The criminal background check must include statewide (South Carolina) data. The statewide data must include South Carolina and any other state or states the worker has resided in within the prior ten years. Potential employees with felony convictions within the last ten (10) years cannot provide services to SCDHHS participants or work in an administrative/office position. Potential employees with non-violent felonies dating back ten (10) or more years can provide services to SCDHHS participants under the following circumstances:

- Participant/responsible party must be notified of the RN or technician's criminal background.

- Documentation signed by the participant/responsible party acknowledging awareness of the criminal background and agreement to have the RN or technician provide care must be placed in the participant record.

Potential administrative/office employees with non-violent felony convictions dating back ten (10) or more years can work in the agency at the Provider's discretion.

Hiring of employees with misdemeanor convictions shall be at the Provider's discretion.

5. Personnel folders: Individual records shall be maintained to document that each member of the staff has met the above requirements.

F. Conduct of Service

The provider must maintain documentation showing that it has complied with the requirements of this section.

1. Participants and/or caregivers shall choose among qualified providers of the telemonitoring service. Once a provider has been chosen by the participant and/or caregiver, the Telemonitoring provider shall receive a referral that will have information on the participant's condition. Telemonitoring providers must accept or decline referrals from SCDHHS within two (2) working days. Failure to respond shall result in the loss of the referral.

2. If the referral is accepted, the provider shall obtain the physician's authorization for the Telemonitoring service. The provider shall notify the Case Manager when it has received the signed physician authorization for Telemonitoring form. A blank copy of the physician authorization form can be obtained on our website.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

TELEMONITORING SERVICE

3. The provider shall initiate Telemonitoring services on the date negotiated with the Case Manager and indicated on the service authorization. The Case Manager must be notified if services are not initiated on that date. Services provided prior to the service authorization date are not reimbursable.

4. The Case Manager shall authorize Telemonitoring services by designating the amount, frequency and duration of service for participants in accordance with the participant's Service Plan. The Service Plan shall be developed utilizing the telemedicine assessment criteria and in consultation with the participant and others involved in the participant's care. The Case Manager must update the Service Plan yearly, or more frequently as needed, and send to the Provider.

5. The Case Manager shall notify the provider immediately if services to a participant are to be terminated. However, the provider should refer to the language in the Community Long Term Care Services Provider Manual in section 1, General Information and Administration, regarding the Provider's responsibility in checking the participant's Medicaid eligibility status.

6. The provider shall install the equipment in the home and train the participant and/or caregiver in the use of the telemonitoring equipment. The installation and training must be done by a trained technician and/or RN knowledgeable of the equipment and able to address issues that may arise during training and in the installation of the product. The daily monitoring fee is inclusive of installation and training.

7. As part of the conduct of service, Telemonitoring must be provided by an RN (or physician) who meets the requirements as stated in the scope and shall:

    a. Be responsible for daily medical telemonitoring of body weight, blood pressure, blood glucose levels, and basic heart rate information. Each day when the physiological data is conveyed, the nurse shall analyze and interpret the data. If the data continues to remain within normal limits, information shall be conveyed at least quarterly, or more often if requested by the primary care physician accepting responsibility for the telemonitoring information. The telemonitoring agency and primary care physician accepting responsibility for the data shall maintain a written protocol that indicates the manner in which data shall be shared in the event of emergencies or other medical complications that arise during the monitoring service.

    b. Call the participant at least monthly to determine if the participant and/or caregiver are utilizing the equipment correctly and that the equipment

continues to operate appropriately.

8. The provider shall notify the Case Manager in the event the provider becomes aware of any of the following situations:

   - Participant is institutionalized, dies or moves out of the service area
   - Participant no longer wishes to receive telemonitoring services
   - Knowledge of the participant's Medicaid ineligibility or potential ineligibility
   - Participant is not able to utilize the telemonitoring equipment any longer

9. Telemonitoring equipment located in the participant's home must, at a minimum, be a FDA Class II Hospital grade medical device that includes a computer/monitor that is programmable for a variety of disease states and for rate and frequency. The equipment must have a digital scale that measures accurately to at least 400 lbs. that is adaptable to fit a glucometer and a blood pressure cuff. All installed equipment must be able to measure, at a minimum, blood pressure, heart rate, oxygen saturation, blood glucose, body weight. Telephones, facsimile machines, and electronic mail systems do not alone meet the requirements of the definition of Telemonitoring, but may be utilized as a component of the telemonitoring system. All data must be transmitted electronically and any fees or costs associated with the transmission are the sole responsibility of the Provider. The maintenance, repair and/or replacement of any damaged telemonitoring equipment are the Provider's sole responsibility and are not a reimbursable Medicaid service. Major telemonitoring equipment failures which affect the ability to transmit or receive data must be repaired within two (2) working days. Any failure in the individual components of a telemonitoring system such as adaptability with a glucose monitor will need to be corrected within one week of discovering the problem associated with the additional equipment.

10. The provider must maintain an individual participant record which documents the following items:

    a. Documentation that Telemonitoring services were initiated on the date negotiated with the Case Manager and indicated on the Medicaid authorization. Services must not be provided prior to the authorized start date and must be provided according to the schedule as indicated on the Service Provision Form/Authorization.

    b. The written protocol for notifying the primary care physician of all

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

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Telemonitoring services.

c. The provider shall maintain a record keeping system which documents:

i. The delivery of services in accordance with the SCDHHS CLTC Service Plan. Monitoring sheets that are reviewed and signed, by the RN, must be filed in the participant's record within two (2) weeks of service delivery.

ii. Documentation that a participant phone call has been made on at least a monthly basis to determine that the participant and/or caregiver are utilizing the equipment correctly and that the equipment continues to operate appropriately.

iii. In the event services cannot be provided as authorized, the provider must maintain documentation of the reason(s) why services were not completed as specified by the Service Provision Form/ Authorization.

G. Administrative Requirements

1. The Provider must inform SCDHHS of the Provider's organizational structure including the Provider personnel with authority and responsibility for employing qualified personnel, ensuring adequate staff education, in-service training and employee evaluations. The Provider shall notify SCDHHS within three (3) working days in the event of a change in or the extended absence of the personnel with the above listed authority.

2. The Provider must provide SCDHHS with a written document showing the organization, administrative control and lines of authority for the delegation of responsibility down to the hands-on participant care level staff at contract implementation. The document should include an organizational chart including names of those currently in the positions. Revisions or modifications to this organizational document must be provided to SCDHHS. It is recommended that this document be readily accessible to all staff.

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

4. The Provider agency shall acquire and maintain, for the duration of the contract liability, insurance and worker's compensation insurance as provided in Article IX, Section D of the Contract. The Provider is required to list SCDHHS – CLTC as a Certificate Holder for informational purposes only on all insurance policies

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

TELEMONITORING SERVICE

using the following address: Post Office Box 8206, Columbia, SC 29202-8206.

5. The Provider shall develop and maintain a Policy and Procedure Manual that describes how activities shall be performed in accordance with the terms of the contract. The Policy and Procedure Manual shall be available during office hours for the guidance of the governing body and personnel and shall be made available to SCDHHS upon request.

6. The Provider must comply with Article IX, Section AA of the Contract regarding safety precautions. The Provider must also have an on-going infectious disease program to prevent the spread of infectious diseases among its employees.

7. The Provider shall ensure that key agency staff are accessible in person, by phone, or by beeper during compliance review audits conducted by SCDHHS and/or its agents.

8. The Provider shall ensure that its office is open and staffed by qualified personnel during the hours of 10:00 a.m. to 4:00 p.m., Monday through Friday. Outside of these hours, the Provider agency must be available by telephone during normal business hours, 8:30 a.m. to 5:00 p.m., Monday through Friday. The Provider must also have a number for emergencies outside of normal business hours. Participant and personnel records must be maintained at the address indicated in the contract and must be made available, upon request, for review by SCDHHS.

FORMS

Number	Name	Revision Date
DHHS 126	Confidential Complaint	06/2007
DHHS 130	Claim Adjustment Form 130	03/2007
DHHS 205	Medicaid Refunds	01/2008
DHHS 931	Health Insurance Information Referral Form	01/2008
	Reasonable Effort Documentation	04/2014
	Authorization Agreement for Electronic Funds Transfer	01/2014
	Duplicate Remittance Advice Request Form	04/2014
	Claim Reconsideration Form	12/2016
CMS-1500 (02/12)	Sample Health Insurance Claim Form	02/2012
	Sample Remittance Advice (four pages)	04/2014
DHHS 175	Community Long Term Care Service Provision Form	07/1992
MR/RD A-3	SCDDSN MR/RD Waiver – Authorization for Services to Be Billed to Medicaid Personal Care	03/2004
MR/RD A-9	SCDDSN MR/RD Waiver – Authorization for Services to Be Billed to Medicaid Psychological Services	03/2004
MR/RD A-12	SCDDSN MR/RD Waiver – Authorization for Services to Be Billed to Medicaid Nursing Services	03/2004
MR/RD A-13	SCDDSN MR/RD Waiver – Authorization for Services to Be Billed to Medicaid Private Vehicle Modification	03/2004
MR/RD A-23	SCDDSN MR/RD Waiver – Authorization for Services to Be Billed to Medicaid Adult Day Health Care Services	03/2004
MR/RD A-25	SCDDSN MR/RD Waiver – Authorization for Services to Be Billed to DSN Board Respite Services	09/2003
MR/RD A-27	SCDDSN MR/RD Waiver – Authorization for Services to Be Billed to Medicaid Behavior Support Services	03/2004

FORMS

Number	Name	Revision Date
MR/RD A-28	SCDDSN MR/RD Waiver – Authorization for Services to Be Billed to DSN Board Residential Habilitation	08/2001
MR/RD A-31	SCDDSN MR/RD Waiver – Authorization for Services to Be Billed to Medicaid Audiology Services	07/2001
MR/RD A-32	SCDDSN MR/RD Waiver – Authorization for ICF/MR (Institutional) Respite Services to Be Billed to DSN Board	08/2003
MR/RD 16	SCDDSN MR/RD Waiver Notice of Termination of Service	08/2001
MR/RD 16 (reverse)	SCDDSN MR/RD Waiver Process for Appealing Decisions	
HASCI 12-D	SCDDSN HASCI Waiver – Authorization for Medicaid Waiver Nursing Services	02/2004
HASCI 12-E	SCDDSN HASCI Waiver – Authorization for Psychological Services	02/2004
HASCI 12-F	SCDDSN HASCI Waiver – Authorization for PERS Services	02/2004
HASCI 12-H	SCDDSN HASCI Waiver – Authorization for Respite Services	02/2004

STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH
AND HUMAN SERVICES

CONFIDENTIAL COMPLAINT

SEND TO: DIRECTOR, DIVISION OF PROGRAM INTEGRITY
DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. BOX 100210, 1801 MAIN STREET, COLUMBIA, SOUTH CAROLINA 29202-3210

PROGRAM INTEGRITY

THIS REPORT IS DESIGNED FOR THE REPORTING OF POSSIBLE ABUSE BY MEDICAID PROVIDERS AND/OR RECIPIENTS. USE THE SPACE BELOW TO EXPLAIN IN DETAIL YOUR COMPLAINT. PLEASE IDENTIFY YOURSELF AND WHERE YOU CAN BE REACHED FOR FUTURE REFERENCES. UNLESS OTHERWISE INDICATED, ALL INFORMATION SHOULD BE PRINTED OR TYPED.

YOUR COMPLAINT WILL REMAIN CONFIDENTIAL.

SUSPECTED INDIVIDUAL OR INDIVIDUALS:

NPI or MEDICAID PROVIDER ID: (if applicable)	MEDICAID RECIPIENT ID NUMBER: (if applicable)
ADDRESS OF SUSPECT:	LOCATION OF INCIDENT:
	DATE OF INCIDENT:

COMPLAINT:

NAME OF PERSON REPORTING: (Please print)	SIGNATURE OF PERSON REPORTING:	DATE OF REPORT

ADDRESS OF PERSON REPORTING:	TELEPHONE NUMBER OF PERSON REPORTING:
	SIGNATURE: (SCDHHS Representative Receiving Report)

South Carolina Department of Health and Human Services - Claim Adjustment Form 130

Provider Name: (Please use black or blue ink when completing form)

Provider Address :

Provider City , State, Zip:

Total paid amount on the original claim:

Original CCN:

Provider ID:

NPI:

Recipient ID:

Adjustment Type:

- ◯ Void
- ◯ Void/Replace

Originator:

- ◯ DHHS
- ◯ MCCS
- ◯ Provider
- ◯ MIVS

Reason For Adjustment: (Fill One Only)

- ◯ Insurance payment different than original claim
- ◯ Keying errors
- ◯ Incorrect recipient billed
- ◯ Voluntary provider refund due to health insurance
- ◯ Voluntary provider refund due to casualty
- ◯ Voluntary provider refund due to Medicare
- ◯ Medicaid paid twice - void only
- ◯ Incorrect provider paid
- ◯ Incorrect dates of service paid
- ◯ Provider filing error
- ◯ Medicare adjusted the claim
- ◯ Other

For Agency Use Only

Analyst ID:

- ◯ Hospital/Office Visit included in Surgical Package
- ◯ Independent lab should be paid for service
- ◯ Assistant surgeon paid as primary surgeon
- ◯ Multiple surgery claims submitted for the same DOS
- ◯ MMIS claims processing error
- ◯ Rate change
- ◯ Web Tool error
- ◯ Reference File error
- ◯ MCCS processing error
- ◯ Claim review by Appeals

Comments:

Signature:_____ Date:_____

Phone:_____

South Carolina Department of Health and Human Services
Form for Medicaid Refunds

Purpose: This form is to be used for all refund checks made to Medicaid. This form gives the information needed to properly account for the refund. If the form is incomplete, the provider will be contacted for the additional information.

Items 1, 2 or 3, 4, 5, 6, & 7 must be completed. **Attach appropriate document(s) as listed in item 8.**

1. Provider Name: _____

2. Medicaid Legacy Provider # ☐☐☐☐☐☐
(Six Characters)

OR

3. NPI# ☐☐☐☐☐☐☐☐☐☐ **& Taxonomy** ☐☐☐☐☐☐☐☐☐☐

4. Person to Contact: _____ **5. Telephone Number:** _____

6. Reason for Refund: [check appropriate box]

☐ Other Insurance Paid (please complete **a – f** below and attach insurance EOMB)
- **a** Type of Insurance: ( ) Accident/Auto Liability ( ) Health/Hospitalization
- **b** Insurance Company Name _____
- **c** Policy #:_____
- **d** Policyholder: _____
- **e** Group Name/Group: _____
- **f** Amount Insurance Paid:_____

☐ Medicare
- ( ) Full payment made by Medicare
- ( ) Deductible not due
- ( ) Adjustment made by Medicare

☐ Requested by DHHS (please attach a copy of the request)

☐ Other, describe in detail reason for refund:

_____
_____
_____
_____

7. Patient/Service Identification:

Patient Name	Medicaid I.D.# (10 digits)	Date(s) of Service	Amount of Medicaid Payment	Amount of Refund

8. Attachment(s): [Check appropriate box]

☐ Medicaid Remittance Advice (required)

☐ Explanation of Benefits (EOMB) from Insurance Company (if applicable)

☐ Explanation of Benefits (EOMB) from Medicare (if applicable)

☐ Refund check

Make all checks payable to: South Carolina Department of Health and Human Services
Mail to: SC Department of Health and Human Services
Cash Receipts
Post Office Box 8355
Columbia, SC 29202-8355

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID HEALTH INSURANCE INFORMATION REFERRAL FORM

Provider or Department Name: _____ Provider ID or NPI: _____

Contact Person: _____ Phone #: _____ Date: _____

I ADD INSURANCE FOR A MEDICAID BENEFICIARY WITH NO INSURANCE IN THE MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) – ALLOW 25 DAYS

Beneficiary Name: _____ Date Referral Completed: _____

Medicaid ID#: _____ Policy Number: _____

Insurance Company Name: _____ Group Number: _____

Insured's Name: _____ Insured SSN: _____

Employer's Name/Address: _____

II CHANGES TO AN INSURANCE RECORD THAT IS IN THE MMIS – MIVS SHALL WORK WITHIN 5 DAYS

_____ a. beneficiary has never been covered by the policy – close insurance.

_____ b. beneficiary coverage ended - terminate coverage (date) _____

_____ c. subscriber coverage lapsed - terminate coverage (date) _____

_____ d. subscriber changed plans under employer - new carrier is _____

- new policy number is _____

_____ e. beneficiary to add to insurance already in MMIS for subscriber or other family member.

(name) _____

ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.

Submit this information to Medicaid Insurance Verification Services (MIVS).

Fax:	**or**	**Mail:**
803-252-0870		Post Office Box 101110 Columbia, SC 29211-9804

III NEW POLICY NUMBERS FOR INSURANCE IN THE MMIS WITH THE SUBSCRIBER SSN (SCDHHS is collecting new unique policy numbers and plans to replace existing insurance records through MMIS online modification as computer resources are available.)

Medicaid Beneficiary ID: _____ SSN: _____

Carrier Name/Code: _____ New Unique Policy Number: _____

Submit this information to South Carolina Department of Health and Human Services (SCDHHS).

Fax:	**or**	**Mail:**
803-255-8225		Post Office Box 8206, Attention TPL Columbia, SC 29202-8206

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
REASONABLE EFFORT DOCUMENTATION

PROVIDER _____ **DOS** _____

NPI or MEDICAID PROVIDER ID _____

MEDICAID BENEFICIARY NAME _____

MEDICAID BENEFICIARY ID# _____

INSURANCE COMPANY NAME _____

POLICYHOLDER _____

POLICY NUMBER _____

ORIGINAL DATE FILED TO INSURANCE COMPANY _____

DATE OF FOLLOW UP ACTIVITY _____

RESULT:

FURTHER ACTION TAKEN:

DATE OF SECOND FOLLOW UP _____

RESULT:

I HAVE EXHAUSTED ALL OPTIONS FOR OBTAINING A PAYMENT OR SUFFICIENT RESPONSE FROM THE PRIMARY INSURER.

_____

(SIGNATURE AND DATE)

ATTACH A COPY OF THE FORM TO A NEW CLAIM AND FORWARD TO YOUR MEDICAID CLAIMS PROCESSING POST OFFICE BOX.

Revised 04/2014

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

PROVIDER INFORMATION

Provider Name _____

Doing Business As Name (DBA) _____

Provider Address

Street _____

City _____ State/Province _____

Zip Code/Postal Code _____ Medicaid Provider Number _____

Provider Federal Identification Number (TIN) or Employer Identification Number (EIN) _____

National Provider Identifier (NPI) _____

Provider EFT Contact Information

Provider Contact Name _____

Telephone Number _____ Telephone Number Extension _____

Email Address _____

FINANCIAL INSTITUTION INFORMATION

Financial Institution Name _____

Financial Institution Address _____

Street _____

City _____ State/Province _____

Zip Code/Postal Code _____

Financial Institution Routing Number _____

Type of Account at Financial Institution (select one) ☐ Checking ☐ Savings

Provider's Account Number with Financial Institution _____

Account Number Linkage to Provider Identifier (select one)

☐ Provider Tax Identification Number (TIN)

☐ National Provider Identifier (NPI)

REASON FOR SUBMISSION: ☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment

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 above and the financial institution named above, 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.

All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any Medicaid direct deposits are made.

Written Signature of Person Submitting Enrollment _____

Printed Name of Person Submitting Enrollment _____

Submission Date _____

TO PROCESS YOUR EFT ENROLLMENT OR CHANGE EXISTING INFORMATION, PLEASE RETURN THIS COMPLETED FORM ALONG WITH VERIFICATION OF YOUR ELECTRONIC DEPOSIT INFORMATION ON YOUR FINANCIAL INSTITUTION'S LETTERHEAD TO:

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

SPECIAL INSTRUCTIONS: For questions regarding the status of your EFT enrollment, please contact the Provider Service Center at 1-888-289-0709. Please refer to the Electronic Funds Transfer (EFT) section of the Provider Enrollment manual found on the SCDHHS Provider web page for instructions on how to complete updates to your EFT information.

Effective January 01, 2014, providers have the capability to link their EFT payment transaction with their electronic remittance advice (ERA) via a matching EFT Reassociation Trace Number. This trace number will automatically be included in your SCDHHS electronic remittance advice. In order for this matching reassociation trace number to appear in your EFT notification, you must contact your financial institution and request the addition of this information. Any questions regarding this matching trace number and your ERA can be directed to the Provider Service Center at 1-888-289-0709.

South Carolina Department of Health and Human Services
Duplicate Remittance Advice Request Form

Purpose: This form is to be used for all requests for duplicate remittance advices from South Carolina Medicaid. The form must be completed in its entirety in order to honor the request. If the form is incomplete, the form will be returned requesting the additional information.

Please contact the SCDHHS Medicaid Provider Service Center (PSC) at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us for instructions on submission of your request.

1. Provider Name: _____

2. Medicaid Legacy Provider # _____ (Six Characters)

   NPI# _____ & Taxonomy _____

3. Person to Contact: _____ 4. Telephone Number: _____

5. Requesting:

   ☐ Remittance Advice Pages ☐ Edit Correction Form (ECF) Pages Only*

   (*) ECFs are available only for Remittance Advice dates prior to January 17, 2014. Please note that SCDHHS no longer accepts ECFs for processing as of April 1, 2014.

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

   _____
   _____
   _____
   _____
   _____

   Note: Remittance advices are available electronically through the Web Tool. Please check the Web Tool for the availability of the remittance advice date before submitting your request.

7. Street Address for delivery of request:

   Street: _____

   City: _____

   State: _____

   Zip Code: _____

8. Charges for duplicate remittance advice(s) are as follows:

   Request Processing Fee - $20.00

   Page(s) copied - .20 per page

I understand and acknowledge that a charge is associated with this request and will be deducted from my provider's payment by debit adjustment on a future remittance advice.

_____ _____

Authorizing Signature **Date**

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Nikki R. Haley GOVERNOR
Christian L. Soura DIRECTOR
P.O. Box 8206 > Columbia, SC 29202
www.scdhhs.gov

Submit your Claim Reconsideration request to:

Fax: 1-855-563-7086
or
Mail: South Carolina Healthy Connections Medicaid
ATTN: Claim Reconsiderations
Post Office Box 8809
Columbia, SC 29202-8809

CLAIM RECONSIDERATION FORM

Instructions: Complete this form within 30 days of receipt of the remittance advice reflecting the denied claim, and attach all documentation in support of your request. Allow up to 60 days for a written response. Claim disputes must first be initiated through the Provider Service Center (PSC). Enter the PSC Communication ID in the required field below. For questions, contact the PSC at 1-888-289-0709.

Section 1: Beneficiary Information

Name (Last, First, MI): _____

Date of Birth: _____ . ŜyŜŦλŎλI·ℕẽ Medicaid ID:

_____ψψψψψψψ

Section 2: Provider Information

Specify your affiliation: ☐ Physician ☐ Hospital ☐ Other (DME, Lab, Home Health Agency, etc.): _____

NPI: _____ Medicaid Provider ID: _____ψψ___ Facility/Group/Provider Name: _____

Return Mailing Address: _____
Street or Post Office Box *State* *ZIP*

Contact: _____ Email: _____ Telephone #: _____ψ Fax #: _____

Section 3: Claim Information

Communication ID: _____ CCN: _____ Date(s) of Service: _____

Section 4: Claim Reconsideration Information

What area is your denial related to? (Please select below)

- ☐ Ambulance Services
- ☐ Clinic Services
- ☐ Community Long Term Care (CLTC)
- ☐ Community Mental Health Services
- ☐ Durable Medical Equipment (DME)
- ☐ Early Intervention Services
- ☐ Federally Qualified Health Center (FQHC)
- ☐ Enhanced Services
- ☐ Home Health Services
- ☐ Hospice Services
- ☐ Hospital Services
- ☐ Licensed Independent Practitioner's Rehabilitative Services (LIPS)
- ☐ Local Education Agencies (LEA)
- ☐ Nursing Facility Services
- ☐ Optional State Supplementation (OSS)
- ☐ Pharmacy Services
- ☐ Physicians Laboratories, and Other Medical Professionals
  Specify: _____ψψ
- ☐ Private Rehabilitative Therapy and Audiological Services
- ☐ PRTF CHANCE Waiver
- ☐ Psychiatric Hospital Services
- ☐ Rehabilitative Behavioral Health Services (RBHS)
- ☐ Rural Health Clinic (RHC)
- ☐ Targeted Case Management (TCM)
- ☐ Other: _____

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections
MEDICAID

Nikki R. Haley GOVERNOR
Christian L. Soura DIRECTOR
P.O. Box 8206 > Columbia, SC 29202
www.scdhhs.gov

Section 5: Desired Outcome

Request submitted by:

Print Name: _____

Signature: _____ Date: _____

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Sample Remittance Advice (page 1)

This page of the sample Remittance Advice shows a paid claim, suspended claim and rejected claim.

```
  PROVIDER ID.                                          PROFESSIONAL SERVICES            PAYMENT DATE                 PAGE
+--------------+  DEPT OF HEALTH AND HUMAN SERVICES                                   +------------+               +----+
| AB00080000   |                                          REMITTANCE ADVICE           | 02/14/2014 |               |  1 |
+--------------+   SOUTH CAROLINA MEDICAID PROGRAM                                    +------------+               +----+
+---------+-----------------+------+---------+------+--------+--------+-+----------+-------------------+---+-------+-------+-------+
|PROVIDERS|      CLAIM      |      |SERVICE RENDERED|  AMOUNT|TITLE 19|S|RECIPIENT |RECIPIENT NAME     |M  |TLE. 18| COPAY | TITLE |
| OWN REF.|   REFERENCE     |      | DATE(S) |      |  BILLED| PAYMENT|T|    ID.   |F M                | O |ALLOWED| AMT   |  18   |
|  NUMBER |      NUMBER     |PY IND|MMDDYY   | PROC.|        |MEDICAID|S|  NUMBER  |I I LAST NAME      |  D|CHARGES|       |PAYMENT|
+---------+-----------------+------+---------+------+--------+--------+-+----------+-------------------+---+-------+-------+-------+
|         |                 |      |         |      |        |        | |          |                   |   |       |       |       |
|ABB1AA   |1403004803012700A|      |         |      |  27.00 |    6.72|P|1112233333|M   CLARK          |   |       |       |       |
|         |              01 |      |101713   |71010 |  27.00 |    6.72|P|          |                   |026|       |   0.00|   0.00|
|         |                 |      |         |      |        |        | |          |                   |   |       |       |       |
|ABB2AA   |1403004804012700A|                |      | 259.00 |    0.00|S|1112233333|M   CLARK          |   |       |       |       |
|         |              01 |      |101713   |74176 | 259.00 |    0.00|S|          |                   |026|       |   0.00|   0.00|
|         |                 |                |      |        |        | |          |                   |   |       |       |       |
|ABB3AA   |1403004805012700A|      |         |      |   24.00|    0.00|R|1112233333|M   CLARK          |   |       |   0.00|       |
|         |              01 |      |071913   |A5120 |   12.00|    0.00|R|          |                   |000|       |       |   0.00|
|         |              02 |      |071913   |A4927 |   12.00|    0.00|R|          |                   |000|       |       |   0.00|
|         |                 |      |         |      |        |        | |          | Edits:  L00  946  L02  852 08/30/13          |
|         |                 |      |         |      |        |        | |          |                   |   |       |       |       |
|         |           TOTALS|      |        3|      |  310.00|        | |          |                   |   |       |   0.00|   0.00|
|         |                 |      |         |      |        |        | |          |                   |   |       |       |       |
+---------+-----------------+------+---------+------+--------+--------+-+-+--------+-------------------+---+-------+-------+-------+
                                          |            |   |     $6.72|
                                          +------------+   +------------+    STATUS CODES:       PROVIDER NAME AND ADDRESS
FOR AN EXPLANATION OF THE                   CERT. PG TOT    MEDICAID PG TOT                     +--------------------------------+
ERROR CODES LISTED ON THIS                +-------------+  +-------------+    P = PAYMENT MADE  |ABC HEALTH PROVIDER             |
FORM REFER TO:  "MEDICAID                 |       $0.00 |  |      $286.46|    R = REJECTED      |                                |
PROVIDER MANUAL".                         +-------------+  +-------------+    S = IN PROCESS    |PO BOX 000000                   |
                                            CERTIFIED AMT   MEDICAID TOTAL    E = ENCOUNTER     |FLORENCE           SC 00000     |
IF YOU STILL HAVE QUESTIONS+-------------+ +-------------+  +-------------+    +---------+       |                                |
PHONE THE D.H.H.S. NUMBER  |             | |             |  |         0.00|    |         |       +--------------------------------+
SPECIFIED FOR INQUIRY OF   +-------------+ +-------------+  +-------------+    +---------+
CLAIMS IN THAT MANUAL.                                       CHECK TOTAL      CHECK NUMBER
```

Sample Remittance Advice (page 2)

This page of the sample Remittance Advice shows a paid claim, as well as a Void/Replacement claim for which both the Void and the Replacement processed during the same payment cycle.

```
  PROVIDER ID.                                          PROFESSIONAL SERVICES          PAYMENT DATE                PAGE
+--------------+  DEPT OF HEALTH AND HUMAN SERVICES                                  +------------+               +----+
| AB00080000   |                                          REMITTANCE ADVICE          | 02/28/2014 |               |  1 |
+--------------+   SOUTH CAROLINA MEDICAID PROGRAM                                   +------------+               +----+
+---------+-----------------+------+---------+------+--------+--------+-+----------+-------------------+---+-------+-------+-------+
|PROVIDERS|      CLAIM      |      |SERVICE RENDERED|  AMOUNT|TITLE 19|S|RECIPIENT |RECIPIENT NAME     |M  |TLE. 18| COPAY | TITLE |
| OWN REF.|   REFERENCE     |      | DATE(S) |      |  BILLED| PAYMENT|T|    ID.   |F M                | O |ALLOWED|   AMT |  18   |
|  NUMBER |      NUMBER     |PY IND|MMDDYY   | PROC.|        |MEDICAID|S|  NUMBER  |I I LAST NAME      |  D|CHARGES|       |PAYMENT|
+---------+-----------------+------+---------+------+--------+--------+-+----------+-------------------+---+-------+-------+-------+
|         |                 |      |         |      |        |        | |          |                   |   |       |       |       |
|ABB222222|1405200415812200A|      |         |      | 1192.00|  243.71|P|1112233333|M   CLARK          |   |       |   0.00|       |
|         |              01 |      |021814   |S0315 |  800.00|  117.71|P|          |                   |000|       |       |   0.00|
|         |              02 |      |021814   |S9445 |  392.00|  126.00|P|          |                   |000|       |       |   0.00|
|         |                 |      |         |      |        |        | |          |                   |   |       |       |       |
|         |                 |      |         |      |        |        | |          |                   |   |       |       |       |
|         |VOID OF ORIGINAL CCN 13283002244813300A PAID 20131018      | |          |                   |   |       |       |       |
|ABB222222|1405200077700000U|                 |      |1412.00-| 273.71-|P|1112233333|M   CLARK          |   |       |       |       |
|         |              01 |      |100213   |S0315 |1112.00-| 143.71-|P|          |                   |000|       |       |       |
|         |              02 |      |100213   |S9445 | 300.00-| 130.00-|P|          |                   |000|       |       |       |
|         |                 |      |         |      |        |        | |          |                   |   |       |       |       |
|         |REPLACEMENT OF ORIGINAL CCN 1304711253670430A PAID 20131018| |          |                   |   |       |       |       |
|ABB222222|1405200414812200A|      |         |      | 1001.50|   42.75|P|1112233333|M   CLARK          |   |       |   0.00|       |
|         |              01 |      |100213   |S0315 |  142.50|   42.75|P|          |                   |000|       |       |   0.00|
|         |              02 |      |100313   |S9445 |  859.00|    0.00|R|          |                   |000|       |       |   0.00|
|         |                 |      |         |      |        |        | |          |                   |   |       |       |       |
|         |                 |      |         |      |        |        | |          |                   |   |       |   0.00|   0.00|
|         |                 |      |         |      |        |        | |          |                   |   |       |       |       |
|         |                 |      |         |      |        |        | |          |                   |   |       |       |       |
+---------+-----------------+------+---------+------+--------+--------+-+-+--------+-------------------+---+-------+-------+-------+
                                          |            |   |     $286.46|
                                          +------------+   +------------+    STATUS CODES:       PROVIDER NAME AND ADDRESS
FOR AN EXPLANATION OF THE                  CERT. PG TOT    MEDICAID PG TOT                     +--------------------------------+
ERROR CODES LISTED ON THIS               +-------------+  +-------------+    P = PAYMENT MADE  |ABC HEALTH PROVIDER             |
FORM REFER TO:  "MEDICAID                |       $0.00 |  |      $286.46|    R = REJECTED      |                                |
PROVIDER MANUAL".                        +-------------+  +-------------+    S = IN PROCESS    |PO BOX 000000                   |
                                           CERTIFIED AMT   MEDICAID TOTAL    E = ENCOUNTER     |FLORENCE            SC 00000    |
IF YOU STILL HAVE QUESTIONS+-------------+ +-------------+  +-------------+    +---------+       |                                |
PHONE THE D.H.H.S. NUMBER  |             | |             |  |         0.00|    |         |       +--------------------------------+
SPECIFIED FOR INQUIRY OF   +-------------+ +-------------+  +-------------+    +---------+
CLAIMS IN THAT MANUAL.                                       CHECK TOTAL      CHECK NUMBER
```

Sample Remittance Advice (page 3)

This page of the sample Remittance Advice shows a claim-level Void without a corresponding Replacement claim.

```
PROVIDER ID.                                                  +----------------+              PAYMENT DATE                  PAGE
+--------------+  DEPT OF HEALTH AND HUMAN SERVICES           |     CLAIM      |             +------------+                +----+
|  AB11110000  |                                              |  ADJUSTMENTS   |             | 02/28/2014 |                |  2 |
+--------------+   SOUTH CAROLINA MEDICAID PROGRAM            |                |             |            |                +----+
                                                              +----------------+             +------------+

+---------+-----------------+---+---------+------+--------+--------+-+-+-+----------+----------+---+------+-----------------------+
|PROVIDERS|       CLAIM     |   |SERVICE RENDERED|  AMOUNT|TITLE 19|S|S|RECIPIENT |RECIPIENT NAME|M  | ORG  |                       |
| OWN REF.|   REFERENCE     |PY | DATE(S) |      |  BILLED| PAYMENT|T|    ID.   |          F  M| O |CHECK |    ORIGINAL CCN       |
|  NUMBER |      NUMBER     |IND|MMDDYY   | PROC.|        |MEDICAID|S|  NUMBER  |LAST NAME I  I|  D| DATE |                       |
+---------+-----------------+---+---------+------+--------+--------+-+----------+--------------+---+----  |-----------------------+
|         |                 |   |         |      |        |        | |          |              |   |      |                       |
|         |                 |   |         |      |        |        | |          |              |   |      |                       |
|ABB222222|1405200077700000U|             |      | 513.00-| 197.71-|P|1112233333|CLARK     M   |   |131018| 1328300224813300A     |
|         |              01 |   |100213   |S0315 | 453.00 | 160.71-|P|          |              |000|      |                       |
|         |              02 |   |100213   |S9445 |  60.00 |  33.00-|P|          |              |000|      |                       |
|         |                 |             |      |        |        | |          |              |   |      |                       |
|         |          TOTALS |           1 |      | 513.00-| 193.71-| |          |              |   |      |                       |
|         |                 |             |      |        |        | |          |              |   |      |                       |
|         |                 |             |      |        |        | |          |              |   |      |                       |
|         |                 |             |      |        |        | |          |              |   |      |                       |
|         |                 |             |      |        |        | |          |              |   |      |                       |
|         |                 |             |      |        |        | |          |              |   |      |                       |
|         |                 |             |      |        |        | |          |              |   |      |                       |
|         |                 |             |      |        |        | |          |              |   |      |                       |
|         |                 |             |      |        |        | |          |              |   |      |                       |
|         |                 |             |      |        |        | |          |              |   |      |                       |
|         |                 |             |      |        |        | |          |              |   |      |                       |
|         |                 |             |      |        |        | |          |              |   |      |                       |
|         |                 |             |      |        |        | |          |              |   |      |                       |
|         |                 |             |      |        |        | |          |              |   |      |                       |
+---------+-----------------+-------------+------+--------+--------+-+----------+--------------+---+------+-----------------------+
                                                   MEDICAID TOTAL     CERTIFIED AMT                        TO BE REFUNDED
          PROVDER                  DEBIT BALANCE  +-------------+    +-------------+   +-------------+    IN THE FUTURE
          INCENTIVE                PRIOR TO THIS  |      $243.71|    |     0.00|   |   |         0.00|      +----------+
          CREDIT AMOUNT            REMITTANCE     +-------------+    +-------------+   +-------------+      |      0.00|
         +-------------+          +-------------+                                                          +----------+
         |         0.00|          |         0.00|     ADJUSTMENTS
         +-------------+          +-------------+    +-------------+    +-------------+    PROVIDER NAME AND ADDRESS
                                                     |     $193.71-|    |             |   +--------------------------------+
                                  YOUR CURRENT       +-------------+    +-------------+   |ABC HEALTH PROVIDER             |
                                  DEBIT BALANCE        CHECK TOTAL      CHECK NUMBER      |                                |
                                 +-------------+    +-------------+    +---------+       |PO BOX 000000                   |
                                 |        0.00 |    |       $50.00|    |  4197304|       |FLORENCE            SC 00000    |
                                 +-------------+    +-------------+    +---------+       +--------------------------------+
```

Sample Remittance Advice (page 4)

This page of the sample Remittance Advice shows four gross-level adjustments.
Gross-level adjustments always appear on the final page of the Remittance Advice.

PROVIDER ID.		ADJUSTMENTS	PAYMENT DATE	PAGE
ABC1110000	DEPT OF HEALTH AND HUMAN SERVICES SOUTH CAROLINA MEDICAID PROGRAM		02/28/2014	3

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE DATE(S) MMDDYY	PROC / DRUG CODE	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME I I F M	ORIG. CHECK DATE	ORIGINAL PAYMENT	ACTION	DEBIT / CREDIT AMOUNT	EXCESS REFUND
TPL 2	1404900004000100U	-						DEBIT	-2389.05	
TPL 4	1405500076000400U	-						DEBIT	-1949.90	
TPL 5	1404900004000100U	-						DEBIT	-477.25	
TPL 6	1405500076000400U	-						CREDIT	477.25	
							PAGE TOTAL:		4338.95	0.00

PROVDER INCENTIVE CREDIT AMOUNT	DEBIT BALANCE PRIOR TO THIS REMITTANCE	MEDICAID TOTAL	CERTIFIED AMT		TO BE REFUNDED IN THE FUTURE
0.00	0.00	0.00	0.00	0.00	0.00

ADJUSTMENTS	YOUR CURRENT DEBIT BALANCE	CHECK TOTAL	CHECK NUMBER
-4338.95	0.00	0.00	0.00

PROVIDER NAME AND ADDRESS

ABC HEALTH PROVIDER
PO BOX 000000
FLORENCE SC 00000

Community Long Term Care
Service Provision Form

PROVIDER: VERIFY
MEDICAID ELIGIBILITY MONTHLY

TYPE OF AUTHORIZATION:
New

From:

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: _____ CLTC PROCEDURE CODE: _____

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

Comments:

Total Units Authorized: Sun Mon Tue Wed Thur Fri Sat Unit Cost: $

CLIENT INFORMATION				
NAME		BIRTHDATE	SEX	
ADDRESS				
CLTC CLIENT NO.	SOCIAL SEC NO.	MEDICAID NO.	ELIGIBILITY TYPE	
PRIMARY PHONE	SECONDARY PHONE	THIRD PHONE		
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

S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/RD WAIVER

AUTHORIZATION FOR SERVICES TO BE *BILLED TO MEDICAID*

TO: _____

_____

RE: _____
Recipient's Name / **Date of Birth**

_____
Address

Medicaid # /__/__/__/__/__/__/__/__/__/__/__/

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization # /___/___/___/___/___/___/___/___/

Personal Care Services (T1020) – Attach MR/RD Form 10

☐ Personal Care I (PC I) S5130

☐ Personal Care II (PC II) T1019

Number of Units Per Week to be Provided: _____ (one unit = 15 minutes)
Start Date: _____

Service coordinator/early interventionist: Name / Address / Phone # (Please Print):

_____

_____

_____

_____

_____ _____
Signature of Person Authorizing Services Date

MR/RD Form A-3 (3/04)

S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/RD WAIVER

AUTHORIZATION FOR SERVICES TO BE *BILLED TO MEDICAID*

TO: _____

_____

RE: _____
Recipient's Name / **Date of Birth**

_____
Address

Medicaid # /__/__/__/__/__/__/__/__/__/__/__/

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization # /___/___/___/___/___/___/___/___/___/

PSYCHOLOGICAL SERVICES (H0046):

Assessment: Number of Units _____ (one unit = 30 minutes)

Counseling/Therapy: Start Date: _____
Number of Units (one unit = 30 minutes) _____
Frequency: _____

**** NO MORE THAN 8 HOURS/16 UNITS PER DAY MAY BE AUTHORIZED ****

Service coordinator/early interventionist: Name / Address / Phone # (Please Print):

_____

_____

_____

_____

_____ _____
Signature of Person Authorizing Services Date

MR/RD Form A-9 (3/04)

S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/RD WAIVER

AUTHORIZATION FOR SERVICES TO BE *BILLED TO MEDICAID*

TO: _____

_____

RE: _____
Recipient's Name / **Date of Birth**

_____
Address

Medicaid # /__/__/__/__/__/__/__/__/__/__/__/

NOTE: The provider is responsible for pursuing all other resources prior to accessing Medicaid. State Plan Medicaid resources must be exhausted before accessing MR/RD Waiver. Our information indicates this person has:

☐ Medicaid Only ☐ 3rd Party liability ☐ Medicare

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization # /__/__/__/__/__/__/__/__/__/

Nursing Services:

Total Number of Units Per Week to be Provided: _____ (one unit = 60 minutes)

☐ LPN Hours/Week (S9124) _____

☐ RN Hours/Week (S9123) _____

Start Date: _____

Service coordinator/early interventionist: Name / Address / Phone # (Please Print):

_____

_____

_____

_____

_____ _____
Signature of Person Authorizing Services Date

MR/RD Form A-12 (3/04)

S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/RD WAIVER

AUTHORIZATION FOR SERVICES TO BE *BILLED TO MEDICAID*

TO: _____

_____

RE: _____
Recipient's Name / **Date of Birth**

_____
Address

Medicaid # /__/__/__/__/__/__/__/__/__/__/__/

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization # /___/___/___/___/___/___/___/___/

Private Vehicle Modification (X9322):

General Description: _____

_____

_____

Cost: _____
(Attach a copy of the bid)

Service coordinator/early interventionist: Name / Address / Phone # (Please Print):

_____

_____

_____

_____

_____ _____
Signature of Person Authorizing Services Date

MR/RD Form A-13 (3/04)

S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/RD WAIVER

AUTHORIZATION FOR SERVICES TO BE *BILLED TO MEDICAID*

TO: _____

_____

RE: _____
Recipient's Name / **Date of Birth**

_____
Address

Medicaid # /__/__/__/__/__/__/__/__/__/__/__/

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization # /___/___/___/___/___/___/___/___/

Adult Day Health Care Services (X6987)

Number of Units Per Week: _____ one unit = 1 (5 hour) day

Start Date: _____

OR

The above named recipient cannot tolerate 5 hour day. Therefore you are authorized to provide:
Number of Units Per Week:_____ (one unit = _____ hours per day)

Start Date: _____

Service coordinator: Name / Address / Phone # (Please Print):

_____

_____

_____

_____

_____ _____
Signature of Person Authorizing Services Date

MR/RD Form A-23 (3/04)

S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/RD WAIVER

AUTHORIZATION FOR SERVICES TO BE *BILLED TO DSN BOARD*

TO: _____

_____

RE: _____
Recipient's Name / **Date of Birth**

_____
Address

Medicaid # /__/__/__/__/__/__/__/__/__/__/__/

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Respite Services

Hourly Respite
Number of Units Per Week: _____ (one unit = 1 hour of service)

Daily Respite:
Number of Units Per _____ : _____
(one unit = 1 respite period of more than 8 consecutive hours)

REMIT BILL TO (Please print):

_____

_____

_____

_____

_____ _____
Signature of Person Authorizing Services Date

MR/RD Form A-25 (9/03)

S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/RD WAIVER

AUTHORIZATION FOR SERVICES TO BE *BILLED TO MEDICAID*

TO: _____

_____

RE: _____
Recipient's Name / **Date of Birth**

_____
Address

Medicaid # /__/__/__/__/__/__/__/__/__/__/__/

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization # /___/___/___/___/___/___/___/___/___/

BEHAVIOR SUPPORT SERVICES (H0045)

Assessment: Number of Units _____ (one unit = 30 minutes)

Number of Units (one unit = 30 minutes) _____
Frequency: _____
Start Date: _____

**** NO MORE THAN 8 HOURS/16 UNITS PER DAY MAY BE AUTHORIZED****

Service coordinator/early interventionist: Name / Address / Phone # (Please Print):

_____

_____

_____

_____

_____ _____
Signature of Person Authorizing Services Date

MR/RD Form A-27 (3/04)

S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/RD WAIVER

AUTHORIZATION FOR SERVICES TO BE *BILLED TO DSN BOARD*

TO: _____

_____

RE: _____
Recipient's Name / **Date of Birth**

_____
Address

Medicaid # /__/__/__/__/__/__/__/__/__/__/__/

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Residential Habilitation

Hourly:
Number of Units Per Week: _____
(one unit = 1 hour of service provided to someone in an SLP I setting)

Daily:
Number of Units Per Year: _____
(one unit = 1 night (present at midnight) in a CTH I, CTH II, CRCF or SLP II)

REMIT BILL TO (Please print):

_____

_____

_____

_____

_____ _____
Signature of Person Authorizing Services Date

MR/RD Form A-28 (8/01)

S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/RD WAIVER

AUTHORIZATION FOR SERVICES
TO BE BILLED TO MEDICAID

TO: _____

_____

RE: _____
Recipient's Name / **Date of Birth**

_____
Address

Medicaid # / / / / / / / / / / /

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization # / / / / / / / /

Audiology Services:

____ Hearing Aid Evaluation: $49.00
____ Hearing Aid Orientation: $24.00
____ Hearing Aid Analysis: $10.50
____ Hearing Aid Re-Check: $16.00
____ Conduction Test: $8.50
____ Impedance Test: $10.25
____ Hearing Consultation: $13.00

Service coordinator/early interventionist: Name / Address / Phone # (Please Print):

_____

_____

_____

_____ _____
Signature of Person Authorizing Services Date

S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/RD WAIVER

AUTHORIZATION FOR ICF/MR (INSTITUTIONAL) RESPITE SERVICES TO BE *BILLED TO DSN BOARD*

☐ Center-Based Respite

☐ Coastal Center

☐ Midlands Center

☐ Pee Dee Center

☐ Saleeby Center

☐ Whitten Center

☐ Community ICF/MR

_____
Name of facility

TO: _____
For Center Based: Claims and Collections (See Attached)
For Community ICF/MR: Board/Provider Finance Director

_____
Address

RE: _____
Recipient's Name / Date of Birth

Medicaid # / / / / / / / / / / /

Social Security # / / / / / / / / / / / /

You are hereby authorized to provide institutional respite to the consumer named above. The consumer cannot be admitted to the ICF/MR (DHHS 181 completed) without first notifying the Service Coordinator (noted below) and verifying that the consumer has been disenrolled from the MR/RD Waiver. Please note: This nullifies any previous authorization to this provider for this service.

Institutional Respite

☐ Number of Units _____ (one unit = number of nights spent in the ICF/MR)
Start Date: _____

Service Coordinator: _____

Board/Provider: _____

Address: _____

Phone Number (with extension when appropriate): _____

_____ _____
Signature of Person Authorizing Services Date

MR/RD Form A-32 (8/03)

S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/RD WAIVER-NOTICE OF TERMINATION OF SERVICE

DATE FORM IS COMPLETED: _____

PROVIDER: _____

_____

RE: _____ _____/_____/_____
Recipient's Name Date of Birth

Medicaid # _____ _____ _____ _____ _____ _____ _____ _____ _____ _____
1 2 3 4 5 6 7 8 9 10

YOU ARE HEREBY NOTIFIED TO TERMINATE THE PROVISION OF THE FOLLOWING SERVICE TO THE PERSON NAMED ABOVE. ONLY THE NUMBER OF UNITS RENDERED PRIOR TO OR ON THE EFFECTIVE DATE OF _____/_____/_____ MAY BE BILLED.

For SC/EI: the effective date is 10 calendar days from the date the form is completed with the exception of death, loss of Medicaid, or admission to an ICF/MR or NF. This allows the consumer 10 days notice prior to termination of service.

- ☐ Respite Care
- ☐ Adult Day Health Care
- ☐ Assistive Technology:_____
- ☐ Personal Care Services
- ☐ Medicaid Waiver Nursing Services
- ☐ Habilitation (specify)
  - ☐ Residential habilitation
  - ☐ Day Habilititation
  - ☐ Prevocational services
  - ☐ Supportive Employment services
- ☐ Prescribed Drugs
- ☐ Adult Dental Services
- ☐ Envionmental Modifications
- ☐ CheckBox14
- ☐ CheckBox15
- ☐ CheckBox22
- ☐ Physical Therapy Services
- ☐ CheckBox17
- ☐ CheckBox18
- ☐ CheckBox19
- ☐ CheckBox20
- ☐ Private Vechicle Modifications

Reason:

- ☐ Change in need no longer justifies original request
- ☐ Change in ICF/MR Level of Care
- ☐ Change in provider availability
- ☐ CheckBox28
- ☐ CheckBox30
- ☐ Death (do not send a copy to the family
- ☐ Medical Condition has improvided
- ☐ No longer meets ICF/MR Level of Care
- ☐ Medicaid ineligible
- ☐ Consumer moved out of state
- ☐ Hospital/Nursing home stay exceeded more than 30 consecutive calendar days

Comments (required for all reasons:_____

_____

Service Coordinator/Early Interventionist: _____

DSN Board/Provider: _____ Phone: _____

Address: _____

Signature: _____ Date: _____/_____/_____

Original: Provider Copy: Consumer/Legal Guardian and File

MR/RD Form 16 (08/01)

SCDDSN RECONSIDERATION PROCESS AND SCDHHS MEDICAID APPEALS PROCESS

The SC Department of Disabilities and Special Needs (SCDDSN) is responsible for the day-to-day operations of the Mental Retardation/Related Disabilities (MR/RD) Waiver and the Head and Spinal Cord Injury (HASCI) Waiver. A request for reconsideration of an adverse decision **must be** sent in writing to the State Director at SCDDSN, P. O. Box 4706, Columbia, SC 29240. The SCDDSN reconsideration process **must be** completed in its entirety before seeking an appeal from the South Carolina Department of Health and Human Services (SCDHHS).

A formal request for a reconsideration must be made in writing within thirty (30) calendar days of receipt of written notification of the adverse decision. The request must state the basis of the complaint, previous efforts to resolve the complaint and the relief sought. The reconsideration request must be dated and signed by the consumer, representative, or person assisting the consumer in filing the request. If necessary, staff will assist the consumer in filing a written reconsideration.

Note: In order for waiver benefits/services to continue during the reconsideration/appeal process, the consumer/representative's request for reconsideration must be submitted within ten (10) calendar days of the written notification of the adverse decision. If the adverse action is upheld, the consumer/representative may be required to repay waiver benefits received during the reconsideration/appeal process.

The State Director or his designee shall issue a written decision within ten (10) working days of receipt of the written reconsideration request and shall communicate this decision to the consumer/representative. If the State Director upholds the original adverse action/decision, the reason(s) shall be specifically identified in the written decision.

If the consumer/representative fully completes the above reconsideration process and is dissatisfied with the results, the consumer/representative has the right to request an appeal with the SCDHHS. The purpose of an administrative appeal is to prove error in fact or law. The consumer/representative must submit a written request to the following address no later than thirty (30) calendar days from the receipt of the SCDDSN written reconsideration decision:

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

The consumer/representative must attach a copy of the written reconsideration decision received from the SCDDSN regarding the specific matter on appeal. In the appeal request the consumer/representative must clearly state with specificity, which issue(s) the consumer/representative wishes to appeal.

Unless the request is made to the above address within thirty (30) calendar days of the receipt of the SCDDSN written reconsideration decision, the SCDDSN decision will be final and binding. An appeal request is considered filed at the above address if postmarked by the thirtieth (30th) calendar day following receipt of the SCDDSN written reconsideration decision. The consumer/representative shall be advised by the SCDHHS Division of Appeals and Hearings as to the status of the appeal request.

South Carolina Department of Disabilities and Special Needs
Head and Spinal Cord Injury Waiver
Authorization for Medicaid Waiver Nursing Services

Medicaid #: _____
1 2 3 4 5 6 7 8 9 10

Referred To: _____

_____

_____

Individuals Name	**Address**
Date of Birth	**City/State/Zip**

Prior Authorization Number: _____ Billing should be submitted to: ☐ DHHS ☐ DSN Board
1 2 3 4 5 6 7

You are hereby authorized to provide:

Medicaid Waiver Nursing Services: ☐ **LPN (S9124)** ☐ **RN (S9123)**

Start Date: _____

Authorized Total: _____ **Units per** _____

Only the number of units rendered may be billed.
Please note: This nullifies any previous authorization to this provider for Medicaid Waiver Nursing Services.

The service is authorized for the individual named above. Only medical services may be billed to the Waiver under Medicaid Waiver Nursing Services and documentation must be provided for any services rendered. The services must be specifically for the Waiver participant and must be medically necessary, as indicated by the individual's physician.

The following services are requested:

_____

_____

_____

_____

Comments: _____

_____

_____

_____

PLEASE PRINT

DSN Board Name: _____ Svc. Coord.: _____

Address: _____

Phone: ( ) - ext. _____

Signature: _____ Date: _____

South Carolina Department of Disabilities and Special Needs
Head and Spinal Cord Injury Waiver
Authorization for Psychological Services

Medicaid #: _____
1 2 3 4 5 6 7 8 9 10

Referred To: _____

_____

_____

Individuals Name	**Address**
Date of Birth	**City/State/Zip**

Prior Authorization Number: _____
1 2 3 4 5 6 7

Billing should be submitted to: ☐ DHHS ☐ DSN Board

You are hereby authorized to provide:

Psychological Services

- ☐ Psychological Assessment (HØØ23)
- ☐ Cognitive Rehabilitation Therapy (HØØ23)
- ☐ Drug and Alcohol Abuse Counseling (T1ØØ7)
- ☐ Family/Individual Therapy - Psychologist (HØØ23)
- ☐ Family/Individual Therapy - LISW (HØØ23)
- ☐ Family/Individual Therapy - BA/MH Practitioner (HØØ23)
- ☐ Psychiatric Services (HØØ23)
- ☐ Neuropsychological Assessment (GØ114)

Start Date: _____

Authorized Total: _____ **Units per** _____

Only the number of units rendered may be billed.
Please note: This nullifies any previous authorization to this provider for psychological services..

Comments: _____

_____

_____

_____

PLEASE PRINT

DSN Board Name: _____ Svc. Coord.: _____

Address: _____

Phone: ( ) - ext. _____

Signature: _____ Date: _____

South Carolina Department of Disabilities and Special Needs
Head and Spinal Cord Injury Waiver
Authorization for PERS Services

Medicaid #: _____
1 2 3 4 5 6 7 8 9 10

Referred To: _____

_____

_____

Individuals Name	**Address**
Date of Birth	**City/State/Zip**

Prior Authorization Number: _____
1 2 3 4 5 6 7

Billing should be submitted to: ☐ DHHS ☐ DSN Board

You are hereby authorized to provide:

☐ **PERS Services**

☐ **PERS Installation (S516Ø)** **Start Date:** _____

☐ **PERS Monitoring (S5161)** **Start Date:** _____

Only the number of units rendered may be billed.
Please note: This nullifies any previous authorization to this provider for PERS Services.

PLEASE PRINT

DSN Board Name: _____ **Svc. Coord.:** _____

Address: _____

Phone: ( ) - ext. _____

Signature: _____ Date: _____

South Carolina Department of Disabilities and Special Needs
Head and Spinal Cord Injury Waiver
Authorization for Respite Services

Medicaid #: _____
1 2 3 4 5 6 7 8 9 10

Referred To: _____

_____

_____

Individuals Name	**Address**
Date of Birth	**City/State/Zip**

Prior Authorization Number: _____ Billing should be submitted to: ☐ DHHS ☐ DSN Board
1 2 3 4 5 6 7

You are hereby authorized to provide:

Respite Services:

Services will be provided in the following location:

- ☐ **Individual's Home** ☐ **Hourly (X7Ø28)** ☐ **Daily (X7Ø27)**
- ☐ **Caregiver's Home** (must be licensed by DDSN) ☐ **Hourly (X7Ø28)** ☐ **Daily (X7Ø27)**
- ☐ **Licensed Respite Care Facility (X7Ø027)**
- ☐ **ICF/MR (HØØ45)**
- ☐ **Nursing Facility (HØØ45)**
- ☐ **Hospital (HØØ45)**
- ☐ **CRCF (T1Ø2Ø)**

Start Date: _____

Authorized Total: _____ **Units per** _____

Only the number of units rendered may be billed.
Please note: This nullifies any previous authorization to this provider for respite services..

Comments: _____

_____

_____

_____

PLEASE PRINT

DSN Board Name: _____ Svc. Coord.: _____

Address: _____

Phone: ( ) - ext. _____

Signature: _____ Date: _____

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Review the resolution instructions below for the edit code(s) that apply to your claim. **Submit a new claim with the corrected information and attach documentation when necessary or applicable to complete the processing of the claim.** If the claim does not require corrections, but needs to be reprocessed as a result of a system update, submit a new claim for processing after the system has been updated. **Remittance Advice pages are not an acceptable form to correct claim errors and will be disregarded.**

Note: For dates of service on or before **September 30, 2015**, the ICD-9-CM manual should be referenced for ICD coding guidance. For dates of service on or after **October 1, 2015**, the ICD-10-CM manual should be referenced for ICD coding guidance.

Edit Code	Description	CARC	RARC	Resolution
007	PAT DAILY INCOME RATE MORE THAN HOME RATE	45 – Charge exceeds fee schedule/maximum allowable or contracted/ legislated fee arrangement.		Patient's daily recurring income is greater than the nursing facility's daily rate. If the recurring income is incorrect, make the appropriate correction and submit a new claim. If the recurring income is correct, contact the PSC.
050	DATE OF BIRTH/ DATE OF SERV. INCONSISTENT	14 – The date of birth follows the date of service.		The date of birth and/or date of service are inconsistent. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1 A), date of birth (field 3), date of service (field 24 A unshaded) **UB CLAIM:** Medicaid ID (field 60), date of birth (field 10), date of service (field 6) If the date of birth is correct according to your records, contact the local county Medicaid office to update the system. After verifying that the system has been updated, submit a new claim.
051	DATE OF DEATH/ DATE OF SERV INCONSISTENT	13 – The date of death precedes the date of service.		The date of death and/or date of service are inconsistent. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1 A), date of service (field 24 A unshaded) **UB CLAIM:** Medicaid ID (field 60), date of service (field 6) **NH CLAIM:** Submit termination DHHS Form 181 with monthly billing. If the date of death is correct according to your records, contact the local county Medicaid office to see if there is an error with the patient's date of death. After verifying that the system has been updated, submit a new claim.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
052	ID/RD WAIVER CLM FOR NON ID/RD WAIVER RECIP	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	The claim was submitted with an ID/RD waiver-specific procedure code, but the recipient was not a participant in the ID/RD waiver. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), date of service (field 24A unshaded), procedure code (field 24D unshaded) If the recipient's Medicaid ID is correct, the procedure code is correct, and an ID/RD waiver form has been obtained, contact the service coordinator listed at the bottom of the waiver form. After the system has been updated, submit a new claim.
053	NON ID/RD WAIVER CLM FOR ID/RD WAIVER RECIP	A1 – Claim/service denied.	N34 – Incorrect claim/format for this service.	The claim was submitted for an ID/RD waiver recipient, but the procedure code is not an ID/RD waiver procedure code. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), date of service (field 24 A unshaded), procedure code (field 24 D unshaded)
055	MEDICARE B ONLY SUFFIX WITH A COVERAGE	16 – Claim/service lacks information which is needed for adjudication.	MA04 – Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	**UB CLAIM:** Submit a claim to Medicare Part A.
056	MEDICARE B ONLY SUFFIX/NO A COV/NO 620	16 – Claim/service lacks information which is needed for adjudication.	M56 – Incomplete/invalid provider payer identification.	**UB CLAIM:** Enter Medicare carrier code 620, Part A - Mutual of Omaha carrier code 635, or Part B - Mutual of Omaha carrier code 636 (fields 50 A-C). Enter the Medicare Part B payment (fields 54 A-C). Enter the Medicare ID number (fields 60 A-C). The carrier code, payment, and ID number should be entered on the same lettered line, A, B, or C.
057	MEDICARE B ONLY SUFFIX/NO A COV/NO $	107 – Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.		**UB CLAIM:** Enter Medicare carrier code 620, Part A - Mutual of Omaha carrier code 635, or Part B - Mutual of Omaha carrier code 636 (fields 54 A – C) which corresponds with the line on which you entered the Medicare carrier code (fields 50 A – C).
058	RECIP NOT ELIG FOR MED. COMPLEX CHILDREN'S WAIVER SVCS	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	The edit cannot be manually corrected. The provider needs to submit billing through the Care Call System.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
059	MED. COMPLEX CHILDREN'S WAIVER RECIP SVCS REQUIRE PA	15- The authorization number is missing, invalid, or does not apply to the billed services or provider.	N517 – Resubmit a new claim with the requested information.	The edit cannot be manually corrected. The provider needs to submit billing through the Care Call System. Contact recipient's PCP to obtain authorization for this service.
060	MED.COMPLEX CHILDREN'S WAIVER, CLAIM TYPE NOT ALLOWED	16 – Claim/service lacks information which is needed for adjudication.	N34 – Incorrect claim form/format for this service.	The edit cannot be manually corrected. The provider needs to submit billing through the Care Call System.
061	INMATE RECIP ELIG FOR EMER INST SVC ONLY	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	The recipient is eligible for emergency institutional services only. If the service was not directly related to emergency institutional services, service is non-covered. Verify that the claim information was billed correctly. **UB CLAIM:** Only inpatient claims will be reimbursed.
062	HEALTHY CONNECTIONS KIDS (HCK) – RECIPIENT in MCO Plan/Service Covered by MCO	24 – Charges are covered under a capitation agreement/ managed care plan.		This recipient is in the Healthy Connections Kids (HCK) Program and enrolled with an MCO. These services are covered by the MCO. Bill the MCO.
079	PRIVATE REHAB UNITS EXCEEDED	273 – Coverage/ program guidelines were exceeded.		The number of units billed for this procedure code exceeds the authorized limit. Refer to the Prior Authorization letter from the QIO to determine the number of units authorized. If the prior authorization unit number is correct, attach the QIO prior authorization letter to the NEW claim for review and consideration for payment. Make corrections to the field(s) below. **CMS-1500 CLAIM**: Date of service (field 24A unshaded), procedure code (field 24D unshaded), units (field 24G unshaded) **UB CLAIM:** Date of service (field 45), procedure code (field 44), units (field 46)
080	SERVICES NON-COVERED FOR RECIPIENTS OVER 21 YEARS OF AGE	6 – The procedure/ revenue code is inconsistent with the patient's age.	N129 – Not eligible due to the patient's age.	These services are non-covered for South Carolina Medicaid Eligible recipients over the age of 21.Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), date of birth (field 3), procedure code (field 24D unshaded) If the date of birth is correct according to your records, contact the local county Medicaid office to update the system. After verifying that the system has been updated, submit a new claim.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
101	INTERIM BILL	135 – Claim denied. Interim bills cannot be processed.		**UB CLAIM:** Verify the bill type (field 4) and the discharge status (field 17). Medicaid does not process interim bills. Please do not file a claim until the recipient is discharged from acute care.
110	PROCEDURE CODE REQUIRES OBESITY PRIMARY DIAGNOSIS	16 – Claim/service lacks information which is needed for adjudication.	M76 - Missing/incomplete/invalid diagnosis or condition.	Verify that the correct procedure code and diagnosis code were billed. Check the current version of the ICD-CM manual for correct coding. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Diagnosis code (field 21), procedure code (field 24D unshaded)
117	DRG 469 - PRIN DIAG NOT EXACT ENOUGH	16 – Claim/service lacks information which is needed for adjudication.	M81 –You are required to code to the highest level of specificity.	This is a non-covered DRG. Verify the diagnoses and procedure codes and make corrections to the field(s) below. **UB CLAIM:** Diagnosis code (field 67), procedure code (field 74)
118	DRG 470 - PRINCIPAL DIAGNOSIS INVALID	16 – Claim/service lacks information which is needed for adjudication.	MA63 – Missing/incomplete/ invalid principal diagnosis.	Resolution is the same as for edit code 117.
119	INVALID PRINCIPAL DIAGNOSIS	16 – Claim/service lacks information which is needed for adjudication.	MA63 – Missing/incomplete/ invalid principal diagnosis.	This claim contains an invalid principal diagnosis. Verify the valid diagnosis in the current ICD-CM manual and make corrections to the field(s) below. **UB CLAIM:** Diagnosis code (field 67)
120	CLM DATA INADEQUATE CRITERIA FOR ANY DRG	A8 – Claim Denied ungroupable DRG.		**UB CLAIM:** Verify data with the medical records department.
121	INVALID AGE	6 – Procedure/revenue code inconsistent with age.		Validate recipient's date of birth on the claim. If there is a discrepancy on the recipient's file, contact the county Medicaid Eligibility office for correction. If the recipient's date of birth is correct, verify that the correct diagnosis code is billed. Check the most current edition of the ICD-CM manual for the correct gestational age range and weight combination. Make corrections to the field(s) below and submit a new claim. **UB CLAIM:** Date of Birth (field 10), Diagnosis code (fields 67 A-Q)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
122	INVALID SEX	16 – Claim/service lacks information which is needed for adjudication.	MA39 – Missing/incomplete/ invalid gender.	This claim contains an invalid sex. Make corrections to the field(s) below. **UB CLAIM:** Sex (field 11) Contact your county Medicaid Eligibility office to correct the sex on the recipient's file if there is a discrepancy according to your records. After the county Medicaid Eligibility office has made the correction and updated the system, submit a new claim.
123	INVALID DISCHARGE STATUS	16 – Claim/service lacks information which is needed for adjudication.	N50 – Missing/incomplete/invalid discharge information.	This claim contains an invalid discharge status code. Check the most current edition of the NUBC manual for a list and descriptions of valid discharge status codes. Make corrections to the field(s) below. **UB CLAIM:** Status (field 17)
125	PPS PROVIDER RECORD NOT ON FILE	CARC B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.		**UB CLAIM:** The prospective payment system (PPS) provider record is not on file to display the reimbursement for the facilities. The provider is not enrolled with Medicaid and will not be considered for payment.
127	PPS STATEWIDE RECORD NOT ON FILE	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.		**UB CLAIM:** The prospective payment system (PPS) statewide record is not on file to display the reimbursement for the facilities. The provider is not enrolled with Medicaid and will not be considered for payment.
128	DRG PRICING RECORD NOT ON FILE	A8 – Claim denied ungroupable DRG.		This DRG is not currently priced by Medicaid. Verify the diagnoses and procedure codes and make corrections to the field(s) below. **UB CLAIM:** Diagnosis code (fields 67 A-Q), procedure code (field 74)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
150	TPL COVER VERIFIED/FILING NOT IND ON CLM	22 - This care may be covered by another payer per coordination of benefits.		Please see INSURANCE POLICY INFORMATION for the three-character carrier code that identifies the insurance company, as well as the policy number and the policyholder's name. Identify the insurance company by referencing the numeric carrier code list in the applicable provider manual or on the DHHS website. File the claim(s) with the primary insurance before re-filing to Medicaid. If the carrier that has been billed is not the insurance for which the claim received the edit 150, the provider must file with the insurance carrier that is indicated. If the system needs to be updated, contact the TPL office. After verifying that the system has been updated, submit a new claim. Verify that the information in the fields below was billed correctly. **CMS 1500 CLAIM:** Enter the carrier code (fields 9D and 11C), policy number (fields 9A and 11). If payment is made, enter the total amount(s) paid (fields 9C, 11B and 29). Adjust the balance due (field 30). If payment is denied (i.e., applied to the deductible, policy lapsed, etc.) by the other insurance company, put a "1" (denial indicator) (field 10D). **UB CLAIM:** Enter the carrier code (field 50). Enter the policy number (field 60). If payment is made, enter the amount paid (field 54). If payment is denied, enter 0.00 (field 54) and also enter code 24 and the date of denial in the Occurrence Code (fields 31-34 A-B). **NOTE:** Please refer to the Medicaid Web-based Claims Submission Tool (Web Tool) to verify insurance information. Click here for additional resolutions tips at MedicaideLearning.com.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
151	MULTIPLE INS POL/NOT ALL FILED-CALL TPL	22 - This care may be covered by another payer per coordination of benefits.		Eliminate any duplicate primary insurance policy entries ensuring one carrier per block. Medicaid coverage should not be entered in either primary block. If there is no duplicate information, refer to the INSURANCE POLICY INFORMATION, and file the claim(s) with each insurance company listed before re-filing to Medicaid. Documentation must show that each policy has been billed, and that proper coordination of benefits has been followed, *e.g.,* bill primary carrier first, then bill second carrier for the difference. If there are three or more separate third-party payers, the claim must be processed by the Third-Party Liability, attach the documentation to your new claim. Verify that the information in the field(s) below was billed correctly. **CMS 1500 CLAIM:** Insurance carrier number (fields 9D and 11C), policy number (fields 9A and 11) **UB CLAIM:** Insurance information (field 50) **NOTE:** Please refer to the Medicaid Web-based Claims Submission Tool (Web Tool) to verify insurance information.
155	POSS NOT POSITIVE INS MATCH/OTHER ERRORS	22 - This care may be covered by another payer per coordination of benefits.		Bill the primary insurer(s) according to the resolution instructions for edit code 150.
156	TPL VERIFIED/FILING NOT INDICATED ON CLM	22 - This care may be covered by another payer per coordination of benefits.		File a claim with the insurance company listed under INSURANCE POLICY INFORMATION. Identify the insurance company by referencing the numeric carrier code list in the applicable provider manual or on the DHHS website. If the insurance company denies payment or makes a partial payment, attach a copy of the explanation of benefits with your claim. If the insurance carrier pays the claim in full, no further action is necessary. **NOTE:** Please refer to the Medicaid Web-based Claims Submission Tool (Web Tool) to verify insurance information.
165	TPL BALANCE DUE/ PATIENT RESPONSIBILITY MUST BE PRESENT/NUMERIC	16-Claim/service lacks information which is needed for adjudication.	MA92 – Missing plan information for other insurance.	When there is a third party payer on the claim that is primary to Medicaid, the "patient responsibility", entered in the "balance due" and the co-pay, coinsurance and deductible for the third party payer, cannot be blank or nonnumeric. Verify that the information in the field(s) below was billed correctly. **CMS 1500 CLAIM:** Amount paid (field 29), balance due (field 30)

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Edit Code	Description	CARC	RARC	Resolution
170	LAB PROC BILLED/NO CLIA # ON FILE	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Attach a copy of your CLIA certification to the new claim.
171	NON-WAIVER PROC/PROV HAS CERT OF WAIVER	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Our records indicate that your CLIA certificate of waiver allows Medicaid reimbursement for waivered procedures only. Lab services billed are not waivered procedures. If your CLIA certification has changed, attach a copy of your updated CLIA certificate from CMS to a new claim.
172	D.O.S. NONCOVERED ON CLIA CERT DATE	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Medicaid will not reimburse for services outside CLIA certification dates. If your CLIA certification has been renewed, attach a copy of your updated CLIA certificate from CMS to a new claim. Contact your lab director or CMS for current CLIA certificate information.
174	NON-PPMP PROC/PROV HAS PPMP CERT	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Our records indicate that your CLIA certificate of PPMP allows Medicaid reimbursement for PPMP procedures only. Lab services billed are not PPMP procedures. If your CLIA certification has changed, attach a copy of your updated CLIA certificate from CMS to a new claim.
201	MISSING RECIPIENT ID NUMBER	31 – Claim denied, as patient cannot be identified as our insured.		The recipient's 10-digit Medicaid ID number must be entered. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A) **UB CLAIM:** Medicaid ID (field 60)
202	MISSING NATIONAL DRUG CODE (NDC)	16 – Claim/service lacks information which is needed for adjudication.	M119 - Missing/incomplete/ invalid/deactivated/withdrawn National Drug Code (NDC).	The NDC is missing from the claim. Make corrections to the field(s) below. **CMS 1500 CLAIM:** NDC (field 24A shaded) **UB CLAIM:** NDC (field 43)
206	MISSING DATE OF SERVICE	16 – Claim/service lacks information which is needed for adjudication.	M59 – Missing/incomplete/invalid "to" date(s) of service.	The date of service is missing. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24A unshaded) **UB CLAIM:** Date of service (field 45)
207	MISSING SERVICE CODE	16 – Claim/service lacks information which is needed for adjudication.	M51 – Missing/incomplete/invalid procedure codes.	The code for the service/procedure is missing. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
208	NO LINES ON CLAIM	16 – Claim/service lacks information which is needed for adjudication.	N34 – Incorrect claim form/ format for this service.	Submit a new claim with the billable services.
209	MISSING LINE ITEM SUBMITTED CHARGE	16 – Claim/service lacks information which is needed for adjudication.	M79 – Missing/incomplete/invalid charge.	The line item submitted charge is missing. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Charges (field 24F unshaded) **UB CLAIM:** Charges (field 47)
210	MISSING TAXONOMY CODE	16 – Claim/service lacks information which is needed for adjudication.	N255 – Missing/incomplete/invalid billing provider taxonomy.	The taxonomy code is missing from the claim. Taxonomy codes are required when an NPI is shared by multiple legacy provider numbers. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Taxonomy code (field 24J shaded) or (field 33B) **UB CLAIM**: Taxonomy code (field 81 A-D)
213	LINE ITEM MILES OF SERVICE MISSING	16 – Claim/service lacks information which is needed for adjudication.	M22 – Missing/incomplete/invalid number of miles traveled.	The number of miles of service is missing from the line item. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Units (field 24G unshaded)
219	PRESENT ON ADMISSION (POA) INDICATOR IS MISSING, DIAGNOSIS IS NOT EXEMPT	A1 – Claim/service denied.	N434 – Missing/incomplete/invalid Present on Admission indicator.	This edit code cannot be manually corrected. Submit a new claim with the corrected information.
225	FUND CODE NOT ASSIGNED	16 – Claim/service lacks information which is needed for adjudication.	M56 – Missing/incomplete/invalid payer identifier.	The system is unable to crosswalk the information on the claim to an assigned fund code. Verify the correct procedure code, modifier, NPI and/or legacy number was submitted. Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Provider ID (field 33A & 33B), procedure code (field 24D unshaded), modifier (field 24D unshaded) **UB CLAIM**: Provider ID (field 56), procedure code, modifier (field 44 or 74) **Note:** Fund codes may identify specific procedure codes, modifiers, and provider type/provider specialties. If these are submitted in the wrong combination or entered incorrectly, the system searches but cannot find the appropriate fund code and is unable to process the claim.

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Edit Code	Description	CARC	RARC	Resolution
227	MISSING LEVEL OF CARE	16 – Claim/service lacks information which is needed for adjudication.	N188 – The approved level of care does not match the procedure code submitted.	The level of care is a required field. Enter the corrected information on a new claim.
233	PRIMARY DIAGNOSIS CODE IS MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA63 – Missing/incomplete/ invalid principal diagnosis.	The primary diagnosis code is missing. Enter a primary diagnosis code from the current edition of the ICD-CM manual. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Primary diagnosis code (field 21)
234	PLACE OF SERVICE MISSING	16 – Claim/service lacks information which is needed for adjudication.	M77-Missing/incomplete/invalid place of service.	The place of service is missing from the claim. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Place of service (24B unshaded)
239	MISSING LINE NET CHARGE	16 – Claim/service lacks information which is needed for adjudication.	M79-Missing/incomplete/invalid charge.	The line net charge is a required field. Enter the corrected information on a new claim.
243	ADMISSION DATE/START OF CARE MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA40 – Missing/incomplete/ invalid admission date.	**UB CLAIM:** Enter the admission date/start of care date (field 12).
244	PRINCIPAL DIAGNOSIS CODE MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA63 – Missing/incomplete/ invalid principal diagnosis.	**UB CLAIM:** Enter the principal diagnosis code (field 67).
245	TYPE OF BILL MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA30 – Missing/incomplete/ invalid type of bill.	**UB CLAIM:** Refer to the most current edition of the NUBC manual for valid type of bill. Enter a valid Medicaid bill type code (field 4).
246	FIRST DATE OF SERVICE MISSING	16 – Claim/service lacks information which is needed for adjudication.	M52 – Missing/incomplete/invalid "from" date(s) of service.	**UB CLAIM**: Enter the first date of service (field 6).
247	MISSING LAST DATE OF SERVICE	16 – Claim/service lacks information which is needed for adjudication.	M59 – Missing/incomplete/invalid "to" date(s) of service.	**UB CLAIM:** Enter the last date of service (field 6).
248	TYPE OF ADMISSION MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA41 – Missing/incomplete/ invalid admission type.	**UB CLAIM:** Refer to the most current edition of the NUBC manual for valid types of admissions. Enter a valid Medicaid type of admission code (field 14).
249	TOTAL CLAIM CHARGE MISSING	16 – Claim/service lacks information which is needed for adjudication.	M54 – Missing/incomplete/invalid total charges.	**UB CLAIM:** Enter revenue code 001 on the total charges line (field 42). This revenue code must be listed as the last field.

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Edit Code	Description	CARC	RARC	Resolution
252	PATIENT STATUS MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA43 – Missing/incomplete/ invalid patient status.	**UB CLAIM:** Refer to the most current edition of the NUBC manual for patient status. Enter the valid Medicaid patient status code (field 17).
253	SOURCE OF ADMISSION MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA42 – Missing incomplete/ invalid admission source.	**UB CLAIM:** Refer to the most current edition of the NUBC Manual for source of admission. Enter a valid Medicaid source of admission code (field 15).
263	MISSING TOTAL DAYS	16 – Claim/service lacks information which is needed for adjudication.	M53 – Missing/incomplete/invalid days or unit(s) of service.	Make the appropriate correction to the claim by entering or correcting the total number of days.
270	DOS/DISCH REQUIRES ICD-9 CODES/ICD-9 INDICATOR	16 – Claim/service lacks information which is needed for adjudication.	N517 – Resubmit a new claim with the requested information.	The DOS/ICD Indicator is inconsistent with the diagnosis or ICD surgical procedure code billed. For claims containing ICD-9 codes, the dates of service must be prior to 10/1/2015. The ICD Indicator field is required and must contain a "9" or be left blank (which will default to a 9) to indicate this is an ICD-9 claim. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24-A), ICD Indicator (field 21) **UB CLAIM:** Date of service/date of discharge (field 6), ICD Indicator (field 66)
271	DOS/DISCH REQUIRES ICD-10 CODES/ICD-10 INDICATOR	16 – Claim/service lacks information which is needed for adjudication.	N517 – Resubmit a new claim with the requested information.	The DOS/ICD Indicator is inconsistent with the diagnosis or ICD surgical procedure code billed. For claims containing ICD-10 codes, the dates of service must be on or after 10/1/2015. The ICD Indicator field is required and must contain a "0" to indicate this is an ICD-10 claim. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24-A), ICD Indicator (field 21) **UB CLAIM:** Date of service/date of discharge (field 6), ICD Indicator (field 66)
281	PROCEDURE CODE MODIFIER MISSING	4 – The procedure code is inconsistent with the modifier used, or a required modifier is missing.		The modifier of the billed procedure code is missing. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded), modifier (field 24D unshaded)

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Edit Code	Description	CARC	RARC	Resolution
300	UB82 FORM NO LONGER ACCEPTED	16 – Claim/service lacks information which is needed for adjudication.	N34 – Incorrect claim/format for this service.	Submit claim on appropriate claim form.
304	TOTAL CLAIM CHARGE NOT NUMERIC	16 – Claim/service lacks information which is needed for adjudication.	M54 – Missing/incomplete/invalid total charges.	The total claim charge is missing or not numeric. Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Total charge (field 28)
305	INVALID TAXONOMY CODE	16 – Claim/service lacks information that is needed for adjudication.	N255 – Missing/incomplete/invalid billing provider taxonomy.	Taxonomy code must be valid. Update the taxonomy code on the claim to the one that the provider registered with SCDHHS or contact Provider Enrollment to add the taxonomy code that is being used on the claim. After Provider Enrollment has updated the system, submit a new claim. Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Taxonomy code (field 24J shaded) or (field 33B) **UB CLAIM**: Taxonomy code (field 81 A-D) Please visit http://www.wpc-edi.com/codes/taxonomy for valid taxonomy codes.
308	INVALID PROCEDURE CODE MODIFIER	4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.	N519 – Invalid combination of HCPCS modifiers.	The modifier for the line item service/procedure is invalid. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Modifier (field 24D unshaded)
309	INVALID LINE ITEM MILES OF SERVICE	16 – Claim/service lacks information which is needed for adjudication.	M22 – Missing/incomplete/invalid number of miles traveled.	The number of miles is invalid. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Units (field 24G unshaded)
310	INVALID PLACE OF SERVICE	16 – Claim/service lacks information which is needed for adjudication.	M77 – Incomplete/invalid place of service(s).	Medicaid requires the numeric coding for place of service. Enter the appropriate place of service code. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Place of service (24B unshaded)
311	INVALID LINE ITEM SUBMITTED CHARGE	16 – Claim/service lacks information which is needed for adjudication.	M79 – Missing/incomplete/invalid charge.	The line item submitted charge is invalid. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Charges (field 24F unshaded) **UB CLAIM:** Charges (field 47)

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Edit Code	Description	CARC	RARC	Resolution
312	MODIFIER NON-COVERED BY MEDICAID	4 – The procedure code is inconsistent with the modifier used, or a required modifier is missing.	N519 – Invalid combination of HCPCS modifiers.	A modifier not accepted by Medicaid has been filed. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Modifier (field 24D unshaded)
316	THIRD PARTY CODE INVALID	16 – Claim/service lacks information which is needed for adjudication.	MA92 – Missing plan information for other insurance.	Incorrect third party code was used. Correct coding would be “1” for denial or “6” for crime victim. If a third party payer is not involved with this claim, the field should be blank. Make corrections to the field(s) below. **CMS-1500 CLAIM:** TPL code (field 10D)
317	INVALID INJURY CODE	16 – Claim/service lacks information which is needed for adjudication.	M76 – Missing/incomplete/invalid diagnosis or condition.	Incorrect injury code was used. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Injury code (field 10 A-C) Correct coding would be "2" for work related accident, "4" for automobile accident, or "6" for other accident.
318	INVALID EMERGENCY INDICATOR / EPSDT REFERRAL CODE	16 – Claim/service lacks information that is needed for adjudication.	M76 – Missing/incomplete/invalid diagnosis or condition.	Verify that the emergency indicator/EPSDT referral code is valid. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Emergency indicator (field 24C unshaded)
322	INVALID AMT RECEIVED FROM OTHER RESOURCE	16 – Claim/service lacks information which is needed for adjudication.	M49 – Missing/incomplete/invalid value code(s) and/or amount(s).	Enter a valid number amount in "amount other sources". Make corrections to the field(s) below. **CMS-1500 CLAIM:** Amount Paid (field 29)
323	INVALID LINE ITEM UNITS OF SERVICE	16 – Claim/service lacks information which is needed for adjudication.	M53 - Missing/incomplete/invalid days or unit(s) of service.	The units of service for the line item are invalid. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Units (field 24G unshaded) **UB CLAIM:** Units (field 46)
330	INVALID LINE ITEM DATE OF SERVICE	16 – Claim/service lacks information which is needed for adjudication.	M52 – Missing/incomplete/invalid “from” date(s) of service.	The date of service for the line item is invalid. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24A unshaded) **UB CLAIM:** Date of service (field 45)
334	ERRONEOUS SURGERY – DO NOT PAY	233 – Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.		Services/Treatment is related to a hospital-acquired condition and no payment is due.

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Edit Code	Description	CARC	RARC	Resolution
339	PRESENT ON ADMISSION (POA) INDICATOR IS INVALID	A1- Claim/Service denied.	N434 – Missing/incomplete/ invalid Present on Admission indicator.	This edit code cannot be manually corrected. Submit a new claim with the corrected information.
349	INVALID LEVEL OF CARE	150 – Payer deems the information submitted does not support this level of service.		This claim contains an invalid level of care. Enter the corrected information on a new claim.
354	TOOTH NUMBER NOT VALID LETTER OR NUMBER	16 – Claim/service lacks information which is needed for adjudication.	N39 – Procedure code is not compatible with tooth number/ letter.	Enter the valid tooth number or letter (field 15). Verify tooth number or letter with procedure code.
355	TOOTH SURFACE CODE INVALID	16 – Claim/service lacks information which is needed for adjudication.	N75 – Missing or invalid tooth surface information.	Enter the correct tooth surface code (field 16).
356	IMMUNIZATION AND ADMINISTRATION CODES MUST BE INCLUDED ON CLAIM	272 – Coverage/ program guidelines were not met.		Medicaid requires that immunization and administration codes must be on the claim. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded)
357	MAXIMUM OF THREE ADMINISTRATION UNITS CAN BE BILLED PER DATE OF SERVICE	272 – Coverage/ program guidelines were not met.		Claim exceeds administration units. If there are unit errors, make the appropriate corrections to the field(s) below. If there are no unit errors, the claim will not be considered for payment. **CMS-1500 CLAIM:** Units (field 24G unshaded)
358	SECONDARY ADMINISTRATION CPT CODE NOT ALLOWED PRIOR TO PRIMARY CODE	B15 – This service/ procedure requires that a qualifying service/ procedure be received and covered. The qualifying other service/ procedure has not been received/adjudicated.	N20 – Service not payable with other service rendered on the same date.	If the qualifying "primary" service/procedure has been rendered, complete or enter accurately the required information in the field(s) below. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded)

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Edit Code	Description	CARC	RARC	Resolution
361	SECONDARY PROC CODE NOT ALLOWED PRIOR TO PRIMARY PROC CODE	B15 – This service/ procedure requires that a qualifying service/ procedure be received and covered. The qualifying other service/ procedure has not been received/adjudicated.	N20 – Service not payable with other service rendered on the same date.	If the qualifying "primary" service/procedure has been rendered, complete or enter accurately the required information in the field(s) below. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded)
367	ADMISSION DATE/START OF CARE INVALID	16 – Claim/service lacks information which is needed for adjudication.	MA40 – Missing/incomplete/ invalid admission date.	The admission date/start of care date is invalid. Date must be six digits and numeric. Make corrections to the field(s) below. **UB CLAIM:** Admission date (field 12)
368	TYPE OF ADMISSION NOT VALID	16 – Claim/service lacks information which is needed for adjudication.	MA41 – Missing/incomplete/ invalid admission type.	Refer to the most current edition of the NUBC manual for valid type of admission. Enter a valid Medicaid type of admission code in the field(s) below. **UB CLAIM:** Admission type (field 14)
369	MONTHLY INCURRED EXPENSES MUST BE VALID	16 – Claim/service lacks information which is needed for adjudication.	M79 – Missing/incomplete/invalid charge.	This claim contains an invalid monthly expense. Enter the corrected information on a new claim.
370	SOURCE OF ADMISSION INVALID	16 – Claim/service lacks information which is needed for adjudication.	MA42 – Missing/incomplete/ invalid admission source.	Refer to the most current edition of the NUBC manual for valid source of admission. Enter a valid Medicaid source of admission code in the field below. **UB CLAIM:** Admission source (field 15)
373	PRINCIPAL SURG PROCEDURE DATE INVALID	16 – Claim/service lacks information which is needed for adjudication.	MA66 – Missing/incomplete/ invalid principal procedure code.	The principal surgical procedure date is invalid. Date must be six digits and numeric. Make corrections to the field(s) below. **UB CLAIM:** Principal procedure date (field 74)
375	OTHER SURGICAL PROCEDURE DATE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M67 – Missing/incomplete/invalid other procedure code(s).	The other surgical procedure date is invalid. Date must be six digits and numeric. Make corrections to the field(s) below. **UB CLAIM:** Other procedure date (field 74 A-E)
376	TYPE OF BILL NOT VALID FOR MEDICAID	16 – Claim/service lacks information which is needed for adjudication.	MA30 – Missing/incomplete/ invalid type of bill.	Refer to the most current edition of the NUBC manual for valid type of bill. Enter a valid Medicaid type of bill in the field(s) below. **UB CLAIM:** Type of bill (field 4)

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Edit Code	Description	CARC	RARC	Resolution
377	FIRST DATE OF SERVICE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M52 – Missing/incomplete/invalid "from" date(s) of service.	The first date of service is invalid. Date must be six digits and numeric. Make corrections to the field(s) below. **UB CLAIM:** Date (field 6)
378	LAST DATE OF SERVICE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M59 – Missing/incomplete/invalid "to" date(s) of service.	The last date of service is invalid. Date must be six digits and numeric. Make corrections to the field(s) below. **UB CLAIM:** Date (field 6)
379	VALUE CODE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M49 – Missing/incomplete/invalid value code(s) and/or amount(s).	This claim contains an invalid value code. Refer to the most current edition of the NUBC manual for valid value codes. Make corrections to the field(s) below. **UB CLAIM:** Value code (fields 39 – 41 A-D)
380	VALUE AMOUNT INVALID	16 – Claim/service lacks information which is needed for adjudication.	M49 – Missing/incomplete/invalid value code(s) and/or amount(s).	This claim contains an invalid value amount. Make corrections to the field(s) below **UB CLAIM:** Value amount (fields 39 – 41 A-D)
381	OCCURRENCE DATE INVALID	16 – Claim/service lacks information which is needed for adjudication.	N299 – Missing/incomplete/ invalid occurrence date(s).	This claim contains invalid occurrence date(s). Dates must be six digits and numeric. Make corrections to the field(s) below **UB CLAIM:** Occurrence date (fields 31 – 34 A-B)
382	PATIENT STATUS NOT VALID FOR MEDICAID	16 – Claim/service lacks information which is needed for adjudication.	MA43 – Missing/incomplete/ invalid patient status.	**UB CLAIM:** Refer to the most current edition of the NUBC manual for valid status codes. Enter a valid Medicaid patient status code (field 17).
383	OCCURR.CODE, INCL. SPAN CODES, INVALID	16 – Claim/service lacks information which is needed for adjudication.	M45 – Missing/incomplete/invalid occurrence codes.	**UB CLAIM:** Refer to the most current edition of the NUBC manual for valid occurrence codes and occurrence span codes. Enter the valid Medicaid occurrence codes (fields 31 – 34, A – B) and the occurrence span codes (fields 35-36, A – B).
384	CONDITION CODE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M44 – Missing/incomplete/invalid condition code.	**UB CLAIM:** Refer to the most current edition of the NUBC manual for valid condition codes. Enter a valid Medicaid condition code (fields 18 – 28).
385	TOTAL CHARGE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M54 – Missing/incomplete/invalid total charges.	**UB CLAIM:** Total charge must be numeric. Enter the correct numeric total charge (field 47).
387	NON COVERED CHARGE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M54 – Missing/incomplete/invalid total charges.	**UB CLAIM:** Charges must be numeric. Enter the correct charge (field 48).

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Edit Code	Description	CARC	RARC	Resolution
390	TPL PAYMENT AMT NOT NUMERIC	16 – Claim/service lacks information which is needed for adjudication.	M49 – Missing/incomplete/invalid value code(s) and/or amount(s).	Enter the numeric payment amount from all primary insurance companies in the field(s) below. Enter 0.00 if no payment was received. If the claim denied by the other insurance company, put a "1" (denial indicator) – see field below. If no third party was involved, delete information entered in the field(s). **CMS 1500 CLAIM:** Third party payment amount (fields - 9C, 11B and 29). If payment is denied by other insurance, put a "1" (denial indicator) (field 10D). **UB CLAIM:** Third party payment amount (field 54). If payment is denied, enter 0.00 (field 54) and also enter code 24 and the date of denial in the Occurrence Code (fields 31-34 A and B).
391	PATIENT PRIOR PAYMENT AMT NOT NUMERIC	16 – Claim/service lacks information which is needed for adjudication.	M49 – Missing/incomplete/invalid value code(s) and/or amount(s).	**UB CLAIM:** Verify the payment amount and enter the correct numeric amount (field 54).
394	OCCURRENCE SPAN CODES"FROM"DATE INVALID	16 – Claim/service lacks information which is needed for adjudication.	N300– Missing/incomplete/invalid occurrence span dates.	The claim contains an invalid occurrence span code "from" date. Dates must be six digits and numeric. Make corrections to the field(s) below. **UB CLAIM:** Occurrence span date (fields 35 – 36 A-B)
395	OCCURRENCE SPAN CODES"THRU"DATE INVALID	16 – Claim/service lacks information which is needed for adjudication.	N300– Missing/incomplete/invalid occurrence span dates.	The claim contains an invalid occurrence span code "thru" date. Date must be six digits and numeric. Make corrections to the field(s) below. **UB CLAIM:** Occurrence span date (fields 35 – 36 A-B)
400	TPL CARR and POLICY # MUST BOTH BE PRESENT	22 – This care may be covered by another payer per coordination of benefits.		Enter a valid carrier code and a valid policy number. Make sure to indicate whether the primary insurance denied or paid the claim as noted in the 150 resolution. **CMS-1500 CLAIM:** Carrier code (fields 9D and 11C), policy number (fields 9A and 11) and denial indicator (field 10D) **UB CLAIM:** Carrier code (field 50), policy number (field 60) and denial indicator (field 31 A-34 B).

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
401	AMT IN OTHER SOURCES/NO TPL CARRIER CODE	22 – This care may be covered by another payer per coordination of benefits.		Enter the applicable third party insurance information for the carrier code, policy number and amount paid. If there are more than two other insurance companies that have paid, enter the total combined amounts paid by all insurance companies. The total combined amounts should be equal to all amounts received from insurance. Make sure to indicate whether the primary insurance denied or paid the claim as noted in the 150 resolution. If the insurance company denied payment, put the denial indicator "1" in the TPL field. If there is no third party involved, be sure all third party fields are deleted of information. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Carrier code (fields 9D and 11C), policy number (fields 9A and 11), amount insurance paid (fields 9C and 11B), total combined insurance amount received (field 29), TPL indicator (field 10D)
402	DEDUCTIBLE EXCEEDS CALENDAR YEAR LIMIT	1 - Deductible amount		**UB CLAIM:** Refer to the EOMB for the deductible amount (including blood deductible). If the amount entered is incorrect, submit a new claim with the corrected information. If it matches, attach the EOMB/Medicare electronic printout to the new claim for review and consideration of payment. Do not add professional fees in the deductible amount. Professional fees should be filed separately on a CMS-1500 form under the hospital-based physician provider number.
403	INCURRED EXPENSES NOT ALLOWED	45 – Charge exceeds fee schedule/maximum allowable or contracted/ legislated fee arrangement.		Verify the requested charge amount. If the charge amount is incorrect, submit a new claim with the corrected information.
411	ANESTHESIA PROC REQUIRES ANES. MODIFIER	4 – The procedure code is inconsistent with the modifier used, or a required modifier is missing.	N519 – Invalid combination of HCPCS modifiers.	An anesthesia procedure requires an anesthesia modifier. Refer to the current list of anesthesia modifiers found in section 2 of your provider manual. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Modifier (field 24D unshaded)
412	SURG PROC NOT VALID W/ANES. MODIFIER	4 – The procedure code is inconsistent with the modifier used, or a required modifier is missing.	N519 – Invalid combination of HCPCS modifiers.	Enter the appropriate anesthesia procedure when an anesthesiologist administers anesthesia during a surgical procedure. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded) **UB CLAIM:** Procedure code (field 44)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
450	ASD SRVC/PROV OR RECIP DOES NOT MATCH	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Recipient is not designated for ASD state plan services. Verify that the Medicaid ID number matches the patient served. Check the procedure code(s) to ensure the correct codes were billed. Submit a new claim with the corrected information. **CMS-1500 CLAIM:** Medicaid ID (field 1A), procedure code (field 24D unshaded)
460	PROCEDURE CODE / INVOICE TYPE INCONSISTENT	16 – Claim/service lacks information which is needed for adjudication.	MA30 – Missing/incomplete/ invalid type of bill.	Oral & Maxillofacial Surgeons must file CPT procedure codes on the CMS-1500 and CDT procedure codes on the ADA Claim Form.
463	INVALID TOTAL DAYS	16 – Claim/service lacks information which is needed for adjudication.	M59 – Missing/incomplete/invalid "to" date(s) of service.	The total days entered on the claim are invalid. Submit a new claim with the corrected information.
468	CARRIER CODE 619 (MEDICAID) LISTED TWICE	16 – Claim/service lacks information which is needed for adjudication.	M56 – Missing/incomplete/invalid payer identification.	**UB CLAIM:** Carrier code 619 is listed twice on either the first or second "other payer" line (field 50). Submit a new claim with the corrected information. Do not remove the 619 after "Medicaid Carrier ID."
469	INVALID LINE NET CHARGE	16 – Claim/service lacks information which is needed for adjudication.	M49 – Missing/incomplete/invalid value code(s) and/or amount(s).	This claim contains an invalid line net charge. Submit a new claim with the corrected information.
501	INVALID DATE ON REVENUE LINE	16 – Claim/service lacks information which is needed for adjudication.	N301 – Missing/incomplete/ invalid procedure date(s).	**UB CLAIM:** This claim contains an invalid date on the revenue line. Enter the correct date (field 45).
502	DOS AFTER THE ENTRY DATE/ JULIAN DATE	110 – Billing date predates service date.		Verify the date of service. A claim cannot be submitted prior to the date of service. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24A unshaded)
504	PROVIDER TYPE AND INVOICE INCONSISTENT	170 – Payment is denied when performed/billed by this type of provider.	N95 – This provider type/provider specialty may not bill this service.	Provider has filed the wrong claim form. Please refer to your provider manual for information on claims filing.
505	MISSING DATE ON REVENUE LINE	16 – Claim/service lacks information which is needed for adjudication.	N301 – Missing/incomplete/invalid procedure date(s).	**UB CLAIM**: The date is missing from the revenue line. Enter the date (field 45).

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
506	PANEL CODE and REVENUE CODE BILLED	16 – Claim/service lacks information which is needed for adjudication.	M50 – Missing/incomplete/ invalid revenue code(s).	**UB CLAIM:** Individual panel code and procedure codes included in the panel cannot be billed in combination on the claim for the same dates of service. Submit a new claim with the corrected information.
507	MANUAL PRICING REQUIRED	133 - The disposition of the claim/service is pending further review.		Submit a new claim and attach appropriate clinical documentation (i.e., QIO prior authorization, manufacture pricing, invoices, etc.). Please refer to the appropriate section in your provider manual.
508	NO LINE ITEM RECORD	16 – Claim/service lacks information which is needed for adjudication.	N34 – Incorrect claim form/ format for this service.	This claim cannot be processed because there is no line item information. Submit a new claim with the corrected information.
509	DOS OVER 2 YRS XOVER/ EXT CARE CLM ONLY	29 – The time limit for filing has expired.	N30 – Patient ineligible for this service.	Claims for payment of Medicare cost sharing amounts must be received and entered into the claims processing system within two years from the date of service or date of discharge, or up to six months following the date of Medicare payment, whichever is later. Attach appropriate documentation (Medicare EOMB) to each claim **NURSING HOME PROVIDERS:** Submit claim and appropriate documentation to : MCCS Nursing Facility Claims Post Office Box 100112 Columbia, SC 29202 Refer to the timely filing guidelines in the appropriate section of your provider manual.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
510	DOS IS MORE THAN 1 YEAR OLD	29 – The time limit for filing has expired.	N30 – Patient ineligible for this service.	Claims for retroactive eligibility must be received and entered into the claims processing system within six months of the recipient's eligibility being added to the Medicaid eligibility system AND be received within three years from the date of service or date of discharge (for hospital claims). If the above time frames are met, attach one of the following documents listed below with each claim. 1) DHHS Form 945, which is a statement verifying the retroactive determination furnished by the eligibility worker, or 2) The computer generated Medicaid eligibility approval letter notifying the recipient that Medicaid benefits have been approved. This can be furnished by the recipient or the eligibility worker. (This is different from the Certificate of Creditable Coverage.) **For NURSING HOME PROVIDERS:** Submit claim and appropriate documentation to: MCCS Nursing Facility Claims Post Office Box 100112 Columbia, SC 29202 Refer to the timely filing guidelines in the appropriate section of your provider manual.
513	INCONSISTENT MEDICARE CARRIER CODE	16 – Claim/service lacks information which is needed for adjudication.	M56 – Missing/incomplete/invalid payer identification.	Enter the correct Medicare Part A or Part B carrier code in the field(s) below. **CMS-1500 CLAIM:** Carrier code (fields 9D and 11C) **UB CLAIM:** Carrier code (field 50)
514	PROC RATE/MILE X MILES NOT=SUBMIT CHRG	16 – Claim/service lacks information which is needed for adjudication.	M79 – Missing/incomplete/invalid charge.	Check the calculations for the rates, miles and submitted changes. Submit a new claim with the corrected information.
515	AMBUL/ITP TRANS. MILEAGE LIMITATION	16 – Claim/service lacks information which is needed for adjudication.	M22-Missing/incomplete/invalid number of miles traveled.	Check the mileage entered on the claim. If corrections are needed, submit a new claim with the corrected information. For review and consideration of payment, attach clinical documentation to the new claim to substantiate the mileage being billed.

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Edit Code	Description	CARC	RARC	Resolution
517	WAIVER SERVICE BILLED. RECIPIENT NOT IN A WAIVER.	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	The claim was submitted for a waiver-specific procedure code, but the recipient was not a participant in a Medicaid waiver Verify that the correct procedure code and Medicaid ID were billed. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), procedure code (field 24D unshaded)
518	PROCEDURE CODE COMBINATION NON-COVERED OR INVALID	16 – Claim/service lacks information which is needed for adjudication.	N56 – Procedure code billed is not correct/valid for the services billed or the date of service billed.	For further assistance, contact DentaQuest at 1-888-307-6553.
519	CMS REBATE TERM DATE HAS EXPIRED/ENDED	29 – The time limit for filing has expired.	N30 – Patient ineligible for this service.	If the National Drug Code (NDC) end date has not expired for that particular date of service, make the appropriate correction and attach a copy of drug label indicating the NDC number billed, as well as the expiration date of the drug administered. Make corrections to the field(s) below. **CMS-1500 CLAIM:** NDC (field 24A shaded)
527	WAIVER RECIPIENT/REQUIRES WAIVER CASE MANAGEMENT (WCM) PROVIDER	A1 – Claims/service denied.	N30 – Patient ineligible for this service	This claim was submitted for a waiver recipient, but the provider is not a Waiver Case Management (WCM) provider. Verify that the Medicaid ID, Provider ID and/or NPI and procedure code(s) were billed correctly. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), procedure code (field 24D unshaded), Provider ID# (field 24J/field 33)
528	PRTF WAIVER RECIPIENT BUT NOT WAIVER SERVICE	A1 – Claim/service denied.	N379 – Claim level information does not match line level information.	The claim was submitted with a procedure code/service that is not in the PRTF service array. Enter the correct procedure code in the field(s) below. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded)
529	REVENUE CODE BEING BILLED OVER 15 TIMES PER CLAIM	A1 – Claim/service denied.	M50 – Missing/incomplete/invalid revenue code(s).	**UB CLAIM:** This edit code cannot be manually corrected. A new claim must be submitted.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
532	RECIPIENT NOT ELIGIBLE FOR NFP WAIVER SERVICES	A1 – Claims/service denied.	N30 – Patient ineligible for this service	The claim was submitted with a Nurse Family Partnership (NFP) Waiver specific procedure code, but the recipient was not eligible for NFP Waiver services. Verify that the correct procedure code and Medicaid ID were billed. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), procedure code (field 24D unshaded)
533	DOS IS MORE THAN 3 YEARS OLD	29 – The time limit for filing has expired.	N30 – Patient ineligible for this service.	Claim exceeds timely filing limits and will not be considered for payment. Refer to the timely filing guidelines in the appropriate section of your provider manual.
534	PROVIDER/CCN DO NOT MATCH FOR ADJUSTMENT	16 – Claim/service lacks information which is needed for adjudication.	M47 –Missing/incomplete/invalid internal or document control number.	Review the original claim and verify the provider number from that claim. Make sure that the correct original provider number is entered on the adjustment claim.
536	PROCEDURE-MODIFIER NOT COVERED ON DOS	182 – Procedure modifier was invalid on the date of service.	N517 – Resubmit a new claim with the requested information.	The procedure code and the modifier are not covered for the date of service billed on the claim. Verify that the correct date of service, procedure code and modifier combination were entered. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24A unshaded), procedure code and modifier (field 24D unshaded)
537	PROC-MOD COMBINATION NON-COVERED/INVALID	4 – The procedure code is inconsistent with the modifier used, or a required modifier is missing.	N519 – Invalid combination of HCPCS modifiers.	The procedure code and modifier combination are not covered or invalid. Verify that the correct procedure code and modifier combination were entered. Make corrections to the field(s) below. **CMS-1500 CLAIM**: Procedure code and modifier (field 24D unshaded) **Note:** If reimbursement is for an assistant surgeon OR multiple births **ONLY** use the Modifier (GB or CG) on the applicable lines(s); attach appropriate clinical documentation (i.e., discharge summary, operative notes, etc.) to the **NEW** claim for review and consideration for payment.
538	PATIENT PAYMENT EXCEEDS MED NON-COVERED	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.		Verify that the prior payment and the total non-covered amounts were entered correctly. A Medicaid recipient is not liable for charges unless they are non-covered services. Make corrections to the field(s) below. **UB CLAIM:** Prior payments (field 54), Non-covered charges (field 48)

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Edit Code	Description	CARC	RARC	Resolution
539	MEDICAID NOT LISTED AS PAYER	31 – Patient cannot be identified as our insured.		**UB CLAIM:** Enter Medicaid payer code 619 (field 50 A - C) which corresponds with the line on which you entered the Medicaid ID number (field 60 A – C).
540	ACCOM REVENUE CODE/OP CLAIM INCONSIST	16 – Claim/service lacks information which is needed for adjudication.	M56 – Missing/incomplete/invalid payer identification.	**UB CLAIM:** Room accommodation revenue codes cannot be used on an outpatient claim. If the room accommodation revenue codes are correct, check the bill type (field 4) and the Health Plan ID (field 51).
541	MISSING LINE ITEM/REVENUE CODE	16 – Claim/service lacks information which is needed for adjudication.	M50 – Missing/incomplete/invalid revenue code (s).	**UB CLAIM:** The revenue code for the line item is missing. The two digits before the edit code tell you on which line the revenue code is missing. Enter the correct revenue code (field 42) for that line.
542	BOTH OCCUR CODE and DATE NEC INC SPAN CODE	16 – Claim/service lacks information which is needed for adjudication.	M46 – Missing/incomplete/invalid occurrence span codes.	**UB CLAIM:** If you have entered an occurrence code (fields 31 – 36 A and B), an occurrence date must be entered. If you have entered an occurrence date in any of these fields, an occurrence code must also be entered.
543	VALUE CODE/AMOUNT MUST BOTH BE PRESENT	16 – Claim/service lacks information which is needed for adjudication.	M49 – Missing/incomplete/invalid value code(s) and/or amount(s).	**UB CLAIM:** If you have entered a value code (fields 39 through 41 A - D), a value amount must also be entered. If you have entered a value amount in these fields, a value code must also be entered
544	NURSING HOME CLAIMS SUBMITTED VIA 837	16 – Claim/service lacks information which is needed for adjudication.	N34 – Incorrect claim form/format for this service.	For further assistance, contact South Carolina Medicaid EDI Support Center at 1-888-289-0709.
545	NO PROCESSABLE LINES ON CLAIM	16 – Claim/service lacks information which is needed for adjudication.	N34 – Incorrect claim form/format for this service.	All lines on the claim have been rejected or deleted. This edit cannot be manually corrected. Submit a new claim with the corrected information.
546	SURGICAL PROCEDURE MUST BE REPORTED AT THE REVENUE CODE LINE LEVEL	16 – Claim/service lacks information which is needed for adjudication.	M20 – Missing/incomplete/invalid HCPCS.	**UB CLAIM:** This claim is incomplete. Enter the surgical procedure code(s) on the claim at the revenue code line level (field 44).
547	PRINCIPAL SURG PROC AND DTE REQUIRED	16 – Claim/service lacks information which is needed for adjudication.	MA66 – Missing/incomplete/ invalid principal procedure code.	**UB CLAIM:** This claim is incomplete. Enter the surgical procedure code and date (field 74).
548	OTHER SURG PROC AND DATE MUST BE PRESENT	16 – Claim/service lacks information which is needed for adjudication.	M67 – Missing/incomplete/invalid other procedure code(s).	**UB CLAIM:** This claim is incomplete. Enter the other surgical procedure codes and dates (fields 74 A – E).

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Edit Code	Description	CARC	RARC	Resolution
550	REPLACE/VOID BILL/ORIGINAL CCN MISSING	16 – Claim/service lacks information which is needed for adjudication.	M47 – Missing/incomplete/invalid internal or document control number.	**UB CLAIM:** Check the remittance advice for the paid claim you are trying to replace or cancel to find the CCN. Enter the CCN (field 64).
551	TYPE ADMISSION/SOURCE CODE INCONSISTENT	16 – Claim/service lacks information which is needed for adjudication.	MA41 – Missing/incomplete/ invalid admission type.	Check the most current edition of the NUBC manual for valid codes for the type of admission and source of admission. Enter the valid Medicaid codes in the field(s) below and submit a new claim. **UB CLAIM:** Admission type (field 14), admission source (field 15)
552	MEDICARE INDICATED/NO MEDICAID LIABILITY	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.		Medicare coverage was indicated on the claim form. Enter the correct and complete insurance information in the field(s) below. **CMS-1500 CLAIM:** Insurance carrier code (fields 9D and 11C), policy number (field 9A and 11), insurance amount paid (fields 9C and 11B) **UB CLAIM:** Insurance carrier code (field 50), policy number (field 60), insurance amount paid (field 54)
553	ALLOW AMT=ZERO/UNABLE TO DETERMINE PYMT	16 – Claim/service lacks information which is needed for adjudication.	M79 – Missing/incomplete/invalid charge.	**UB CLAIM:** Information is incorrect or missing which is necessary to allow the Medicaid system to calculate the payment for the claim. Check for errors in the following fields: revenue codes (field 42), CPT codes (field 44), ICD surgical codes (field 74), diagnosis codes (field 67), condition codes (fields 18 – 28) and value codes (fields 39-41 A-D) as applicable. If this edit code appears with other edit codes, it may be resolved by correcting the other edit codes first
554	VALUE CODE/3RD PARTY PAYMENT INCONSISTENT	16 – Claim/service lacks information which is needed for adjudication.	MA92 – Missing plan information for other insurance.	**UB CLAIM:** If you have entered value code 14 (fields 39 through 41 A – D), you must also enter a prior payment (field 54).
555	TPL PAYMENT > PAYMENT DUE FROM MEDICAID	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.		**UB CLAIM:** Correct the payment amount you have entered in prior payment (field 54). If the amount is correct, no payment from Medicaid is due. Do not submit a new claim.
557	CARR PYMTS MUST = OTHER SOURCES PYMTS	22 – This care may be covered by another payer per coordination of benefits.		If any amount appears in the amount received from insurance field, you must indicate a third party payment. If there is no third party insurance involved, delete information entered in the insurance fields. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Insurance amount paid (fields 9C and 11B), amount rec'd insurance (field 29)

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Edit Code	Description	CARC	RARC	Resolution
558	REVENUE CHGS NOT WITHIN +- $1 OF TOTAL	16 – Claim/service lacks information which is needed for adjudication.	M54 – Missing/incomplete/invalid total charges.	**UB CLAIM:** Recalculate your revenue charges (field 47). If a line has been deleted by you on a previous claim submission the charges on these lines should no longer be added into the total charges.
559	MEDICAID PRIOR PAYMENT NOT ALLOWED	B13 – Previously paid. Payment for this claim/ service may have been provided in a previous payment.		**UB CLAIM:** Prior payment from Medicaid (field 54 A - C) should never be indicated on a claim. Make the appropriate correction.
560	REVENUE CODES INCONSISTENT	16 – Claim/service lacks information which is needed for adjudication.	M50 – Missing/incomplete/invalid revenue code(s).	**UB CLAIM:** Check for revenue code errors (field 42). Revenue code 100 is an all-inclusive revenue code and cannot be used with any other revenue code except 001, which is the total charges revenue code.
561	CLAIM ALREADY DEBITED (RETRO-MEDICARE), CANNOT ADJUST	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.		Retroactive Medicare claim already debited or scheduled for debit. Cannot adjust this claim. Contact the PSC.
562	CLAIM ALREADY DEBITED (HEALTH CLAIM), CANNOT ADJUST	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.		Retroactive Healthcare claim already debited or scheduled for debit. Cannot adjust this claim. Contact the PSC.
563	CLAIM ALREADY DEBITED (PAY & CHASE CLAIM), CANNOT ADJUST	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.		Medicaid Pay & Chase claim already debited or scheduled for debit. Cannot adjust this claim. Contact the PSC.
564	OP REV 450,459,510,511 COMB NOT ALLOWED	16 – Claim/service lacks information which is needed for adjudication.	M50- Missing/incomplete/invalid revenue code(s).	**UB CLAIM:** These revenue codes should never appear in combination on the same claim. If a recipient was seen in the emergency room, clinic, and treatment room (field 14) on the same date of service for the same or related condition, charges for both visits should be combined under either revenue code 450, 510, or 761 (field 42). If the recipient was seen in the ER and clinic on the same date of service for unrelated conditions, both visits should be billed on separate claims using the correct revenue code. If the recipient is a PEP member, and was triaged in the ER, the submitted claim should be filed with only revenue code 459. No other revenue codes should be filed with revenue code 459.

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Edit Code	Description	CARC	RARC	Resolution
565	THIRD PARTY PAYMENT/NO 3RD PARTY ID	22 - This care may be covered by another payer per coordination of benefits.		**UB CLAIM:** If a prior payment is entered (field 54), information in all other TPL-related fields (50 and 60) must also be entered.
567	NONCOV CHARGES > OR = TOTAL CHARGES	16 – Claim/service lacks information which is needed for adjudication.	M54 – Missing/incomplete/invalid total charges.	**UB CLAIM:** Check the total of non-covered charges (field 48) and total charges (field 47) to see if they were entered correctly. If they are correct, no payment from Medicaid is due. If incorrect, submit a new claim.
568	CORRESPONDING ADJUSTMENT (VOID) IS SUSPENDED OR DENIED	107 –The related or qualifying claim/service was not previously paid or identified on this claim.		Review the edit code assigned to the void adjustment claim to determine if it can be corrected. If the void adjustment claim can be corrected, make the necessary changes and submit a new claim
569	ORIGINAL CCN IS INVALID OR ADJUSTMENT CLAIM	16 – Claim/service lacks information which is needed for adjudication.	M47 – Missing/incomplete/invalid internal or document number.	Check the original CCN on the Form 130 as it is either invalid or a CCN for an adjustment claim. Correct the Form 130 and resubmit.
570	OP REV 760 762, 769 COMB NOT ALLOWED	16 – Claim/service lacks information which is needed for adjudication.	M50- Missing/incomplete/invalid revenue code(s).	**UB CLAIM:** These revenue codes (field 42) cannot be used in combination for the same day (field 45); bill either revenue code 762 or 769 on an outpatient claim.
575	REPLACE/VOID CLM/CCN INDICATED NOT FOUND	16 – Claim/service lacks information which is needed for adjudication.	M47 – Missing/incomplete/invalid internal or document control number.	**NOTE:** Only paid claims can be replaced or voided. Review the original claim and verify the claim control number (CCN) and recipient Medicaid ID number from that claim. Make sure that the correct original CCN and recipient Medicaid ID number are on the new claim. **UB CLAIM:** Check the CCN you have entered (field 64 A – C) with the CCN on the remittance advice of the paid claim you want to replace or void. If this edit appears with other edits, it may be corrected by correcting the other edit codes. If edit code 575 and 863 are the only edits on the replacement claim (new claim), the replacement claim criteria have not been met (see Section 3 on replacement claims).
576	TYPE OF BILL AND PROVIDER TYPE INCONSISTENT	16 – Claim/service lacks information which is needed for adjudication.	MA30 – Missing/incomplete invalid type of bill.	**UB CLAIM:** If the bill type you have entered (field 4) is 131 or 141, you must use your outpatient number (field 51). If the bill type is 111 (field 4), you must use your inpatient number.

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Edit Code	Description	CARC	RARC	Resolution
584	NATIVE AMERICAN HEALTH SERVICE PROCEDURE-MODIFIER COMBINATION NON-COV/INVALID	4 - The procedure code is inconsistent with the modifier used or a required modifier is missing.	N519 – Invalid combination of HCPCS modifiers.	The procedure code and modifier combination are not covered or invalid. Verify that the correct procedure code and modifier combination were entered. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Procedure code and modifier (field 24D unshaded)
587	1ST DATE OF SERV SUBSEQUENT TO LAST DOS	16 – Claim/service lacks information which is needed for adjudication.	MA31- Missing/incomplete/invalid beginning and ending dates of the period billed.	**UB CLAIM:** Correct the "from" and "through" dates (field 6). "From" date must be before "through" date. Be sure you check the year closely.
588	1ST DOS SUBSEQUENT TO ENTRY DATE	16 – Claim/service lacks information which is needed for adjudication.	MA31- Missing/incomplete/invalid beginning and ending dates of the period billed.	**UB CLAIM:** Correct the "from" date of service (field 6). Be sure to check the year closely.
589	LAST DOS SUBSEQUENT TO DATE OF RECEIPT	16 – Claim/service lacks information which is needed for adjudication.	MA31- Missing/incomplete/invalid beginning and ending dates of the period billed.	**UB CLAIM:** Correct the "through" date of service (field 6). Be sure to check the year closely.
590	NO DISCHARGE DATE ON FINAL BILL	16 – Claim/service lacks information which is needed for adjudication.	N50 – Missing/incomplete/invalid discharge information.	**UB CLAIM:** Enter the discharge date (field 6). Submit a new claim with the corrected information.
591	NCCI – PROCEDURE CODE COMBINATION NOT ALLOWED	236 - This procedure or procedure/modifier combination is not compatible with another procedure or procedure/ modifier combination provided on the same day according to the National Correct Coding Initiative.		This procedure code combination is not allowed on the same date of service. Therefore, only one procedure code was paid. Note: The National Correct Coding Initiative (NCCI) does not allow the rendering or payment of certain procedure codes on the same date of service. For NCCI guidelines and specific code combinations; please refer to Medicaid bulletins about NCCI edits or the CMS website.
594	FINAL BILL/DISCHRG DTE BEFORE LAST DOS	16 – Claim/service lacks information which is needed for adjudication.	N50 – Missing/incomplete/invalid discharge information.	**UB CLAIM:** Check the occurrence code 42 and date (fields 31 through 34 A and B), and the "through" date (field 6). These dates must be the same.
597	ACCOMODATION UNITS/STMT PERIOD INCONSISTENT	16 – Claim/service lacks information which is needed for adjudication.	MA31- Missing/incomplete/invalid beginning and ending dates of the period billed.	**UB CLAIM:** Check the dates entered (field 6); the covered days calculated (field 7); the discharge date (fields 31 through 34 A – B) and the units entered for accommodation revenue codes (field 42) the discharge date and "through" date must be the same). If the dates (field 6) are correct, the system calculated the correct number of days, so the units for accommodation revenue codes should be changed. If the dates are incorrect, correcting the dates will correct the edit.

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Edit Code	Description	CARC	RARC	Resolution
598	QIO INDICATOR 3/ APPROVAL DATES REQUIRED	16 – Claim/service lacks information which is needed for adjudication.	M52 – Missing/incomplete/invalid "from" date(s) of service.	**UB CLAIM:** If condition code C3 is entered (fields 31 through 34 A – B), the approved dates must be entered in occurrence span, (fields 35-36 A or B).
599	QIO DATES/OCCUR SPAN DATES N/SEQUENCED	16 – Claim/service lacks information which is needed for adjudication.	M52 – Missing/incomplete/invalid "from" date(s) of service.	**UB CLAIM:** The dates which have been entered (fields 35 - 36 A or B) (occurrence span), do not coincide with any date in the statement covers dates (field 6). There must be at least one date in common in these two fields.
600	QIO DATE/STATEMENT COVERS DATES DON'T OVERLAP	16 – Claim/service lacks information which is needed for adjudication.	M52 – Missing/incomplete/invalid "from" date(s) of service.	**UB CLAIM:** The date(s) of service do not coincide with statement covers dates (field 6). Verify the approved date(s) received from the QIO are correct.
603	REVENUE/CONDITION/ VALUE CODES INCONSISTENT	16 – Claim/service lacks information which is needed for adjudication.	M49 – Missing/incomplete/invalid value code(s) and/or amount(s).	Medicaid only sponsors a semi-private room. When a private room revenue code is used, condition code 39 or value codes 01 or 02 and value amounts must be on the claim. See current NUBC manual for definition of codes. Make corrections to the field(s) below. **UB CLAIM:** Condition codes (fields 18-28), value codes (39-41 A-D), revenue codes (field 42)
605	NCCI - UNITS OF SERVICE EXCEED LIMIT	273 – Coverage/ program guidelines were exceeded.		The number of units billed on the specified line exceeds the allowable limit based on NCCI guidelines. **Note:** For NCCI guidelines, please refer to Medicaid bulletins about NCCI edits or the CMS website.
606	CASE MANAGEMENT PROVIDER/SERVICE NOT CASE MANAGEMENT	170 – Payment is denied when performed/billed by this type of provider.	N95 – This provider type/provider specialty may not bill this service.	Verify that the correct taxonomy code has been entered on the claim. Submit a new claim with the corrected information. Make corrections to the field below: **CMS-1500 CLAIM:** Taxonomy code (field 24J shaded)
636	COPAYMENT AMOUNT EXCEEDS ALLOWED AMOUNT	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.		The Medicaid recipient is responsible for a Medicaid copayment for this service/date of service. The allowed payment amount is less than the recipient's copayment amount; therefore no payment is due from Medicaid. Please collect the copayment from the Medicaid recipient. Do not submit a new claim.
637	COINS AMT GREATER THAN PAY AMT	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.		**UB CLAIM:** Correct the coinsurance amount (fields 39 A-41 D). If the coinsurance amount is correct, attach a copy of the Medicare EOMB.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
642	MEDICARE COST SHARING REQUIRES COINS/DEDUCTIBLE	16 – Claim/Service lacks information which is needed for adjustment.	N479 – Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	**UB CLAIM:** For Medicaid to consider payment of the claim, the Medicare coinsurance and deductible (fields 39 – 41 A-D) must be present.
672	NET CHRG/TOTAL DAYS X DAILY RATE UNEQUAL	16 – Claim/service lacks information which is needed for adjudication.	M54 – Missing/incomplete/invalid total charges.	Make the appropriate correction(s) to calculations on the claim.
673	REJECT LOC 6 - EXCLUDES SWING BEDS	96 – Non-covered charge(s).	N188 – The approved level of care does not match the procedure code submitted.	If there is a recurring income change that impacts the coinsurance payment, submit a new claim and attach appropriate documentation (Form 181, EOMB).
674	NH RATE - PAT DAY INC NOT = PAT DAY RATE	16 – Claim/service lacks information which is needed for adjudication.	N153 – Missing/incomplete/invalid room and board rate.	Make the appropriate corrections to the rate amounts on the claim.
690	OTHER SOURCES AMT MORE THAN MEDICAID AMT	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.		Verify and correct the dollar amounts entered in the insurance payment field(s) below. If the amounts are correct, no payment is due from Medicaid. Do not submit a new claim. **CMS-1500 CLAIM:** Insurance amount paid (fields 9C and 11B), amount rec'd insurance (field 29)
693	MENTAL HEALTH VISIT LIMIT EXCEEDED	273 – Coverage/ program guidelines were exceeded.		Additional services require Prior Authorization from the QIO. If the authorization number is incorrect, submit a new claim with the corrected information. Contact the QIO for review and consideration of authorization for additional visits.
700	PRIMARY/PRINCIPAL DIAG CODE NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	MA63 – Missing/incomplete/ invalid principal diagnosis.	Medicaid requires the complete diagnosis code as specified in the current edition of Volume I of the ICD-CM manual, (including fifth digit sub-classification when listed). Check for valid diagnosis code in Volume I of the ICD-CM manual and make corrections to the field (s) below. **CMS-1500 CLAIM:** Diagnosis code (field 21) **UB CLAIM:** Diagnosis code (field 67)
701	SECONDARY/ OTHER DIAG CODE NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	M64 – Missing/incomplete/invalid other diagnosis.	Follow the resolution for edit code 700 and submit a new claim. The secondary diagnosis code appears in the fields below. **CMS-1500 CLAIM:** Diagnosis code (field 21) **UB CLAIM:** Diagnosis code (fields 67 A-Q)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
703	RECIP AGE/PRIM/PRINCIPAL DIAG INCONSISTENT	9 – The diagnosis is inconsistent with the patient's age.	N517 – Resubmit a new claim with the requested information.	The recipient's age is not consistent with the diagnosis code being billed. Check the patient's Medicaid ID number. A common error is entering another family member's number. Make sure the number matches the patient served. Verify that the correct diagnosis code and date of birth are entered on the claim. The date of birth in our system is based on the claim run date. Contact your county Medicaid Eligibility office if your records indicate a different date of birth. After the county Medicaid Eligibility office has updated the system, submit a new claim. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), date of birth (field 3), diagnosis code (field 21) **UB CLAIM:** Medicaid ID (field 60), date of birth (field 10), diagnosis code (field 67)
704	RECIP AGE/SECONDARY/OTHER DIAG INCONSISTENT	9 – The diagnosis is inconsistent with the patient's age.	N517 – Resubmit a new claim with the requested information.	Follow the resolution for edit code 703 and submit a new claim with corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), date of birth (field 3), diagnosis code (field 21) **UB CLAIM:** Medicaid ID (field 60), date of birth (field 10), diagnosis code (fields 67 A-Q)
705	RECIP SEX/PRIM/PRINCIPAL DIAG INCONSISTENT	10 – The diagnosis is inconsistent with the patient's gender.	N517 – Resubmit a new claim with the requested information.	The recipient's sex is not consistent with the diagnosis code being billed. Check the patient's Medicaid ID number. A common error is entering another family member's number. Make sure the number matches the patient served. Verify that the correct diagnosis code and sex are entered on the claim. Contact your county Medicaid Eligibility office if your records indicate a different sex. After the county Medicaid Eligibility office has updated the system, submit a new claim. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), sex (field 3), diagnosis code (field 21) **UB CLAIM:** Medicaid ID (field 60), sex (field 11), diagnosis code (field 67)
706	RECIP SEX/SECONDARY/OTHER DIAG INCONSISTENT	10 – The diagnosis is inconsistent with the patient's gender.	N517 – Resubmit a new claim with the requested information.	Follow the resolution for edit code 705 and submit a new claim with corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), sex (field 3), diagnosis code (field 21) **UB CLAIM:** Medicaid ID (field 60), sex (field 11), diagnosis code (fields 67 A-Q)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
707	PRIN. DIAG. NOW REQUIRES 4TH OR 5TH DIGIT	16 – Claim/service lacks information which is needed for adjudication.	MA63 – Missing/incomplete/ invalid principal diagnosis.	Medicaid requires a complete diagnosis code as specified in the current edition of the ICD-CM manual. The diagnosis code requires a fourth or fifth digit. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Diagnosis code (field 21) **UB CLAIM:** Diagnosis code (field 67)
708	SEC. DIAG. NOW REQUIRES 4TH OR 5TH DIGIT	16 – Claim/service lacks information which is needed for adjudication.	M64 – Missing/incomplete/invalid other diagnosis.	Follow the resolution for edit code 707 with corrections to the field(s) below. **CMS-1500 CLAIM:** Diagnosis code (field 21) **UB CLAIM:** Diagnosis code (fields 67 A-Q)
709	SERV/PROC CODE NOT ON REFERENCE FILE	16 – Claim/service lacks information which is needed for adjudication.	N65 – Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	Check the most current applicable provider manual to verify that the correct procedure code is being billed. If the procedure code is incorrect, submit a new corrected claim. If the code is correct, attach appropriate documentation to your new claim for review and consideration for payment.
710	SERV/PROC/DRUG REQUIRES PA-NO NUM ON CLM	15 – The authorization number is missing, invalid, or does not apply to the billed services or provider.	N517 – Resubmit a new claim with the requested information.	The claim is missing the required prior authorization number. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Prior authorization number (field 23) **UB CLAIM:** Treatment authorization code (field 63) **NOTE**: If the prior authorization number was not obtained prior to rendering the service, you will not be considered for payment.
711	RECIP SEX - SERV/PROC/DRUG INCONSISTENT	16 – Claim/service lacks information which is needed for adjudication.	MA39 – Missing/incomplete/ invalid gender.	The recipient's sex is not consistent with the procedure code being billed. Check the patient's Medicaid ID number. A common error is entering another family member's number. Make sure the number matches the patient served. Verify that the correct procedure code and sex are entered on the claim. Contact your county Medicaid Eligibility office if your records indicate a different sex. After the county Medicaid Eligibility office has updated the system, submit a new claim. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), sex (field 3), procedure code (field 24D unshaded) **UB CLAIM:** Medicaid ID (field 60), sex (field 11), procedure code (field 44)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
712	RECIP AGE-PROC INCONSIST/NOT ID/RD RECIP	6 – The procedure/ revenue code is inconsistent with the patient's age.	N517 – Resubmit a new claim with the requested information.	The recipient's age is not consistent with the procedure code being billed. Check the patient's Medicaid ID number. A common error is entering another family member's number. Make sure the number matches the patient served. Verify that the correct procedure code and date of birth are entered on the claim. Contact your county Medicaid Eligibility office if your records indicate a different date of birth. After the county Medicaid Eligibility office has updated the system, submit a new claim. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), date of birth (field 3), procedure code (field 24D unshaded) **UB CLAIM:** Medicaid ID (field 60), date of birth (field 10), procedure code (field 44)
713	NUM OF BILLINGS FOR SERV EXCEEDS LIMIT	151 – Payment adjusted because the payer deems the information submitted does not support this many/ frequency of services.		Check the number of units on the specified line to be sure the correct number of units has been entered for service being billed. If the number of units is correct, check the procedure code to be sure it is correct. For review and consideration for payment of additional units, submit a new claim and attach appropriate clinical documentation to substantiate the services being billed. Please refer to the applicable provider policy manual for the specific documentation requirements. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded), units (field 24G unshaded) **UB CLAIM:** Procedure code (field 44), units (field 46).
714	SERV/PROC/DRUG REQUIRES DOC-MAN REVIEW	133 – The disposition of the claim/service is pending further review.		The service/procedure has to be reviewed by Medicaid prior to payment. Attach appropriate clinical documentation (i.e., Sterilization Consent Form 1723, medical records, etc.) to the new claim for manual review. Please refer to the applicable provider policy manual for the specific documentation requirements.
715	PLACE OF SERVICE/PROC CODE INCONSISTENT	5 – The procedure code/bill type is inconsistent with the place of service.	M77 – Missing/incomplete/invalid place of service.	Check the procedure code and the place of service code to be sure that they are correct. If incorrect, make corrections to the field(s) below. If the procedure code is correct, attach appropriate clinical documentation to the new claim for review and consideration for payment verifying where the procedure/service was provided. **CMS-1500 CLAIM:** Place of service (field 24B unshaded), procedure code (field 24D unshaded)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
716	PROV TYPE INCONSISTENT WITH PROC CODE	8 – The procedure code is inconsistent with the provider type/ specialty (taxonomy).	N95 – This provider type/provider specialty may not bill this service.	The type of provider rendering this service/procedure code is NOT authorized. If the provider type is correct, attach appropriate clinical documentation to the new claim for review and consideration for payment.
717	SERV/PROC/DRUG NOT COVERED ON DOS	A1 – Claim/service denied.	N56 – Procedure code billed is not correct/valid for the services billed or the date of service billed.	The service/procedure is not covered for the date of service billed on the claim. Check the procedure code and the date of service on the indicated line to be sure both are correct. The procedure code may have been deleted from the program or changed to another procedure code.
718	PROC REQUIRES TOOTH NUMBER/SURFACE INFO	16 – Claim/service lacks information which is needed for adjudication.	N37 – Missing/incomplete/ invalid tooth number/letter.	The procedure requires either a tooth number and/or surface information (fields 15 and 16).
719	SERV/PROC/DRUG ON PREPAYMENT REVIEW	133 – The disposition of this claim/service is pending further review.		Check the prior authorization number, procedure code(s) and modifier(s) to ensure that the information on the claim matches the information on the prior approval letter. Attach appropriate documentation to the claim for review and consideration for payment. Refer to the applicable provider policy manual for the specific documentation requirements.
720	MODIFIER 22 REQUIRES ADD'L DOCUMENT	251 – The attachment content received did not contain the content required to process the claim or service.	N29 – Missing documentation/ orders/notes/summary/report/ chart.	For review and consideration for payment, attach appropriate clinical documentation (i.e., medical records, radiology reports, operative notes, anesthesia records, etc.) to the new claim to justify the unusual procedural services, increased intensity indications, difficulty of procedure or severity of patient's condition for review and consideration for payment.
721	CROSSOVER PRICING RECORD NOT FOUND	A1 – Claim/service denied.	N8 - Crossover claim denied by previous payer and complete claim data not forwarded. Resubmit this claim to this payer to provide adequate data to adjudication.	Pricing record not found for the specific procedure code and modifier being billed. Please verify that the correct procedure code and modifier were submitted. If the provider has knowledge that the specific procedure code and modifier being billed is valid and a covered service by Medicaid, submit a new claim, and attach the appropriate clinical documentation (i.e., medical records and pricing information) to have the procedure code/modifier considered for payment and added to the system. **Note:** If the procedure code/modifier is not valid and non-covered by Medicaid, the claim will not be considered for payment. Do not submit a new claim.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
722	PROC MODIFIER and SPEC PRICING NOT ON FILE	4 – The procedure code is inconsistent with the modifier used, or a required modifier is missing.	N517 – Resubmit a new claim with the requested information.	Verify that the correct procedure code and modifier were submitted. If the provider has knowledge that the specific procedure code and modifier being billed is valid and a covered service by Medicaid, submit a new claim, and attach the appropriate clinical documentation (i.e., medical records and pricing information) to have the procedure code/modifier considered for payment and added to the system. **Note:** The Medicaid pricing system is programmed specifically for procedure codes, modifiers, and provider specialties. If these are submitted in the wrong combination, the system searches but cannot "find" a price, and the line will automatically reject with edit code 722. Attaching documentation for review and consideration for payment or system updates is not applicable to all provider types. Please refer to the appropriate policy manual for procedure codes and modifiers that are applicable to your provider type/specialty to ensure that you are using the correct procedure code and modifier. A common error is entering the incorrect modifier or entering no modifier. If the code/modifier is not valid and non-covered by Medicaid, the claim will not be considered for payment.
724	PROCEDURE CODE REQUIRES BILLING IN WHOLE UNITS	16 – Claim/service lacks information which is needed for adjudication.	M53 –Missing/incomplete/invalid days or unit(s) of service.	Verify that the units were billed correctly for the procedure code. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded), units (field 24G unshaded) **UB CLAIM:** Procedure code (field 44), units (field 46).
725	INCONTINENCE MODIFIER INCONSISTENT	4 - The procedure code is inconsistent with the modifier used or a required modifier is missing.	N517 – Resubmit a new claim with the requested information.	Correct the procedure code and modifier. Check the Web Tool for the RSP status of the recipient. Contact the Service Coordinator to verify the correct procedure code and modifier were authorized. Make corrections to the field(s) below. **CMS 1500 CLAIM**: Procedure code (field 24D unshaded) and modifier (24D unshaded)
727	DELETED PROCEDURE CODE/CK CPT MANUAL	16 – Claim/service lacks information which is needed for adjudication.	M51 – Missing/incomplete/invalid, procedure code(s).	Check the procedure code and the date of service to verify their accuracy. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24A unshaded), procedure code (field 24D unshaded) **UB CLAIM:** Procedure code (field 44), date of service (field 45)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
732	PAYER ID NUMBER NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	M56 – Missing/incomplete/invalid provider payer identifier.	Verify that the correct insurance carrier code information is entered on the claim. To view a complete listing of carrier codes, visit the Provider Information webpage on the DHHS website http://provider.scdhhs.gov. The carrier code listing is also included in the provider manuals. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Insurance carrier number (field 9D and 11C) **UB CLAIM:** Insurance carrier number (field 50)
733	INS INFO CODED, PYMT OR DENIAL MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA83 – Did not indicate whether we are the primary or secondary payer.	**CMS-1500 CLAIM:** If any third-party insurer has not made a payment, there should be a TPL denial indicator. If all carriers have made payments, there should be no TPL denial indicator. If payment is denied (*i.e.,* applied to the deductible, policy lapsed, etc.) by either primary insurance carrier, put a "1" (denial indicator) and 0.00 for the amount insurance paid. If there are multiple insurers and any payer made a 0.00 payment, put a "1" (denial indicator) and 0.00 for the amount the insurance paid. If payment is made, remove the "1" from the TPL indicator field and enter the amount(s) insurance paid and total combined amount received. Adjust the net charge in the balance due. If no third party insurance was involved, delete all information entered in the insurance fields. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Carrier code (fields 9D and 11C), policy number (fields 9A and 11), amount insurance paid (fields 9C and 11B), total combined insurance amount received (field 29), TPL indicator (field 10D) **UB CLAIM:** If any third-party insurer has not made a payment, there should be a TPL occurrence code and date (fields 31-34 A-B). If payment is denied show 0.00 (field 54). If payment is made enter the amount (field 54) and TPL indicator (fields 31 A-34 B).
734	REVENUE CODE REQUIRES UNITS	16 – Claim/service lacks information which is needed for adjudication.	M53 -Missing/incomplete/invalid days or unit(s) of service.	**UB CLAIM:** The revenue code listed (field 42) requires units of service (field 46).
735	REVENUE CODE REQUIRES AN ICD SURGICAL PROCEDURE OR DELIVERY DIAGNOSIS CODE	16 – Claim/service lacks information which is needed for adjudication.	M76 – Missing/incomplete/invalid diagnosis or condition.	**UB CLAIM:** On inpatient claims w/ revenue codes 360 OR, 361 OR-Minor, or 369 OR-Other, an ICD surgical code is required (fields 74 A-E). On inpatient claims w/ revenue codes 370 Anesthesia, 710 Recovery Room, 719 Other Recovery Room or 722 Delivery Room, a delivery diagnosis code is required (fields 67 A-Q) or an ICD surgical code is required (fields 74 A-E).

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Edit Code	Description	CARC	RARC	Resolution
736	PRINCIPAL SURGICAL PROCEDURE NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	MA66 – Missing/incomplete/ invalid principal procedure code.	**UB CLAIM:** Verify the correct procedure code was submitted (field 74). The two digits in front of the edit code on the remittance advice identify which surgical procedure code is not on file.
737	OTHER SURGICAL PROCEDURE NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	M67 – Missing/incomplete/invalid other procedure code(s).	**UB CLAIM:** Follow the resolution for edit code 736, except the procedure code (fields 74 A-E).
738	PRINCIPAL SURG PROC REQUIRES PA/NO PA #	15 – Payment adjusted because the submitted authorization number is missing, invalid or does not apply to billed services or provider.	N517 – Resubmit a new claim with the requested information.	**UB CLAIM:** Enter the prior authorization number (field 63). If the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment.
739	OTHER SURG PROC REQUIRES PA/NO PA NUMBER	15 – Payment adjusted because the submitted authorization number is missing, invalid or does not apply to billed services or provider.	N517 – Resubmit a new claim with the requested information.	**UB CLAIM:** Follow the resolution for edit code 738.
740	RECIP SEX/PRINCIPAL SURG PROC INCONSIST	7 – The procedure/ revenue code is inconsistent with the patient's gender.	N517 – Resubmit a new claim with the requested information.	The recipient's sex is not consistent with the principal surgical procedure code being billed. Check the patient's Medicaid ID number. A common error is entering another family member's number. Make sure the number matches the patient served. Verify that the correct principal surgical procedure code and sex are entered on the claim. Contact your county Medicaid Eligibility office if your records indicate a different sex. After the county Medicaid Eligibility office has updated the system, submit a new claim. Make corrections to the field(s) below. **UB CLAIM:** Medicaid ID (field 60), sex (field 11), procedure code (field 74)
741	RECIP SEX/OTHER SURG PROC INCONSISTENT	7 – The procedure/ revenue code is inconsistent with the patient's gender.	N517 – Resubmit a new claim with the requested information.	Follow resolution for edit code 740. The two digits in front of the edit code on the remittance advice identify which other surgical procedure code (fields 74 A - E) is inconsistent with the recipient's sex.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
742	RECIP AGE/PRINCIPAL SURG PROC INCONSIST	6 – The procedure/ revenue code is inconsistent with the patient's age.	N517 – Resubmit a new claim with the requested information.	The recipient's age is not consistent with the principal surgical procedure code being billed. Check the patient's Medicaid ID number. A common error is entering another family member's number. Make sure the number matches the patient served. Verify that the correct principal surgical procedure code and date of birth are entered on the claim. Contact your county Medicaid Eligibility office if your records indicate a different date of birth. After the county Medicaid Eligibility office has updated the system, submit a new claim. Make corrections to the field(s) below. **UB CLAIM:** Medicaid ID (field 60), date of birth (field 10), procedure code (field 74)
743	RECIPIENT AGE/OTHER SURG PROC INCONSIST	6 – The procedure/ revenue code is inconsistent with the patient's age.	N517 – Resubmit a new claim with the requested information.	Follow the resolution for edit code 742. The two digits in front of the edit code on the remittance advice identify which other surgical procedure code (fields 74 A - E) is inconsistent with the recipient's age.
746	PRINCIPAL SURG PROC EXCEEDS FREQ LIMIT	96 – Non-covered charge(s).	N435 – Exceeds number/ frequency approved /allowed within time period without support documentation.	**UB CLAIM:** The system has already paid for the procedure entered (field 74). Verify the procedure code is correct. If there is a correction needed; submit a new claim. If this is a replacement claim (new claim), attach appropriate clinical documentation to the claim for review and consideration for payment. If the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment.
747	OTHER SURG PROC EXCEEDS FREQ LIMIT	96 – Non-covered charge(s).	N435 – Exceeds number/ frequency approved /allowed within time period without support documentation.	Follow the resolution for edit code 746. The two digits in front of the edit code on the remittance advice identify which other surgical procedure (fields 74 A - E) exceeded the frequency limitation.
748	PRINCIPAL SURG PROC REQUIRES DOC	251 – The attachment content received did not contain the content required to process the claim or service.	N29 – Missing documentation /orders/notes/summary/ report/chart.	**UB CLAIM:** The principal surgical procedure (field 74) requires documentation. Attach appropriate clinical documentation (i.e., discharge summary, operative note, etc.) to the new claim for review and consideration for payment. Documentation will not be reviewed or retained by Medicaid until the provider corrects all other edits. Refer to the appropriate policy manual for specific Medicaid coverage guidelines and documentation requirements.
749	OTHER SURG PROC REQUIRES DOC/MAN REVIEW	251 – The attachment content received did not contain the content required to process the claim or service.	N29 – Missing documentation /orders/notes/summary/ report/chart.	Follow the resolution for edit code 748. The two digits in front of the edit code on the remittance advice identify which other surgical procedure (fields 74 A - E) requires documentation for manual review.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
750	PRIN SURG PROC NOT COV OR NOT COV ON DOS	96 – Non-covered charge(s).	N56 – Procedure code billed is not correct/valid for the services billed or the date of service billed.	**UB CLAIM:** Check the principal surgical procedure code and date (field 74) to verify their accuracy. Check to see if the principal surgical procedure code is listed on the non-covered surgical procedures list in the appropriate provider policy manual. Check the most recent edition of the ICD-CM manual to be sure the code you are using has not been deleted or changed to another code. If corrections are needed; submit a new claim.
751	OTHER SURG PROC NOT COV/NOT COV ON DOS	96 – Non-covered charge(s).	N56 – Procedure code billed is not correct/valid for the services billed or the date of service billed.	Follow the resolution for edit code 750. The two digits in front of the edit code on the remittance advice identify which other surgical procedure code (fields 74 A – E) is not covered on the date of service.
752	PRINCIPAL SURGICAL PROCEDURE ON REVIEW	133 – The disposition of this claim/service is pending further review.		**UB CLAIM:** For review and consideration for payment, attach appropriate clinical documentation (i.e., discharge summary, operative notes, etc.) to the new claim which supports the principal surgical procedure (field 74).
753	OTHER SURGICAL PROCEDURE ON REVIEW	133 – The disposition of this claim/service is pending further review.		Follow the resolution for edit code 752. The two digits in front of the edit code on the remittance advice identify which other surgical procedure code (fields 74 A – E) is on review.
754	REVENUE CODE NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	M50 – Missing/incomplete/invalid revenue code(s).	**UB CLAIM:** The revenue code is invalid. Correct the revenue code (field 42).
755	REVENUE CODE REQUIRES PA/PEND FOR REVIEW	133 – The disposition of this claim/service is pending further review.		**UB CLAIM:** A revenue code (field 42) requires a prior authorization number. Enter the prior authorization number (field 63).
757	OTHER DIAG REQUIRES PA/NO PA NUMBER	15 – Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	N517 – Resubmit a new claim with the requested information.	**UB CLAIM:** The other diagnosis (fields 67 A-Q) requires a prior authorization number. Enter the prior authorization number (field 63).
758	PRIM/PRINCIPAL DIAG REQUIRES DOC	251 – The attachment content received did not contain the content required to process the claim or service.	N29 – Missing documentation/ orders/notes/summary/report/ chart.	The primary/principal diagnosis requires documentation. If the primary/principal diagnosis is correct, attach appropriate clinical documentation (i.e., operative report, chart notes, etc.) to the new claim along with the PA letter if prior authorization was obtained for review and consideration for payment. Refer to the applicable provider policy manual for documentation requirements.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
759	SEC/OTHER DIAG REQUIRES DOC/MAN REVIEW	251 – The attachment content received did not contain the content required to process the claim or service.	N29 – Missing documentation/ orders/ notes/summary/report/ chart.	The secondary/other diagnosis requires documentation. Follow the resolution for edit code 758 using the secondary/other diagnosis code.
760	PRIMARY DIAG CODE NOT COVERED ON DOS	16 – Claim/service lacks information which is needed for adjudication.	MA63 – Missing/incomplete/ invalid principal diagnosis.	Check the current ICD-CM manual to verify that the primary diagnosis is correctly coded and correct date of service was billed. If there are corrections needed; submit a new claim. If the diagnosis code and the date of service are correct, then it is not covered and will not be considered for payment.
761	SEC/OTHER DIAG CODE NOT COVERED ON DOS	16 – Claim/service lacks information which is needed for adjudication.	M64 – Missing/incomplete/invalid other diagnosis.	The secondary/other diagnosis code is not covered for the date of service billed. Follow the resolution for edit code 760 using the secondary/other diagnosis code.
762	PRINCIPAL DIAG ON REVIEW/MANUAL REVIEW	133 – The disposition of this claim/service is pending further review.		**UB CLAIM:** The principal diagnosis code (field 67) requires manual review. Attach appropriate clinical documentation (i.e., history, physical, and discharge summary, etc.) to the new claim for review and consideration for payment. Refer to the applicable provider policy manual for documentation requirements.
763	OTHER DIAG ON REVIEW/MANUAL REVIEW	133 – The disposition of this claim/service is pending further review.		Follow the resolution for edit code 762. The two digits before the edit code on the remittance advice identify which other diagnosis code (fields 67 A-Q) requires manual review.
764	REVENUE CODE REQUIRES DOC/MANUAL REVIEW	133 – The disposition of this claim/service is pending further review.		**UB CLAIM:** The revenue code (field 42) requires manual review. Attach appropriate clinical documentation to the new claim for review and consideration for payment. Refer to the applicable provider policy manual for documentation requirements.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
765	RECIPIENT AGE/REVENUE CODE INCONSIST	6 – The procedure/ revenue code is inconsistent with the patient's age	N517 – Resubmit a new claim with the requested information.	The recipient's age is not consistent with the revenue code being billed. Check the patient's Medicaid ID number. A common error is entering another family member's number. Make sure the number matches the patient served. Verify that the correct revenue code and date of birth are entered on the claim. Contact your county Medicaid Eligibility office if your records indicate a different date of birth. After the county Medicaid Eligibility office has updated the system, submit a new claim. Make corrections to the field(s) below. **UB CLAIM:** Medicaid ID (field 60), date of birth (field 10), revenue code (field 42)
766	NEED TO PRICE OP SURG	16 – Claim/service lacks information which is needed for adjudication.	M79 – Missing/incomplete/invalid charge.	**UB CLAIM:** Verify that the correct procedure code was entered (field 44). If the code is correct, attach appropriate clinical documentation (i.e., discharge summary, operative notes, etc.) to the new claim for review and consideration for payment.
768	ADMIT DIAGNOSIS CODE NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	MA65 – Missing/incomplete/ invalid admitting diagnosis.	**UB CLAIM:** Verify and correct the admit diagnosis code that was entered on the claim. Medicaid requires the complete diagnosis code as specified in the current edition of the ICD-CM manual, (including fifth digit sub-classification when listed).
769	ASST. SURGEON NOT ALLOWED FOR PROC CODE	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Procedure does not allow reimbursement for an assistant surgeon. If the edit appears unjustified or an assistant surgeon was medically necessary due to unforeseen circumstances, attach clinical documentation (i.e., operative report, chart notes, etc.) to the new claim to justify the assistant surgeon. Refer to the applicable provider policy manual for documentation requirements.
771	PROV NOT CERTIFIED TO PERFORM THIS SERV	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Medicaid does not have an FDA certificate on file for the rendering provider. Verify that the procedure code is correctly coded and make corrections to the field(s) below. If applicable, attach the FDA certificate to the new claim. If you are not a certified mammography provider, or a lab provider, this edit code is not correctable. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded)
773	INAPPROPRIATE PROCEDURE CODE USED	16 – Claim/service lacks information which is needed for adjudication.	M51 – Missing/incomplete/invalid procedure code(s).	Verify that an appropriate procedure code is used and make corrections to the field(s) below. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
774	LINE ITEM SERV CROSSES STATE FISCAL YEAR	16 – Claim/service lacks information which is needed for adjudication.	N63 – Rebill services on separate claim lines.	Change the units in the field(s) below to reflect days billed on or before 6/30. Add a line to the claim to reflect days billed on or after 07/01. **CMS-1500 CLAIM:** Units (field 24G unshaded)
775	EARLY DELIVERY < 39 WEEKS NOT MEDICALLY NECESSARY	50 – These are non-covered services because this is not deemed a "medical necessity" by the payer.	N180 – This item or service does not meet the criteria for the category under which it was billed.	**CMS 1500 CLAIM:** Verify that the correct procedure code and modifier were billed. For review and consideration for payment, attach appropriate clinical documentation (i.e., medical necessity, entire obstetrical records, radiology, laboratory, and pharmacy records, ACOG Patient Safety Checklist or comparable patient safety justification form, etc.) to the new claim to substantiate the services being billed. Refer to the applicable provider policy manual for documentation requirements.
778	SEC CARRIER PRIOR PAYMENT NOT ALLOWED	16 – Claim/service lacks information which is needed for adjudication.	MA04 – Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	**UB CLAIM:** Prior payment for a carrier secondary to Medicaid should not appear on claim. Correct prior payment (field 54).
780	REVENUE CODE REQUIRES PROCEDURE CODE	16 – Claim/service lacks information which is needed for adjudication.	M51 – Missing/incomplete/invalid procedure code(s).	**UB CLAIM:** Some revenue codes require a CPT/HCPCS code. Enter the appropriate revenue code (field 42) and CPT/HCPCS code (field 44). A list of revenue codes that require a CPT/HCPCS code is located in Section 4 of the applicable provider manual.
786	ELECTIVE ADMIT,PROC REQ PRE-SURG JUSTIFY	197 – Precertification / authorization/ notification absent.		**UB CLAIM:** When type of admission (field 14) is elective, and the procedure requires prior authorization, a prior authorization number from QIO must be entered (field 63). If the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment. Contact the QIO for consideration for payment for retroactive eligibility and emergency services.
790	TB RECIP / SERVICE IS NOT TB	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Recipient is eligible for TB services only. Verify that the Medicaid ID number matches the patient served. Check the procedure code(s) and/or modifier to ensure the correct codes were billed. Submit a new claim with the corrected information.

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Edit Code	Description	CARC	RARC	Resolution
794	PRINCIPAL MINOR SURGICAL PROCEDURE REQUIRES QIO APPROVAL	A1 – Claim/service denied.	N175 – Missing review organization approval.	**UB CLAIM:** Prior authorization is required from QIO. Enter PA number (field 63). If the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment. Contact the QIO for consideration for payment for retroactive eligibility and emergency services.
795	SURG RATE CLASS/NOT ON FILE-NOT COV DOS	16 – Claim/service lacks information which is needed for adjudication.	N65 – Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	**UB CLAIM:** Verify that the procedure code (field 44) and date of service (field 45) were entered correctly. If correct, attach appropriate clinical documentation (i.e., discharge summary, operative notes, etc.) to the new claim for review and consideration for payment.
796	PRINC DIAG NOT ASSIGNED LEVEL-MAN REVIEW	133 – The disposition of this claim/service is pending further review.		**UB CLAIM:** Verify that the diagnosis code (field 67) was submitted correctly. If correct, attach appropriate clinical documentation to support the diagnosis to the new claim for review and consideration for payment.
797	OTHER DIAG NOT ASSIGNED LEVEL-MAN REVIEW	133 – The disposition of this claim/service is pending further review.		Follow the resolution for edit code 796. The two digits in front of the edit code on the remittance advice identify which other diagnosis code (fields 67 A-Q) has not been assigned a level.
798	SURGERY PROCEDURE REQUIRES PA# FROM QIO	A1 – Claim/service denied.	N175 – Missing review organization approval.	A prior authorization from the QIO is required for the surgery procedure billed. Contact the QIO for the authorization number and submit a new claim. If the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Prior authorization number (field 23) **UB CLAIM:** Treatment authorization code (field 63) Contact the QIO for consideration for payment for retroactive eligibility and emergency services.
799	OP PRIN/OTHER PROC REQ QIO APPROVAL	A1 – Claim/service denied.	N175 – Missing review organization approval.	Follow the UB claim resolution for edit code 798. The two digits in front of the edit code on the remittance advice identify which principal/other procedure requires QIO prior authorization (field 63).

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Edit Code	Description	CARC	RARC	Resolution
801	PROCEDURE CODE COMBINATION NOT ALLOWED – SAME DOS/CLAIM	16 – Claim/service lacks information which is needed for adjudication.	N56 – Procedure code billed is not correct/valid for the services billed or the date of service billed.	The provider should review the remittance advice for the procedure codes not allowed on the same date of service. If two or more of the RBHS Community Support Services (CSS) procedure codes were rendered on the same date of service, Medicaid will only reimburse one of the procedures rendered. Submit a new claim with one procedure code rendered, per one date of service, provided that the clinical documentation supports the service billed. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded), date of service (field 24A) Refer to the Same Day Service Restrictions policy for Community Support Services in Section 2 of the RBHS provider manual.
802	PROCEDURE CODE COMBINATION NOT ALLOWED – SAME DOS/DIFFERENT CLAIM	16 – Claim/service lacks information which is needed for adjudication.	N56 – Procedure code billed is not correct/valid for the services billed or the date of service billed.	Medicaid will not reimburse the same or multiple providers for rendering RBHS Community Support Services (CSS) procedure codes on the same day. If another provider was paid for the same or another RBHS CSS for the same date of service, the second billing provider will not be paid. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded), date of service (field 24A) Refer to the Same Day Service Restrictions policy for Community Support Services in Section 2 of the RBHS provider manual.
808	HEALTH OPPORTUNITY ACCOUNT (HOA) IN DEDUCTIBLE PERIOD	119 – Benefit maximum for this time period or occurrence has been reached.	N435 – Exceeds number/ frequency approved/allowed within time period without support documentation.	Attach supporting documentation to the new claim to indicate the recipient's HOA status and deductible payments for review and consideration for payment.

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Edit Code	Description	CARC	RARC	Resolution
820	SERVICES REQUIRE ICORE PA - PA MISSING OR NOT ON FILE	15 – The authorization number is missing, invalid, or does not apply to the billed services or provider.	N517 – Resubmit a new claim with the requested information.	Service Requires Prior Authorization from ICORE prior to rendering the service. No prior authorization number is on the claim or the prior authorization number on the claim is not on file for the recipient. If the prior authorization number is missing, submit a new claim with the prior authorization number provided by ICORE. If a valid prior authorization number is on the claim, contact ICORE for the system to be updated. After ICORE has updated the system, submit a new claim with the valid prior authorization number. Make corrections to the field(s) below. **CMS-1500 CLAIM**: Prior authorization number (field 23) **Notes**: If **Medicaid** is primary and the prior authorization number was not obtained from ICORE prior to rendering the service, you will not be considered for payment. If **Medicaid** is Secondary, a prior authorization does not need to be obtained from ICORE prior to rendering the service. Contact ICORE for consideration for payment for retroactive eligibility and emergency services.

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Edit Code	Description	CARC	RARC	Resolution
821	SERVICES REQUIRE ICORE PA – PA ON CLAIM NOT VALID	15 – The authorization number is missing, invalid, or does not apply to the billed services or provider.	N517 – Resubmit a new claim with the requested information.	Service Requires Prior Authorization from ICORE and the Prior Authorization information on the claim is not valid. Compare the Prior Authorization information received from ICORE to the claim to determine if there are any differences. For example, verify the PA number, check the date(s) of service to see if they are within the service authorization dates for the PA, and verify the NPI of the rendering provider, the procedures codes billed and that the units billed do not exceed the limit ICORE has authorized. If changes are needed, submit a new claim with the corrected information in the field(s) below. If you have verified that all prior authorization information on the claim matches the information on the ICORE PA letter, contact ICORE for further assistance. After ICORE has resolved the validity issue, submit a new claim with the valid prior authorization information. **CMS-1500 CLAIM**: Prior authorization number (field 23), date of service (field 24A unshaded), procedure code (field 24D unshaded), units (field 24G unshaded), line provider NPI (field 24J unshaded). **Notes**: If **Medicaid** is primary and the prior authorization number was not obtained from ICORE prior to rendering the service, you will not be considered for payment. If **Medicaid** is Secondary, a prior authorization does not need to be obtained from ICORE prior to rendering the service. If the service is denied, a request must be submitted to ICORE for prior authorization. A new claim with the corrected information must be submitted. Contact ICORE for consideration for payment for retroactive eligibility and emergency services.

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Edit Code	Description	CARC	RARC	Resolution
837	SERVICE REQUIRES QIO PA–PA MISSING OR NOT ON FILE	15–The authorization number is missing, invalid, or does not apply to the billed services or provider.	N517 – Resubmit a new claim with the requested information.	Service Requires Prior Authorization from the QIO prior to rendering the service. No authorization number is on the claim or the authorization number is not on file for the recipient on the claim. If the authorization number is missing, make corrections to the field(s) below. If an authorization number is on the claim, the number needs to be reviewed and updated; contact the QIO. After the QIO has updated the system, submit a new claim. **CMS-1500 CLAIM:** Prior authorization number (field 23) **UB CLAIM:** Treatment authorization code (field 63) **Notes:** If **Medicaid** is primary and the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment. If **Medicaid** is Secondary, a prior authorization does not need to be obtained from the QIO prior to rendering the service. If the service is denied, a request must be submitted to QIO for prior authorization. A new claim with the corrected information must be submitted. For UB claims (Inpatient only): If beneficiary is partially eligible for the dates of service on the claim; attach the DHHS Form 945 Verification of Medicaid Eligibility Letter to the **NEW** claim for review and consideration for payment. Contact the QIO for consideration for payment for retroactive eligibility and emergency services.

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Edit Code	Description	CARC	RARC	Resolution
838	SERVICE REQUIRES QIO PA – PA ON CLAIM NOT VALID	15 – The authorization number is missing, invalid, or does not apply to the billed services or provider.	N517 – Resubmit a new claim with the requested information.	Service Requires Prior Authorization from the QIO and the Prior Authorization on claim is not valid. Compare the Prior Authorization received from the QIO to the claim to determine if there are any differences. For example, verify that the PA number on the claim matches PA number on the QIO letter, check the date(s) of service/date of admission to see if they are within the service authorization dates for the PA, and verify the NPI of the rendering provider, the procedures codes billed and that the units billed do not exceed the limit authorized. If changes are needed, submit a new claim with the corrected information in the field(s) below. If you have verified that all prior authorization information on the claim matches the information on the QIO PA letter, attach the QIO PA letter to the new claim for review and consideration for payment. **CMS-1500 CLAIM:** Prior authorization number (field 23), date of service (field 24A unshaded), procedure code (field 24D unshaded), units (field 24G unshaded), line provider NPI (field 24J unshaded) **UB CLAIM:** Treatment authorization code (field 63), date of admission (field 12), procedure code (field 44 or 74), units (field 46) **Notes:** If **Medicaid** is primary and the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment. If **Medicaid** is Secondary, a prior authorization does not need to be obtained from the QIO prior to rendering the service. If the service is denied, a request must be submitted to QIO for prior authorization. A new claim with the corrected information must be submitted For UB claims (Inpatient only): If beneficiary is partially eligible for the dates of service on the claim; attach the DHHS Form 945 Verification of Medicaid Eligibility Letter to the **NEW** claim for review and consideration for payment. Contact the QIO for consideration for payment for retroactive eligibility and emergency services.

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Edit Code	Description	CARC	RARC	Resolution
839	IP ADMISSION REQUIRES QIO PA – PA MISSING OR NOT ON FILE	15 – The authorization number is missing, invalid, or does not apply to the billed services or provider.	N517 – Resubmit a new claim with the requested information.	**UB CLAIM:** IP Admission Requires Prior Authorization (field 63) from the QIO. No prior authorization number on the claim or authorization number is not on file for the recipient. If the authorization number is missing, add it to a new claim and resubmit. If an authorization number is on the claim, the number needs to be reviewed and updated. Contact the QIO. After the QIO has updated the system, submit a new claim. **Notes:** If **Medicaid** is primary **or** the beneficiary has **Medicare PART B ONLY** and the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment. If Medicaid is **Secondary**, a prior authorization does not need to be obtained from the QIO prior to rendering the service. If the service is denied, a request must be submitted to QIO for prior authorization. A new claim with the corrected information must be submitted. **For UB claims (Inpatient only):** If beneficiary is partially eligible for the dates of service on the claim; attach the DHHS Form 945, Verification of Medicaid Eligibility Letter, to the **NEW** claim for review and consideration for payment. For retroactive eligibility, contact the QIO for authorization.
843	RTF SERVICES REQUIRE PA	15 – The authorization number is missing, invalid, or does not apply to the billed services or provider.	N517 – Resubmit a new claim with the requested information.	**UB CLAIM:** RTF services require Prior Authorization (field 63) from the QIO. If the authorization number is missing, add it to a new claim and resubmit. If an authorization is on the claim, the number needs to be reviewed and updated. Contact the QIO. After the QIO has updated the system, submit a new claim. **Notes:** If **Medicaid** is primary and the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment. If Medicaid is **Secondary**, a prior authorization does not need to be obtained from the QIO prior to rendering the service. For UB claims (Inpatient only): If beneficiary is partially eligible for the dates of service on the claim; attach the DHHS Form 945 Verification of Medicaid Eligibility Letter to the **NEW** claim for review and consideration for payment. For retroactive eligibility, contact the QIO for authorization.

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Edit Code	Description	CARC	RARC	Resolution
844	IMD SERVICES REQUIRE PA	15 – The authorization number is missing, invalid, or does not apply to the billed services or provider.	N517 – Resubmit a new claim with the requested information.	**UB CLAIM:** IMD services require Prior Authorization (field 63) from the QIO. If the authorization number is missing, add it to a new claim and resubmit. If an authorization is on the claim, the number needs to be reviewed and updated. Contact the QIO. After the QIO has updated the system, submit a new claim. **Notes:** If **Medicaid** is primary and the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment. If Medicaid is **Secondary**, a prior authorization does not need to be obtained from the QIO prior to rendering the service. For UB claims (Inpatient only): If beneficiary is partially eligible for the dates of service on the claim; attach the DHHS Form 945 Verification of Medicaid Eligibility Letter to the **NEW** claim for review and consideration for payment. For retroactive eligibility, contact the QIO for authorization.
850	HOME HEALTH VISITS FREQUENCY EXCEEDED	B1 – Non-Covered visits.	N30 – Patient ineligible for this service.	**CMS 1500 CLAIM:** The frequency for visits has exceeded the allowed amount and prior authorization is required by the QIO. If there is an error, make the appropriate correction to the claim. Refer to the applicable provider policy manual. If the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment.
851	DUP SERVICE, PROVIDER SPEC and DIAGNOSIS	18 – Exact duplicate claim/ service.	N522 – Duplicate of a claim processed, or to be processed, as a crossover claim.	Verify that the procedure code and the diagnosis code were billed correctly. If incorrect, make corrections to the field(s) below. If correct, the first provider will be paid. The second provider of the same practice specialty will not be reimbursed for services rendered for the same diagnosis. If the 2nd provider should be reviewed and considered for payment, attach appropriate clinical documentation to the new claim which substantiates the services rendered. **CMS-1500 CLAIM:** Diagnosis code (field 21), procedure code (field 24D unshaded)

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Edit Code	Description	CARC	RARC	Resolution
852	DUPLICATE PROV/ SERV FOR DATE OF SERVICE	B13 – Previously paid. Payment for this claim/ service may have been provided in a previous payment.		1. Review the remittance advice for the duplicate payment date. 2. Check the patient's financial record to see whether payment was received. 3. If two or more of the same procedures were performed on the same date of service and you only received payment for the first date of service, initiate a void to void the original paid claim. Submit a new claim (replacement claim) with the corrected information. 4. If two or more of the same procedures were performed on the same date of service by different individual providers, attach appropriate clinical documentation (i.e., operative notes, clinical service notes, physician orders, etc.) to the claim for review and consideration for payment. When applicable if two or more of the same procedure were performed on the same date of service and only one procedure was paid, make the appropriate correction to the modifier (field 24D unshaded) on the claim to indicate a repeat procedure. Refer to your manual for applicable repeat modifiers. For further instructions on Void and Replacement claims, refer to Section 3 of the applicable provider policy manual.
853	DUPLICATE SERV/DOS FROM MULTIPLE PROV	B20 – Procedure/ service was partially or fully furnished by another provider.		Medicaid will not reimburse a physician if the procedure was also performed by a laboratory, radiologist, or a cardiologist. If none of the above circumstances apply, attach appropriate clinical documentation (i.e., operative notes, clinical service notes, physician orders, etc.) to the new claim for review and consideration for payment. Verify that the procedure code (field 24D unshaded on the claim) and date of service (field 24A on the claim) were billed correctly. If incorrect, make the appropriate corrections and submit a new claim. If correct, this indicates that the first provider was paid and additional providers should attach appropriate clinical documentation (i.e., operative notes, clinical service notes, physician orders, etc.) to the new claim for review and consideration for payment.
854	VISIT WITHIN SURG PKG TIME LIMITATION	A1 – Claim/service denied.	M144 – Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	If the visit is related to the surgery and is the only line on the claim. The visit will not be paid. If the visit is related to the surgery and is on the claim with other payable lines, remove the line with the 854 edit and submit a new claim. This indicates you do not expect payment for this line. If the visit is unrelated to the surgical package, enter the appropriate modifier, 24 or 25, on the new claim (field 24D unshaded).

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Edit Code	Description	CARC	RARC	Resolution
855	SURG PROC/PAID VISIT/TIME LIMIT CONFLICT	151 – Payment adjusted because the payer deems the information submitted does not support this many/ frequency of services.		If the visit and surgery are related, request recoupment of the visit to pay the surgery. If the visit and surgery are non-related, attach clinical documentation (i.e., operative notes, clinical service notes, physician orders, etc.) to the new claim to justify the circumstances for review and consideration of payment.
856	2 PRIM SURGEON BILLING FOR SAME PROC/DOS	B20 – Procedure/ service was partially or fully furnished by another provider.		Check to see if individual provider number is correct, and the appropriate modifier is used to indicate different operative session, assistant surgeon, surgical team, etc. Make appropriate changes to the field(s) below and submit a new claim. If no modifier is applicable, and field is correct, attach appropriate clinical documentation (i.e., operative notes, etc.) to the new claim for review and consideration for payment. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded), modifier (field 24D unshaded), line provider NPI (field 24J unshaded)
857	DUP LINE – REV CODE, DOS, PROC CODE, MODIFIER	18 – Exact duplicate claim/service.	N522 – Duplicate of a claim processed, or to be processed, as a crossover claim.	**UB CLAIM:** The two-digit number in front of the edit code on the remittance advice identifies which line of field 42 or 44 contains the duplicate code. Make the appropriate correction to the new claim. Duplicate revenue or CPT/HCPCS codes should be combined into one line by deleting the whole duplicate line and adding the units and charges to the other line.
858	TRANSFER TO ANOTHER INSTITUTION DETECTED	B20 –Procedure/ service was partially or fully furnished by another provider.		Check to make sure the dates of service are correct. If there are errors, make the appropriate correction to the new claim.
859	DUPLICATE PROVIDER FOR DATES OF SERVICE	B20 – Procedure/ service was partially or fully furnished by another provider.		**UB CLAIM:** Check the remittance advice for the dates of previous payments that conflict with this claim. If this is a duplicate claim or if the additional charges do not change the payment amount, disregard the rejection. If additional services were performed on the same day and will result in a different payment amount, complete a replacement claim (new claim). If services were not done on the same date of service, a new claim should be filed with the correct date of service. Attach clinical documentation (i.e., operative notes, physician orders, etc.) for both the paid claim and new claim(s) explaining the situation.

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Edit Code	Description	CARC	RARC	Resolution
860	RECIP SERV FROM MULTI PROV FOR SAME DOS	B20 – Procedure/ service was partially or fully furnished by another provider.		**UB CLAIM:** This edit most frequently occurs with a transfer from one hospital to another. One or both of the hospitals entered the wrong "from" or "through" dates (field 6). Verify the date(s) of service. If incorrect, enter the correct dates of service the new claim. If the dates are correct, attach appropriate clinical documentation (i.e., discharge summary, transfer document, ambulance document, etc.) to the new claim for review and consideration for payment. If the claim has a 618 carrier code (field 50), the claim may be duplicating against another provider's Medicare primary inpatient or outpatient claim, or against the provider's own Medicare primary inpatient or outpatient claim. If either situation occurs, attach the Medicare EOMB to the new claim for review and consideration for payment.
863	DUPLICATE PROV/SERV FOR DATES OF SERVICE	B13 – Previously paid. Payment for this claim/ service may have been provided in a previous payment.		**UB CLAIM:** Check the remittance advice for the dates of service for the paid claims that conflict with this claim. If all charges are paid for the date(s) of service, disregard the rejection. Submit a new claim, if it will result in a different payment amount. **Note:** Payment changes usually occurs when there is a change in the inpatient DRG or reimbursement type, or a change in the outpatient reimbursement type.
865	DUP PROC/SAME DOS/DIFF ANES MOD	B13 – Previously paid. Payment for this claim/ service may have been provided in a previous payment.		You have been paid for this procedure with a different modifier. Verify by the anesthesia record the correct modifier. Make appropriate corrections, if applicable, and submit a new claim. If the paid claim is correct, discard the rejection. If this procedure should be paid, attach appropriate clinical documentation to the new claim for review and consideration for payment. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded), modifier (field 24D unshaded)
866	NURS HOME CLAIM DATES OF SERVICE OVERLAP	B13 – Previously paid. Payment for this claim/ service may have been provided in a previous payment.		Check the remittance advice for the dates of service for the paid claims that conflict with this claim. If all charges are paid for the date(s) of service, discard the claim. Submit a new DHHS Form 181 with monthly billing, if it will result in a different payment amount and different dates of service.
867	DUPLICATE ADJ - ORIGINAL CLM ALRDY VOIDED	18 – Exact duplicate claim/service.	N522 – Duplicate of a claim processed, or to be processed, as a crossover claim.	Provider has submitted an adjustment claim for an original claim that has already been voided. An adjustment cannot be made on a previously voided claim. Discard the claim.

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Edit Code	Description	CARC	RARC	Resolution
877	SURGICAL PROCS ON SEPERATE CLMS/SAME DOS	B13 – Previously paid. Payment for this claim/ service may have been provided in a previous payment.		This edit indicates payment has been made for a primary surgical procedure at 100%. The system has identified that another surgical procedure for the same date of service was paid after manual pricing and approval. This indicates a review is necessary to ensure correct payment of the submitted claim. Make corrections to the claim by entering appropriate modifiers to indicate different operative sessions, assistant surgeon, surgical team, etc., and attach appropriate clinical documentation to the new claim for review and consideration for payment. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded), date of service (field 24A unshaded)
883	CARE CALL SERVICE BILLED OUTSIDE THE CARE CALL SYSTEM	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	This edit cannot be manually corrected. The provider needs to submit billing through the Care Call System.
884	OVERLAPPING PROCEDURES (SERVICES) SAME DOS/SAME PROVIDER	B13 – Previously paid. Payment for this claim/ service may have been provided in a previous payment.		Check the remittance advice for the dates of service for the paid claims that conflict with this claim. Check the patient's financial records to see whether payment was received. If payment was received, discard the rejection. If the claim/service is incorrect, void the claim and submit a new claim with the corrected information. If the procedures (services) overlap, attach appropriate clinical documentation to the new claim to substantiate the services being billed for review and consideration for payment.
885	PROVIDER BILLED AS ASST and PRIMARY SURGEON	B13 – Previously paid. Payment for this claim/ service may have been provided in a previous payment.		Verify which surgeon was primary and which was the assistant. Check the individual provider number. The modifier may need correcting to indicate different operative sessions, surgical team, etc. Attach applicable clinical documentation to the new claim for review and consideration for payment, if applicable, to determine which surgeon was primary and which was the assistant surgeon. If you have been paid incorrectly as a primary and/or assistant surgeon, void the paid claim and submit a new claim with the corrected information. Make appropriate corrections to the field(s) below. **CMS-1500 CLAIM:** Individual provider ID (field 24J unshaded), modifier (field 24D unshaded)

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Edit Code	Description	CARC	RARC	Resolution
887	PROV SUBMITTING MULT CLAIMS FOR SURGERY	B13 – Previously paid. Payment for this claim/ service may have been provided in a previous payment		**CMS 1500 CLAIM:** First check your records to see if this claim has been paid. If it has, discard the rejection. If multiple procedures were performed and some have been paid, attach appropriate clinical documentation (i.e., Medicare EOB, sterilization consent forms, etc.), and remittance advice from original claim to the new claim for review and consideration for payment. If two surgical procedures were performed at different times on this DOS (two different operative sessions), enter the modifier 78 or 79 (field 24D unshaded) on the new claim.
888	DUP DATES OF SERVICE FOR EXTENDED NH CLM	B13 – Previously Paid. Payment for this claim/ service may have been provided in a previous payment.		Check your records to see if this claim has been paid. If this is a duplicate claim, disregard the rejection. If dates of service are different or payment amount is different, submit a corrected DHHS Form 181 and EOMB with a new claim.
889	PROVIDER PREVIOUSLY PD AS AN ASST SURGEON	B13 – Previously paid. Payment for this claim/ service may have been provided in a previous payment.		**CMS 1500 CLAIM:** Verify which surgeon was primary and which was the assistant. If the surgeon has been paid as the assistant, and was the primary surgeon, void the paid claim and submit a new claim with the corrected information. If a review is needed, attach applicable clinical documentation (i.e., operative notes, surgical team, etc.) to the new claim for review and consideration for payment.
892	DUP DATE OF SERVICE,PROC/MOD ON SAME CLM	18 – Exact duplicate claim/service.	N522 – Duplicate of a claim processed, or to be processed, as a crossover claim.	If duplicate services were not provided, delete the duplicate line from the claim. If duplicate services were provided and the correct duplicate modifier was billed, attach support clinical documentation to the new claim for review and consideration for payment. Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Modifier (field 24D unshaded) **Note**: If reimbursement is for an assistant surgeon OR multiple births**;** use the Modifier (GB or CG) on the applicable lines(s).
893	CONFLICTING AA/QK MOD SUBMITTED SAME DOS	B20 – Procedure/ service was partially or fully furnished by another provider.		Claims are conflicting for the same date of service regardless of the procedure code, one with AA modifier and one with QK/QY modifier. Verify the correct modifier and/or procedure code for the date of service by the anesthesia record. Attach applicable clinical documentation to the new claim for review and consideration for payment. Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24A unshaded), Procedure code (field 24D unshaded), Modifier (field 24D unshaded),

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
894	CONFLICTING QX/QZ MOD SUBMITTED SAME DOS	B20 – Procedure/ service was partially or fully furnished by another provider.		Claims are conflicting for the same date of service regardless of the procedure code, one with QX modifier and one with QZ modifier. Verify by the anesthesia record if the procedure was rendered by a supervised or independent CRNA. Attach applicable clinical documentation to the new claim for review and consideration for payment. Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24A unshaded), Procedure code (field 24D unshaded), Modifier (field 24D unshaded),
895	CONFLICTING AA and QX/QZ MOD SAME PROC/DOS	B20 – Procedure/ service was partially or fully furnished by another provider.		Claims have been submitted by an anesthesiologist as personally performed anesthesia services and a CRNA has also submitted a claim. Verify by the anesthesia record the correct modifier for the procedure code on the date of service. Attach applicable clinical documentation to the new claim for review and consideration for payment. Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24A unshaded), Procedure code (field 24D unshaded), Modifier (field 24D unshaded),
897	MULT. SURGERIES ON CONFLICTING CLM/DOS	59 – Processed based on multiple or concurrent procedure rules.		**CMS 1500 CLAIM:** First check your records to see if this claim has been paid. If it has, discard the rejection. If multiple procedures were performed and some have been paid, attach appropriate clinical documentation (i.e., operative note and remittance from original claim, etc.) to the new claim for review and consideration for payment. If two surgical procedures were performed at different times on this DOS (two different operative sessions), enter the correct modifier 78 or 79 (field 24D unshaded) on the new claim.
899	CONFLICTING QK/QZ MOD FOR SAME DOS	B20 – Procedure/ service was partially or fully furnished by another provider.		Verify by the anesthesia record the correct modifier and procedure code for the date of service. If this procedure was rendered by an anesthesia team, the supervising physician should bill with QK modifier and the supervised CRNA should bill with the QX modifier. The QY modifier indicates the physician was supervising a single procedure. Attach applicable clinical documentation to the new claim for review and consideration for payment. Refer to the applicable policy manual for clinical documentation guidelines. Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24A unshaded), Procedure code (field 24D unshaded), Modifier (field 24D unshaded),

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Edit Code	Description	CARC	RARC	Resolution
900	PROVIDER ID IS NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	N77 – Missing/incomplete/invalid designated provider number.	Check your records to make sure that the provider ID number on the claim is correct. Make the appropriate correction to the new claim For assistance, contact Provider Enrollment at 1-888-289-0709.
901	INDIVIDUAL PROVIDER ID NUM NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	N77 – Missing/incomplete/invalid designated provider number.	Check your records to make sure that the individual provider ID number is correct. Submit a new claim with the corrected information. For assistance, contact Provider Enrollment at 1-888-289-0709. Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Individual provider ID (field 24J unshaded),
902	PROVIDER NOT ELIGIBLE ON DATE OF SERVICE	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Pay-to-provider was not eligible for date of service or was not enrolled when service was rendered. Verify whether the date of service on claim is correct. Submit a new claim with the corrected information. For provider's eligibility status, contact Provider Enrollment at 1-888-289-0709. **Note:** If the provider was not eligible on the date of service, you will not be considered for payment. Discard the rejection.
903	INDIV PROVIDER INELIGIBLE ON DTE OF SERV	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Verify whether the date of service on the claim is correct. Submit a new claim with the corrected information. For provider's eligibility status, contact Provider Enrollment at 1-888-289-0709. **Note:** If the provider was not eligible on the date of service, you will not be considered for payment. Discard the rejection.
904	PROVIDER SUSPENDED ON DATE OF SERVICE	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Verify whether the date of service on the claim is correct. If not, correct and submit a new claim. Direct further questions to SCDHHS Program Integrity at (803) 898-2640.
905	INDIVIDUAL PROVIDER SUSPENDED ON DOS	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Follow the resolution for edit 904.
906	PROVIDER ON PREPAYMENT REVIEW	A1 – Claim/service denied.	N35 – Program Integrity/ utilization review decision.	For assistance, direct questions to SCDHHS Program Integrity at (803) 898-2640.

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907	INDIVIDUAL PROVIDER ON PREPAYMENT REVIEW	A1 – Claim/service denied.	N35 – Program Integrity/ utilization review decision.	For assistance, direct questions to SCDHHS Program Integrity at (803) 898-2640.
908	PROVIDER TERMINATED ON DATE OF SERVICE	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Follow the resolution for edit 903
909	INDIVIDUAL PROVIDER TERMINATED ON DOS	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Follow the resolution for edit 903.
911	INDIV PROV NOT MEMBER OF BILLING GROUP	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	**CMS 1500 CLAIM:** Verify whether the provider number entered (field 24J) on the claim is correct. If incorrect, submit a new claim with the corrected information. If the provider number is correct, contact Provider Enrollment at 1-888-289-0709 to have the individual provider number added to the billing group ID number. After the system has been updated, submit a new claim.
912	PROV REQUIRES PA/NO PA NUMBER ON CLAIM	15 – The authorization number is missing, invalid, or does not apply to the billed services or provider.	N517 – Resubmit a new claim with the requested information.	Prior authorization approval is required. If the authorization number is missing, enter the correct PA number on the new claim. If you do not have a PA number, attach the authorization approval letter to the new claim. For emergency services, attach the appropriate clinical documentation to the new claim for review and consideration for payment.
914	INDIV PROV REQUIRES PA/NO PA NUM ON CLM	15 – The authorization number is missing, invalid, or does not apply to the billed services or provider.	N517 – Resubmit a new claim with the requested information.	Prior authorization approval is required. If the authorization number is missing, enter the correct PA number on the new claim. If you do not have a PA number, attach the authorization approval letter to the new claim. For emergency services, attach the appropriate clinical documentation to the new claim for review and consideration for payment.
915	GROUP PROV ID/NO INDIV ID ON CLAIM/LINE	16 – Claim/service lacks information which is needed for adjudication.	N77 – Missing/incomplete/invalid designated provider number.	Verify the rendering individual physician and enter his or her provider ID number in the field(s) below and submit a new claim. **CMS-1500 CLAIM:** Provider ID number (field 24J)

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Edit Code	Description	CARC	RARC	Resolution
916	CRD PRIM DIAG CODE/PROV NOT CERTIFIED	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	**CMS 1500 CLAIM:** Verify and enter the correct primary diagnosis code (field 21) on the new claim. If correct, attach clinical documentation/certification for review and consideration for payment to the new claim, if applicable.
917	CRD SEC DIAG CODE/PROV NOT CERTIFIED	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Follow the resolution for edit 916 according to the secondary diagnosis code.
918	CRD PROCEDURE CODE/PROV NOT CERTIFIED	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	**CMS 1500 CLAIM:** Verify and enter the correct procedure code (field 24D unshaded) and submit a new claim. If correct, attach clinical documentation/certification for review and consideration for payment to the new claim, if applicable.
919	NO PA# ON CLM/PROV OUT OF 25 MILE RADIUS	40 – Charges do not meet qualifications for emergent/urgent care.		Prior authorization approval is required for services outside of the SC Medicaid service area. If the authorization number is missing, enter the correct PA number on the new claim. If you do not have a PA number, attach the authorization approval letter to the new claim. For emergency services, attach the appropriate clinical documentation to the new claim for review and consideration for payment.
920	Transportation Service is covered by Contractual Transportation Broker / not covered fee-for-service	109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/ contractor.	N381 – Consult our contractual agreement for restrictions/ billing/payment information related to these changes.	The transportation service is covered by a Contractual Transportation Broker and not fee-for-service by Medicaid. Contact the recipient's contracted provider for payment.
921	Ambulance service is payable by Contractual Transportation Broker / not covered fee-for-service	109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/ contractor.	N381 – Consult our contractual agreement for restrictions/ billing/payment information related to these changes.	The ambulance service is covered by a Contractual Ambulance Broker and not fee-for-service by Medicaid. Contact the recipient's contracted provider for payment.
922	URGENT SERVICE/OOS PROVIDER	133 – The disposition of the claim/service is pending further review.		Verify the urgent service/out-of-state provider requirements were followed. Attach the appropriate clinical documentation to the new claim for review and consideration for payment.

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Edit Code	Description	CARC	RARC	Resolution
923	PROVIDER TYPE / CAT. INCONSIST W/ LEVEL OF CARE	150 – Payer deems the information submitted does not support this level of service.		Verify that the provider information, procedure code and level of care are correct. If there are errors, submit a new claim with the corrected information. Refer to the applicable provider manual for appropriate provider type and level of care.
924	RCF PROV/RECIP PAY CAT NOT 85 OR 86	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Check the recipient's eligibility to verify the payment category for the date of service that was rendered. If there are errors, submit a new claim with corrected DHHS CRCF-01 Form with the monthly billing and other applicable documentation. If the recipient's payment category has been updated to 85 or 86, submit a new claim with the DHHS CRCF-01 Form with the monthly billing.
925	AGES > 21 &< 65 / IMD HOSPITAL NON-COVERED	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Check the claim to make sure the recipient's age is from 21-64. Submit a new claim with the corrected information. If correct, attach appropriate clinical documentation (i.e., admission forms/ psychiatric prior authorizations, etc.), to the new claim for review and consideration for payment.
926	AGE 21-22/MENTAL INST SERV N/C - MAN REV	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Check the claim to make sure the recipient's age is from 21-22. Submit a new claim with the corrected information. If correct, attach appropriate clinical documentation (i.e., admission forms/ psychiatric prior authorizations, etc.), to the new claim for review and consideration for payment.
927	PROVIDER NOT AUTHORIZED AS HOSPICE PROV	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Provider was not authorized or enrolled as a hospice provider when service was rendered and will not be considered for payment. For provider's enrollment or eligibility status, contact Provider Enrollment at 1-888-289-0709.
928	RECIP UNDER 21/HOSP SERVICE REQUIRES PA	15 – The authorization number is missing, invalid, or does not apply to the billed services or provider.	N517 – Resubmit a new claim with the requested information.	**UB CLAIM:** No authorization number from the referring state agency is on the claim. Make the appropriate correction and submit a new claim. Attach appropriate clinical documentation to the new claim for review and consideration for payment, if applicable.
929	NON QMB RECIPIENT	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Provider is Medicare only provider attempting to bill for a non-QMB (Medicaid only) recipient. Medicaid does not provide reimbursement to QMB providers for non-QMB recipients.

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Edit Code	Description	CARC	RARC	Resolution
932	PAY TO PROV NOT GROUP/LINE PROV NOT SAME	16 – Claim/service lacks information which is needed for adjudication.	N77 – Missing/incomplete/invalid designated provider number.	Verify and correct the provider ID and/or NPI to ensure it is the same as the Provider ID and/or NPI on the line(s). Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Provider ID (field 24J) NPI (field 33 A & B)
933	REV CODE 172 OR 175/NO NICU RATE ON FILE	147 – Provider contracted/ negotiated rate expired or not on file.		**UB CLAIM:** Verify the correct revenue code (field 42) was billed. If the revenue code is incorrect, make the appropriate correction to the new claim. If the provider was not contracted when the service was rendered, the negotiated rate expired, or the codes were not on file, the edit is valid and will not be considered for payment.
934	PRIOR AUTHORIZATION NH PROV ID NOT AUTHORIZED	15 – The authorization number is missing, invalid, or does not apply to the billed services or provider.	N517 – Resubmit a new claim with the requested information.	Enter the correct Nursing Facility Provider number in the Prior Authorization field(s) below. **CMS-1500 CLAIM:** Prior Authorization (field 23)
935	PROVIDER WILL NOT ACCEPT TITLE 18 (MEDICARE) ASSIGNMENT	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Provider cannot bill for services on a beneficiary who is dually eligible. Services can only be billed for beneficiaries who are Medicaid only. Contact Provider Enrollment at 1-888-289-0709 regarding changes to enrollment status.
936	NON EMERGENCY SERVICE/OOS PROVIDER	40 – Charges do not meet qualifications for emergent/urgent care.		**UB CLAIM:** If diagnosis code (field 67) and surgical procedure codes (field 44 or 74) have been coded correctly, this outpatient service is not covered for out-of-state providers. No payment is due from Medicaid.
938	PROV WILL NOT ACCEPT TITLE 19 (MEDICAID) ASSIGNMENT	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Provider cannot bill for services on a beneficiary who is Medicaid only. Services can only be billed for a beneficiary who is dually eligible. Contact Provider Enrollment at 1-888-289-0709 regarding changes to enrollment status.
939	IND PROV WILL NOT ACCEPT T-19 (MEDICAID) ASSIGNMENT	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Provider cannot bill for services on a beneficiary who is Medicaid only. Services can only be billed for a beneficiary who is dually eligible. Contact Provider Enrollment at 1-888-289-0709 regarding changes to enrollment status.
940	BILLING PROV NOT RECIP IPC PHYSICIAN	170 - Payment is denied when performed/billed by this type of provider.	N95 – This provider type/provider specialty may not bill this service.	Contact that recipient's IPC physician to obtain the authorization for the service. Submit the IPC/OSCAP authorization form or IPC/OSCAP termination form with the monthly billing.

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Edit Code	Description	CARC	RARC	Resolution
941	NPI ON CLAIM NOT FOUND ON PROVIDER FILE	208 – National Provider Identifier – Not matched.		Check the NPI that was entered on the claim to ensure it is correct. If correct, register the NPI with Provider Enrollment. Medicaid Provider Enrollment Mailing address: PO Box 8809, Columbia, SC 29202-8809 Phone: 1-888-289-0709 Fax: (803) 870-9022
942	INVALID NPI	207 – National Provider Identifier – invalid format.	N257 – Missing/incomplete/ invalid billing provider/supplier primary identifier.	The NPI used on the claim is inconsistent with numbering scheme utilized by NPPES. Submit a new claim with the corrected information.
943	TYPICAL PROVIDER, NO NPI ON CLAIM	206 – National Provider Identifier – missing.		Typical providers must use the NPI and six-character Medicaid Legacy Provider Number or NPI only for each rendering and billing/pay-to provider. When billing with NPI only, the taxonomy code for each rendering and billing/pay-to provider must also be included. Submit a new claim with the corrected information.
944	TAXONOMY ON CLAIM HAS NOT BEEN REGISTERED WITH PROVIDER ENROLLMENT FOR THE NPI USED ON THE CLAIM	16 – Claim/service lacks information which is needed for adjudication.	N255 – Missing/incomplete/invalid billing provider taxonomy.	Correct the taxonomy on the claim so that it is one that the provider registered with SCDHHS the claim or contact Provider Enrollment to add the taxonomy that is being used on the claim. Once Provider Enrollment has updated the system, submit a new claim. Medicaid Provider Enrollment Mailing address: PO Box 8809, Columbia, SC 29202-8809 Phone: 1-888-289-0709 Fax: (803) 870-9022
945	PROFESSIONAL COMPONENT REQUIRED FOR PROV	A1 – Claim/service denied.	N13 – Payment based on professional/technical component modifier(s).	The services were rendered on an inpatient or outpatient basis. Enter a "26" modifier in field(s) below. Services described in this manual do not require a modifier. **CMS-1500 CLAIM:** Modifier (field 24D unshaded)
946	UNABLE TO CROSSWALK TO LEGACY PROVIDER NUMBER	16 – Claim/service lacks information which is needed for adjudication.	N77 – Missing/incomplete/invalid designated provider number.	The NPI, taxonomy code, and/or zip code + 4 must be entered on the claim and must match the NPI information that the provider registered with SC Medicaid. Submit a new claim with the corrected information. Contact Provider Enrollment at 1-888-289-0709 to verify the NPI information which was registered or to make any updates to the NPI information contained on the provider's file.
947	ATYPICAL PROVIDER AND NPI UTILIZED ON THE CLAIM	16 – Claim/service lacks information which is needed for adjudication.	N77 – Missing/incomplete/invalid designated provider number.	Atypical providers must continue to use their legacy number on the claim. Do not include an NPI if you are an atypical provider. Submit a new claim with the corrected information

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948	CONTRACT RATE NOT ON FILE/SERV NC ON DOS	147 – Provider contracted/negotiated rate expired or not on file.		Review your contract to verify if the correct procedure code/rate and date of service were billed. Submit a new claim with the corrected information. If the procedure code/rate needs to be added, attach appropriate documentation to the claim for review and consideration for payment.
949	CONTRACT NOT ON FILE FOR ELECTRONIC CLAIMS	A1 – Claim/service denied.	N51 — Electronic interchange agreement not on file for provider/submitter.	Contact the EDI Support Center at 1-888-289-0709 for further assistance.
950	RECIPIENT ID NUMBER NOT ON FILE	31 – Patient cannot be identified as our insured.		Check the patient's Medicaid ID number to make sure it was entered correctly. Remember, the patient's Medicaid numbers is 10 digits (no alpha characters). If there is a discrepancy with the patient's Medicaid ID number, contact the Medicaid Eligibility office in the patient's county of residence to correct the number on the patient's file. After the county Medicaid Eligibility office has updated the system, submit a new claim. Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A) **UB CLAIM:** Medicaid ID (field 60)
951	RECIPIENT INELIGIBLE ON DATES OF SERVICE	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Always check the patient's Medicaid eligibility on each date of service. Medicaid eligibility may change. If the patient was eligible, contact your county Medicaid Eligibility office and have them update the patient's Medicaid eligibility on the system. After the county Medicaid Eligibility office has updated, submit a new claim. If the patient was not eligible for Medicaid on the date of service, the patient is responsible for your charges. If the patient was eligible for some but not all of your charges, submit a new claim with the corrected information.
952	RECIPIENT PREPAYMENT REVIEW REQUIRED	15 – The authorization number is missing, invalid, or does not apply to the billed services or provider.	N517 – Resubmit a new claim with the requested information.	Verify the correct prior authorization number. If the authorization number is incorrect, make the appropriate correction to the new claim. Attach appropriate documentation to the new claim for review and consideration for payment, if applicable.

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953	BUYIN INDICATED - POSSIBLE MEDICARE	22 - This care may be covered by another payer per coordination of benefits.		File with Medicare first. If this has already been done, enter the Medicare carrier code, Medicare number, and Medicare payment in field(s) below and submit a new claim. If no payment was made, on the new claim, enter '1' in the TPL field. **CMS-1500 CLAIM:** Medicare carrier code (field 9D & 11C), Medicare number (field 9A & 11), Medicare payment (fields 9C,11B & 29), and TPL indicator (field 10 D) **UB CLAIM:** (Inpatient/Outpatient): Medicare carrier code (field 50), Medicare number (field 60), and Medicare payment (field 54). If no payment was made, enter 0.00 (field 54) and occurrence code 24 or 25 (fields 31-34 A-B) and the date Medicare denied. **UB CLAIM:** (Inpatient Only): Attach the Medicare EOMB to the claim, if Medicare (Part A) benefits are exhausted or non-existent, prior to admission and patient is still in the same spell of illness, enter the 620 carrier code (field 50), enter the Medicare ancillary payment(s) (field 54 A) and enter the recipient's Medicare ID (field 60 A) the claim with the corrected information. Click here for additional resolutions tips at MedicaideLearning.com.
957	DIALYSIS PROC CODE/PAT NOT CIS ENROLLED	16 – Claim/service lacks information which is needed for adjudication.	N188 – The approved level of care does not match the procedure code submitted.	Attach the ESRD enrollment form (Form 218) for the first date of service to the new claim. Please refer to the applicable policy manual for documentation submission guidelines.
958	IPC DAYS EXCEEDED OR NOT AUTH ON DOS	273 – Coverage/ program guidelines were exceeded.		Integrated Personal Care services/OSCAP are authorized with start and end dates of service. If the start and end dates of service are incorrect, submit a new IPC/OSCAP form with the corrected information on the new claim. If correct, attach a copy of the service provision form and/or any applicable DHHS forms to the new claim for review and consideration for payment. Please refer to the applicable policy manual for documentation submission guidelines
960	EXCEEDS ESRD M'CARE 90 DAY ENROLL PERIOD	16 – Claim/service lacks information which is needed for adjudication.	MA92 – Missing plan information for other insurance.	For review and consideration for payment, attach the denial letter or document from the Social Security Administration (SSA) and Medicare letter denying benefits to the new claim. Please refer to the applicable policy manual for documentation submission guidelines.

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Edit Code	Description	CARC	RARC	Resolution
964	FFS CLAIM FOR SLMB/QDWI RECIP NOT CVRD	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Medicaid pays Medicare premiums only for recipients in these Medicaid payment categories. Fee-for-service Medicaid claims are not reimbursed.
965	PCCM RECIP/PROV NOT PCP-PROC REQ REFERAL	243 - Services not authorized by network/ primary care providers.	N95 – This provider type/provider specialty may not bill this service.	Contact the recipient's primary care physician (PCP) and obtain authorization for the procedure. Enter the authorization number provided by the PCP in the field(s) below and submit the new claim. **CMS-1500 CLAIM:** (field 19) **UB CLAIM:** Treatment authorization code (field 63)
966	RECIP NOT ELIG FOR VENT WAIVER SERV	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	**CMS 1500 CLAIM:** The claim was submitted with a Mechanical Ventilator Dependent Waiver (MVDW) specific procedure code, but the patient was not a participant in the MVDW. Verify the procedure code (field 24D unshaded) and Medicaid ID number (field 1A). Make the appropriate corrections on the new claim. If the patient Medicaid ID number is correct, the procedure code is correct and a MVDW form has been obtained, contact the service coordinator listed at the bottom of the waiver form. Once the system has been updated, submit a new claim.
967	RECIP NOT ELIG FOR HD and SPINAL SERVICES	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	The claim was submitted with a Head and Spinal Cord Injured (HASCI) waiver-specific procedure code, but the patient was not a participant in the HASCI waiver. Verify the procedure code (field 24D unshaded) and Medicaid ID number (field 1A). If incorrect, make the appropriate corrections to the new claim. If the patient Medicaid ID number is correct, the procedure code is correct and the HASCI waiver form has been obtained, contact the service coordinator listed at the bottom of the waiver form. Once the system has been updated, submit a new claim.
970	HOSPICE SERV/RECIP NOT ENROLLED FOR DOS	96 – Non-covered charges.	N143 – The patient was not in a hospice program during all or part of the service dates billed.	Service is hospice. Recipient is not enrolled in hospice for the date of service.
974	RECIP IN MCO/MCO COVERS FIRST 90 DAYS	24 – Charges are covered under a capitation agreement/ managed care plan.		If you are a provider with the MCO plan, bill the MCO for the first 90 days.

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975	PACE PARTICIPANT/ALL SERVICES PROVIDED BY PACE	109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/ contractor.	N381 – Consult our contractual agreement for restrictions/billing/payment information related to these charges.	Contact recipient's PACE organization.
976	HOSPICE RECIPIENT/ SERVICE REQUIRES PA	B9 – Patient is enrolled in a Hospice.		Use the SCDHHS Web Tool to determine who the Hospice provider is. Contact the hospice provider to obtain the prior authorization number. Enter the authorization number in the field(s) below and submit a new claim. **CMS 1500 CLAIM:** Prior authorization number/MHN referral Number (field 19) **UB CLAIM:** Prior authorization number (field 63)
977	FREQUENCY FOR AMBULATORY VISITS EXCEEDED	151 – Payment adjusted because the payer deems the information submitted does not support this many/ frequency of services.		Exceptions may be made to this edit under the following criteria: 1. A claim must be returned within six months of the rejection with a copy of verification of coverage attached indicating ambulatory visits were available for the date of service being billed. The availability of ambulatory visits must have been verified on the actual date of service being billed or the day before. 2. If the visit code was a line item rejection and other services paid on the claim, the provider must file a new claim within six months of the rejection with a copy of verification of coverage indicating ambulatory visits were available for the date of service being billed. The availability of ambulatory visits must have been verified on the actual date of service being billed or the day before. 3. All timely filing requirements must be met. Provider options: Submit a request to Medicaid for additional ambulatory visit(s). Once authorization is obtained, submit a new claim along with SCDHHS approval letter, **or** Bill the patient for the non-covered office visit only. Medicaid will reimburse lab work, injections, x-rays, etc., done in addition to the office visit, **or** Change the office visit code to the minimal established office E/M code, 99211, and accept the lower reimbursement. This code does not count toward the ambulatory visits.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
978	FREQUENCY FOR IP HOSPITAL VISITS EXCEEDED	151 – Payment adjusted because the payer deems the information submitted does not support this many/ frequency of services.		**UB CLAIM:** The frequency for visits has exceeded the allowed amount. If there is an error, make the appropriate correction to the new claim. If correct, for review and consideration for payment of additional visits, attach appropriate clinical documentation to the new claim to substantiate the services being billed.
979	FREQ. FOR CHIROPRACTIC VISITS EXCEEDED	151 – Payment adjusted because the payer deems the information submitted does not support this many/ frequency of services.		The frequency for visits has exceeded the allowed amount. If there is an error, make the appropriate correction to the new claim. **CMS-1500 CLAIM:** Unit(s) (field 24G)
980	H HLTH NURS CARE N/C FOR DUAL ELIG RECIP	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	File your claim with the Medicare intermediary.
984	RECIP LIVING ARR INDICATES MEDICAL FAC	5 – The procedure code/bill type is inconsistent with the place of service.	M77 – Missing/incomplete/invalid place of service.	Verify patient's place of residence on date of service. If there are errors, submit a new claim with the corrected information. If correct, for review and consideration for payment, attach applicable documentation (i.e., insurance EOB) to the new claim which verifies the place of residence.
985	RECIP NOT ELIG FOR CHILDREN'S PCA SERV	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Check to make sure you have billed the correct Medicaid ID number, procedure code and that this client is in the CHPC program. If you have not billed the correct Medicaid ID number or procedure code, or the client is not in the CHPC program, submit a new claim with the corrected information.
987	RECIP NOT ELIG FOR HIV/AIDS WAIVER SERV	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	The claim was submitted with a HIV/AIDS Waiver-specific procedure code, but the patient was not a participant in the HIV/AIDS Waiver. Check the procedure code and Medicaid ID number. If incorrect, make the appropriate corrections to the new claim. If the patient Medicaid number is correct, the procedure code is correct, and a HIV/AIDS Waiver form has been obtained, contact the service coordinator listed at the bottom of the waiver form. Once the system has been updated, submit a new claim.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
988	CRD PROCEDURE/DOS PRIOR TO COVERAGE	26 – Expenses incurred prior to coverage.	N30 – Patient ineligible for this service.	Call PSC representative to see what the recipient's first date of treatment is. If dates of service on the claim are prior to enrollment date, verify enrollment date. If enrollment date is correct, change dates on the new claim If enrollment date is wrong, the recipient's file will need to be updated. Attach a new enrollment form (DHHS Form 218) to the new claim
989	RECIP IN MCO/SERV COVERED BY MCO	24 – Charges are covered under a capitation agreement/ managed care plan.		Recipient is enrolled with a Managed Care Organization (MCO), the MCO is responsible for management of this recipients' medical services. If you are a provider with the MCO, bill the MCO for the medical service. Discard the rejection. SCDHHS Fee for Service (FFS) Medicaid is not responsible for claim payment for this recipient. **UB CLAIM Only:** Attach EOB denial from the MCO, to the **NEW** claim for review and consideration for payment. Click here for additional resolution tips at MedicaideLearning.com.
990	FP RECIP/SERVICE IS NOT FP	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Make sure the Medicaid ID number matches the patient served. Check the diagnosis code(s), procedure code(s), and/or modifier to ensure the correct codes were billed. If incorrect, make the appropriate changes by adding a family planning diagnosis code, procedure code, and/or FP modifier to the new claim. If this service was not directly related to family planning it is non-covered under the Family Planning Waiver and by Medicaid, therefore the patient is responsible for the charges. Click here for additional resolution tips at MedicaideLearning.com.
991	RECIP ISCEDC/COSY-LIMITED SERVS. COVERED	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Limited services are covered for this recipient. This is not a covered service.
993	RECIP NOT ELIG FOR PACE SERV	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	The recipient was not eligible for PACE when the service was rendered. Verify that the information on the claim is correct. If not correct, submit a new claim with the corrected information. If the recipient's PACE eligibility status has been updated in the system, submit a new claim.
994	RECIP ELIG FOR EMERGENCY SVCS ONLY	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Recipient is eligible for "emergency medical services" only. Transportation services and/or any other non-emergent medical services are non-covered for these recipients and will not be considered for payment.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
995	INMATE RECIP ELIG FOR INSTIT. SVCS ONLY	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Recipient eligible for institutional services only. Review the claim to determine if the services were directly related to institutional services. If there are errors, submit a new claim with the corrected information. If the services are not directly related to institutional services, the services are non-covered and will not be considered for payment. **UB CLAIM:** Only inpatient claims will be reimbursed.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
754	1199 SEIU NATIONAL BENEFIT FUND	PO BOX 1007	NEW YORK	NY	101081007	(646) 473-9200	
462	1ST MEDICAL NETWORK	PO BOX 724317	ATLANTA	GA	31139	(888) 980-6676	CODE ASSIGNED BY SCHA
710	21ST CENTURY HEALTH AND BENEFITS, INC.	PO BOX 5037	CHERRY HILL	NJ	08034	(800) 323-4890	
B14	A.C.S. CONSULTING SERVICES, INC.	PO BOX 2000	WINSTON-SALEM	NC	271022000	(336) 759-2013	
B14DN	A.C.S. CONSULTING SERVICES, INC.	PO BOX 2000	WINSTON-SALEM	NC	271022000	(336) 759-2013	
650	ABBEVILLE COUNTY	-	-	-	-	-	
543	ACHA/CAREINGTON INTERNATIONAL CORP	PO BOX 2568	FRISCO	TX	75034	(800) 290-0523	CODE ASSIGNED BY SCHA
266	ACMG ADMINISTRATORS OF SOUTH CAROLINA	2570 TECHNICAL DR.	MIAMISBURG	OH	45342	(800) 232-6242	
786	ACS BENEFIT SERVICES, INC.	PO BOX 2000	WINSTON-SALEM	NC	271022000	(800) 849-5370	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C49	ACS CONSULTING SERVICES, INC.	PO BOX 2000	WINSTON-SALEM	NC	27102	(800) 849-5370	WAS PENN WESTERN
355	ACTIVA HEALTH GROUP	4350 E. CAMELBACK RD. # 200	PHOENIX	AZ	85018	(602) 468-9500	
341	ADMINISTRATIVE CONCEPTS, INC.	994 OLD EAGLE SCHOOL RD., STE. 1005	WAYNE	PA	19087	(888) 293-9229	
563	ADMINISTRATIVE SERVICE CONSULTANTS	3301 E ROYALTON RD. BLDG. D	BROADVIEW HEIGHTS	OH	44147	-	
346	ADMINISTRATIVE SERVICES, INC.	2187 NORTHLAKE PARKWAY STE. 106 BLD #9	TUCKER	GA	30084	(770) 934-3953	
829	ADMINISTRATIVE SOLUTIONS	PO BOX 2490	ALPHARETTA	GA	30023	(678) 339-0211	
731	ADOVA HEALTH	PO BOX 725549	ATLANTA	GA	31139	(866) 470-4959	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C15	ADVANCE PCS	PO BOX 52188	PHOENIX	AZ	850722196	(480) 391-4600	SEE CARRIER 471
D11	ADVANCED BENEFIT SOLUTIONS	PO BOX 71490	PHOENIX	AZ	85050	(888) 419-1094	CODE NOT REQUESTED BY MEDICAID ASSIGNED BY SCHA MEDICARE SUPPLEMENTAL PLAN
310	ADVANCED DATA SOLUTIONS	PO BOX 723097	ATLANTA	GA	31139	(800) 742-5246	
C72	ADVANCED INSURANCE ADMINISTRATION	125 MERRILL DR. STE. 2000	LITTLE ROCK	AR	72211	(888) 242-4800	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
D33	ADVANTRA FREEDOM	PO BOX 7154	LONDON	KY	407427154	(800) 713-5095	MEDICARE ADVANTAGE PLAN
C88	ADVENTIST RISK MANAGEMENT	PO BOX 1928	GRAPEVINE	TX	76099	(800) 638-0589	
899	AETNA HEALTH PLANS OF THE CAROLINAS, INC.	3 CENTERVIEW DR.	GREENSBORO	NC	27407	(800) 459-1466	HMO PLAN ONLY
A55	AETNA LIFE AND CASUALTY	PO BOX 36890	LOUISVILLE	KY	40232	(800) 423-3289	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D16	AETNA MEDICARE OPEN PLAN	PO BOX 14079	LEXINGTON	KY	405124079	(800) 624-0756	MEDICARE ADVANTAGE PLAN
100RX	AETNA PHARMACY	PO BOX 52444	PHOENIX	AZ	850722444	(800) 238-6279	
100	AETNA US HEALTHCARE	PO BOX 14079	LEXINGTON	KY	40512	(800) 333-4432	
100DN	AETNA US HEALTHCARE	PO BOX 14094	LEXINGTON	KY	40512	(800) 451-7715	
B43	AFFINITY HEALTH PLAN	PO BOX 981726	EL PASO	TX	799981726	(866) 247-5678	
776	AFID (ASSO. OF FRANCHISE AND INDEPENDENT DIST.	1 S. LIMESTONE ST., STE. 301	SPRINGFIELD	OH	45502	(866) 766-9016	CODE IN OPEN STATUS BY SCHA
595	AFLAC -AMERICAN FAMILY LIFE ASSO CO	1932 WYNNTON RD.	COLUMBUS	GA	31999	(800) 992-3522	
289	AFTRA HEALTH FUND	261 MADISON AVE.	NEW YORK	NY	10016	(800) 562-4690	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
E55	AG ADMINISTRATORS	PO BOX 979	VALLEY FORGE	PA	19482	(800) 634-8628	
651	AIKEN COUNTY	-	-	-	-	-	
455	ALASKA TEAMSTER TRUST	520 E 34TH AVE., STE. 107	ANCHORAGE	AK	995034116	(800) 478-4450	CODE ASSIGNED BY SCHA
344	ALIA CLAIMS DEPARTMENT	PO BOX 9060	PHOENIX	AZ	850689060	(800) 882-5707	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
299	ALICARE	PO BOX 1447	NEW YORK	NY	10116	(212) 539-5115	
200	ALL AMERICAN LIFE INSURANCE CO.	8501 WEST HIGGINS RD.	CHICAGO	IL	60631	(773) 399-6645	
199	ALL OTHER CARRIERS	-	-	-	-	-	
E54	ALLEGIANCE BENEFIT PLAN MANAGEMENT	PO BOX 3018	MISSOULA	MT	598063018	(800) 781-7204	
560	ALLEN MEDICAL CLAIMS ADMINISTRATORS	PO BOX 978	FT. VALLEY	GA	310300978	(800) 825-5406	
652	ALLENDALE COUNTY	-	-	-	-	-	
272	ALLIANCE HEALTH BENEFIT PLAN	PO BOX 6443	ROCKVILLE	MD	20850	(800) 342-3289	
521	ALLIANCE PPO, INC.	PO BOX 934	FREDERICK	MD	21705	(800) 235-0123	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
							SCHA
A33	ALLIANT HEALTH PLANS, INC.	PO BOX 21109	ROANOKE	VA	24108	(800) 283-4927	
413	ALLIED BENEFITS SYSTEM	PO BOX 909786-60690	CHICAGO	IL	606909786	(800) 288-2078	
135	ALLIED NATIONAL, INC.	PO BOX 419233	KANSAS CITY	MO	641416233	(800) 825-7531	CARRIER WAS ALLIED GROUP INSURANCE TRUST
115	ALLSTATE INSURANCE	PO BOX 7068	COLUMBIA	SC	29202	(800) 366-8997	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
193	ALLSTATE WORKPLACE DIVISION	PO BOX 853916	RICHARDSON	TX	750853916	(800) 937-7039	
581	ALTA RX	PO BOX 30081	SALT LAKE CITY	UT	84130	(800) 998-5033	
A02	ALTERNATIVE BENEFITS PLANS, INC.	2920 BRANDYWINE RD. STE. 106	ATLANTA	GA	30341	(800) 241-7319	
E44	ALTERNATIVE INSURANCE RESOURCE, INC.	PO BOX 680787	BIRMINGHAM	AL	352660787	(800) 451-4318	
B96	ALTERNATIVE RISK MANAGEMENTS (ARM LTD)	814 N.W. HIGHWAY	ARLINGTON HEIGHTS	IL	60004	(800) 392-1770	
234	ALWAYSCARE BENEFITS, INC.	PO BOX 80139	BATON ROUGE	LA	70898	(888) 729-5433	DENTAL PLAN
161	AMA INSURANCE AGNECY, INC.	200 N. LASALLE ST., STE. 400	CHICAGO	IL	606819785	(800) 458-5736	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
297	AMALGAMATED LIFE INSURANCE	PO BOX 1451	NEW YORK	NY	101161451	(212) 473-5700	
C07	AMERIBEN SOLUTIONS	PO BOX 7186	BOISE	ID	83707	(800) 786-7930	
309	AMERICAN ADMINISTRATIVE GROUP	PO BOX 5227	LISLE	IL	605325227	(630) 493-9252	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
910	AMERICAN ADMINISTRATIVE GROUP	PO BOX 5227	LISLE	IL	605325227	(800) 354-5112	WAS GALLAGER & BASSETT SERVICES
469	AMERICAN ASSOCIATION OF RETIRED PERSONS (AARP)	PO BOX 740819	ATLANTA	GA	30374	(800) 523-5880	
B61	AMERICAN BEHAVIORAL	3680 GRANDVIEW PARKWAY STE 100	BIRMINGHAM	AL	35243	(800) 925-8327	
968	AMERICAN BENEFIT ADMINISTRATIVE SERVICES	PO BOX 0928	BROOKFIELD	WI	53008	(630) 416-1111	
271	AMERICAN BENEFIT PLAN ADMINISTRATOR	22OO-B ROSSELLE ST.	JACKSONVILLE	FL	32204	(800) 468-5126	
488	AMERICAN BENEFITS MANAGEMENT	8310 PORT JACKSON AVE. NORTHWEST	NORTH CANTON	OH	44720	(330) 966-5500	
B44	AMERICAN CHOICE HEALTH PLAN, LLC	PO BOX 922043	HOUSTON	TX	77292	(800) 633-4226	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
B44DN	AMERICAN CHOICE HEALTH PLAN, LLC	PO BOX 922009	HOUSTON	TX	77292	(800) 598-9799	
A93	AMERICAN COLLEGE OF SURGEONS	PO BOX 2522	FORT WORTH	TX	761132522	(800) 433-1672	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
778	AMERICAN CONTINENTAL INSURANCE CO	PO BOX 5008	BRENTWOOD	TN	37024	(800) 264-4000	
D48	AMERICAN CONTINENTAL INSURANCE CO	PO BOX 2368	BRENTWOOD	TN	37024	(615) 337-1300	MEDICARE ADVANTAGE PLAN
106	AMERICAN FIDELITY ASSURANCE BENEFITS	PO BOX 25160	OKLAHOMA CITY	OK	731250160	(800) 654-8489	
150	AMERICAN GENERAL LIFE AND ACCIDENT INS CO	PO BOX 1500	NASHVILLE	TN	372021500	(800) 888-2452	
951	AMERICAN GROUP ADMINISTRATORS	101 CONVENTION CENTER DR. STE. 200	LAS VEGAS	NE	89109	(800) 842-4742	
A57	AMERICAN GROUP ADMINISTRATORS, INC.	101 CONVENTION CENTER DR. STE 200	LAS VEGAS	NV	89109	(800) 842-4742	CODE ASSIGNED BY SCHA
118	AMERICAN HEALTH & LIFE INSURANCE	300 ST. PAUL PLACE	BALTIMORE	MD	21202	(301) 332-3000	
C92	AMERICAN HEALTH CARE	3850 ATHERTON RD.	ROCKLIN	CA	95765	(800) 872-8276	
C92DN	AMERICAN HEALTH CARE	3001 DOUGLAS ST.	ROSEVILLE	CA	95661	(800) 872-8276	
919	AMERICAN HEALTH GROUP, INC.	PO BOX 1500	MAUMEE	OH	43537	(800) 872-8276	
383	AMERICAN HEALTHCARE ALLIANCE	PO BOX 8530	KANSAS CITY	MO	641140530	(877) 284-0102	
119	AMERICAN HERITAGE LIFE INSURANCE	1776 AMERICAN HERITAGE LIFE DR.	JACKSONVILLE	FL	32224	(800) 535-8086	
840	AMERICAN, INCOME LIFE INSURANCE COMPANY	PO BOX 2608	WACO	TX	76797	(817) 772-3050	
B69	AMERICAN INSURANCE ADMINISTRATORS	PO BOX 2348	COLUMBUS	OH	432162348	(800) 922-1245	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA.
D38	AMERICAN INSURANCE ADMINISTRATORS	PO BOX 2348	COLUMBUS	OH	43216	(800) 922-1245	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
369	AMERICAN INTERNATIONAL GROUP	PO BOX 25050	WILMINGTON	DE	19899	(800) 468-7077	
167	AMERICAN INTERNATIONAL GROUP (AIG) ACCIDENT	PO BOX 26050	OVERLAND PARK	KS	66225	(888) 722-1668	
A62	AMERICAN MEDICAL AND LIFE INSURANCE (AMLI)	PO BOX 1353	CHICAGO	IL	60690	(888) 264-1512	
532	AMERICAN MEDICAL SECURITY	PO BOX 19032	GREEN BAY	WI	543079032	(800) 232-5432	
120	AMERICAN NATIONAL INSURANCE COMPANY	PO BOX 1790	GALVESTON	TX	77553	(800) 899-6803	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
B98	AMERICAN PIONEER LIFE INSURANCE COMPANY	PO BOX 130	PENSACOLA	FL	32591	(800) 538-1053	
321	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	PO BOX 188004	CHATTANOOGA	TN	37422	(800) 222-2798	
321DN	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	PO BOX 1358	GLEN BURNIE	MD	21060	(800) 222-2798	
164	AMERICAN PROGRESSIVE INSURANCE	PO BOX 130	PENSACOLA	FL	325910130	(800) 626-8913	
A05	AMERICAN PUBLIC LIFE INSURANCE CO.	PO BOX 925	JACKSON	MS	39205	(800) 256-8606	
722	AMERICAN REPUBLIC INSURANCE COMPANY	PO BOX 21670	EAGAN	MN	55121	(800) 247-2190	
C70	AMERICAN RETIREMENT LIFE	PO BOX 30010	AUSTIN	TX	757553010	(866) 459-1755	REQUESTED BY THE SCHA
875	AMERICAN SENTINEL	PO BOX 61140	HARRISBURG	PA	171061140	(800) 692-7338	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
503	AMERICAN SPECIAL RISK MANAGEMENT	509 SOUTH LENOLA RD., BLDG. TWO	MOORESTOWN	NJ	08057	(800) 359-7475	
C82	AMERICAN STANDARD LIFE & ACCIDENT INS. CO.	PO DRAWER 3248, 224 NORTH INDEPENDENT	ENID	OK	73701	(405) 233-4000	CODE IN OPEN STATUS BY SCHA
253	AMERICAN STERLING INSURANCE SERVICES	PO BOX 26103	OVERLAND PARK	KS	66225	(877) 292-6037	
125	AMERICAN TRAVELERS LIFE INSURANCE COMPANY	3220 TILLMAN DR.	BEN SALEM	PA	19020	(215) 244-1600	
275	AMERICAN TRUST ADMINISTRATORS	PO BOX 87	SHAWNEE MISSION	KS	66201	(913) 451-4900	
496	AMERICAN VETERINARIAN MEDICINE ASSN.	PO BOX 909720	CHICAGO	IL	606049720	(800) 621-6360	
D61	AMERICA'S 1ST CHOICE	PO BOX 210769	COLUMBIA	SC	29210	(866) 321-3947	MEDICARE ADVANTAGE PLAN
D23	AMERICA'S HEALTH CHOICE MEDICAL PLANS,(HMO)	762 SOUTH US HWY. ONE PMB 224	VERO BEACH	FL	32962	(800) 308-9823	MEDICARE ADVANTAGE PLAN
557	AMERICORP INS. CO	PO BOX 3430	CARMEL	IN	46082	(866) 699-4186	
D51	AMERIGROUP COMMUNITY CARE	PO BOX 61010	VIRGINIA BEACH	VA	234661010	(800) 600-4441	MEDICAID HMO
D94	AMERIGROUP COMMUNITY CARE	PO BOX 61010	VIRGINIA BEACH	VA	234661010	(800) 600-4441	MEDICAID HMO
D60	AMERIGROUP COMMUNITY CARE OF SC	PO BOX 31789	VIRGINIA BEACH	VA	234661789	(800) 600-4441	CODE ASSIGNED BY SCHA
284	AMERIHEALTH ADMINISTRATORS	720 BLAIR RD.	HORSHAM	PA	19044	(800) 345-4017	
110	AMERIHEALTH HMO, INC.	PO BOX 41574	PHILADELPHIA	PA	191011574	(888) 632-3862	CODE ASSIGNED BY SCHA
894	AMERIHEALTH MERCY HEALTH PLAN	PO BOX 7118	LONDON	KY	40742	(888) 991-7200	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A10	AMERISCRIPT	4301 DARROW RD. STE. 4200	STOW	OH	44224	(800) 681-6912	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
210	AMERITAS LIFE INSURANCE	PO BOX 82520	LINCOLN	NE	68501	(800) 255-9678	
B08	AMFIRST INSURANCE CO	PO BOX 16708	JACKSON	MS	39236	(888) 888-2519	
653	ANDERSON COUNTY	-	-	-	-	-	
330	ANNUITY BOARD OF SOUTHERN BAPTIST CONVENTION	PO BOX 2190	NASHVILLE	TN	37234	(214) 720-0511	
X0Y	ANTHEM BLUE CROSS AND BLUE SHIELD	PO BOX 105187	ATLANTA	GA	30348	(800) 622-4822	
X0YDN	ANTHEM BLUE CROSS AND BLUE SHIELD	PO BOX 659444	SAN ANTONIO	TX	78265	(800) 622-4822	
X0YRX	ANTHEM BLUE CROSS AND BLUE SHIELD	PO BOX 37010	LOUISVILLE	KY	40233	(800) 622-4822	
529	ANTHEM HEALTH	3575 KROGER BLVD. , STE. 400	DULUTH	GA	30316	(800) 888-1966	
579	ANTHEM PRESCRIPTION MANAGEMENT	PO BOX 145433	CINCINNATI	OH	45250	(800) 662-0210	USE CARRIER A24
D65	ANTHEM SENIOR ADVANTAGE	PO BOX 37690	LOUISVILLE	KY	402337180	(888) 290-9160	MEDICARE ADVANTAGE PLAN
171	AON	PO BOX 66	WINSTON-SALEM	NC	27102	(800) 368-3804	
523	APA PARTNERS, INC.	PO BOX 1506	LATHAM	NY	121108006	(800) 833-3650	
705	APS HEALTHCARE, INC.	PO BOX 1307	ROCKVILLE	MD	20849	(800) 221-8699	
D13	ARCADIAN	PO BOX 4946	COVINA	CA	91723	(800) 775-6490	CODE ORIGINALLY ASSIGNED AS MA IN ERROR USE CODE 816 FOR MA PLAN
816	ARCADIAN MEMBER CARE	PO BOX 4946	COVINA	CA	91723	(800) 573-8597	MEDICARE ADVANTAGE PLAN
981	ARGUS HEALTH SYSTEMS	PO BOX 419019	KANSAS CITY	MO	64141	(800) 522-7487	
A49	ARIZONA FOUNDATION FOR MEDICAL CARE	PO BOX 2909	PHOENIX	AZ	850622909	(602) 231-8855	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
X1I	ARKANSAS BLUE CROSS AND BLUE SHIELD, INC.	PO BOX 2181	LITTLE ROCK	AR	72203	(501) 378-2010	
B78	ARM GROUP (OMNICARE)	340 QUADRANGLE DR.	BOILINGBROOK	IL	60440	(800) 968-7222	
972	ASR CORP (ADMINISTRATION SYSTEM RESEARCH)	PO BOX 6392	GRAND RAPIDS	MI	49516	(800) 968-2449	
505	ASSOCIATED ADMINISTRATORS	PO BOX 27806	BALTIMORE	MD	212857806	(800) 638-2972	
898	ASSOCIATION & SOCIETY INS. CORP	PO BOX 2510	ROCKVILLE	MD	20847	(800) 638-2610	
934	ASSOCIATION & SOCIETY INS. CORP	PO BOX 2510	ROCKVILLE	MD	20847	(800) 638-2610	
458	ASSOCIATION BENEFIT PLAN (MEDICARE)	PO BOX 668587	CHARLOTTE	NC	282668587	(800) 634-0069	CODE ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
386	ASSURANT HEALTH	PO BOX 2806	CLINTON	IA	527332806	(800) 553-7654	WAS FORTIS INSURANCE COMPANY
386DN	ASSURANT HEALTH	PO BOX 2940	CLINTON	IA	527332940	(800) 442-7742	DHHS INTERNAL RECOVERY CLAIMS BILLING MUST BE FAX TO: 414-224-0472
448	ASSURANT HEALTH INSURANCE	PO BOX 42033	HAZELWOOD	MD	63042	(800) 553-7654	CODE ASSIGED BY SCHA
451	ASSURECARE RISK MANAGEMENT	340 QUANRINGLE BLVD.	BOILING BROOK	IL	60440	(800) 759-7422	
105	ATHENE ANNUITY AND LIFE ASSURANCE COMPANY	PO BOX 19038	GREENVILLE	SC	29602	(864) 609-1000	
971	ATLANTA ADMINISTRATIONS	135 BEAVER ST.	WALTHAM	MA	02452	(800) 548-1256	
B34	ATLANTA LIFE INSURANCE COMPANY	100 AUBURN AVE., NE	ATLANTA	GA	30303	(404) 659-2100	
122	ATLANTIC COAST LIFE INSURANCE COMPANY	PO BOX 20010	CHARLESTON	SC	294130010	(843) 763-8680	
B45	ATLANTICARE	PO BOX 613	HAMMONTON	NJ	08037	(888) 328-2287	
526	AULTCARE	PO BOX 6910	CANTON	OH	44706	(800) 344-8858	
588	AUTOMATED BENEFIT SERVICES, INC.	PO BOX 321223	DETROIT	MI	482321223	(800) 275-1896	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B82	AVANTE HEALTH	1111 E. HERNDON AVE. STE. 308	FRESNO	CA	93720	(866) 416-3617	
C40	AVERA HEALTH PLANS	PO BOX 381506	BIRMINGHAM	AL	35238	(888) 322-2115	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
494	AVESIS PHARMACY NETWORK	3724 N 3RD ST. STE 300	PHOENIX	AZ	85012	(602) 241-3400	
B58	AVMED HEALTH	PO BOX 569000	MIAMI	FL	332569000	(800) 452-8633	
A72	BABB, INC.	850 RIDGE AVE.	PITTSBURGH	PA	15212	(800) 245-6102	
358	BAKERY & CONFECTIONERY UNION	10401 CONNECTICUT AVE. STE 300	KENSINGTON	MD	208953960	(301) 468-3742	
654	BAMBERG COUNTY	-	-	-	-	-	
987	BANKERS FIDELITY LIFE INS CO	PO BOX 105652	ATLANTA	GA	30348	(404) 266-5500	
815	BANKERS FIDELITY LIFE INSURANCE COMPANY	PO BOX 260040	PLANO	TX	75026	(866) 458-7499	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
123	BANKERS LIFE & CASUALTY	PO BOX 66927	CHICAGO	IL	606660927	(800) 621-3724	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
655	BARNWELL COUNTY	-	-	-	-	-	
644	BCBS OF GEORGIA	PO BOX 9907	COLUMBUS	GA	31908	(800) 441-2273	MEDICARE INTERMEDIARY
X0BDN	BCBS OF GEORGIA DENTAL	PO BOX 659444	SAN ANTONIO	TX	78265	(404) 842-8000	
X0MDN	BCBS OF MASSACHUSETTS	PO BOX 986005	BOSTON	MA	02298	800-253-5210	DENTAL ONLY
867	BCBS OF NC	PO BOX 30087	DURHAM	NC	27702	(919) 489-7431	
C62	BCBS OF SC MEDICARE BLUE PRIVATE (PFFS)	PO BOX 100133	COLUMBIA	SC	29202	(800) 605-3256	MEDICARE ADVANTAGE PLAN
C63	BCBS OF SC MEDICARE BLUE&MEDICARE BLUE PLUS (PPO)	PO BOX 100133	COLUMBIA	SC	29202	(800) 605-3256	MEDICARE ADVANTAGE PLAN
643	BCBS OF TENNESSEE	730 CHESTNUT ST.	CHATTANOOGA	TN	37402	(877) 296-6189	MEDICARE INTERMEDIARY
656	BEAUFORT COUNTY	-	-	-	-	-	
881	BEHAVIORAL HEALTH SYSTEMS	PO BOX 830724	BIRMINGHAM	AL	352830724	(800) 245-1150	
C08	BENECARD	PO BOX 2187	CLIFTON	NJ	07015	(800) 737-9528	
750	BENEFIT ADMINISTRATIVE SERVICES	PO BOX 4509	ROCKFORD	IL	61110	(815) 969-9663	
C79	BENEFIT ADMINISTRATIVE SYSTEM, LTD	PO BOX 17475 JOVANNA DR., STE. 1B	HOMEWOOD	IL	60430	(708) 799-7400	
E87	BENEFIT ADMINISTRATIVE SYSTEMS	PO BOX 2920	MILWAUKEE	WI	53201	(800) 525-0582	
B37	BENEFIT ADMINISTRATORS	PO BOX 21308	COLUMBIA	SC	29221	(877) 840-0936	
B37DN	BENEFIT ADMINISTRATORS	PO BOX 1957	BEATTYVILLE	KY	41311	(800) 325-8424	
300	BENEFIT ADMINISTRATORS, INC.	PO BOX 6279	ERIE	PA	16512	(800) 777-2524	
300DN	BENEFIT ADMINISTRATORS, INC.	PO BOX 6279	ERIE	PA	16512	(800) 777-2524	
475	BENEFIT ASSISTANCE CORP.	PO BOX 950	HURRICANE	WV	25526	(304) 562-1913	
319	BENEFIT CONCEPTS	PO BOX 60608	KING OF PRUSSIA	PA	19406	(800) 220-2600	
A86	BENEFIT MANAGEMENT CO	PO BOX 269000	WESTON	FL	333269000	(800) 262-9175	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C12	BENEFIT MANAGEMENT, INC.	PO BOX 1090	GREAT BEND	KS	66210	(800) 290-1368	
C11	BENEFIT MANAGEMENT SERVICES, INC.	PO BOX 1317	MATTHEWS	NC	28106	(800) 228-1803	
C11DN	BENEFIT MANAGEMENT SERVICES, INC.	PO BOX 1178	MATTHEWS	NC	28106	(800) 228-1813	
301	BENEFIT PLAN ADMINISTRATORS	2145 FORD PARKWAY, STE. 300	ST. PAUL	MN	55116	(800) 277-8973	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
C28	BENEFIT PLAN MANAGEMENT	PO BOX 536	ROCKLYN	MA	02370	(877) 642-7500	
311	BENEFIT PLANNERS, INC.	PO BOX 682010	SAN ANTONIO	TX	78269	(210) 699-1872	
980	BENEFIT SUPPORT, INC.	PO BOX 2977	GAINSVILLE	GA	30503	(800) 777-4782	
772	BENEFIT SYSTEMS, INC.	PO BOX 6001	INDIANAPOLIS	IN	462066001	(800) 824-3216	
127	BENEFITSOURCE, INC.	PO BOX 240	MONROE	MI	48161	(800) 423-1028	CODE ASSIGNED BY SCHA
A25	BENESCRIPT	8300 E. MAPLEWOOD AVE.	GREENWOOD VILLAGE	CO	80111	(800) 345-3189	
985	BENESIGHT	PO BOX 340	PUEBLO	CO	81002	(800) 362-1116	
A81	BENESYS	PO BOX 90082	LUBBOCK	TX	79402	(337) 234-1789	
256	BENICOMP	8310 CLINTON PARK DR.	FT. WAYNE	IN	46825	(800) 837-7400	CODE ASSIGNED BY SCHA
380	BENMARK, INC.	PO BOX 16767	JACKSON	MS	39236	(601) 366-0596	
481	BENOVATION	3481 CENTRAL PARKWAY, STE 200	CINCINNATI	OH	45223	(800) 681-6912	CODE ASSIGNED BY SCHA
657	BERKELEY COUNTY	-	-	-	-	-	
904	BEST CHOICE HEALTH PLAN	PO BOX 21128	FORT LAUDERDALE	FL	33335	(800) 867-4446	
E29	BEST LIFE AND HEALTH INSURANCE CO.	PO BOX 890	MERIDIAN	ID	836800890	(800) 433-0088	
D08	BIG LOTS ASSOCIATE BENEFIT PLAN	PO BOX 9071	DUBLIN	OH	430170971	(877) 254-2363	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
X2X	BLUE CROSS BLUE SHIELD OF HAWAII	PO BOX 44500	HONOLULU	HI	96801	(800) 776-4672	
902	BLUE CARE NETWORK OF MI	PO BOX 68710	GRAND RAPID	MI	49516	(800) 658-8878	CODE ASSIGNED BY SCHA. THIS IS THE HMO TO CC 504 WHICH IS THE POS
C64	BLUE CHOICE HEALTH PLAN (PPO)	PO BOX 6170	COLUMBIA	SC	29260	(877) 275-3256	MEDICARE ADVANTAGE (PPO)
922	BLUE CHOICE HEALTHPLAN	PO BOX 6170	COLUMBIA	SC	292606170	(803) 786-8466	WAS COMPANION HEALTHCARE NAME CHANGE EFFECTIVE 7/1/05
403	BLUE CHOICE/MEDICAID	PO BOX 6170	COLUMBIA	SC	29260	(877) 275-3256	MEDICAID HMO
X2G	BLUE CROSS & BLUE SHIELD CENTRAL NEW YORK, INC.	PO BOX 4809	SYRACUSE	NY	132214809	(315) 448-3801	
X2W	BLUE CROSS & BLUE SHIELD OF ARIZONA, INC.	PO BOX 13466	PHOENIX	AZ	850023466	(602) 864-4100	
X1V	BLUE CROSS & BLUE SHIELD OF COLORADO	700 BROADWAY	DENVER	CO	80273	(303) 831-2131	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
X1H	BLUE CROSS & BLUE SHIELD OF CONNECTICUT, INC.	PO BOX 533	NORTH HAVEN	CT	06473	(203) 239-4961	
X0L	BLUE CROSS & BLUE SHIELD OF DELAWARE, INC.	PO BOX 1991	WILMINGTON	DE	19899	(302) 421-0260	
X0B	BLUE CROSS & BLUE SHIELD OF GEORGIA/ATLANTA, INC.	PO BOX 9907	COLUMBUS	GA	319086007	(404) 842-8000	FOR GEORGIA STATE EMPLOYEES USE CARRIER 419 GEORGIA STATE HEALTH BENEFIT PLAN
X1M	BLUE CROSS & BLUE SHIELD OF KANSAS	1133 SOUTHWEST TOPEKA BLVD.	TOPEKA	KS	66629	(785) 291-4180	
X2B	BLUE CROSS & BLUE SHIELD OF KANSAS CITY	PO BOX 419169	KANSAS CITY	MO	641416169	(800) 892-6048	
X0U	BLUE CROSS & BLUE SHIELD OF KENTUCKY, INC.	9901 LINN STATION RD.	LOUISVILLE	KY	40223	(502) 423-2011	
X1L	BLUE CROSS & BLUE SHIELD OF LOUISIANA	PO BOX 98029	BATON ROUGE	LA	708989029	(504) 291-5370	
X1Q	BLUE CROSS & BLUE SHIELD OF MAINE	2 GANNETT DR.	SOUTH PORTLAND	ME	041066911	(207) 775-1550	
X01	BLUE CROSS & BLUE SHIELD OF MARYLAND, INC.	PO BOX 14115	LEXINGTON	KY	40512	(800) 524-4555	
X0I	BLUE CROSS & BLUE SHIELD OF MARYLAND, INC.	PO BOX 9836	BALTIMORE	MD	21204	(800) 524-4555	USE CARRIER X01
X1K	BLUE CROSS & BLUE SHIELD OF MEMPHIS	85 NORTH DANNY THOMAS BLVD.	MEMPHIS	TN	38103	(901) 529-3111	
X0Q	BLUE CROSS & BLUE SHIELD OF MICHIGAN	PO BOX 312500	DETROIT	MI	48231	(800) 482-0898	
X0QDN	BLUE CROSS & BLUE SHIELD OF MICHIGAN	PO BOX 49	DETROIT	MI	48231	(888) 826-8152	
X1P	BLUE CROSS & BLUE SHIELD OF MINNESOTA	PO BOX 64338	ST. PAUL	MN	55164	(800) 382-2000	
X0Z	BLUE CROSS & BLUE SHIELD OF MISSISSIPPI, INC.	PO BOX 1043	JACKSON	MS	39215	(601) 932-3800	
X2U	BLUE CROSS & BLUE SHIELD OF MISSOURI	1831 CHESTNUT ST.	ST. LOUIS	MO	63103	(314) 923-4444	AKA ALLIANCE BLUE CROSS BLUE SHIELD
X1U	BLUE CROSS & BLUE SHIELD OF NEBRASKA	PO BOX 3248, MAIN P.O. STATION	OMAHA	NE	681800001	(402) 390-1820	
X0S	BLUE CROSS & BLUE SHIELD OF NEW JERSEY, INC.	PO BOX 1219	NEWARK	NJ	07101	(800) 624-1110	AKA HORIZON BCBS OF NEW JERSEY
X0SDN	BLUE CROSS & BLUE SHIELD OF NEW JERSEY, INC.	PO BOX 1311	MINNEAPOLIS	MN	55440	(800) 355-2583	AKA HORIZON BCBS OF NEW JERSEY
X0C	BLUE CROSS & BLUE SHIELD OF NORTH CAROLINA	PO BOX 35	DURHAM	NC	27702	(800) 214-4844	
X0CDN	BLUE CROSS & BLUE SHIELD OF NORTH CAROLINA	PO BOX 2100	WINSTON-SALEM	NC	271022100	(919) 489-7431	
X2J	BLUE CROSS & BLUE SHIELD OF NORTH DAKOTA	4510 13TH AVE. SW	FARGO	ND	581210001	(800) 368-2312	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
X2T	BLUE CROSS & BLUE SHIELD OF OKLAHOMA	PO BOX 3283	TULSA	OK	74102	(918) 560-3535	
X1F	BLUE CROSS & BLUE SHIELD OF RHODE ISLAND	500 EXCHANGE ST.	PROVIDENCE	RI	02903	(401) 831-7300	
X0P	BLUE CROSS & BLUE SHIELD OF TENNESSEE	1 CAMERON HILL CIRCLE	CHATTANOOGA	TN	374020002	(800) 468-9736	
X0PDN	BLUE CROSS & BLUE SHIELD OF TENNESSEE	1 CAMERON HILL CIRCLE STE. 0002	CHATTANOOGA	TN	374020002	(800) 565-9140	
X1W	BLUE CROSS & BLUE SHIELD OF UTAH	PO BOX 30270	SALT LAKE CITY	UT	841300270	(801) 333-2100	
X2H	BLUE CROSS & BLUE SHIELD OF UTICA-WATERTOWN, INC.	12 RHOADS DR., UTICA BUSINESS DISTRICT	UTICA	NY	13501	(315) 798-4238	
X2S	BLUE CROSS & BLUE SHIELD OF VERMONT	PO BOX 2365	SOUTH BURLINGTON	VT	54072365	(802) 247-2583	
X0F	BLUE CROSS & BLUE SHIELD OF VIRGINIA	PO BOX 27401	RICHMOND	VA	23279	(800) 991-6061	
X2O	BLUE CROSS & BLUE SHIELD OF WEST VIRGINIA, INC.	PO BOX 1353	CHARLESTON	WV	25325	(304) 347-7709	
X1J	BLUE CROSS & BLUE SHIELD OF WESTERN NEW YORK, INC.	PO BOX 80	BUFFALO	NY	142400080	(800) 888-0757	
X0H	BLUE CROSS & BLUE SHIELD UNITED OF WISCONSIN	PO BOX 2025	MILWAUKEE	WI	53201	(414) 224-6100	
X1D	BLUE CROSS /BLUE SHIELD OF NATIONAL CAPITAL AREA	550 12TH ST. SW	WASHINGTON	DC	20024	(202) 479-8000	
X0O	BLUE CROSS AND BLUE SHIELD OF ALABAMA	PO BOX 2294	BIRMINGHAM	AL	35201	(800) 517-6425	DO NOT USE FOR MEDICARE.THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE.
X0ODN	BLUE CROSS AND BLUE SHIELD OF ALABAMA	PO BOX 830389	BIRMINGHAM	AL	352830389	(800) 517-6425	
X0D	BLUE CROSS AND BLUE SHIELD OF FLORIDA	PO BOX 1798	JACKSONVILLE	FL	322310014	(800) 727-2227	
401	BLUE CROSS AND BLUE SHIELD OF SC	PO BOX 100300	COLUMBIA	SC	29202	(803) 788-3860	DO NOT USE FOR MEDICARE.THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE. STREET ADDRESS 4101 PERVICAL RD. COLA 29219
401DN	BLUE CROSS AND BLUE SHIELD OF SC	4101 PERCIVAL RD.	COLUMBIA	SC	29219	(803) 788-3860	THIS CODE USED ONLY FOR DENTAL CLAIMS WHERE BCBS IS THE INSURANCE CARRIER
X0N	BLUE CROSS AND BLUE SHIELD OF TEXAS	PO BOX 660044	DALLAS	TX	752660044	(800) 451-0287	
X0NDN	BLUE CROSS AND BLUE SHIELD OF TEXAS	PO BOX 660247	DALLAS	TX	75266	(800) 494-7218	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
X2F	BLUE CROSS AND BLUE SHIELD OF THE ROCHESTER AREA	PO BOX 22999	ROCHESTER	NY	14692	(716) 325-3630	TO VERIFY DENTAL COVERAGE CALL 1-800-724-1675
X2FDN	BLUE CROSS AND BLUE SHIELD OF THE ROCHESTER AREA	PO BOX 22999	ROCHESTER	NY	14692	(716) 325-3630	DENTAL
453	BLUE CROSS ANTHEM MEDICARE ADVANTAGE	2100 CORPORATE CENTER	NEWBURY PARK	CA	913201431	(800) 676-2583	MEDICARE ADVANTAGE PLAN
X2Y	BLUE CROSS BLUE SHIELD OF MONTANA	PO BOX 5004	GREAT FALLS	MT	59403	(406) 791-4000	
X1A	BLUE CROSS BLUE SHIELD OF NEW MEXICO	PO BOX 27630	ALBUQUERQUE	NM	87125	(800) 711-3795	
X1FDN	BLUE CROSS BLUE SHIELD OF RHODE ISLAND	PO BOX 69427	HARRISBURG	PA	171069427	(800) 831-2400	DENTAL ONLY
X0W	BLUE CROSS OF CALIFORNIA	PO BOX 60007	LOS ANGELES	CA	90060	(800) 677-6669	
D67	BLUE CROSS OF FLORIDA HEALTH OPTIONS	PO BOX 1798	JACKSONVILLE	FL	32231	(877) 352-2583	MEDICARE ADVANTAGE PLAN
X0A	BLUE CROSS OF GEORGIA/COLUMBUS, INC.	PO BOX 9907	COLUMBUS	GA	319089907	(800) 441-2273	POLICIES SHOULD BE ADDED WITH XOB. BCBS OF OF GA.
X0ARX	BLUE CROSS OF GEORGIA/COLUMBUS, INC.	PO BOX 9907	COLUMBUS	GA	319089907	(800) 441-2273	DO NOT USE FOR MEDICARE.THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE.
X2V	BLUE CROSS OF IDAHO HEALTH SERVICE, INC.	PO BOX 7408	BOISE	ID	83707	(208) 344-7411	
X0T	BLUE CROSS OF ILLINOIS	PO BOX 805107	CHICAGO	IL	60680	(800) 634-8644	
X0TDN	BLUE CROSS OF ILLINOIS	PO BOX 23059	BELLEVILLE	IL	62223	(866) 826-0914	
X0M	BLUE CROSS OF MASSACHUSETTS, INC.	PO BOX 986020	BOSTON	MA	022986020	(800) 253-5210	
XOV	BLUE CROSS OF NORTHEASTERN NEW YORK, INC.	PO BOX 15013	ALBANY	NY	12212	(518) 438-5500	
X2L	BLUE CROSS OF NORTHEASTERN PENNSYLVANIA	PO BOX 890179	CAMP HILL	PA	170890179	(800) 829-8599	
X1X	BLUE CROSS OF OHIO	PO BOX 956	TOLEDO	OH	43696	(800) 362-1279	
X1E	BLUE CROSS OF PUERTO RICO	PO BOX 366068	SAN JUAN	PR	009366068	(809) 759-9898	
X2M	BLUE CROSS OF WASHINGTON AND ALASKA	PO BOX 91059	SEATTLE	WA	981119159	(800) 722-1471	
X1YDN	BLUE SHIELD OF CALIFORNIA	PO BOX 272590	CHICO	CA	959272590	(888) 702-4171	
X1Y	BLUE SHIELD OF CALIFORNIA	PO BOX 272540	CHICO	CA	95927	(888) 235-1765	
X0V	BLUE SHIELD OF NORTHEASTERN NEW YORK	PO BOX 15013	ALBANY	NY	12212	(518) 453-4600	
D41	BLUEGRASS FAMILY HEALTH	PO BOX 22738	LEXINGTON	KY	40522	(800) 787-2680	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
390	BOARD OF PENSIONS EVANGELICAL LUTHERAN CHURCH	PO BOX 59093	MINNEAPOLIS	MN	554590093	(612) 333-7651	
337	BOARD OF PENSIONS OF THE PRESBYTERIAN CHURCH OF	PO BOX 13896	PHILADELPHIA	PA	19101	(800) 773-7752	
404	BOB JONES UNIVERSITY	1700 WADE HAMPTON BLVD.	GREENVILLE	SC	29614	(864) 370-1800	
190	BOILERMAKERS NATIONAL HEALTH & WELFARE FUND	754 MINNESOTA AVE., STE. 522	KANSAS CITY	KS	661012762	(913) 342-6555	
739	BOLLINGER, INC.	PO BOX 727	SHORT HILLS	NJ	07078	(866) 267-0092	
702	BOON CHAPMAN BENEFIT ADMINISTRATORS	PO BOX 9201	AUSTIN	TX	787669201	(800) 252-9653	CODE ASSIGNED BY SCHA
C22	BOSTON MUTUAL LIFE INSURANCE COMPANY	120 ROYALL ST.	CANTON	MA	02021	(617) 828-7000	
854	BOYD CARE (BOYD BROTHERS TRANSPORTATION)	PO BOX 70	CLAYTON	AL	36016	(334) 775-1284	
D58	BRAVO HEALTH MEDICARE ADVANTAGE	PO BOX 4433	BALTIMORE	MD	21223	(800) 556-1570	MEDICARE ADVANTAGE PLAN
294	BRIDGESTONE/FIRESTONE COMPANIES	PO BOX 26605	AKRON	OH	44319	(800) 237-8447	
E89	BROADREACH MEDICAL RESOURCES	1350 BROADWAY #410	NEW YORK	NY	10018	(888) 718-2375	
852	BUILDERS MUTUAL INSURANCE CO	PO BOX 150006	RALEIGH	NC	276240006	(800) 809-4861	
E30	BUSINESS ADMINISTRATORS AND CONSULTANTS, INC.	PO BOX 107	REYNOLDSBURG	OH	43068	(800) 521-2654	
304	BUTLER BENEFIT SERVICE, INC.	PO BOX 3310	DAVENPORT	IA	528083310	(866) 927-2200	
262	CAIC (CONTINENTAL AMERICAN INS. CO)	PO BOX 6080226	MISSION VIEJO	CA	926906080	(888) 730-2244	
658	CALHOUN COUNTY	-	-	-	-	-	
973	CAMBRIDGE INTEGRATED SERVICES GROUP, INC.	PO BOX 1687	GRAND RAPIDS	MI	49501	(800) 766-9780	USE CARRIER 171 AON
832	CAMERON AND ASSOCIATES	6100 LAKE FOREST DR.	ATLANTA	GA	30328	(800) 387-9919	
998	CANADA LIFE ASSURANCE CO.	6201 POWERS FERRY RD., STE. 100	ATLANTA	GA	30348	(800) 333-2542	
X2K	CAPITAL BLUE CROSS	PO BOX 211457	EAGAN	MN	551213057	(800) 962-2242	
274	CAPITAL DISTRICT PHYSICIANS PLAN	PO BOX 66602	ALBANY	NY	122066602	(800) 926-7526	
966	CAPITOL ADMINISTRATORS OF THE SOUTHEAST	PO BOX 188061	CHATTANOOGA	TN	37422	(888) 650-6566	
166	CAPITOL AMERICAN LIFE INSURANCE COMPANY	PO BOX 94953	CLEVELAND	OH	441014953	(216) 696-6400	
128	CAPITOL LIFE INSURANCE COMPANY	PO BOX 1200	DENVER	CO	80201	(800) 525-2115	PER HOSP. ASSO. 07/02, THIS IS STILL A VALID CARRIER

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
D42	CARE IMPROVEMENT PLUS	PO BOX 4347	SCRANTON	PA	18505	(866) 686-2506	MEDICARE ADVANTAGE PLAN
764	CARE LINK HEALTH PLAN	PO BOX 7373	LONDON	KY	407427373	(800) 348-2922	
B92	CARE SOURCE	ONE SOUTH MAIN	DAYTON	OH	45402	(800) 488-0134	
151	CARELINK	PO BOX 7373	LONDON	KY	40742	(800) 348-2922	MEDICAID HMO
471	CAREMARK	PO BOX 52195	PHOENIX	AZ	850722195	(800) 303-0187	
280	CAREMARK PRESCRIPTION SERVICES	PO BOX 52188	PHOENIX	AZ	850722196	(800) 841-5550	USE CARRIER 471
903	CAREPLUS HEALTH PLAN	PO BOX 31286	TAMPA	FL	336313286	(800) 867-4445	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B04	CARITEN HEALTHCARE	PO BOX 22987	KNOXVILLE	TN	37933	(800) 284-0042	CODE IN OPEN STATUS BY SCHA
D21	CARITEN SENIOR HEALTH	PO BOX 22885	KNOXVILLE	TN	37933	(865) 670-7790	MEDICARE ADVANTAGE PLAN
945	CAROLINA ATLANTIC MEDICAL SERVICES ORGANIZATION	PO BOX 22528	CHARLESTON	SC	29413	(800) 810-0906	DORMANT 8/06
A71	CAROLINA BEHAVIORAL HEALTH ALLIANCE	PO BOX 571137	WINSTON-SALEM	NC	271571137	(800) 475-7900	
498	CAROLINA BENEFIT ADMINISTRATORS	PO BOX 3257	SPARTANBURG	SC	29304	(864) 573-6937	
445	CAROLINA CARE PLAN/MEDICAL MUTUAL INS. CO. OF OHIO	PO BOX 6018	CLEVELAND	OH	441011018	(800) 315-3143	ALSO KNOWN AS SUPERMED ANOTHER PHONE # 800-232-3143
445DN	CAROLINA CARE PLAN/MEDICAL MUTUAL INS. CO.	PO BOX 6018	CLEVELAND	OH	441011018	(80) 031-5314	DENTAL ONLY
723	CAROLINA CONTINENTAL INSURANCE	PO BOX 427	COLUMBIA	SC	29202	(803) 256-6265	
E12	CAROLINA CRESCENT	1201 MAIN ST. STE 970	COLUMBIA	SC	29201	(803) 251-6630	HEALTHY KIDS CONNECTION
559	CAROLINA HOSPITAL SYSTEMS BENEFIT PLAN	PO BOX 100569	FLORENCE	SC	295010659	(843) 661-3875	
623	CAROLINA MEDICARE PRIME HMO	201 EXECUTIVE CENTER DR.	COLUMBIA	SC	29210	(803) 750-7473	MEDICARE ADVANTAGE PLAN
C77	CARPENTERS HOSPITALIZATION PLAN	3611 CHESTER AVE.	CLEVELAND	OH	44114	(800) 421-3959	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
336	CASEBP (CATSKILL AREA SCHOOLS EMPLOYEE PLAN)	PO BOX 968022	SCHAUMBERG	IL	60196	(800) 962-6294	
CAS	CASUALTY CASE	-	-	-	-	-	
366	CATALYST RX	PO BOX 968022	SCHAUMBERG	IL	601968022	(800) 997-3784	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
572	CATAMARAN	PO BOX 968022	SCHAUMBERG	IL	601968022	(877) 839-8119	FORMERLY HEALTH TRANS
C66	CATERPILLAR, INC.	PO BOX 62920	COLORADO SPRINGS	CO	809622920	(309) 494-2363	
C04	CBA BLUE	PO BOX 2365	SOUTH BURLINGTON	VT	03036	(888) 222-9206	
B11	CBCA ADMINISTRATORS, INC.	PO BOX 1339	MINNEAPOLIS	MN	55440	(800) 824-3882	
339	CELTIC INDIVIDUAL HEALTH	PO BOX 33839	INDIANAPOLIS	IN	462030839	(800) 477-7870	
907	CELTIC LIFE INSURANCE CO.	PO BOX 46337	MADISON	WI	53744	(800) 766-2525	
X0X	CENTRAL BENEFITS MUTUAL INSURANCE COMPANY	PO BOX 16526	COLUMBUS	OH	43216	(614) 464-5870	
273	CENTRAL BENEFITS USA (CENBEN USA)	PO BOX 619059	DALLAS	TX	85261	(800) 772-5924	CODE ASSIGNED BY SCHA
C13	CENTRAL RESERVE LIFE OF NORTH AMERICA INSURANCE CO	17800 ROYALTON RD.	STRONGSVILLE	OH	441365197	(800) 321-3997	
507	CENTRAL STATES HEALTH & LIFE CO. OF OMAHA	PO BOX 34350	OMAHA	NE	68134	(402) 397-1111	
476	CENTRAL STATES, SOUTHEAST & SOUTHWEST	PO BOX 5116	DEPLAINES	IL	60017	(800) 323-5000	
476DN	CENTRAL STATES, SOUTHEAST & SOUTHWEST	PO BOX 5116	DEPLAINES	IL	60017	(800) 323-5000	
C84	CENTRAL UNITED & CHRISTIAN MUTUAL LIFE INS. CO.	2727 ALLEN PARKWAY	HOUSTON	TX	770192115	(713) 529-0045	
A54	CENTURY HEALTHCARE	PO BOX 2256	GRAPEVINE	TX	76099	(888) 444-1995	NEIC 30018
813	CENTURY PLANNER	9201 WATSON RD, STE. 350	ST. LOUIS	MO	631261509	(800) 776-2453	
604	CHAMPVA	PO BOX 469064	DENVER	CO	80246	(303) 331-7599	
659	CHARLESTON COUNTY	-	-	-	-	-	
E66	CHCCARE OF SOUTH CAROLINA	140 STONE RIDGE DR.	COLUMBIA	SC	29210	(866) 802-2474	
D66	CHCCARES OF SOUTH CAROLINA	140 STONE RIDGE DR.	COLUMBIA	SC	29210	(866) 802-2474	MEDICAID HMO
B71	CHCS SERVICES, INC.	PO BOX 12467	PENSACOLA	FL	325912457	(888) 803-1780	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
660	CHEROKEE COUNTY	-	-	-	-	-	
A99	CHEROKEE INSURANCE	PO BOX 853925	RICHARDSON	TX	750853925	(800) 201-0450	
B03	CHESAPEAKE LIFE INS. CO.	PO BOX 809025	DALLAS	TX	753809025	(888) 756-3534	
661	CHESTER COUNTY	-	-	-	-	-	
662	CHESTERFIELD COUNTY	-	-	-	-	-	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
992	CHESTERFIELD RESOURCES, INC.	PO BOX 1884	AKRON	OH	44309	(800) 321-0935	
541	CHILDRENS REHAB SERVICES	PO BOX 4217	SPARTANBURG	SC	293054217	(864) 596-2227	CODE ASSIGNED BY SCHA
E51	CHOICE BENEFITS	3801 OLD GREENWOOD RD.	FT. SMITH	AR	75278	(800) 451-6907	
535	CHP DIRECT/SUPERMED	PO BOX 94648	CLEVELAND	OH	441014648	(800) 773-1445	
B91	CHRISTIAN BROTHERS EMPLOYEE BENEFIT TRUST	1205 WINDHAM PARKWAY	ROMEOVILLE	IL	60446	(800) 807-0400	
511	CIGNA BEHAVIORAL HEALTH	PO BOX 188022	CHATTANOOGA	TN	37422	(800) 336-4091	
134	CIGNA CONN GENERAL LIFE INSURANCE	PO BOX 182223	CHATTANOOGA	TN	374227223	(800) 882-4462	DO NOT USE FOR MEDICARE.THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE
134DN	CIGNA CONN GENERAL LIFE INSURANCE	PO BOX 188037	CHATTANOOGA	TN	37422	(800) 244-6224	DO NOT USE FOR MEDICARE.THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE
134RX	CIGNA CONN GENERAL LIFE INSURANCE	PO BOX 188053	CHATTANOOGA	TN	374228053	(800) 622-5579	USE CARRIER CODE 718
136	CIGNA FLEXCARE	PO BOX 30575	CHARLOTTE	NC	282303211	-	CODE ASSIGNED BY SCHA
999	CIGNA HEALTHCARE OF SC/HEALTHSOURCE SC	PO BOX 190024	CHARLESTON	SC	294199024	(800) 720-3150	BOUGHT BY CIGNA HEALTHCARE CC 134
452	CIGNA INTERNATIONAL EXPATRIATE BENEFITS	PO BOX 15050	WILMINGTON	DE	19850	(800) 441-2668	
D57	CIGNA MEDICARE ACCESS	PO BOX 22174	TEMPE	AZ	852852174	(800) 577-9410	MEDICARE ADVANTAGE PLAN
718	CIGNA PHARMACY SERVICES	PO BOX 188053	CHATTANOOGA	TN	374228053	(800) 622-5579	
646	CIGNA-MEDICARE	PO BOX 671	NASHVILLE	TN	37202	(615) 244-5600	MEDICARE INTERMEDIARY
407	CINERGY HEALTH INS.	1844 N. NOB HILL RD. #623	PLANTATION	FL	33322	(800) 847-1148	
177	CINERGY HEALTH PREFERRED PLAN	144 N BEVERWYCK RD. #332	LAKE HIAWATHA	NJ	080341997	(800) 847-1148	CODE IN OPEN STATUS BY SCHA
A63	CITIZENS INSURANCE	PO BOX 1627	ANDERSON	SC	29622	(864) 334-0090	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
839	CITIZENS SECURITY LIFE INS.	PO BOX 436149	LOUISVILLE	KY	402536149	(502) 244-2420	
D56	CITRUS HEALTH CARE, INC.	PO BOX 20547	TAMPA	FL	33622	(866) 769-1157	MEDICARE ADVANTAGE PLAN
574	CITY OF AMARILLO GROUP HEALTH	PO BOX 15130	AMARILLO	TX	79105	(806) 378-4235	CODE IN OPEN STATUS BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
114	CLAIMEDIX, INC.	PO BOX 140067	KANSAS CITY	MO	64114	(800) 922-4262	CODE ASSIGNED BY SCHA
A41	CLAIMS MANAGEMENT SERVICES	PO BOX 10888	GREEN BAY	WI	54307	(800) 472-7130	
219	CLAIMS PRO	PO BOX 577	SOUTHFIELD	MI	48075	(800) 837-9600	RX CARRIER ONLY
A73	CLAIMS TECHNOLOGY, INC.	100 COURT AVE., STE. 306	DES MOINES	IA	50309	(800) 245-8813	
536	CLAIMSWARE MANAGEMED	PO BOX 6125	GREENVILLE	SC	29606	(864) 234-8200	
536DN	CLAIMSWARE MANAGEMED	PO BOX 6125	GREENVILLE	SC	29606	(864) 234-8200	
663	CLARENDON COUNTY	-	-	-	-	-	
259	CNA HEALTHCARE PARTNERS	PO BOX 34197	LITTLE ROCK	AK	72203	(800) 508-3772	
887	CNIC HEALTH SOLUTIONS	PO BOX 3559	ENGLEWOOD	CO	80155	(800) 426-7453	
A51	COAL MINE WORKERS COMP PROGRAM	PO BOX 8300	LONDON	KY	407428300	(866) 335-8319	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C14	COASTAL LUMBER CO	PO BOX 1576	WALTERBORO	SC	29488	(843) 538-2876	CODE IN OPEN STATUS BY SCHA
664	COLLETON COUNTY	-	-	-	-	-	
132	COLONIAL LIFE AND ACCIDENT INSURANCE COMPANY	PO BOX 1365	COLUMBIA	SC	29202	(803) 798-7000	
A06	COLONIAL PENN FRANKLIN LIFE INSURANCE COMPANY	1818 MARKET ST.	PHILADELPHIA	PA	191811250	(800) 523-4000	THIS CARRIER PART OF CONSECO INSURANCE GROUP
175	COLUMBIA UNIVERSAL LIFE INSURANCE CO.	PO BOX 200225	AUSTIN	TX	787200225	(512) 345-3200	
133	COMBINED INSURANCE COMPANY OF AMERICA	PO BOX 6700	SCRANTON	PA	18505	(800) 225-4500	
609	COMM FOR BLIND					-	
974	COMMERCE BENEFIT GROUP	PO BOX 900	ELYRIA	OH	44036	(800) 223-9941	
457	COMMERICAL TRAVELERS	70 GENESSE ST.	UTICA	NY	13502	(800) 756-3702	CODE ASSIGNED BY SCHA
986	COMMONWEALTH BENEFIT ADMINISTRATORS	115 HANOVER ST.	ASHLAND	VA	23005	(800) 526-1677	
B36	COMMONWEALTH INDEMNITY PLAN	PO BOX 9016	ANDOVER	MA	01810	(800) 442-9033	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D18	COMMUNITY CARE SENIOR HEALTH PLAN	PO BOX 3249	TULSA	OK	741013249	(800) 642-8065	MEDICARE ADVANTAGE PLAN
911	COMMUNITY HEALTH PARTNERS	PO BOX 5787	SPARTANBURG	SC	29304	(888) 962-8437	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
							SCHA
287	COMMUNITY HEALTH PLAN	PO BOX 14467	CINCINNATI	OH	45250	(888) 800-8717	
X1S	COMMUNITY MUTUAL INSURANCE COMPANY	1351 WILLIAM HOWARD TAFT RD.	CINCINNATI	OH	45206	(513) 282-1016	CODE IN OPEN STATUS BY SCHA
416	COMPANION BENEFIT ALTERNATIVES	PO BOX 100185	COLUMBIA	SC	29202	(800) 868-1032	THIS CARRIER ASSIGNED BY SCHA NOT REQUESTED OR USED BY DHHS.
433	COMPANION LIFE	PO BOX 100102	COLUMBIA	SC	29202	(803) 788-0500	
B65	COMPASS ROSE HEALTH PLAN	PO BOX 141501	NASHVILLE	TN	37214	(877) 531-1159	
548	COMPBENEFITS INSURANCE CO.	PO BOX 804483	CHICAGO	IL	606804106	(800) 594-0977	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C56	COMPDENT	1930 BISHOP LANE STE. 132	LOUISVILLE	KY	40218	(800) 633-1262	
A39	COMPLETE BENEFITS SOLUTIONS	6071 CARMEL RD. STE 305	CHARLOTTE	NC	28226	(866) 270-2316	
A58	COMPREHENSIVE BENEFITS	PO BOX 8955	MELVILLE	NY	11747	(800) 828-3605	
853	COMPSYCH CORP.	PO BOX 8379	CHICAGO	IL	60680	(877) 595-5282	
412	CONNECTICARE	PO BOX 546	FARRINGTON	CT	06034	(800) 251-7722	
882	CONNECTICARE	PO BOX 4000	FARMINGTON	CT	06034	(877) 224-8230	CODE ASSIGNED BY SCHA
331	CONSECO HEALTH INS. CO	PO BOX 66904	CHICAGO	IL	606660904	(800) 541-2254	
525	CONSECO MEDICAL INSURANCE CO.	PO BOX 1205	ROCKFORD	IL	61105	(800) 947-0319	USE CODE 282 WASHINGTON NATIONAL
C16	CONSOLIDATED BENEFITS, INC.	PO BOX 23686	COLUMBIA	SC	29224	(803) 736-5088	
970	CONSOLIDATED WORKERS ASSOCIATION (CWA)	PO BOX 2647	CHINO HILLS	CA	91709	(800) 919-5514	CODE ASSIGNED BY SCHA
802	CONSTITUTION LIFE INSURANCE CO	PO BOX 130	PENSACOLA	FL	325910130	(800) 789-6364	
A04	CONSULTEC PRESCRIPTION BENEFITS MANAGEMENT	9040 ROSWELL RD., STE. 700	ATLANTA	GA	303501853	(800) 365-4944	
154	CONSUMER DRN BENEFITS ASSO.	PO BOX 6080-228	MISSION VIEIO	CA	926906080	(888) 411-4208	CODE ASSIGNED BY SCHA
C31	CONSUMER HEALTH SOLUTIONS	PO BOX 3492	SPARTANBURG	SC	29304	(864) 573-9541	THE CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
592	CONTEC	525 LOCUS GROVE RD.	SPARTANBURG	SC	29303	(864) 503-8333	CODE ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
C39	CONTINENTAL GENERAL INSURANCE COMPANY	PO BOX 247007	OMAHA	NE	681247007	(402) 397-3200	
895	CONTINENTAL LIFE INS. OF TENNESSEE	PO BOX 1188	BRENTWOOD	TN	37024	(800) 264-4000	
A07	CONTINENTAL LIFE INSURANCE CO. OF SOUTH CAROLINA	PO BOX 6138	COLUMBIA	SC	29260	(803) 782-4947	
830	CONTRACTORS EMPLOYEE BENEFIT ADM. (CEBA)	PO BOX 559017	AUSTIN	TX	78755	(800) 247-7724	
192	CONVENTRY HEALTHCARE OF NEBRASKA, INC.	PO BOX 7705	LONDON	KY	40742	(800) 288-3343	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
928	COOK INSURANCE	PO BOX 1029	BLOOMINGTON	IN	47402	(800) 593-2080	
483	COOPERATIVE BENEFITS ADMINISTRATORS	PO BOX 6249	LINCOLN	NE	68506	(402) 483-9250	
551	COOPERATIVE MANAGED CARE SERVICES LLC	PO BOX 502530	INDIANAPOLIS	IN	46250	(866) 873-4516	CODE IN OPEN STATUS BY SCHA
211	COORDINATED BENEFIT PLANS, INC.	PO BOX 853925	RICHARDSON	TX	750853925	(800) 753-1000	
843	CORE MANAGEMENT RESOURCES GROUP	PO BOX 840	MACON	GA	31202	(888) 741-2673	
552	CORESOURCE, INC.	PO BOX 2920	CLINTON	IA	52733	(800) 327-5462	
552DN	CORESOURCE, INC.	6100 FAIRVIEW RD.	CHARLOTTE	NC	28210	(800) 327-5462	
571	CORESOURCE, INC.	PO BOX 8215	LITTLE ROCK	AR	722218215	(888) 604-9397	CODE IN OPEN STATUS BY SCHA
364	CORESTAR	PO BOX 1195	MINNEAPOLIS	MN	55440	(800) 444-6965	
857	CORPORATE BENEFIT SERVICES, INC.	PO BOX 211778	EAGAN	MN	55121	(704) 373-0447	
857DN	CORPORATE BENEFIT SERVICES, INC.	PO BOX 12954	CHARLOTTE	NC	28220	(704) 373-0447	
A98	CORPORATE BENEFIT SERVICES OF AMERICA, INC.	PO BOX 738	HOPKINS	MN	55343	(800) 765-4224	
831	CORPORATE BENEFIT SOLUTIONS, INC.	PO BOX 8215	LITTLE ROCK	AR	72221	(888) 604-9397	
780	CORPORATE SYSTEMS ADMINISTRATION, INC.	PO BOX 4985	JOHNSON CITY	TN	376024985	(800) 275-2847	
213	COVENANT ADMINISTRATORS	PO BOX 105738	ATLANTA	GA	30348	(770) 239-6230	
480	COVENTRY HEALTH CARE OF THE CAROLINAS	PO BOX 7715	LONDON	KY	40742	(800) 889-1947	COVENTRY HEALTH CARE IS PARENT CO. OF SOUTHERN HEALTH AND WELLPATH
191	COVENTRY HEALTHCARE OF DELAWARE, INC.	PO BOX 7713	LONDON	KY	40742	(800) 833-7423	
482	COVENTRY HEALTHCARE OF GEORGIA	PO BOX 7711	LONDON	KY	40742	(866) 732-1017	
443	COVENTRY HEALTHCARE OF KANSAS	PO BOX 7109	LONDON	KY	39026	(866) 785-8077	CODE ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
B22	COVENTRY HEALTHCARE OF VIRGINIA	PO BOX 7704	LONDON	KY	40742	(800) 627-4872	
246	COVENTRY HEALTH CARE RX	PO BOX 8400	LONDON	KY	40742	(800) 947-6824	
879	COVENTRY OF THE CAROLINAS	PO BOX 7102	LONDON	KY	40742	(866) 208-3610	FORMALLY WELLPATH
245	COVENTRY OF THE CAROLINA'S	PO BOX 7102	LONDON	KY	40742	(800) 935-7284	
632	CRIME VICTIMS	-	-	-	-	-	
155	CROSSAMERICA HEALTH PLAN	PO BOX 5778	PARSIPPANY	NJ	07054	(866) 302-7332	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
169	CROWN CORK & SEAL COMPANY, INC.	930 BEAUMONT AVE.	SPARTANBURG	SC	29303	(864) 585-6456	
420	CUNA MUTUAL INSURANCE GROUP	PO BOX 391	MADISON	WI	53701	(608) 238-5851	
E93	CUSTOM DESIGN BENEFITS	5589 CHEVIOT RD.	CINCINNATI	OH	45247	(800) 598-2929	
194	DAKOTACARE	PO BOX 7406	SIOUX FALLS	SD	571177406	(800) 325-5598	CODE ASSIGNED BY SCHA
665	DARLINGTON COUNTY	-	-	-	-	-	
D74	DART MANAGEMENT CORP	PO BOX 318	MASON	MI	488540318	(800) 248-0457	
A65	DATARX	5920 ODELLE ST.	CUMMINGS	GA	30040	(877) 823-1273	
436	DAVIS-GARVIN AGENCY	#1 FERNANDINA CT.	COLUMBIA	SC	29212	(803) 732-0060	
B09	DEARBORN NATIONAL	PO BOX 23060	BELLEVILLE	IL	62223	(800) 348-4512	
B70	DECARE DENTAL	PO BOX 1348	MINNEAPOLIS	MN	55440	(800) 371-6561	
834	DEFINITY HEALTH	PO BOX 9525	AMHERST	NY	14226	(866) 333-4648	BROUGHT OUT BY UNITED HEALTHCARE CARRIER 113
500	DELTA DENTAL	PO BOX 1809	ALPHARETTA	GA	30023	(800) 521-2651	
370	DELTAHEALTH SYSTEMS	PO BOX 9554	SALT LAKE	UT	84109	(877) 474-0605	WAS P5 HEALTH PLUS SOLUTIONS
370DN	DELTAHEALTH SYSTEMS	PO BOX 702500	WEST VALLEY	UT	84170	(877) 474-0605	
879DN	DENEX DENTAL	111 ROCKVILLE PIKE STE. 700	ROCKVILLE	MD	20850	(866) 690-4908	DENEX DENTAL IS A PLAN UNDER WELLPATH SELECT/COVENTRY
C68	DENTAL BENEFIT PROVIDERS	PO BOX 389	ROCKVILLE	MD	20848	(800) 445-9090	
901	DENTAL CARE PLUS	100 CROWNE POINT PLACE	CINCINNATI	OH	45241	(800) 367-9466	
858	DENTAQUEST	PO BOX 2136	COLUMBIA	SC	29202	(800) 307-6553	NAIC 52040 MEDICAID DENTAL CLAIMS PROCESSOR

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
621	DEPT CORRECTIONS					-	
179	DESERET MUTUAL BENEFIT ADMINISTRATOR	PO BOX 45530	SALT LAKE CITY	UT	84145	(800) 777-3622	
450	DESERET SECURE	PO BOX 45530	SALT LAKE CITY	UT	841450530	(877) 220-0110	MEDICARE ADVANTAGE PLAN
955	DESIGN SAVERS PLAN	2814 SPRING RD., STE. 122	ATLANTA	GA	30339	(800) 616-5709	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
611	DHEC C. CHILDREN					-	
610	DHEC CANCER					-	
629	DHEC FAMILY PLANNING	-	-	-	-	-	
627	DHEC HEART	-	-	-	-	-	
628	DHEC HEMOPHILIA	-	-	-	-	-	
613	DHEC HIGH RISK MATERNITY					-	
612	DHEC LOW RISK MATERNITY					-	
625	DHEC MIGRANT HEALTH					-	
626	DHEC SICKLE CELL					-	
615	DHEC STERILIZATION					-	
630	DHEC TB	-	-	-	-	-	
725	DIALYSIS CLINIC, INC.	203 FREEMONT AVE.	SPARTANBURG	SC	29303	(864) 585-2046	
554	DIAMOND G EMPLOYEE BENEFIT TRUST	PO BOX 1298	GREENVILLE	TN	37744	(423) 639-6145	
666	DILLON COUNTY	-	-	-	-	-	
707	DILLON YARN MEDICAL BENEFITS	1019 TITAN RD	DILLON	SC	29536	(843) 774-7353	
516	DIRECT REIMBURSEMENT BENEFIT PLANS	1111 ALDERMAN DR., STE. 420	ALPHARETTA	GA	30202	(770) 664-5594	
258	DIVERSIFIED ADMINISTRATION CORPORATION	PO BOX 299	MARLBOROUGH	CT	06447	(888) 322-2524	
474	DIVERSIFIED PHARMACUETICAL	PO BOX 169052	DULUTH	MN	55816	(800) 233-8065	USE CODE 333 EXPRESS SCRIPTS
667	DORCHESTER COUNTY	-	-	-	-	-	
849	E.O.S. HEALTH	PO BOX 27088	TEMPE	AZ	85285	(888) 456-8417	
567	EASTERN BENEFIT SYSTEMS	200 FREEWAY DR. E.	EAST ORANGE	NJ	07018	(800) 524-0227	
B63	EASTERN LIFE AND HEALTH INSURANCE	PO BOX 10188	LANCASTER	PA	17605	(800) 233-0307	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
A14	EB RX	2045 MIDWAY DR.	TWINSBURG	OH	44087	(800) 800-7153	
668	EDGEFIELD COUNTY	-	-	-	-	-	
137	EDUCATORS MUTUAL LIFE INSURANCE COMPANY	PO BOX 3149	LANCASTER	PA	17601	(717) 397-2751	
C80	ELDER HEALTH (MHN/HMC)	PO BOX 4433	BALTIMORE	MD	21223	(888) 776-8851	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D25	ELDER PLAN, INC. (HMO)	PO BOX 199100	BROOKLYN	NY	11219	(718) 921-8818	MEDICARE ADVANTAGE
B24	EMBLEM HEALTH CARE CO.	PO BOX 3000	NEW YORK	NY	10116	(212) 501-4444	
X0EDN	EMPIRE BCBS DENTAL	PO BOX 791	MINNEAPOLIS	MN	554400791	(800) 722-8879	
X0E	EMPIRE BLUE CROSS AND BLUE SHIELD	PO BOX 1407 CHURCH ST. STATION	NEW YORK	NY	10008	(800) 342-9816	
D64	EMPIRE HEALTHCHOICE ASSURANCE, INC.	PO BOX 100300 CLAIMS PROCESSING	COLUMBIA	SC	29204	(803) 788-8562	MEDICARE ADVANTAGE PLAN
C43	EMPLOYEE BENEFIT ADMINISTRATORS	PO BOX 5150	GREENVILLE	SC	29606	(864) 235-6474	
A90	EMPLOYEE BENEFIT CLAIMS, INC.	9501 WEST DEVON	ROSEMONT	IL	60018	(312) 696-3660	
499	EMPLOYEE BENEFIT CONSULTANTS	PO BOX 928	FINDLAY	OH	45839	(800) 558-7798	
869	EMPLOYEE BENEFIT MANAGEMENT SERVICES	PO BOX 21367	BILLINGS	MT	59104	(800) 777-3575	
506	EMPLOYEE BENEFIT PLAN ADMINISTRATORS	PO BOX 2000	EXETER	NH	03833	(800) 258-7298	
446	EMPLOYEE BENEFIT SERVICES	PO BOX 9888	SAVANNAH	GA	314120088	(803) 577-8051	USE CODE 345 EMPLOYEE BENEFIT SERVICES
345	EMPLOYEE BENEFIT SERVICES, INC.	PO BOX 1929	FORT MILL	SC	29716	(800) 242-1510	
345DN	EMPLOYEE BENEFIT SERVICES, INC.	PO BOX 1929	FORT MILL	SC	29716	(800) 242-1510	
761	EMPLOYEE BENEFIT STRATEGIES	229 EAST MICHIGAN AVE., STE. 235	KALAMAZOO	MI	49007	(800) 325-7477	
317	EMPLOYEE BENEFITS MANAGEMENT CORPORATION	4789 RINGS RD.	DUBLIN	OH	43017	(800) 552-0455	
CO9	EMPLOYEE BENEFITS TRUST	PO BOX 1431	WICHITA FALLS	TX	76307	(817) 761-7611	CODE ASSIGNED WITH LETTER O INSTEAD OF NUMERIC ZERO.
D79	EMPLOYEE HEALTH INSURANCE MANAGEMENT (EHIM)	26711 NORTHWESTERN HWY STE 400	SOUTHFIELD	MI	48033	(800) 311-3446	
743	EMPLOYEE PLANS, INC.	PO BOX 2362	FT. WAYNE	IN	468012362	(260) 625-7500	
550	EMPLOYEE SECURITY, INC.	7125 THOMAS EDISON DR.,	COLUMBIA	MD	21046	(800) 638-1134	THIS CODE NOT REQUESTED

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CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
		STE. 105					BY MEDICAID. ASSIGNED BY SCHA
A97	EMPLOYER PLAN SERVICES, INC.	2180 NORTH LOOP WEST, STE. 400	HOUSTON	TX	77018	(800) 447-6588	
247	EMPLOYERS DIRECT HEALTH	5050 SPRING VALLEY RD.	DALLAS	TX	752443909	(800) 872-9934	CARRIER WAS FIRST INTEGRATED HEALTH
130	EMPLOYERS LIFE INSURANCE COMPANY	PO BOX 6305	SPARTANBURG	SC	29304	(888) 962-8437	CARRIER WAS COASTAL STATE LIFE INS. CO.
C24	ENCOMPASS HEALTH MANAGEMENT SYSTEM	6000 WEST TOWN PARKWAY STE 350	DES MOINES	IA	50266	(800) 511-3389	
824	ENVISION RX OPTIONS	2181 EAST AURORA RD STE 201	TWINSBURG	OH	44087	(800) 361-4542	
509	EQUITABLE LIFE AND CASUALTY	PO BOX 2460	SALT LAKE CITY	UT	84110	(800) 352-5150	
510	EQUITABLE PLAN SERVICES	PO BOX 720460	OKLAHOMA	OK	73172	(800) 749-2631	
C94	ERIN GROUP ADMINISTRATORS	PO BOX 7777	LANCASTER	PA	17604	(800) 433-3746	ANOTHER PHONE NUMBER 717-581-1300
C94DN	ERIN GROUP ADMINISTRATORS	PO BOX 7777	LANCASTER	PA	17604	(800) 433-3746	ANOTHER PHONE NUMBER 717-581-1300
180	ESIS	PO BOX 31122	TAMPA	FL	33631	(800) 884-7975	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
461	EVERCARE	PO BOX 31350	SALT LAKE CITY	UT	841310350	(888) 866-8298	MEDICARE ADVANTAGE PLAN
C18	EVOLUTIONS HEALTHCARE SYSTEMS	PO BOX 5001	NEW PORT RICHEY	FL	34656	(800) 881-4474	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D20	EXCELLUS MEDICARE BLUE CHOICE OPTIMUM	PO BOX 41915	ROCHESTER	NY	14604	(877) 883-9577	MEDICARE ADVANTAGE PLAN
333	EXPRESS SCRIPTS	PO BOX 2902	CLINTON	IA	527332902	(800) 451-6245	
A35	FABRI-KAL CORPORATION	PO DRAWER C	PIEDMONT	SC	29773	(864) 299-1720	CODE IN OPEN STATUS BY SCHA
669	FAIRFIELD COUNTY	-	-	-	-	-	
B49	FALLON COMMUNITY HEALTH PLAN	PO BOX 15121	WORCHESTER	MA	01615	(800) 868-5200	
A16	FCE BENEFIT ADMINISTRATOR	4615 WALZEM RD. STE 300	SAN ANTONIO	TX	782181610	(800) 899-9355	
402	FEDERAL EMPLOYEE PLAN BLUE CROSS	I-20 AT ALPINE RD.	COLUMBIA	SC	29260	(803) 788-3860	
A50	FEDERAL EMPLOYEES COMPENSATION ACT	PO BOX 8300	LONDON	KY	407428300	(866) 335-8319	THIS CODE NOT REQUESTED

APPENDIX 2 CARRIER CODES

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CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
							BY MEDICAID. ASSIGNED BY SCHA
441	FEDERAL MOGUL HEALTHCARE	PO BOX 1999	DETROIT	MI	48235	(800) 522-0041	
290	FEDERATED MUTUAL INSURANCE COMPANY (REGIONAL)	PO BOX 31716	TAMPA	FL	336313716	(813) 496-8100	
769	FEDEX FREIGHTWAYS	PO BOX 840	HARRISON	AR	72602	(800) 874-4723	
738	FHA-TPA DIVISION	PO BOX 327810	FT. LAUDERDALE	FL	333329711	(803) 798-8698	CODE IN OPEN STATUS BY SCHA
205	FIDELITY LIFE SECURITY	3130 BROADWAY	KANSAS CITY	MO	641112406	(800) 648-8624	
941	FIDELITY SECURITY LIFE INSURANCE CO	419 E MAIN ST.	MIDDLETOWN	NY	10940	(800) 826-7531	THE CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A36	FIELDCREST CANNON (CANNON MILLS)	PO BOX 5000	EDEN	NC	272895000	(800) 222-3693	
467	FIRSERV HEALTH	PO BOX 182173	COLUMBUS	OH	432182173	(800) 848-2664	USE CODE 139
288	FIRST ADMINISTRATORS, INC.	PO BOX 9900	SIOUX CITY	IA	51102	(800) 206-0827	
348	FIRST AGENCY, INC.	5071 WEST H AVE.	KALAMAZOO	MI	490098501	(269) 381-6630	THIS CODE ASSIGNED BY SCHA 8/28/07
354	FIRST BENEFITS CORP	PO BOX 879	ANDERSON	IN	46015	-	CODE ASSIGNED BY SCHA
A74	FIRST CAROLINA CARE, INC.	PO BOX 381686	BIRMINGHAM	AL	35238	(800) 811-3298	
775	FIRST CHOICE BENEFITS MANAGEMENT	PO BOX 658	BELOIT	WI	535120658	(800) 303-5770	
B90	FIRST CHOICE VIP CARE	PO BOX 307	LINTHICUM	MD	210900307	(800) 575-0418	THIS IS A MEDICARE ADVANTAGE PLAN.
789	FIRST COMMUNITY HEALTH PLAN, INC.	PO BOX 382947	BIRMINGHAM	AL	35238	(800) 734-7826	CODE IN OPEN STATUS BY SCHA
803	FIRST CONTINENTAL LIFE INSURANCE	PO BOX 1911	CARMEL	IN	46032	(800) 538-1235	
946	FIRST HEALTH	PO BOX 1377	THOMASVILLE	GA	31799	(866) 847-8235	
245RX	FIRST HEALTH	PO BOX 23070	TUCSON	AZ	85734	(800) 554-4954	
456	FIRST HEALTH (A COVENTRY HEALTH CARE CO)	PO BOX 21680	EAGAN	MN	551210680	(866) 477-5465	
249	FIRST HEALTH WORKERS COMP ONLY	PO BOX 23070	TUCSON	AZ	85735	(800) 554-4954	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
351	FISERV	PO BOX 8077	WAUSAU	WI	544028077	(866) 684-8090	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY

APPENDIX 2 CARRIER CODES

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CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
							SCHA
139	FISERV HEALTH	PO BOX 30541	SALT LAKE CITY	UT	841300541	(800) 826-9781	WAS WAUSAU INS. CO.
352	FISERV HEALTH-COLORADO	PO BOX 720	PUEBLO	CO	810020720	(800) 446-8182	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
670	FLORENCE COUNTY	-	-	-	-	-	
C75	FLORIDA 1ST SERVICE ADMINISTRATORS, INC.	PO BOX 3607	WINTER HAVEN	FL	338853067	(800) 226-3155	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
719	FLORIDA HEALTH ALLIANCE	PO BOX 10269	JACKSONVILLE	FL	322470269	(904) 354-8335	
913	FLORIDA HOSPITAL HEALTHCARE SYSTEM	PO BOX 536847	ORLANDO	FL	328536847	(800) 741-4810	
B20	FMH BENEFIT SERVICES, INC.	PO BOX 25946	OVERLAND PARK	KS	66225	(800) 990-9058	
B05	FOCUS HEALTHCARE MANAGEMENT, INC.	720 COOL SPRINGS BLVD.	FRANKLIN	TN	37067	(615) 778-4000	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A94	FORETHOUGHT LIFE INSURANCE COMPANY	PO BOX 981721	EL PASO	TX	79998	(877) 492-5870	
C02	FOUNDATION BENEFITS ADMINISTRATORS	6300 BRIDGEPOINT PKWAY, BLDG. 3 #400	AUSTIN	TX	78730	(888) 368-7910	
870	FOUNDATION HEALTH	PO BOX 453219	SUNRISE	FL	33345	(800) 441-5501	
393	FOUNTAINHEAD ADMINISTRATORS, INC.	PO BOX 13188	BIRMINGHAM	AL	35202	(800) 991-9155	
B79	FOX-EVERETT, INC.	PO BOX 6012	RIDGELAND	MI	39158	(877) 476-6327	
765	FREEDOM HEALTH	PO BOX 151348	TAMPA	FL	33684	(800) 401-2740	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C83	FREEDOM LIFE INSURANCE CO. OF AMERICA	PO BOX 1468	ARLINGTON	TX	76004	(866) 973-4647	
587	FUTURE SCRIPTS	PO BOX 419019	KANSAS CITY	MO	64141	(888) 678-7012	
842	GARDNER AND WHITE, INC.	PO BOX 40619	INDIANAPOLIS	IN	462400619	(317) 257-9131	
842DN	GARDNER AND WHITE, INC.	PO BOX 40619	INDIANAPOLIS	IN	462400619	(317) 257-9131	
D54	GATEWAY HEALTH PLAN MEDICARE ASSURED	PO BOX 11560	ALBANY	NY	122110655	(800) 685-5209	MEDICARE ADVANTAGE PLAN
864	GE GROUP ADMINISTRATORS	PO BOX 150809	ARLINGTON	TX	76015	(888) 255-8961	
442	GE LIFE & ANNUITY ASSURANCE CO.	PO BOX 6700	LYNCHBURG	VA	24505	(800) 253-0856	
845	GEISINGER HEALTH PLAN GOLD	PO BOX 8200	DANVILLE	PA	178218200	(800) 498-9731	MEDICARE ADVANTAGE PLAN

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CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
C97	GEM GROUP	1200 THREE GATEWAY CENTER	PITTSBURGH	PA	15222	(800) 242-8923	
232	GENERAL ADJUSTMENT BUREAU	PO BOX 81808	ATLANTA	GA	30366	(404) 457-9555	CODE ASSIGNED BY SCHA
728	GENERAL PRESCRIPTION PROGRAMS, INC.	305 MADISON AVE. STE 1166B	NEW YORK	NY	10165	(800) 341-2234	
799	GENWORTH FINANCIAL	PO BOX 8021	SAN RAFAEL	CA	949129974	(800) 876-4582	WAS GE FINANCIAL SERVICES
997	GENWORTH FINANCIAL	PO BOX 10821	CLEARWATER	FL	33757	(877) 825-9337	CODE IN OPEN STATUS BY SCHA
671	GEORGETOWN COUNTY	-	-	-	-	-	
730	GEORGIA HEALTHCARE PARTNERSHIP	PO BOX 16388	SAVANNAH	GA	314163088	(800) 566-6710	
419	GEORGIA STATE HEALTH BENEFIT PLAN	PO BOX 38151	ATLANTA	GA	30334	(800) 626-6402	
365	GERBER CHILDRENS WEAR, INC.	PO BOX 2126	GREENVILLE	SC	29602	(864) 987-5200	
749	GERBER LIFE INSURANCE COMPANY	PO BOX 2088	GRAND RAPIDS	MI	49501	(800) 253-3074	
905	GERBER LIFE MEDICARE SUPPLEMENT	PO BOX 2271	OMAHA	NE	68103	(877) 656-5425	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B88	GETTYSBURG HEALTH ADMINISTRATORS	PO BOX 1169	FREDERICK	MD	21702	(800) 497-4474	
183	GILSBAR INSURANCE COMPANY	PO BOX 2947	COVINGTON	LA	70434	(800) 234-2643	
459	GLASS MOTORS & PLASTIC (GMPA)	5245 BIG PINE WAY, SE 33907	FORT MYERS	FL	33907	(813) 936-6242	
A44	GLOBAL MEDICAL MANAGEMENT, INC.	7901 SW 36TH ST. STE 100	DAVIE	FL	33328	(954) 370-6404	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
144	GLOBE LIFE & ACCIDENT INSURANCE	204 N. ROBINSON	OKLAHOMA CITY	OK	73102	(972) 540-6542	
145	GMP EMPLOYERS RETIREE TRUST	5245 BIG PINE WAY SE	FORT MYERS	FL	33907	(941) 936-6242	
931	GOOD SAMARITAN PROGRAM	5151 WEST HWY 40	BEACHGROVE	IN	46140	(317) 894-2000	
379	GOODYEAR TIRE & RUBBER COMPANY	PO BOX 677 DEPT. 609	AKRON	OH	44309	(216) 796-6531	
302	GOVERNMENT EMPLOYEE HOSP. ASSN (GEHA)	PO BOX 4665	INDEPENDENCE	MO	640514665	(816) 257-5500	
302DN	GOVERNMENT EMPLOYEE HOSP. ASSOC. (GEHA)	PO BOX 2336	INDEPENDENCE	MO	64051	-	DENTAL COVERAGE
B31	GREAT AMERICAN LIFE INS. CO (GALIC)	PO BOX 559002	AUSTIN	TX	787553010	(800) 880-2745	
313	GREAT WEST HEALTHCARE	1000 GREAT WEST DR.	KENNETT	MO	63857	(800) 663-8081	
308	GREAT WEST LIFE	PO BOX 188061	CHATTANOOGA	TN	374228061	(800) 663-8081	GREAT WEST/CIGNA

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308DN	GREAT WEST LIFE	PO BOX 188037	CHATTANOOGA	TN	37422	(877) 631-4227	
121	GREATER HEALTHCARE	PO BOX 3400	MONROE	NC	28110	(704) 225-8887	
672	GREENVILLE COUNTY	-	-	-	-	-	
673	GREENWOOD COUNTY	-	-	-	-	-	
B99	GROUP & PENSION ADMINISTRATORS, INC.	PO BOX 749075	DALLAS	TX	75374	(866) 206-3224	
181	GROUP ADMINISTRATORS, LTD.	450 E. REMINGTON RD.	SCHAUMBURG	IL	60173	(847) 519-1880	
745	GROUP BENEFIT SERVICES	1312 BELLONE AVE.	LUTHERVILLE	MD	21093	(800) 638-6085	
343	GROUP BENEFITS ADMINISTRATORS	70 GRAND AVE.	RIVEREDGE	NJ	07661	(201) 343-3003	
906	GROUP HEALTH ADMINISTRATOR, INC.	PO BOX 6244	CHARLOTTE	NC	282071018	(800) 222-5790	
508	GROUP HEALTH, INC. /EMBLEM HEALTH COMPANY	PO BOX 3000	NEW YORK	NY	101163000	(212) 501-4444	
889	GROUP INSURANCE ADMINISTRATION, INC.	3350 PEACHTREE RD NE STE. 1040	ATLANTA	GA	30326	(800) 621-0683	
889DN	GROUP INSURANCE ADMINISTRATION, INC.	3350 PEACHTREE RD NE STE. 1040	ATLANTA	GA	30326	(800) 621-0683	
389	GROUP LINK	PO BOX 20593	INDIANAPOLIS	IN	46220	(800) 359-7408	
A83	GROUP RESOURCES, INC.	PO BOX 100043	DULUTH	GA	300969343	(770) 623-8383	
D46	GROUPHEALTH OPTIONS, INC.	PO BOX 34585	SEATTLE	WA	98124	(888) 767-4670	MEDICARE ADVANTAGE PLAN
727	GUARANTEE MUTUAL LIFE CO.	8801 INDIAN HILLS DR.	OMAHA	NE	68114	(800) 462-4660	
236	GUARANTEE TRUST LIFE INSURANCE	1275 MILWAUKEE AVE.	GLENVIEW	IL		(847) 699-0600	
283	GUARDIAN HEALTHCARE	PO BOX 4197	SCRANTON	PA	77010	(866) 850-1256	MEDICARE ADVANTAGE PLAN
362	GUARDIAN HEALTHCARE	PO BOX 4197	SCRANTON	PA	18505	(866) 850-1253	MEDICARE ADVANTAGE PLAN
418	GUARDIAN INSURANCE COMPANY	PO BOX 8007	APPLETON	WI	549128007	(800) 685-4542	CODE ASSIGNED BY SCHA
237DN	GUARDIAN LIFE INSURANCE CO. OF AMERICA	PO BOX 2459	SPOKANE	WA	99210	(800) 541-7846	
237	GUARDIAN LIFE INSURANCE COMPANY OF AMERICA	PO BOX 8019	APPLETON	WI	54913	(800) 873-4542	
176	GUIDESTAR HEALTH SYSTEMS	PO BOX 35238	BIRMINGHAM	AL	35238	(800) 595-6949	
674	HAMPTON COUNTY	-	-	-	-	-	
A96	HAMRICKS, INC.	742 PEACHOID RD.	GAFFNEY	SC	29340	(864) 487-7505	
547	HARRINGTON HEALTH	PO BOX 30544	SALT LAKE CITY	UT	841300544	(877) 737-0769	

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146	HARTFORD INSURANCE GROUP	PO BOX 25600	CHARLOTTE	NC	28212	(704) 536-6230	
162	HARVARD PILGRIM HEALTHCARE	PO BOX 656653	SAN ANTONIO	TX	82655	(800) 421-3550	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A84	HCC LIFE INSURANCE COMPANY	PO BOX 2005	FARMINGTON HILLS	MI	48333	(866) 400-4102	
201	HCH ADMINISTRATORS	PO BOX 1986	PEORIA	IL	61656	(800) 322-1516	
201DN	HCH ADMINISTRATORS	PO BOX 1986	PEORIA	IL	61656	(800) 322-1516	
837	HEALTH ADMINISTRATION SERVICES	PO BOX 6724208	HOUSTON	TX	77267	(800) 865-5440	
B87	HEALTH ALLIANCE	PO BOX 6003	URBANA	IL	616036003	(800) 322-7451	
823	HEALTH ALLIANCE PLAN	PO BOX 02459	DETROIT	MI	48202	(800) 422-4641	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
264	HEALTH AMERICA	PO BOX 7089	LONDON	KY	40742	(800) 788-8445	
B25	HEALTH AND WELFARE FUND LOCAL 218	PO BOX 115027	ATLANTA	GA	30310	(404) 755-5665	
B84	HEALTH CARE CORPORATION	203 JANDERS RD.	CARY	IL	60013	-	CODE IN OPEN STATUS BY SCHA
713	HEALTH CARE CREDIT UNION ASSOC. HCCUA	PO BOX 260957	PLANT	TX	750260957	(866) 373-6366	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
748	HEALTH CARE SAVINGS, INC.	4530 PARK RD	CHARLOTTE	NC	28209	-	CODE ASSIGNED BY SCHA
203	HEALTH CARE SUPPORT/PRIVATE HEALTH CARE SYSTEM	29 COLUMBIA HEIGHTS	BROOKLYN	NY	11201	(800) 554-4022	CODE ASSIGNED BY SCHA
562	HEALTH CLAIMS SERVICES,INC.	PO BOX 9615	DEERFIELD BEACH	FL	33442	(800) 222-3560	
A75	HEALTH COST SOLUTIONS	PO BOX 1439	HENDERSONVILLE	TN	37077	(888) 229-5020	WAS LIFECARE CENTERS OF AMERICA
B75	HEALTH DESIGN PLUS	PO BOX 2584	HUDSON	OH	442362584	(800) 893-0777	
960	HEALTH EOS	PO BOX 6090	DER PERE	WI	541156090	(800) 435-5694	CODE ASSIGNED BY SCHA. NOT REQUESTED BY MEDICAID
286	HEALTH EXCHANGE (TPA FOR CERNER HEALTH)	PO BOX 165750	KANSAS CITY	MO	64116	(800) 231-4015	CODE IN OPEN STATUS BY SCHA
B27	HEALTH FIRST (PPO)	PO BOX 17709	GREENVILLE	SC	29606	(864) 289-3000	
884	HEALTH FIRST HEALTH PLANS	PO BOX 565001	ROCKLEDGE	FL	329565001	(800) 716-7737	CODE IN OPEN STATUS BY

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CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
							SCHA
447	HEALTH NET	PO BOX 14700	LEXINGTON	KY	405125225	(900) 438-7886	MEDICARE ADVANTAGE PLAN
874	HEALTH NET	PO BOX 14700	LEXINGTON	KY	40512	(888) 747-7823	THIS CODE NOT REQUESTED BY SCHA. ASSIGNED BY SCHA
281	HEALTH NETWORK AMERICA/TRIVERIS	PO BOX 307	EATONTOWN	NJ	07724	(800) 337-1421	CODE ASSIGNED BY SCHA
220	HEALTH NEW ENGLAND	ONE MONARCH PLACE, STE. 1500	SPRINGFIELD	MA	011441500	(800) 310-2835	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B01	HEALTH PARTNERS	PO BOX 1289	MINNEAPOLIS	MN	554401289	(888) 922-2313	
B01DN	HEALTH PARTNERS DENTAL	PO BOX 1172	MINNEAPOLIS	MN	55440	(888) 922-2313	
C09	HEALTH PLAN ADMINISTRATORS	PO BOX 2638	ROCKFORD	IL	61132	(815) 633-5800	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
382	HEALTH PLAN OF NEVADA	PO BOX 15645	LAS VEGAS	NV	891145615	(800) 777-1840	MEDICARE ADVANTAGE PLAN
349	HEALTH PLAN SELECT	PO BOX 382767	BIRMINGHAM	AL	352382767	(800) 293-6260	
357	HEALTH PLAN SERVICES	PO BOX 30298	TAMPA	FL	33630	(800) 237-7767	
126	HEALTH PLAN SERVICES (COVENTRY HEALTH CARE)	PO BOX 24146	SEATTLE	WA	98124	(800) 861-0056	CODE ASSIGNED BY SCHA
332	HEALTH PLANS, INC.	PO BOX 5199	WESTBOROUGH	MA	01581	(800) 532-7575	
324	HEALTH REIMBURSEMENT MANAGEMENT PARTNERSHIP	5 HUTCHINSON DR.	DANVERS	MA	01923	(888) 999-4767	CODE IN OPEN STATUS BY SCHA
225	HEALTH SERVICES FOUNDATION	PO BOX 2109	LIVERMORE	CA	94551	(510) 449-7070	
A79	HEALTH SPECIAL RISK	4001 N. JOSEY LANE	CARROLLTON	TX	75007	(972) 492-6474	
A27	HEALTHCARE SUPPORT	25 COLUMBIA HEIGHTS	BROOKLYN HEIGHTS	NY	112012482	(800) 554-4022	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
758	HEALTHCHOICE	PO BOX 24870	OKLAHOMA	OK	731270870	(800) 489-2974	CODE ASSIGNED BY SCHA
814	HEALTHCOMP ADMINISTRATORS	PO BOX 45018	FRESNO	CA	93718	(800) 442-7247	
E61	HEALTHEZ	PO BOX 398220	MINNEAPOLIS	MN	55439	(855) 280-9638	
524	HEALTHFIRST	PO BOX 130217	TYLER	TX	75713	(800) 477-8957	CODE ASSIGNED BY SCHA TPA
D19	HEALTHFIRST 65 PLUS	PO BOX 5196	NEW YORK	NY	10274	(888) 260-1010	MEDICARE ADVANTAGE PLAN

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
639	HEALTHFIRST HMO	255 ENTERPRISE BLVD. STE. 20	GREENVILLE	SC	29615	(864) 455-1100	MEDICAID HMO
387	HEALTHGRAM	PO BOX 11088	CHARLOTTE	NC	28220	(800) 446-5439	HEALTHGRAM FORMERLY PRIMARY PHYSICIAN CARE
387DN	HEALTHGRAM	PO BOX 11088	CHARLOTTE	NC	28220	(800) 446-5439	DENTAL - HEALTHGRAM FORMERLY PRIMARY PHYSICIANS CARE
577	HEALTHMARKETS CARE ASSURED	PO BOX 69349	HARRISBURG	PA	17110	(877) 219-5460	CODE ASSIGNED BY SCHA
440	HEALTHNET	PO BOX 14702	LEXINGTON	KY	40512	(800) 641-7761	
753	HEALTHNET	PO BOX 2226	AUGUSTA	GA	309032226	(900) 977-8221	
767	HEALTHSCOPE BENEFITS	PO BOX 619055	DALLAS	TX	752619055	(800) 600-6212	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A67	HEALTHSCOPE BENEFITS	PO BOX 99005	LUBBOCK	TX	794906831	(800) 967-6831	
553DN	HEALTHSCOPE BENEFITS, INC.	PO BOX 99005	LUBBOCK	TX	79490	(800) 967-6831	
553	HEALTHSCOPE BENEFITS, INC.	PO BOX 99005	LUBBOCK	TX	79490	(888) 373-6102	
305	HEALTHSMART	PO BOX 3262	CHARLESTON	WV	25332	(866) 869-5597	
C32DN	HEALTHSMART	PO BOX 3262	CHARLESTON	WV	25332	(800) 435-4351	FORMALLY WELLS FARGO
920	HEALTHSMART PREFERRED CARE	PO BOX 53010	LUBBOCK	TX	794533010	(806) 473-2500	
876	HEALTHSOURCE OF NC, INC.	PO BOX 28087	RALEIGH	NC	27611	(800) 849-9000	USE CODE 134 CIGNA HEALTHCARE
519	HEALTHSOURE ADMINISTRATORS	PO BOX 382617	BIRMINGHAM	AL	35238	(877) 893-9294	
D81	HEARTLAND NATIONAL LIFE INSURANCE CO.	PO BOX 2878	SALT LAKE CITY	UT	84110	(800) 872-3860	REQUESTED BY THE SCHA
242	HELLER ASSOCIATES	8228 MAYFIELD RD. STE. 5B	CHESTERLANDE	OH	44026	(440) 527-2955	CODE IN OPEN STATUS BY SCHA
848	HERITAGE	PO BOX 1730	AUBURNDALE	FL	33823	(800) 282-2460	
732	HERTZ CLAIM MANAGEMENT	PO BOX 726	PARK RIDGE	NJ	07656	(201) 307-2177	
117	HEWITT COLEMAN AND ASSOCIATES	PO BOX 6708	GREENVILLE	SC	29606	(864) 240-5840	
X1R	HIGHMARK BLUE CROSS BLUE SHIELD	PO BOX 890062	CAMPHILL	PA	170890062	(412) 544-7000	
D45	HIGHMARK SECURITY BLUE	120 5TH AVE.	PITTSBURGH	PA	15222309	(800) 547-3627	MEDICARE ADVANTAGE PLAN
A78	HIGHWAY TO HEALTH (HTH)	PO BOX 968	HORSHAM	PA	19044	(888) 350-2002	THIS CODE ASSIGNED BY SCHA. NOT REQUESTED BY

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
							MEDICAID
B15	HILLCREST BENEFIT ADMINISTRATORS	PO BOX 1516	MT. DORA	FL	32756	(800) 743-9264	
502	HIP HEALTH PLAN	PO BOX 2803	NEW YORK	NY	101162803	(800) 447-8255	MEDICARE ADVANTAGE PLAN
B81	HM BENEFITS ADMINISTRATORS, INC.	PO BOX 535078	PITTSBURGH	PA	152535078	(800) 279-2624	
A13	HOLDEN & COMPANY	PO BOX 10411	SAVANNAH	GA	31412	(800) 404-3344	
A68	HOLLINGSWORTH SACO LOWELL CORP.	PO DRAWER 2327	GREENVILLE	SC	29602	(864) 859-3211	DORMANT 8/06
984	HOMELAND HEALTHCARE	PO BOX 3726	SEATTLE	WA	98124	(800) 493-4240	
D36	HOP/PSERS HEALTH ADMINISTRATION UNIT	PO BOX 2921	CLINTON	IA	52733	(800) 773-7725	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
239	HORACE MANN LIFE INSURANCE COMPANY	1 HORACE MANN PLAZA	SPRINGFIELD	IL	62715	(217) 789-2500	
238	HORIZON HEALTHCARE	PO BOX 1028	WEST TRENTON	NJ	08628	(800) 792-3666	
675	HORRY COUNTY	-	-	-	-	-	
782	HOUSING BENEFIT PLAN	PO BOX 542077	DALLAS	TX	753542077	(800) 937-2036	
878	HRM CLAIM MANAGEMENT	PO BOX 4022	KALAMAZOO	MI	490034022	(800) 253-0966	
C34	HTH HIGHWAY TO HELP	1 RADNOR CORP CTR., STE. 100	RADNOR	PA	19087	(866) 510-8780	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
836	HUMANA	PO BOX 14601	LEXINGTON	KY	40512	(800) 558-4444	
836DN	HUMANA	PO BOX 14601	LEXINGTON	KY	40512	(800) 558-4444	
C59	HUMANA CHOICE (PPO)	PO BOX 14605	LEXINGTON	KY	405784602	(800) 457-4708	MEDICARE ADVANTAGE PLAN
648	HUMANA GOLD CHOICE (PFFS)	PO BOX 7060	CAMDEN	SC	29020	(877) 511-5000	MEDICARE ADVANTAGE PLAN
793	HUMANA GOLD PLUS	PO BOX 14601	LEXINGTON	KY	405124601	(800) 457-4708	MEDICARE ADVANTAGE PLAN
216	HUMANA HEALTH INSURANCE OF FLORIDA	PO BOX 19080-F	JACKSONVILLE	FL	32245	(800) 457-4708	
752	HYGEIA CORPORATION	15500 NEW BARN RD.	MIAMI LAKES	FL	33014	(800) 591-2650	CODE ASSIGNED BY SCHA
371	ICON BENEFIT ADMINISTRATORS, INC.	PO BOX 53010	LUBBOCK	TX	794533070	(800) 658-9777	
250	IDEAL SCRIPTS	50 WHITE CAP DR.	NORTH KINGSTOWN	RI	02886	(800) 717-6614	
801	IMERICA LIFE AND HEALTH INS. CO	PO BOX 3287	ENGLEWOOD	CO	80155	(888) 273-8020	
B26	IMSCO HEALTH PLAN	PO BOX 697	BUCKEYSTOWN	MD	217170697	(800) 944-2833	IMSCO - INTERNATIONAL MANAGEMENT SERVICE CO.

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
716	INDECS CORP	PO BOX 668	LYNDHURST	NJ	07071	(888) 446-3327	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A08	INDEPENDENCE AMERICAN INS. CO. (IHC HEALTH SOLUTION)	PO BOX 21456	EAGON	MN	55121	(866) 429-0608	
X1G	INDEPENDENCE BLUE CROSS	PO BOX 219669	KANSAS CITY	MO	641219669	(800) 275-2583	
892	INDEPENDENT HEALTH	PO BOX 9066	BUFFALO	NY	14231	(800) 247-1466	
D44	INDEPENDENT HEALTH	PO BOX 9066	BUFFALO	NY	14231	(866) 617-8585	MEDICARE ADVANTAGE PLAN
975	INFORMED RX	PO BOX 968022	SCHAUMBURG	IL	601968022	(800) 645-3332	WAS NATIONAL MEDICAL HEALTH CARD
B51	INNOVIANT	PO BOX 8082	WAUSAU	WI	54402	(877) 559-2955	
C60	INSTILL HEALTH SYSTEMS (FFS)	PO BOX 7061	CAMDEN	SC	290207845	(877) 446-7845	MEDICARE ADVANTAGE PLAN
C61	INSTILL HEALTH SYSTEMS (PPO)	PO BOX 7061	CAMDEN	SC	290207845	(877) 446-7845	MEDICARE ADVANTAGE PLAN
178	INSURANCE & BENEFIT ADVOCATE, INC.	5838 W BRICK RD STE. 106	SOUTH BEND	IN	46628	(866) 200-6700	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
863	INSURANCE ADMINISTRATION CORP.	PO BOX 39119	PHOENIX	AZ	85069	(800) 843-3106	
D02	INSURANCE ADMINISTRATOR OF AMERICA	PO BOX 5082	MT. LAUREL	NJ	08054	(800) 989-6739	
149	INSURANCE COMPANY OF NORTH AMERICA (INA)	195 BROADWAY 11TH FLOOR	NEW YORK	NY	100073100	(212) 618-4000	
756	INSURANCE MANAGEMENT ADMINISTRATORS (IMA)	PO BOX 71120	BOSSIER CITY	LA	711719944	(800) 742-9944	
726	INSURANCE SERVICE AND BENEFITS	3218 HIGHWAY 67 STE. 218	MESQUITE	TX	75150	(800) 878-3157	
C41	INSUREX BENEFITS ADMINISTRATORS, INC.	PO BOX 41779	MEMPHIS	TN	381741799	(901) 725-6435	
C41DN	INSUREX BENEFITS ADMINISTRATORS, INC.	PO BOX 41779	MEMPHIS	TN	381741799	(901) 725-6435	
B80	INTEGRATED BEHAVIORAL HEALTH/IBH	PO BOX 30018	LAGUNA NIGUEL	CA	92607	(800) 395-1616	
735	INTEGRITAS BENEFIT GROUP	PO BOX 1447	CORDOVA	TN	38088	(901) 685-8980	
484	INTEGRITY BENEFITS NETWORK	PO BOX 4537	MARIETTA	GA	30061	(770) 428-1604	
B72	INTEGRITY NATIONAL LIFE INS.	PO BOX 32350	LOUISVILLE	KY	40232	(502) 426-1843	CODE ASSIGNED BY SCHA
A45	INTEQ GROUP	5445 LASIERRA DR., STE. 400	DALLAS	TX	75231	(800) 959-3953	
465	INTER CARE BENEFIT SYSTEMS	PO BOX 3559	ENGLEWOOD	CO	801553559	(303) 770-5710	
809	INTER VALLEY HEALTH PLAN	300 SOUTH PARK PO BOX 6002	POMONA	CA	917696002	(800) 251-8191	CODE ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
C26	INTERACTIVE MEDICAL SYSTEMS, INC.	PO BOX 19108	RALEIGH	NC	27619	(919) 846-8400	
C54	INTER-AMERICAS INS. CORP. (OOIDA)	PO BOX 9510	WICHITA	KS	672770510	-	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
129	INTERGROUP SERVICES CORPORATION	101 LINDENWOOD DR., STE 150	MALVERN	PA	19355	(800) 537-9389	
D01	INTERLINK HEALTH SERVICES	4950 NE BELNAP CT. #205	HILLSBORO	OR	97124	(503) 640-2000	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B76	INTERNATIONAL ASSO. BENEFITS	1747 PENNSYLVANIA AVE. NORTH WEST	WASHINGTON	DC	20006	(800) 275-1171	
983	INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS	3901 E. WINSLOW AVE.	PHOENIX	AZ	85040	(602) 234-0497	
101	INTERNATIONAL CLAIMS SERVICES	27092 BURBANK ST.	FOOTHILL RANCH	CA	92610	(877) 916-7920	ASSIGNED BY SCHA
189	INTERNATIONAL EDUCATION EXCHANGE SERVICES	PO BOX 370	ITHACA	NY	148510307	(866) 433-7462	
464	INTERNATIONAL MEDICAL GROUP	407 N. FULTON ST.	INDIANAPOLIS	IN	46202	(800) 628-4664	
473	INTERNATIONAL MISSION BOARD (IMB)	PO BOX 6767	RICHMOND	VA	232300767	(804) 219-1585	CODE ASSIGNED BY SCHA
454	INTERNATIONAL UNION OF OPERATING ENGINEERS	166 WEST KELLY ST.	METUCHEN	NJ	08840	(908) 548-6662	
411	INTERPLAN HEALTH GROUP	PO BOX 90613	ARLINGTON	TX	76006	-	CODE ASSIGNED BY SCHA
A19	ISLAND GROUP ADMINISTRATION, INC.`	3 TOILSOME LANE	EAST HAMPTON	NY	11937	(800) 926-2306	CODE ASSIGNED BY SCHA
958	ITPE-NMU HEALTH AND WELFARE FUND	PO BOX 13817	SAVANNAH	GA	31416	(912) 352-7169	
958DN	ITPE-NMU HEALTH AND WELFARE FUND	PO BOX 13817	SAVANNAH	GA	31416	(912) 352-7169	
757	J C PENNEY LIFE INSURANCE COMPANY	PO BOX 869090	PLANO	TX	750860909	(972) 881-6000	
827	J. SMITH LANIER	PO BOX 72749	NEWNAN	GA	30271	(888) 295-4864	
996	J.F. MOLLOY & ASSO.	PO BOX 68947	INDIANAPOLIS	IN	46268	(800) 331-3287	SEE CARRIER 942 PRINCIPAL FINANCIAL GROUP
335	J.P. FARLEY CORP.	PO BOX 458022	WESTLAKE	OH	441468022	(440) 250-4300	
676	JASPER COUNTY	-	-	-	-	-	
109	JEFFERSON PILOT INSURANCE COMPANY	PO BOX 26011	GREENSBORO	NC	27420	(336) 691-3000	
514	JLT SERVICES (TPA FOR NY LIFE)	PO BOX 1511	LATHAM	NY	12110	(800) 793-3773	NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
D09	JM FAMILY ENTERPRISES	8019 BAYBERRY RD.	JACKSONVILLE	FL	32256	(800) 892-0059	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
885	JOHN ALDEN INSURANCE COMPANY	PO BOX 020270	MIAMI	FL	33102	(800) 328-4316	
885DN	JOHN ALDEN INSURANCE COMPANY	PO BOX 020270	MIAMI	FL	33102	(800) 328-4316	
202	JOHN HANCOCK INSURANCE COMPANY	PO BOX 852	BOSTON	MA	02117	(800) 233-1449	
B12	JOHN HANCOCK LIFE AND HEALTH INSURANCE	JOHN HANCOCK B5-03 200 BERKELEY ST.	BOSTON	MA	02116	(800) 377-7311	
C71	JOHNS HOPKINS HEALTHCARE	6704 CURTIS CT.	GLEN BURNIE	MD	21060	(800) 261-2393	
417	JULY PRODUCTS	5 GATEWAY CENTER STE 60	PITTSBURG	PA	15222	(866) 900-8322	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
A69	KAISER FOUNDATION HEALTH PLAN OF SOUTHERN CA	PO BOX 7004	DOWNEY	CA	902427004	(800) 331-0420	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
104	KAISER FOUNDATION HEALTH PLAN OF SOUTHERN CA.	PO BOX 7004	DOWNEY	CA	90242	(800) 390-3510	CODE ASSIGNED BY SCHA
528	KAISER PERMANENTE	PO BOX 190849	ATLANTA	GA	31119	(800) 611-1811	MEDICARE ADVANTAGE PLAN
C78	KAISER PERMANENTE	PO BOX 190849	ATLANTA	GA	31119	(404) 261-2590	
537	KAISER PERMANENTE-OHIO REGION	PO BOX 5316-9774	CLEVELAND	OH	441010316	(800) 634-8816	CODE ASSIGNED BY SCHA
C47	KANAWHA BENEFIT SERVICES	PO BOX 50098	KNOXVILLE	TN	379500098	(800) 822-1274	
C47DN	KANAWHA BENEFIT SERVICES	PO BOX 50098	KNOXVILLE	TN	379500098	(800) 822-1274	
153	KANAWHA LIFE INSURANCE COMPANY	PO BOX 6000	LANCASTER	SC	29721	(803) 286-2440	
153DN	KANAWHA LIFE INSURANCE COMPANY	PO BOX 6000	LANCASTER	SC	29721	(803) 286-2440	
868	KANSAS CITY LIFE	PO BOX 9040	AUSTIN	TX	78766	(800) 874-5254	
E80	KANSAS INDEPENDENT PHARMACY (KPSC)	4125 SOUTH WEST GAGE CENTER DR., STE. 203	TOPEKA	KS	66604	(800) 279-3022	
C30	KEENAN AND COMPANY	PO BOX 11431	TORRANCE	CA	90510	(800) 653-3626	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
677	KERSHAW COUNTY	-	-	-	-	-	
760	KEY BENEFIT ADMINISTRATORS	PO BOX 55230	INDIANAPOLIS	IN	46205	(800) 331-4757	
936	KEY BENEFITS-TRANSCHOICE PLUS	PO BOX 3252	MILWAUKEE	WI	53201	(866) 867-6883	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
893	KEYSTON HEALTH PLAN EAST	PO BOX 8339	PHILADELPHIA	PA	19101	(800) 227-3116	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D71	KEYSTONE 65	PO BOX 7799	PHILADELPHIA	PA	191017799	(800) 227-3116	MEDICARE ADVANTAGE PLAN
B66	KIRKE-VAN ORSDEL, INC.	PO BOX 9126	DES MOINES	IA	503069126	(800) 247-2192	USE CODE 759 MEDIPLUS PER SCHA
318	KLAIS & COMPANY	1867 WEST MARKET ST.	AKRON	OH	443136977	(330) 867-8443	
900	KOHLER COMPANY	444 HIGHLAND DR.	KOHLER	WI	530441515	(920) 457-4441	
711	LABORERS DISTRICT COUNCIL OF GA AND SC	PO BOX 607	JONESBORO	GA	302370607	(404) 477-1888	
320	LAMAR LIFE INSURANCE COMPANY	PO BOX 880	JACKSON	MS	39201	(601) 949-3100	
678	LANCASTER COUNTY	-	-	-	-	-	
679	LAURENS COUNTY	-	-	-	-	-	
D04	LBA HEALTH PLANS, INC./PRIMARY SELECT	PO BOX 17098	OWINGS MILL	MD	211177098	(800) 815-8240	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B59	LDI INTEGRATED PHARMACY SERVICES	701 EMERSON RD., STE. 301	CREVE COEUR	MO	63141	(866) 516-3121	
680	LEE COUNTY	-	-	-	-	-	
978	LEGGETT & PLATT	PO BOX 7687	HIGH POINT	NC	27264	(877) 311-2150	
D31	LEON MEDICAL CENTER HEALTH PLAN	PO BOX 65-9006	MIAMI	FL	33265	(305) 559-5366	MEDICARE ADVANTAGE PLAN
681	LEXINGTON COUNTY	-	-	-	-	-	
B62	LIBERTY DENTAL	PO BOX 26110	SANTA ANNA	CA	92799	(888) 902-0349	
943	LIBERTY MUTUAL LIFE INSURANCE	5 HUTCHINSON DR.	DANVERS	MA	01923	(888) 999-4767	CODE IN OPEN STATUS BY SCHA
540	LIBERTY NATIONAL LIFE INSURANCE COMPANY	PO BOX 2612	BIRMINGHAM	AL	35202	(205) 325-2722	
243	LIFE & CASUALTY INSURANCE COMPANY OF TENNESSEE	AMERICAN GENERAL CENTER	NASHVILLE	TN	37250	(615) 749-1000	
B02	LIFE INSURANCE CO. OF ALABAMA	PO BOX 349	GADSDEN	AL	35902	(800) 226-2371	
156	LIFE INSURANCE COMPANY OF GEORGIA	PO BOX 105006	ATLANTA	GA	303485006	(770) 980-5100	
157	LIFE INSURANCE COMPANY OF VIRGINIA, THE	PO BOX 27601	RICHMOND	VA	23230	(804) 281-6000	
408	LIFE INVESTORS INSURANCE COMPANY OF AMERICA	PO BOX 8043	LITTLE ROCK	AR	72203	(501) 376-0426	AKA AEGON

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
515	LIFE OF THE SOUTH INSURANCE COMPANY	PO BOX 45237	JACKSONVILLE	FL	32232	(800) 661-6385	THIS CODE ASSIGNED BY SCHA NOT A MEDICAID REQUEST
241	LIFE REINSURANCE CO.	PO BOX 792070	SAN ANTONIO	TX	78279	(800) 229-1024	
D87	LIFESTYLE HEALTHCARE	345 N. RIVERVIEW STE. 600	WICHITA	KS	67203	(866) 827-6607	FORMERLY MEDOVA HEALTHCARE
138	LIFEWELL HEALTH PLANS	PO BOX 16203	LUBBOCK	TX	79490	(877) 543-3935	SUBSIDIARY OF HEALTHSCOPE
B23	LINCOLN FINANCIAL GROUP	PO BOX 614008	ORLANDO	FL	32861	(800) 423-2765	
323	LINCOLN HERITAGE LIFE INSURANCE CO	PO BOX 10843	CLEARWATER	FL	337578843	(888) 586-8810	
158	LINCOLN NATIONAL LIFE INSURANCE COMPANY	PO BOX 614008	ORLANDO	FL	32861	(800) 423-2765	
796	LINECO	821 PARKVIEW BLVD.	LOMBARD	IL	601483230	(800) 323-7268	CODE ASSIGNED BY SCHA
A53	LONGSHORE & HARBOR WORKERS COMP PROGRAM	PO BOX 8300	LONDON	KY	407428300	(866) 335-8319	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
367	LOOMIS INSURANCE COMPANY	PO BOX 7011	WYOMISSING	PA	196107011	(800) 782-0392	
C85	LOYAL AMERICAN LIFE INSURANCE COMPANY	PO BOX 559004	AUSTIN	TX	78755	(800) 633-6752	
492	LT11-LIFETRAC NETWORK	111100 WAYZATA BLVD.	MINNEAPOLIS	MN	55305	-	CODE ASSIGNED BY SCHA
B18	LUMENOS	PO BOX 69309	HARRISBURG	PA	17106	(877) 495-7223	
504	M CARE	PO BOX 130799	ANN ARBOR	MI	481130779	(215) 657-8920	CODE IN OPEN STATUS BY SCHA
396	MACY'S HR SERVICES	PO BOX 850958	RICHARDSON	TX	75085	(800) 337-2363	CODE ASSIGNED BY SCHA
B16	MAGELLAN RX	11013 WEST BROAD ST., STE. 500	GLEN ALLEN	VA	23060	(800) 659-4112	
A32	MAGELLAN BEHAVIORAL HEALTH	PO BOX 1659	MARYLAND HEIGHTS	MO	63043	(800) 359-2422	
B07	MAGNACARE	PO BOX 1001	GARDEN CITY	NY	11530	(866) 624-6259	
847	MAHONEY BENEFIT ADMINISTRATORS	PO BOX 7260	FORT LAUDERDALE	FL	33338	(800) 280-7093	
327	MAIL HANDLERS BENEFIT PLAN	PO BOX 8402	LONDON	KY	40742	(800) 410-7778	
E23	MAINE SENSE	PO BOX 1959	GRAY	ME	04039	(800) 290-8559	
159	MAKSIN MANAGEMENT CORP	CN98000	PENNSAUKEN	NJ	08110	(800) 257-0625	
438	MAMSI LIFE AND HEALTH INSURANCE CO	PO BOX 993	FREDRICKS	MD	21705	(800) 257-6458	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
860	MANAGED HEALTH NETWORK	PO BOX 209010	AUSTIN	TX	78720	(800) 835-2094	
915	MANAGED HEALTH RESOURCES	PO BOX 30742	CHARLOTTE	NC	28208	(704) 355-5200	
835	MANAGED PHARMACY BENEFITS	1100 NORTH LINDBERGH	ST. LOUIS	MO	63132	(800) 672-9540	THIS CARRIER BOUGHT OUT BY EXPRESS SCRIPTS.
A15	MANAGED PRESCRIPTIONS SERVICES (MPS)	ONE CITY CENTRE STE. 1100	ST. LOUIS	MO	631016922	(800) 759-6959	
932	MANHATTAN INSURANCE GROUP	PO BOX 925309	HOUSTON	TX	772925309	(800) 669-9030	CODE ASSIGNED BY SCHA. NOT REQUESTED BY MEDICAID
682	MARION COUNTY	-	-	-	-	-	
A26	MARKEL SMART STM	PO BOX 15953	LUBBOCK	TX	79490	(800) 279-2290	
683	MARLBORO COUNTY	-	-	-	-	-	
268	MARQUETTE NATIONAL LIFE INS. CO.	PO BOX 130	PENSACOLA	FL	32591	(800) 934-8203	
709DN	MARSH ADVANTAGE AMERICA	501 NORTH BROADWAY, STE. 500	ST. LOUIS	MO	63102	(800) 868-7526	FORMERLY BENEFIT PLAN SERVICES
405	MARSH(INSURANCE TRUST PLAN-DELTA RETIREES)	PO BOX 10432	DES MOINES	IA	503060432	(877) 325-7265	CODE ASSIGNED BY SCHA
531	MARY BLACK HEALTHNETWORK	1690 SKYLYN DR., STE.130	SPARTANBURG	SC	29307	(864) 573-3535	
569	MARYLAND PHYSICIANS CARE	PO BOX 61778	PHOENIX	AZ	85082	(800) 953-8854	CODE IN OPEN STATUS BY SCHA
226	MASTER HEALTH PLAN	PO BOX 16367	AUGUSTA	GA	303919123	(706) 863-5955	
B32	MAXCARE	PO BOX 16430	OKLAHOMA CITY	OK	73113	(800) 259-7765	
E99	MAXORPLUS	320 SOUTH POLK ST., STE. 200	AMARILLO	TX	79101	(800) 687-0707	
E99RX	MAXORPLUS	320 SOUTH POLK ST., STE. 200	AMARILLO	TX	79101	(800) 687-0707	RX ONLY
586	MCA ADMINISTRATORS (MANAGED CARE OF AMERICA)	MANOR OAK TWO, STE 605 1910 COCHRAN RD	PITTSBURGH	PA	15220	(412) 922-0780	WAS DIVERSIFIED GROUP ADMINISTRATORS
684	MCCORMICK COUNTY	-	-	-	-	-	
361	MDI GOVERNMENT HEALTH SERVICES	822 HIGHWAY A1A NORTH STE 310	PONTE VEDRA BEACH	FL	32082	(800) 841-6288	CODE ASSIGNED BY SCHA
368	MED BENEFITS SYSTEM	PO BOX 177	SOUTH BEND	IN	46601	(219) 237-0560	
206	MED COST BENEFITS SERVICES	PO BOX 25307	WINSTON-SALEM	NC	271145307	(800) 795-1023	
206DN	MED COST BENEFITS SERVICES	PO BOX 25987	WINSTON-SALEM	NC	27114	(800) 795-1023	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
223	MED COST PREFERRED	PO BOX 25437	WINSTON-SALEM	NC	27114	(800) 824-7406	CODE ASSIGNED BY SCHA
B38	MEDBEN	PO BOX 1009	NEWARK	OH	43058	(800) 686-8425	
798	MEDCARE INTERNATIONAL	12480 WEST ATLANTIC BLVD., STE. 2	CORAL SPRINGS	FL	33071	-	
873	MEDCO HEALTH	PO BOX 8190	MADISON	WI	537088190	(800) 221-7006	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY THE SCHA
C46	MEDCO HEALTH SOLUTIONS	PO BOX 2902	CLINTON	IA	527332902	(800) 272-7243	USE CARRIER 333 EXPRESS SCRIPTS
152	MEDICA	PO BOX 30990	SALT LAKE CITY	UT	84130	(800) 952-3455	CODE NOT REQUESTED BY MEDICAID ASSIGNED BY SCHA
222	MEDICA	PO BOX 30990	SALT LAKE CITY	UT	84107	(800) 952-3455	
619	MEDICAID, SC					-	
616	MEDICAID-OUT-OF-STATE					-	
C98	MEDICAL BENEFIT ADM. OF MARYLAND, INC.	PO BOX 950	FORREST HILL	MA	60631	(888) 532-3467	
295	MEDICAL BENEFIT ADMINISTRATORS	5940 SEMINOLE CENTER CT.	MADISON	WI	53711	(608) 273-1776	
781	MEDICAL CLAIMS MANAGEMENT CORP	PO BOX 25307	WINSTON-SALEM	NC	271145307	(800) 334-0609	
781DN	MEDICAL CLAIMS MANAGEMENT CORP	PO BOX 12995	CHARLOTTE	NC	282202995	(800) 334-0609	
C25	MEDICAL CLAIMS SERVICES	1 WALL ST.. STE. 2A	RAVENSWOOD	WV	26164	(888) 225-0522	
822	MEDICAL MUTUAL	PO BOX 6018	CLEVELAND	OH	44101	(800) 258-2873	CODE ASSIGNED BY SCHA
539	MEDICAL MUTUAL INSURANCE OF OHIO	PO BOX 94648	CLEVELAND	OH	44101	(800) 362-1279	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
X0R	MEDICAL MUTUAL OF OHIO	PO BOX 6018	CLEVELAND	OH	44101	(216) 687-7000	
X0RDN	MEDICAL MUTUAL OF OHIO	PO BOX 981800	EL PASO	TX	79998	(216) 687-7000	
979	MEDICAL REIMBURSEMENT OF AMERICA	113 SEABOARD LANE	FRANKLIN	TN	37067	(615) 963-3826	THIS CODE IS USED BY SCHA NOT AN ACTIVE MEDICAID CODE
207	MEDICAL SAVINGS HEALTH PLAN	419 E. MAIN ST.	MIDDLETON	NY	10940	(317) 329-8222	
B39	MEDICAL SAVINGS INSURANCE CO.	5835 WEST 74TH ST.	INDIANAPOLIS	IN	462781758	(317) 329-8222	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
X1N	MEDICAL SERVICE CORPORATION OF EASTERN WASHINGTON	PO BOX 3048	SPOKANE	WA	99220	(509) 536-4900	
D99	MEDICARE ADVANTAGE					-	MEDICARE ADVANTAGE PLAN GENERIC CODE
D32	MEDICARE COMPLETE (UNITED HEALTH CARE)	PO BOX 659735	SAN ANTONIO	TX	782659735	(877) 842-3210	MEDICARE ADVANTAGE PLAN
618	MEDICARE PART A					-	
620	MEDICARE PART B ONLY					-	
D14	MEDICARE PLUS BLUE (BCBS OF MICHIGAN)	27000 ELEVEN MILE RD	SOUTHFIELD	MI	48034	(800) 249-5103	MEDICARE ADVANTAGE PLAN
617	MEDICARE RAILROAD (PGBA) PROFESSIONAL PART B	PO BOX 10066	AUGUSTA	GA	30999	(877) 288-7600	
995	MEDIMPACT	10680 TREENA ST., STOP 5	SAN DIEGO	CA	92131	(800) 788-2949	
372	MEDIPLAN	502 VALLEY RD.	WAYNE	NJ	07410	(973) 696-3111	
759	MEDIPLUS	PO BOX 9126	DES MOINES	IA	50309	(800) 247-2192	AKA TROA
E96	MEDPARTNERS ADMINISTRATIVE	6920 POINT INVERNESS WAY	FORT WAYNE	IN	46804	(888) 312-9744	
B56	MEDSAVE USA	3035 LAKELAND HILLS BLVD.	LAKELAND	FL	33805	(800) 226-3155	
746	MED-TAC CLAIMS	PO BOX 9110	NEWTON	MA	02160	(800) 347-9355	
C96	MEDTRACK SERVICES	7101 COLLEGE BLVD., STE. 1000	OVERLAND PARK	KS	66210	(800) 771-4648	
E41	MEDTRAK	7101 COLLEGE BLVD., STE. 1000	OVERLAND PARK	KS	66210	(800) 771-4648	
477	MEGA LIFE AND HEALTH INSURANCE COMPANY	PO BOX 981606	EL PASO	TX	79998	(800) 527-2845	
B50	MEMBER HEALTH	PO BOX 391180	CLEVELAND	OH	44139	(888) 868-5854	
709	MERCER ADMINISTRATION	PO BOX 4546	IOWA CITY	IA	52244	(800) 868-7526	
833	MERCY HEALTH PLANS	PO BOX 4568	SPRINGFIELD	MO	658084568	(800) 647-2240	
377	MERITAIN HEALTH	PO BOX 27267	MINNEAPOLIS	MN	554270267	(800) 925-2272	WAS NORTH AMERICAN ADMINISTRATORS, INC.
A29	MERITAN HEALTH	PO BOX 80884	INDIANAPOLIS	IN	46280	(800) 606-4841	
108	METROPOLITAN LIFE INSURANCE COMPANY	PO BOX 981282	EL PASO	TX	79998	(800) 638-6626	
916	MHEALTH	PO BOX 742567	HOUSTON	TX	77274	(888) 642-5040	
961	MHN (MANAGED HEALTH NETWORK)	PO BOX 27018	LAS VEGAS	NV	89126	(800) 458-4642	CODE ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
790	MHNET BEHAVIORAL HEALTH	PO BOX 7802	LONDON	KY	40742	(800) 752-7242	
988	MID WEST NATIONAL LIFE INS. CO.	PO BOX 981606	EL PASO	TX	799981610	(800) 733-1110	
742	MIDA DENTAL PLAN	2000 TOWN CENTER, STE. 2200	SOUTHFIELD	MI	48075	(800) 937-6432	
C95	MIDWEST SECURITY	2700 MIDWEST DR.	ONALASKA	WI	54650	(800) 236-8672	
D40	MINNESOTA POWER HEALTH PLANS	30 W SUPERIOR ST.	DULUTH	MN	55802	(888) 812-8800	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C06	MISSIONARY MEDICAL	PO BOX 45730	SALT LAKE CITY	UT	84145	(800) 777-1647	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
820	MMSI MAYO MANAGEMENT SERVICES	4001 41ST ST. WEST	ROCHESTER	NM	41154	(800) 635-6671	CODE ASSIGNED BY SCHA SEE CARRIER CODE 536
545	MOLINA HEALTHCARE OF OHIO	PO BOX 22712	LONGBEACH	CA	90801	(800) 642-4148	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
774	MOLINA MEDICARE OPTIONS PLUS	PO BOX 22811	LONG BEACH	CA	90801	(800) 665-1328	MEDICARE ADVANTAGE PLAN
597	MONARCH DIRECT	PO BOX 9004	SPRINGFIELD	MA	01101	(800) 628-9000	
227	MONUMENTAL GENERAL INSURANCE COMPANY	1111 N CHARLES ST.	BALTIMORE	MD	20201	(800) 752-9797	
148	MONUMENTAL LIFE INSURANCE COMPANY	PO BOX 61	DURHAM	NC	27702	(800) 444-5431	
460	MORRIS ASSOCIATES	PO BOX 50440	INDIANAPOLIS	IN	462500440	(317) 554-9000	
D24	MOUNT CARMEL HEALTH PLAN (MCHP) MEDIGOLD (HMO)	PO BOX 6111	WESTERVILLE	OH	43086	(800) 240-3870	
733	MOUNTAIN CLAIMS MANAGEMENT	PO BOX 1008	FRUITLAND	ID	83619	(208) 452-7979	CODE IN OPEN STATUS BY SCHA
A12	MOUNTAIN CLAIMS MANAGEMENT	PO BOX 1008	FRUITLAND	ID	83616	(866) 952-7979	
X2P	MOUNTAIN STATE BLUE CROSS & BLUE SHIELD, INC.	PO BOX 1948	PARKERSBERG	WV	26102	(304) 424-7700	
993	MPI INTERNATIONAL, INC.	PO BOX 81913	ROCHESTER	MI	483081913	(248) 853-9010	
432	M-PLAN CARDINAL HEALTH	PO BOX 357	LINTHICUM	MD	210900357	(800) 675-2605	CODE ASSIGNED BY SCHA
A18	MSH MOBILITY BENEFITS	PO BOX 77	BEEBE PLAIN	VT	05823	(888) 842-1530	CODE ASSIGNED BY SCHA
564	MULTINATIONAL UNDERWRITERS	PO BOX 863	INDIANAPOLIS	IN	46206	(800) 605-2282	CODE ASSIGNED BY SCHA
954	MULTIPLAN	115 5TH AVE.	NEW YORK	NY	100031004	(800) 546-3887	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
593	MUTUAL ASSURANCE ADMINISTRATORS, INC.	PO BOX 42096	OKLAHOMA CITY	OK	73123	(800) 648-9652	
724	MUTUAL MEDICAL PLANS	PO BOX 689	PEORIA	IL	61652	(800) 448-4689	CODE ASSIGNED BY SCHA
107	MUTUAL OF OMAHA	MUTUAL OF OMAHA PLAZA	OMAHA	NE	68175	(800) 228-9090	DO NOT USE FOR MED ADV. THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE.
635	MUTUAL OF OMAHA	MUTUAL OF OMAHA PLAZA	OMAHA	NE	68175	(402) 342-7600	MEDICARE INTERMEDIARY PART A
636	MUTUAL OF OMAHA	MUTUAL OF OMAHA PLAZA	OMAHA	NE	68175	-	MEDICARE INTERMEDIARY PART B
C99	MUTUAL PROTECTIVE MEDICO LIFE INS. CO.	1515 S. 75TH ST.	OMAHA	NE	68124	(800) 228-6080	CARRIER WAS PREVIOUSLY C35.
C35	MUTUAL PROTECTIVE MEDICO LIFE INSURANCE COMPANIES	1515 S 75TH ST.	OMAHA	NE	68124	(800) 228-6080	SEE CODE C99
937	MVP HEALTH CARE	PO BOX 2207	SCHENECTADY	NY	12301	(800) 229-5851	NAME CHANGE ONLY 4/09. WAS PREFERRED CARE
937DN	MVP HEALTH CARE	PO BOX 763	SCHENECTADY	NY	12301	(800) 480-5640	
291	NALC HEALTH BENEFIT PLAN	20547 WAVERLY CT.	ASHBURN	VA	20149	(703) 729-4677	
522	NATIONAL AUTOMATIC SPRINKLER INDUSTRY	800 CORPORATE DR.	LANDOVER	MD	20785	(301) 577-1700	
312	NATIONAL BENEFIT ADMINISTRATORS	PO BOX 690903	CHARLOTTE	NC	282277016	(800) 482-6736	
312DN	NATIONAL BENEFIT ADMINISTRATORS	PO BOX 690903	CHARLOTTE	NC	282277016	(800) 482-6736	
C17	NATIONAL BENEFITS	110 GIBRALTAR RD.	HORSHAM	PA	19044	(215) 443-0404	
260	NATIONAL CLAIMS ADMINISTRATIVE SERVICES	PO BOX 10136	FAIRFAX	VA	220388022	(866) 219-9292	CODE IN OPEN STATUS BY SCHA
267	NATIONAL CLAIMS ADMINISTRATIVE SERVICES	PO BOX 220887	CHARLOTTE	NC	282220887	(704) 364-3865	CODE ASSIGNED BY SCHA
C74	NATIONAL CLAIMS ADMINISTRATIVE SERVICES	PO BOX 981610	EL PASO	TX	799981610	(704) 364-3865	
C74DN	NATIONAL CLAIMS ADMINISTRATIVE SERVICES	PO BOX 220887	CHARLOTTE	NC	28222	(704) 364-3865	
444	NATIONAL DISASTER MEDICAL SYSTEM					-	
599	NATIONAL ELEVATOR INDUSTRY HEALTH BENEFITS	PO BOX 477	NEWTOWN SQUARE	PA	190730477	(800) 523-4702	
A70	NATIONAL EMPLOYEE BENEFIT ADMINISTRATORS	1920 N. FLORIDA MANGO RD	WEST PALM BEACH	FL	33409	(800) 822-5899	
263	NATIONAL FINANCIAL COMPANY	110 WEST 7TH ST., STE. 300	FT WORTH	TX	76102	(800) 725-1407	
B53	NATIONAL FOUNDATION LIFE INSURANCE	110 WEST 7TH ST., STE. 300	FORT WORTH	TX	76102	(800) 221-9039	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
	COMPANY						
472	NATIONAL HEALTH CARE HEALTH BENEFITS PLAN(NHC)	PO BOX 1398	MURFREESBORO	TN	371331398	(615) 890-2020	
929	NATIONAL HEALTH INSURANCE COMPANY	PO BOX 619999	DALLAS/FORT WORTH AIRPORT	TX	752619999	(800) 237-1900	
828	NATIONAL PHARMACUETICAL SERVICES	PO BOX 407	BOYSTOWN	NE	68017	(800) 546-5677	
495	NATIONAL PRESCRIPTION ADMINISTRATORS	PO BOX 1981	EAST HANOVER	NJ	079361981	(800) 522-6727	BOUGHT OUT BY EXPRESS SCRIPTS CC333
334	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	1750 PENNSYLVANIA AVE., NW	WASHINGTON	DC	20006	(800) 638-8432	
C86	NATIONAL STATES INSURANCE COMPANY	PO BOX 27321, 1830 CRAIG PARK CT.	ST. LOUIS	MO	63141	(314) 878-0101	
914	NATIONAL TEACHERS ASSO LIFE INSURANCE CO.	PO BOX 2369	ADDISON	TX	75001	(888) 671-6771	
414	NATIONAL TELEPHONE COOP. ASSN.	1 WEST PACK SQUARE, STE. 600	ASHEVILLE	NC	28801	(828) 252-9776	
558	NATIONAL TRAVELERS LIFE INS. CO.	PO BOX 9197	DES MOINES	IA	50306	(800) 232-5818	INACTIVE 8/02
388	NATIONALWAY HEALTHCARE ASSOCIATES	PO BOX 682708	HOUSTON	TX	77268	(800) 810-7856	
163	NATIONWIDE LIFE INSURANCE COMPANY	PO BOX 182202	COLUMBUS	OH	432182202	(614) 249-7111	
A52	NATIONWIDE SPECIALTY HEALTH CLAIMS	PO BOX 420	SPRINGFIELD	MA	01101	(800) 517-4791	
518	NAT'L ASBESTOS WORKERS MED FUND	PO BOX 188004	CHATTANOOGA	TN	37422	(800) 386-3632	
B67	NAVITUS HEALTH SOLUTIONS LLC	PO BOX 999	APPLETON	WI	549120999	(866) 268-2501	
800	NEBCO (TENNECO)	PO BOX 97	SCRANTON	PA	185040097	(800) 717-7562	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
141	NEOA HEALTH BENEFITS FUND	428 E SCOTT AVE. - PO BOX 3070	KNOXVILLE	TN	37927	-	
806	NETWORK HEALTH PLAN	PO BOX 568	MENASHA	WI	54952	(920) 720-1300	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
360	NEW ENGLAND FINANCIAL	PO BOX 190019	N. CHARLESTON	SC	29419	(800) 408-7681	USE CARRIER 859 NEW ENGLAND GROUP TRUST
859	NEW ENGLAND GROUP TRUST	PO BOX 30466	TAMPA	FL	33630	(800) 654-1731	
248	NEW ENGLAND LIFE INSURANCE	25145 COUNTRY CLUB BLVD.	NORTH OLMSTED	OH	440705300	(800) 255-8063	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
437	NEW ERA LIFE INSURANCE CO	PO BOX 4884	HOUSTON	TX	772104884	(281) 368-7200	
520	NEW JERSEY CARPENTERS	PO BOX 7818	EDISON	NJ	088180846	(800) 624-3096	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
808	NEW MARKET DIMENSION	PO BOX 1338	COCKEYVILLE	MD	21031	(800) 570-6745	
C89	NEW SOURCES BENEFITS	PO BOX 6305	SPARTANBURG	SC	29304	(800) 476-1555	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
165	NEW YORK LIFE INSURANCE COMPANY	PO BOX 105095	ATLANTA	GA	30348	(800) 388-4580	
D39	NEW YORK WELFARE FUND	101-49 WOOKHAVEN BLVD.	OZONE PARK	NY	11416	(718) 845-5800	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
685	NEWBERRY COUNTY	-	-	-	-	-	
B54	NGS AMERICAN, INC.	PO BOX 2310	CLEMENS	MI	48046	(810) 779-7676	
B97	NIPPON LIFE INSURANCE CO.	PO BOX 25951	SHAWNEE MISSION	KS	662255951	(800) 374-1835	
174	NMU PENSION & WELFARE FUND	360 WEST 31ST ST., 3RD FL	NEW YORK	NY	10001	(212) 337-4900	
350	NORTH AMERICA ADMINISTRATORS	PO BOX 1984	NASHVILLE	TN	37203	(615) 256-3561	
384	NORTH AMERICAN BENEFIT NETWORK	PO BOX 94928	CLEVELAND	OH	441014928	(800) 321-4085	
C36	NORTH AMERICAN INSURANCE COMPANY	PO BOX 44160	MADISON	WI	53744	(608) 662-1232	
359	NORTH CAROLINA MUTUAL LIFE INSURANCE	411 W. CHAPEL HILL ST.	DURHAM	NC	27701	(919) 682-9201	
594	NORWEST FINANCIAL	206 EIGHTH ST.	DES MOINES	IA	50309	(515) 243-2131	CODE ASSIGNED BY SCHA
A17	NOVA HEALTHCARE ADMINISTRATORS	2680 GRAND ISLAND BLVD.	GRAND ISLAND	NY	140720308	(800) 333-3195	
A64	NTCA (NAT'L TELECOMMUNICATIONS COOPERATIVE ASSO.)	ONE WEST PACK SQUARE STE 600	ASHEVILLE	NC	288013459	(828) 281-9000	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
170	OCCIDENTAL LIFE INSURANCE COMPANY OF NC	PO BOX 10324	RALEIGH	NC	27605	(919) 831-8189	
686	OCONEE COUNTY	-	-	-	-	-	
821	ODS HEALTH PLAN ADVANTAGE	PO BOX 4030	PORTLAND	OR	972084030	(877) 337-0650	
982	OFFICE OF GROUP BENEFITS STATE OF LOUISIANA	PO BOX 44036	BATON ROUGE	LA	708044036	(800) 272-8451	
591	OLD AMERICAN INSURANCE COMPANY	PO BOX 418573	KANSAS CITY	MO	64141	(816) 753-4900	
C37	OLD SURETY LIFE INSURANCE CO	PO BOX 54407	OKLAHOMA CITY	OK	731541407	(800) 272-5466	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
866	OLYMPIC HEALTH MANAGEMENT	PO BOX 5348	BELLINGHAM	WA	98227	(360) 734-9888	
353	ONE HEALTH PLAN OF SC	PO BOX 190019	N CHARLESTON	SC	29419	(800) 314-9010	CODE ASSIGNED BY SCHA
583	ONE NATION BENEFIT ADMINISTRATORS	PO BOX 528	COLUMBUS	OH	43216	(800) 824-6796	NAME CHANGE WAS ANTHEM BENEFIT ADMINISTRATORS
850	ONENET PPO	PO BOX 934	FREDERICK	MD	217050934	(800) 342-3289	CODE ASSIGNED BY SCHA
807	OPTIMA HEALTH PLAN	PO BOX 5028	TROY	MI	460071199	(800) 229-1199	
896	OPTIMED HEALTH PLAN	4 TERRY DR., STE. 1	NEWTOWN	PA	18940	(800) 482-8770	
891	OPTIMUM CHOICE OF THE CAROLINAS, INC.	4 TAFT CT.	ROCKVILLE	MD	20850	(800) 343-8205	
880	OPTIMUM HEALTH PARTNERS	PO BOX 2243	GREENVILLE	SC	29602	(864) 213-4992	
XYZ	OPTUM RX	PO BOX 29044	HOT SPRINGS	AR	71093	(800) 788-7871	FORMERLY PRESCRIPTION SOLUTIONS
687	ORANGEBURG COUNTY	-	-	-	-	-	
603	OTHER INDIGENT (HOSPITAL CHARITY)			SC		-	
624	OTHER SPONSOR					-	
696	OUT-OF-STATE GA	-	-	-	-	-	
697	OUT-OF-STATE NC	-	-	-	-	-	
698	OUT-OF-STATE OTHER	-	-	-	-	-	
215	OXFORD LIFE INSURANCE COMPANY	PO BOX 46518	MADISON	WI	53744	(877) 469-3073	
D26	OXFORD MEDICARE ADVANTAGE (HMO)	PO BOX 7082	BRIDGEPORT	CT	06601	(800) 234-1228	MEDICARE ADVANTAGE PLAN
394	P5 HEALTH PLAN SOLUTIONS	PO BOX 9554	SALT LAKE CITY	UT	84109	(877) 474-0605	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
771	PACIFIC FIDELITY LIFE INSURANCE CO (P.F.L.)	PO BOX 982009	N RICHLAND HILLS	TX	761828009	(817) 656-6040	USE CODE 477 MEGA LIFE
784	PACIFIC HEALTH ADMINISTRATORS	PO BOX 620123	ORLANDO	FL	328620123	(800) 776-6070	CODE ASSIGNED BY SCHA
399	PACIFIC LIFE AND ANNUITY	PO BOX 34799	PHOENIX	AZ	85067	(800) 733-2285	
254	PACIFIC MUTUAL LIFE INSURANCE COMPANY	700 NEWPORT CENTER DR.	NEWPORT BEACH	CA	92660	(800) 451-2513	
D03	PACIFIC SOURCE	PO BOX 7068	EUGENE	OR	97401	(800) 624-6052	
747	PACIFICARE	PO BOX 6099	CYPRESS	CA	90630	(866) 316-9776	CODE ASSIGNED BY SCHA
787	PACIFICARE SENIOR SUPPLEMENT PLAN	PO BOX 6072	CYPRESS	CA	906300072	(800) 851-3802	
766	PALMER & CAY/CARSWELL, INC.	PO BOX 1286	SAVANNAH	GA	31402	(912) 234-6621	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
766DN	PALMER & CAY/CARSWELL, INC.	PO BOX 1286	SAVANNAH	GA	31402	(912) 234-6621	
B29	PANAMERICAN BENEFIT SOLUTIONS	PO BOX 981644	EL PASO	TX	799981644	(800) 694-9888	WAS US NOW INSURANCE GROUP
255	PAN-AMERICAN LIFE INSURANCE COMPANY	PO BOX 981644	EL PASO	TX	79998	(800) 694-9888	
976	PARAGON BENEFITS, INC.	PO BOX 12288	COLUMBUS	GA	31917	(706) 277-6710	
293	PARAMOUNT HEALTH CARE	PO BOX 497	TOLEDO	OH	43697	(888) 891-2564	
890	PARTNERS NATIONAL HEALTH PLANS OF NORTH CAROLINA	PO BOX 17368	WINSTON-SALEM	NC	271167368	(800) 942-5695	
172	PAUL REVERE LIFE INSURANCE COMPANY	PO BOX 15118	WORCESTER	MA	016150118	(508) 799-4441	
E24	PBM PLUS	300 TECHNECENTER DR. STE. C	MILFORD	OH	45150	(800) 263-2178	
A21	PC HEALTH PLAN ADMINISTRATION	PO BOX 1377	THOMASVILLE	GA	31799	(888) 426-1937	CODE ASSIGNED BY SCHA
363	PEARCE ADMINISTRATION	PO BOX 2437	FLORENCE	SC	29503	(888) 622-6001	GM SOUTHWEST IS THE CLAIMS PROCESSOR FOR PEARCE ADMINISTRATION
538	PENN GENERAL SERVICES	PO BOX 72077	ATLANTA	GA	303581535	(800) 444-1535	CODE ASSIGNED BY SCHA
805	PENN TREATY NETWORK AMERICA (PTNA)	PO BOX 130	PENSACOLA	FL	325910130	(800) 635-7418	CODE ASSIGNED BY SCHA
182	PENN TREATY NETWORK AMERICA INS. CO.	PO BOX 7066	ALLENTOWN	PA	181057066	(800) 362-0700	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C49DN	PENN WESTERN BENEFITS, INC.	PO BOX 2000	WINSTON-SALEM	NC	27102	(800) 846-5370	
X0J	PENNSYLVANIA BLUE SHIELD	PO BOX 890089	CAMP HILL	PA	17089	(800) 637-3493	
173	PENNSYLVANIA LIFE INSURANCE COMPANY	PO BOX 130	PENSACOLA	FL	325910100	(800) 275-7366	
770	PEOPLES BENEFIT LIFE INSURANCE	PO BOX 484	VALLEY FORGE	PA	19493	(800) 523-7900	
708	PERFORMAX	PO BOX 61505	KING OF PRUSSIA	PA	19406	(888) 554-7629	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
862	PERFORMAX	300 CORPORATE PARKWAY	AMHERST	NY	11226	(877) 777-6076	
325	PERSONAL CARE	PO BOX 7141	LONDON	KY	40742	(800) 431-1211	
740	PHARMACARE	PO BOX 52188	PHOENIX	AZ	850722196	(800) 237-6184	AS OF 1/1/08 CO. MERGED WITH CAREMARK (471) ADD NEW POLICIES WITH 471

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
964	PHARMACUETICAL CARE NETWORK	9343 TECH CENTER DR.	SACRAMENTO	CA	95826	(800) 777-0074	
314	PHARMACY ADVANTAGE NETWORK	50 LENNOX POINTE	ATLANTA	GA	30324	(888) 727-5560	SEE CARRIER 366 CATALYST RX
B47	PHARMACY DATA MANAGEMENT, INC.	1170 E WESTERN RESERVE RD	POLAND	OH	44514	(800) 774-0890	
257	PHARMACY NETWORK NATIONAL OF N.C.	4000 OLD WAKEFOREST RD., STE. 101	RALEIGH	NC	27609	(800) 331-7108	SEE CARRIER 366 CATALYST RX
B33	PHARMAVAIL DRUG COMPANY	3380 TRICKHUM RD., BLDG. 400, UNIT 100	WOODSTOCK	GA	30188	(800) 933-3734	
948	PHILADELPHIA AMERICAN LIFE INS. CO.	PO BOX 2465	HOUSTON	TX	77252	(800) 552-7879	
555	PHILADELPHIA AMERICAN LIFE INSURANCE CO	PO BOX 4884	HOUSTON	TX	772104882	(800) 552-7879	CODE ASSIGNED BY SCHA
468	PHOENIX HEALTHCARE	PO BOX 150809	ARLINGTON	TX	76015	(800) 397-6241	
561	PHOENIX MUTUAL LIFE INSURANCE COMPANY	ONE AMERICAN ROW	HARTFORD	CT	06115	(800) 451-2513	THIS CARRIER PURCHASED BY CC864 GE GROUP ADMINISTRATORS
533	PHYSICIANS CARE NETWORK	PO BOX 101111	COLUMBIA	SC	292111111	(888) 323-9271	
326	PHYSICIANS HEALTH PLAN OF MID MICHIGAN	PO BOX 247	ALPHARETTA	GA	300090247	(800) 832-9186	
590	PHYSICIANS HEALTH SERVICES	PO BOX 981	BRIDGEPORT	CT	06601	(800) 848-4747	
773	PHYSICIANS MUTUAL INSURANCE COMPANY	PO BOX 2018	OMAHA	NE	681032018	(800) 228-9100	DO NOT USE THIS CODE FOR MEDICARE ADVANTAGE PLANS OFFERED BY THIS CARRIER
228	PHYSICIANS PLUS INS. CO.	PO BOX 909953	MILWAUKEE	WI	53209	(800) 545-5015	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
688	PICKENS COUNTY	-	-	-	-	-	
A22	PIEDMONT ADMINISTRATORS	PO BOX 25307	WINSTON-SALEM	PA	271145307	(800) 852-7040	
804	PIEDMONT COMMUNITY HEALTHCARE, INC.	PO BOX 14408	CINCINNATI	OH	452500408	(800) 400-7247	
434	PIEDMONT HEALTH ALLIANCE	116 BONHAM CT.	ANDERSON	SC	29621	(864) 375-9661	
487	PIEDMONT INS COMPANY	PO BOX 979	MARION	SC	29571	(843) 423-5541	
B10	PILGRIM HEALTH & LIFE INSURANCE	PO BOX 897	ATLANTA	GA	30303	(404) 659-2100	CODE IN OPEN STATUS BY SCHA
395	PINNACLE CLAIMS MANAGEMENT, INC.	1630 E SHAW AVE., STE. 190	FRESNO	CA	93710	(800) 649-9121	CODE ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
B21	PIONEER HEALTH	PO BOX 6600	HOLYOKE	MA	01041	(800) 423-4586	
792	PIONEER LIFE INSURANCE COMPANY OF ILLINOIS	PO BOX 1250	ROCKFORD	IL	611051250	(815) 987-5000	USE CODE 282 WASHINGTON NATIONAL
338	PITTMAN & ASSOCIATES, INC.	PO BOX 111047	MEMPHIS	TN	38111	(800) 238-1344	
C55	PLAN ADMINISTRATORS (MATURE AMERICAN)	734 15TH ST. NW STE. 500	WASHINGTON	DC	20005	(202) 393-6600	
276	PLAN HANDLERS	930 CANTERBURY PLACE	ESCONDIDO	CA	92025	(800) 538-5512	
886	PLANNED ADMINISTRATORS, INC.	PO BOX 6927	COLUMBIA	SC	29260	(803) 754-0041	
886DN	PLANNED ADMINISTRATORS, INC.	PO BOX 6927	COLUMBIA	SC	29260	(803) 754-0041	
706	PLUMBERS & PIPEFITTERS LOCAL NO. 421	PO BOX 840	MACON	GA	312020840	(888) 741-2673	
585	PLUMBERS & STEAMFITTERS WELFARE FUND	1024 MCKINLEY ST.	PEEKSILL	NY	10566	(914) 737-7220	
751	POLARIS BENEFIT ADMINISTRATORS	PO BOX 2010	WESTERVILLE	OH	43086-	(800) 234-0225	
751DN	POLARIS BENEFIT ADMINISTRATORS	PO BOX 1008	DELAWARE	OH	43015-	(800) 234-0225	
751RX	POLARIS BENEFIT ADMINISTRATORS	PO BOX 1008	DELAWARE	OH	43015-	(800) 234-0225	
589	POLY AMERICA LP	2000 W MARSHALL DR.	GRAND PRAIRIE	TX	75051	(800) 785-5301	CODE IN OPEN STATUS BY SCHA
391	POMCO	PO BOX 6329	SYRACUSE	NY	13217	(800) 234-4393	
385	POSTMASTERS BENEFIT PLAN	1019 N. ROYAL ST.	ALEXANDRIA	VA	22314	(703) 683-5585	
A66	PRAIRIE STATES ENTERPRISES, INC.	PO BOX 23	SHEBOYGAN	WI	530820023	(800) 815-7020	
168	PRECISE BENEFIT ADMINISTRATORS	PO BOX 9064	JERICHO	NY	11753	(516) 390-6000	
877	PRE-EXISTING CONDITION INSURANCE PLAN (PCIP)	PO BOX 300	INDEPENDENCE	MO	640510300	(800) 220-7898	
A11	PREFERRED ADMINISTRATORS	15560 NORTH FLW BLVD.	SCOTTSDALE	AZ	85260	(877) 276-7198	
486	PREFERRED CARE	PO BOX 22920	ROCHESTER	NY	146922920	(800) 999-3920	MEDICARE ADVANTAGE PLAN
347	PREFERRED CARE, INC. (PCI)	1300 VIRGINIA DR., STE. 315	FORT WASHINGTON	PA	19034	(800) 222-3085	
909	PREFERRED HEALTH ALLIANCE CORP.	PO BOX 382048	BIRMINGHAM	AL	35238	(800) 722-8477	
909DN	PREFERRED HEALTH ALLIANCE CORP.	PO BOX 382048	BIRMINGHAM	AL	35238	(205) 969-1155	
270	PREFERRED HEALTH PLAN OF THE CAROLINAS	PO BOX 220397	CHARLOTTE	NC	28222	(866) 636-0239	
303	PREFERRED HEALTH PLAN, INC.	PO BOX 24125	LOUISVILLE	KY	40224	(502) 339-7500	
933	PREFERRED HEALTHCARE SYSTEMS	620 HOWARD AVE.	ALTOONA	PA	166014899	-	CODE ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
B86	PREFERRED ONE ADMINISTRATIVE SERVICES	PO BOX 59212	MINNEAPOLIS	MN	55459	(800) 997-1750	
A43	PREMIER BENEFIT MANAGEMENT, INC.	7070-A KAIGHN AVE.	PENSAUKEN	NJ	08109	-	CODE ASSIGNED BY SCHA
939	PREMIER HEALTH SYSTEMS	PO BOX 1640	COLUMBIA	SC	292021640	(803) 296-8999	CODE ASSIGNED BY SCHA
C65	PRESBYTERIAN HEALTHCARE SERVICES	PO BOX 27489	ALBUQUERQUE	NM	87125	(800) 356-2219	
397	PRIME THERAPEUTIC	PO BOX 25136	LEHIGH VALLEY	PA	18002	(800) 423-1973	
844	PRIME TIME HEALTH PLAN	PO BOX 6905	CANTON	OH	44706	(800) 617-7446	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A42	PRIMERICA LIFE INSURANCE COMPANY	3120 BRECKINRIDGE BLVD.	DULUTH	GA	30199	(404) 381-1000	
479	PRIMEXTRA	PO BOX 1088	TWINSBURG	OH	44087	(800) 433-4893	
942	PRINCIPAL FINANCIAL GROUP	PO BOX 10357	DES MOINES	IA	503060357	(800) 247-4695	
817	PRIORITY HEALTH	PO BOX 232	GRAND RAPIDS	MI	49501	(800) 446-5674	
940	PRIVATE HEALTH CARE SYSTEMS (PHCS)	PO BOX 2914	DES PLAINES	IL	600172914	(800) 531-7662	CODE ASSIGNED BY SCHA 6/18/07
B35	PROCARE RX PBM	1267 PROFESSIONAL PARKWAY	GAINSVILLE	GA	30507	(800) 699-3542	
578	PROFESSIONAL ADMINISTRATORS, INC.	3751 MAGUIRE BLVD., STE. 100	ORLANDO	FL	32814	(800) 741-0521	
965	PROFESSIONAL BENEFIT ADMINISTRATORS, INC. (PBA)	PO BOX 4687	OAKBROOK	IL	605223755	(630) 655-3755	
A20	PROFESSIONAL CLAIMS MANAGEMENT	PO BOX 35276	CANTON	OH	443155276	(800) 325-8424	
A20DN	PROFESSIONAL CLAIMS MANAGEMENT	PO BOX 35276	CANTON	OH	443155276	(800) 325-8424	
316	PROFESSIONAL INSURANCE CORPORATION	2610 WYCLIFF RD.	RALEIGH	NC	27607	(800) 289-1122	
E102	PROTECTIVE LIFE INSURANCE	PO BOX 12687	BIRMINGHAM	AL	35202	(205) 268-7055	CANCER POLICY ONLY
534	PROVANTAGE PRESCRIPTION BENEFIT MANAGEMENT SERVICE	PO BOX 1662	WAUKEHA	WI	53187	(262) 784-4600	
A92	PROVIDENT AMERICAN LIFE & HEALTH INS.	PO BOX 29158	SHAWNEE MISSION	KS	66201915	(800) 753-5133	
485	PROVIDENT HEALTH PLAN	PO BOX 3125	PORTLAND	OR	972083125	(800) 628-3912	CODE ASSIGNED BY SCHA
381	PROVIDENT INDEMNITY LIFE INSURANCE COMPANY	PO BOX 511	NORRISTOWN	PA	19404	(800) 519-9175	
110RX	PROVIDENT/CAREMARK	PO BOX 686005	SAN ANTONIO	TX	78268	(800) 841-5550	USE CODE 280 CAREMARK
328	PROVIDER SELECT, INC.	PO BOX 330070	FORT WORTH	TX	76163	(866) 774-7766	CODE NOT REQUESTED BY

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
							MEDICAID. SCHA ASSIGNED
111	PRUDENTIAL INSURANCE COMPANY OF AMERICA	841 PRUDENTIAL DR.	JACKSONVILLE	FL	32207	(800) 346-3778	THIS CARRIER BOUGHT OUT BY AETNA CC100
251	PYRAMID LIFE INSURANCE CO.	PO BOX 12922	PENSACOLA	FL	325912922	(800) 658-1413	CODE IN OPEN STATUS BY SCHA MEDICARE SUPPLEMENTAL PLAN G
D28	PYRAMID LIFE INSURANCE CO (PFFS)	PO BOX 958465	LAKE MARY	FL	327958465	(407) 628-1776	MEDICARE ADVANTAGE PLAN
230	PYRAMID LIFE INSURANCE COMPANY	PO BOX 772	SHAWNEE MISSION	KS	66201	(800) 444-0321	
221	QUAL CARE	PO BOX 249	PISCATHAWAY	NJ	08855	(800) 992-6613	
A85	QUALCHOICE	PO BOX 25610	LITTLE ROCK	AR	722219914	(800) 235-7111	
A48	QUALMED OF OREGON	PO BOX 286	CLACKMAS	OR	970150286	(800) 568-5628	DORMANT 8/06
X0KRS	REGENCE BCBS OF OREGON	PO BOX 12625 MAILSTOP S4P	SALEM OREGON	OR	97309	(888) 437-1508	RX PLAN ONLY MM CODE X0K
X0KRX	REGENCE BCBS OF OREGON	PO BOX 12625 MAILSTOP S4P	SALEM	OR	97309	(888) 437-1508	
XOKRX	REGENCE BCBS OF OREGON RX PLAN	PO BOX 12625 MAILSTOP S4P	SALEM	OR	97309	(888) 437-1508	RX PLAN ONLY MM PLAN IS X0K
X0K	REGENCE BLUE CROSS BLUE SHIELD OF OREGON	PO BOX 1271	PORTLAND	OR	97207	(503) 225-5221	
795	REGIONAL MEDICAL ADMINISTRATORS, INC.	PO BOX 4128	GLEN RAVEN	NC	272150901	(336) 226-7950	
187	RELIANCE STANDARD LIFE INS. CO.	PO BOX 82510	LINCOLN	NE	68501	(800) 497-7044	
197	RELIANCE STANDARD SPECIALTY PRODUCTS ADM	505 S LENOLA RD., STE. 231	MOORESTOWN	NJ	08057	(866) 375-0775	
B19	RENAISSANCE DENTAL	PO BOX 17250	INDIANAPOLIS	IN	46217	(888) 358-9484	
296	RESERVE NATIONAL INSURANCE	PO BOX 26620	OKLAHOMA CITY	OK	73126	(800) 654-9106	
375	RESTAT	11900 WESTLAKE PARK DR.	MILWAUKEE	WI	53224	(800) 926-5858	
A95	REYNOLDS & REYNOLDS	PO BOX 1272	DAYTON	OH	45401	(800) 736-3539	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
689	RICHLAND COUNTY	-	-	-	-	-	
398	RIGHT CHOICE BENEFITS ADMINISTRATORS	12250 WEBER HILL RD., STE. 100	ST. LOUIS	MO	63127	(800) 365-9036	CODE ASSIGNED BY SCHA
214	RISK BENEFIT MANAGEMENT SERVICES, LLC (RBMS)	PO BOX 241569	ANCHORAGE	AK	99524	(800) 770-3740	
546	RISK MANAGEMENT SERVICES	PO BOX 6309	SYRACUSE	NY	13217	(315) 448-9000	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
A30	RMSCO, INC.	PO BOX 678	LIVERPOOL	NY	130880678	(877) 204-7086	
A30DN	RMSCO, INC.	PO BOX 678	LIVERPOOL	NY	130880678	(877) 204-7086	
218	ROCKY MOUNTAIN HEALTH PLAN (RMHP)	PO BOX 4517	ENGLEWOOD	CO	80155	(888) 479-2000	
278	ROCKY MOUNTAIN HEALTH PLAN	PO BOX 10600	GRAND JUNCTION	CO	81502	(800) 854-4558	
762	ROYAL NEIGHBORS OF AMERICA	PO BOX 10850	CLEARWATER	FL	337578850	(877) 815-8857	CODE ASSIGNED BY SCHA
406	RURAL CARRIER BENEFIT PLAN	PO BOX 7404	LONDON	KY	40742	(800) 638-8432	
A09	RX AMERICA	221 N CHARLES LINDBERG DR.	SALT LAKE CITY	UT	84116	(800) 770-8014	
B89	RXEDO	7800 DALLAS PARKWAY STE 460	PLANO	TX	75024	(888) 879-7336	
C44	S C MEDICAL ASSOCIATION-MEMBERS INSURANCE TRUST	PO BOX 6927	COLUMBIA	SC	29260	(803) 798-6207	
185	S&S HEALTHCARE STRATEGIES	PO BOX 46511	CINCINNATI	OH	45216	(888) 800-8717	
410	SAFECO INSURANCE COMPANY	PO BOX 34699	REDMOND	WA	981241699	(206) 867-8000	
690	SALUDA COUNTY	-	-	-	-	-	
570	SAMBA HEALTH BENEFIT PLAN	11301 OLD GEORGETOWN RD	ROCKVILLE	MD	20852	(800) 638-6589	
231	SAVERS LIFE INSURANCE COMPANY	8064 NORTH POINT BLVD., STE. 201	WINSTON-SALEM	NC	27106	(800) 642-0483	
489	SAVRX	PO BOX 8	FREEMONT	NE	68026	(800) 350-6714	
142	SC DEPT OF DISABILITIES AND SPECIAL NEEDS	PO BOX 4706	COLUMBIA	SC	29240	(803) 898-9795	CODE ASSIGNED BY SCHA
E91	SCOTT AND WHITE HEALTH PLAN	PO BOX 21800	EAGAN	MN	55121	(800) 321-7947	
C20	SCREEN ACTORS GUILD-PRODUCERS HEALTH PLAN	PO BOX 7830	BURBANK	CA	915107830	(800) 777-4013	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
846	SCRIPT CARE, INC.	6380 FOLSOM DR.	BEAUMONT	TX	77706	(800) 880-9988	
435	SEABURY AND SMITH COMPANY, INC.	PO BOX 2545	NASHVILLE	TN	37219	(800) 582-2498	
818	SEAFARERS HEALTH & BENEFIT PLAN (SHBP)	PO BOX 380	PINEY POINT	MD	20674	(800) 252-4674	
596	SECURE HORIZONS	PO BOX 659787	SAN ANTONIO	TX	782659787	(866) 579-8811	MEDICARE ADVANTAGE PLAN
D62	SECURE HORIZONS DIRECT (UNITED HEALTHCARE)	PO BOX 31353	SALT LAKE CITY	UT	84131	(866) 579-8774	MEDICARE ADVANTAGE PLAN
D27	SECURE HORIZONS PACIFICARE	PO BOX 25032	SANTA ANA	CA	927995032	(714) 825-3828	MEDICARE ADVANTAGE PLAN

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
D12	SECUREHORIZONS DIRECT PFFS	PO BOX 12466	PENSACOLA	FL	325912466	(888) 202-4340	MEDICARE ADVANTAGE PLAN
865	SECURIAN DENTAL PLANS	PO BOX 9385	MINNEAPOLIS	MN	554409385	(800) 234-9009	NAIC 93742
184	SECURITY LIFE INSURANCE CO. OF AMERICA	PO BOX 3199	WINSTON-SALEM	NC	27102	(800) 300-9566	
D15	SECURITYCHOICE ENHANCED PLUS	PO BOX 795180	SAN ANTONIO	TX	78279	(888) 445-8916	MEDICARE ADVANTAGE PLAN
C27	SELECT BENEFIT ADMINISTRATORS	PO BOX 3245	MILWAUKEE	WI	53201	(800) 497-3699	
C27DN	SELECT BENEFIT ADMINISTRATORS	PO BOX 440	ASHLAND	WI	54806	(800) 497-3699	
E81	SELECT ADMINISTRATIVE SERVICES (SAS)	PO BOX 3209	GULFPORT	MS	39503	(800) 847-6621	
B48	SELECT HEALTH	PO BOX 30192	SALT LAKE CITY	UT	84123	(800) 538-5038	
E37	SELECT HEALTH	PO BOX 7120	LONDON	KY	40742	(888) 276-2020	HEALTHY KIDS CONNECTION
883	SELECT HEALTH OF SOUTH CAROLINA, INC.	7410 NORTHSIDE DR. STE. 208	CHARLESTON	SC	29420	(843) 569-1759	CODE IN OPEN STATUS BY SCHA
637	SELECT HEALTH/FIRST CHOICE	PO BOX 7120	LONDON	KY	40742	(888) 276-2020	MEDICAID HMO
392	SELF FUNDED GROUP INSURANCE ADMINISTRATORS	PO BOX 1719	KALAMAZOO	MI	490051790	(800) 342-1895	
204	SELF INSURED BENEFIT ADMINISTRATORS	18167 US HWY 19N	CLEARWATER	FL	33764	(727) 532-0400	
229	SELF INSURED PLANS LLC	1016 COLLIER CENTER WAY STE. 200	LOS ANGELES	CA	90080	(800) 421-2342	CODE ASSIGNED BY SCHA
378	SELF INSURERS SERVICE, INC.	2218 SOUTH PRIEST DR.	TEMPE	AZ	85282	-	
744	SENIOR DIMENSIONS	PO BOX 15645	LAS VAGAS	NV	891145645	(800) 925-7455	
930	SENTRY LIFE INSURANCE COMPANY	PO BOX 8025	STEVENS POINT	WI	54481	(800) 426-7234	
A23	SERV U PRESCRIPTION	PO BOX 26096-0096	MILWAUKEE	WI	53226	(800) 759-3203	
D10	SEVEN CORNERS, INC.	PO BOX 3430	CARMEL	IN	46082	(866) 699-4186	
235	SHAW INDUSTRIES	PO BOX 10	DALTON	GA	30722	(800) 321-1855	
490	SHEET METAL LOCAL 20	PO BOX 42489	INDIANAPOLIS	IN	43242	(800) 248-2141	CODE ASSIGNED BY SCHA
A28	SHENANDOAH LIFE INSURANCE CO	PO BOX 12847	ROANOKE	VA	24029	(800) 848-5433	
838	SHESFIELD, OLSON & MCQUEEN	PO BOX 16608	ST. PAUL	MN	55116	(888) 330-8408	
631	SHRINERS	-	-	-	-	-	
208	SIEBA, LTD	PO BOX 5000	ENDICOTT	NY	13761	(800) 252-4624	
D53	SIERRA OPTIMA PLUS CLAIMS	PO BOX 15645	LAS VEGAS	NV	891145645	(888) 274-2207	MEDICARE ADVANTAGE PLAN

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
E97	SIGNATURE CARE	PO BOX 5548	FORT WAYNE	IN	46895	(800) 666-4449	
C87	SIHO INSURANCE SERVICES	PO BOX 1787	COLUMBUS	IN	47202	(800) 873-2022	
E82	SIMPLE BENEFIT PLANS	2810 PREMIER PARKWAY STE. 400	DULUTH	GA	30097	(800) 270-4158	
568	SIMPLIFI	PO BOX 922043	HOUSTON	TX	772922043	(888) 446-5710	FORMERLY CBCA ADMINISTRATORS
B95	SINCLAIR HEALTH SERVICES	PO BOX 30827	SALT LAKE CITY	UT	84130	(888) 800-2230	
576	SIOUX VALLEY HEALTH	PO BOX 91110	SIOUX FALLS	SD	57109	(800) 752-5863	
A77	SISCO	PO BOX 389	DUDUQUE	IA	52004	(800) 457-4725	
D22	SMART VALUE (BC OF GA) (PFFS)	PO BOX 3897	SCRANTON	PA	18505	(866) 865-9329	MEDICARE ADVANTAGE PLAN
478	SMITH ADMINISTRATORS	PO BOX 163289	FORT WORTH	TX	76161	(800) 867-2582	
298	SMITH PREMIERE PHARMACY PLAN	PO BOX 5824	SPARTANBURG	SC	29304	(800) 247-4526	
329	SMITHFIELD FOODS HEALTHCARE	PO BOX 158	SMITHFIELD	VA	23431	(800) 809-5916	
D82	SOLSTICE	PO BOX 14009	LEXINGTON	KY	40512	(877) 760-2247	
B06	SOUTHCARE HEALTHCARE PREFERRED	1100 CIRCLE 75 PARKWAY, STE 1400	ATLANTA	GA	30339	(800) 470-2004	
A87	SOUTHEAST COMMUNITY CARE (ARCADIAN HEALTH)	PO BOX 4946	COVINA	CA	91723	(800) 573-8597	
D43	SOUTHEAST COMMUNITY CARE BY ARCADIAN HEALTH	PO BOX 4946	COVINA	CA	91723	(800) 573-8597	MEDICARE ADVANTAGE PLAN
888	SOUTHEASTERN BENEFIT PLANS, INC.	335 ARCHDALE DR.	CHARLOTTE	NC	282174246	(704) 529-5400	
C48	SOUTHERN ADMINISTRATIVE SERVICES	PO BOX 8069	COLUMBUS	GA	31908	(800) 426-8803	
897	SOUTHERN BENEFIT ADM.	PO BOX 188006	CHATTANOOGA	TN	37422	(800) 678-4656	
897DN	SOUTHERN BENEFITS ADMINISTRATORS DENTAL	5305 VIRGINIA BEACH BLVD.	NORFOLK	VA	23502	(757) 461-8091	
B30	SOUTHERN BENEFITS, SOUTHEASTERN PIPE TRADERS	PO BOX 1449	GOODLETTSVILLE	TN	370701449	(800) 831-4914	
D06	SOUTHERN CALIFORNIA BAKERY & CONFECTIONARY	PO BOX 22041	COMMERCE	CA	90022	(323) 722-7171	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B73	SOUTHERN CALIFORNIA PIPE TRADES TRUST FUND	501 SHATTO PLACE, 5TH FLOOR	LOS ANGELES	CA	90020	(213) 385-6161	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
224	SOUTHERN ELEC. HEALTH FUND	3928 VOLUNTEER DR.	CHATTANOOGA	TN	37416	(423) 899-2593	
B57	SOUTHERN FARM BUREAU LIFE INS. CO.	PO BOX 78	JACKSON	MS	39205	(800) 457-9611	
990	SOUTHERN GROUP ADMINISTRATORS, INC.	200 SOUTH MARSHALL ST.	WINSTON-SALEM	NC	27101	(800) 334-8159	
B52	SOUTHERN PLANNED ADMINISTRATORS	PO BOX 218180	HOUSTON	TX	77218	(281) 829-1033	
186	SOUTHLAND LIFE INSURANCE COMPANY	PO BOX 105006	ATLANTA	GA	303485006	(770) 980-5100	
691	SPARTANBURG COUNTY	-	-	-	-	-	
811	SPARTANBURG REGIONAL HEALTHCARE SYSTEM	PO BOX 1000	LANCASTER	SC	29721	-	CODE ASSIGNED BY SCHA
A89	SPECIAL INSURANCE SERVICES (SIS)	PO BOX 250349	PLANO	TX	750250349	(800) 767-6811	CODE ASSIGNED BY SCHA
736	SPECTERA	2811 LORD BALTIMORE DR.	BALTIMORE	MD	212442644	(800) 638-3120	
741	SPENCER & ASSOCIATES INS.	1 S. LIMESTONE ST. STE 301	SPRINGFIELD	OH	45502	(866) 766-9016	CODE ASSIGNED BY SCHA
573	ST JOHN'S CLAIMS ADMINISTRATION	PO BOX 14409	SPRINGFIELD	MO	65814	(877) 875-7700	
512	ST11-STRATEGIC HEALTH	9501 NE 2ND AVE.	MIAMI SHORES	FL	33138	-	CODE ASSIGNED BY SCHA
A46	STANDARD INSURANCE COMPANY	PO BOX 82622	LINCOLN	NE	68501	(503) 321-7000	
C42	STANDARD CORPORATION	1400 MAIN ST. STE 1300	COLUMBIA	SC	29201	(803) 771-6785	
C38	STANDARD LIFE & ACCIDENT INSURANCE COMPANY	PO BOX 1800	GALVESTON	TX	775531800	(888) 350-1488	
188	STANDARD LIFE & CASUALTY INSURANCE COMPANY	PO DRAWER 1514	FORT MILL	SC	29716	(803) 548-3657	
307	STANDARD SECURITY LIFE INS. CO OF NEW YORK	PO BOX 828	PARK RIDGE	IL	60068	(866) 513-1479	
B74	STAR HRG	PO BOX 54150	PHOENIX	AZ	850784150	(800) 288-1474	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
240	STARBRIDGE	PO BOX 55270	PHOENIX	AZ	85078	(800) 308-5948	POLICIES BEGINNING WITH"R" NEED TO BE "E" INDICATORS AND GO TO PO BOX 188004, CHATTANOOGA, TN 37422 POLICIES WITH PH SSN STAYS AS "C".
952	STARK TRUSS CO., INC.	PO BOX 2080C	STOW	OH	44224	(800) 456-4002	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A03	STARMARK	PO BOX 2942	CLINTON	IA	52733	(800) 522-1246	THIS CARRIER HANDLES GROUPS WITH LESS THAN 50

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
							EMPLOYEES. SEE CC212 FOR GROUPS OVER 50 EMPLOYEES.
400	STATE EMPLOYEES HEALTH PLAN BLUE CROSS	4101 PERCIVAL RD.	COLUMBIA	SC	29219	(800) 868-2520	CLAIMS SHOULD BE SENT TO THE ATTN OF SARAH TOWNES AX-B10
373	STATE FARM INSURANCE COMPANIES	7401 CYPRESS GARDENS BLVD.	WINTER HAVEN	FL	338880007	(863) 318-3000	
147	STATE MUTUAL INSURANCE	PO BOX 10811	CLEARWATER	FL	337578811	(888) 780-6388	
B60	STATE MUTUAL LIFE ASSURANCE COMPANY OF AMERICA	1100 31ST ST.	DOWNERS GROVE	IL	60515	(800) 323-3359	CODE IN OPEN STATUS BY SCHA
B83	STATE OF LOUISIANA EMPLOYEES	PO BOX 44036	BATON ROUGE	LA	70804	(800) 272-8451	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A91	STATES GENERAL LIFE INS. CO	115 WEST 7TH ST., STE. 1200	FORT WORTH	TX	761027012	(800) 782-8375	
A47	STATESMAN NATIONAL LIFE INSURANCE COMPANY	3815 MONTROSE BLVD.	HOUSTON	TX	77006	(713) 526-6000	
244	STERLING INVESTORS LIFE INS. CO.	PO BOX 10844	CLEARWATER	FL	337578844	(877) 604-5240	
233	STERLING LIFE INSURANCE	PO BOX 5348	BELLINGHAM	WA	98227	(800) 688-0010	
645	STERLING MEDICARE CHOICE HMO	PO BOX 70	LINTHIEUM	MD	21900	(615) 244-5600	MEDICARE ADVANTAGE PLAN
140	STERLING OPTION I (PFFS)	PO BOX 5348	BELLINGHAM	WA	982270010	-	MEDICARE ADVANTAGE PLAN
374	STONEBRIDGE LIFE INSURANCE CO.	2700 W. PLANO PARKWAY	PLANO	TX	75075	(800) 331-9955	
714	STOWE ASSOCIATES	2872 WOODCOCK BLVD. #200	ATLANTA	GA	30341	(800) 533-7896	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
734	STRATEGIC OUTBURSTING, INC.	PO BOX 241508	CHARLOTTE	NC	28224	(888) 836-7764	CODE NOT REQUESTED BY MEDICAID ASSIGNED BY SCHA
C05	STRATEGIC OUTSOURCING, INC. (SOI)	PO BOX 241508	CHARLOTTE	NC	28224	(888) 836-7764	
A40	STRATEGIC RESOURCE COMPANY	PO BOX 14079	LEXINGTON	KY	40512	(888) 772-9682	
C93	STUDENT ASSURANCE INSURANCE SERVICES	PO BOX 196	STILL WATER	MN	55085	(800) 328-2739	
A61	SUMMACARE HEALTH PLAN	PO BOX 3620	AKRON	OH	743893628	(800) 996-8701	
209	SUMMIT AMERICA INSURANCE SERVICES	PO BOX 25936	OVERLAND PARK	KS	662255936	(877) 246-6997	
692	SUMTER COUNTY	-	-	-	-	-	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
342	SUN LIFE INSURANCE COMPANY OF CANADA	ONE SUN LIFE EXECUTIVE PARK	WELLESLEY	MA	02181	(800) 225-3950	
861	SUPERIOR ESSEX	PO BOX 724907	ATLANTA	GA	31139	(877) 291-7920	
C45	TALL TREE ADMINISTRATORS	PO BOX 71747	SALT LAKE CITY	UT	841710747	(877) 453-4201	
C19	TAYLOR BENEFIT RESOURCES, INC.	PO BOX 6580	THOMASVILLE	GA	31758	(888) 352-5246	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
712	TDI MANAGED CARE SERVICES	620 EPSILON DR.	PITTSBURG	PA	15238	(800) 581-5300	CARRIER BOUGHT OUT BY PHARMACARE CC 740
C50	TENNESSEE BENEFIT ADMINISTRATORS	PO BOX 3257	SPARTANBURG	SC	29304	-	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C01	TERMINIX SERVICE	PO BOX 2627	COLUMBIA	SC	29202	(803) 772-1783	CODE ASSIGNED BY SCHA
497	TEXAS INTERNATIONAL	PO BOX 11007	WINSTON-SALEM	NC	27116	(866) 307-4711	
B94	THE CAPELLA GROUP	PO BOX 200368	ARLINGTON	TX	76006	(888) 411-3888	
C33	THE DESTINY HEALTH PLAN	PO BOX 4628	OAKBROOK	IL	60522	(866) 826-9345	
269	THE EPOCH GROUP	PO BOX 12170	OVERLAND PARK	KS	66212	(800) 255-6065	
785	THE HARVEST INSURANCE CO.	PO BOX 956003	LAKE MARY	FL	327950856	(800) 253-0856	CODE ASSIGNED BY SCHA
E43	THE HEALTH PLAN INSURANCE CO.	52160 NATIONAL RD. EAST	ST. CLAIRSVILLE	OH	43950	(740) 699-6273	
763	THE PROVIDENT	PO BOX 31499	TAMPA	FL	33631	(800) 525-7268	
B28	THE STANDARD	PO BOX 82622	LINCOLN	NE	68501	(800) 547-9515	
542	THIRD PARTY ADMINISTRATORS/AMERICAN BENEFIT	1733 PARK ST.	NAPERVILLE	IL	60563	(800) 631-5917	
315	THOMAS COOPER AND COMPANY	PO BOX 22557	CHARLESTON	SC	29413	(843) 722-2115	
315DN	THOMAS COOPER AND COMPANY	PO BOX 22557	CHARLESTON	SC	29413	(843) 722-2115	
A01	THRIVENT FINANCIAL FOR LUTHERANS	4341 N. BALLARD RD.	APPLETON	WI	54919	(800) 847-4836	
463	TIM BAR CORP	PO BOX 449	HANOVER	PA	17331	(717) 632-4727	
322	TIME INSURANCE COMPANY	PO BOX 981602	EL PASO	TX	799980624	(800) 553-7654	USE 386 ASSURANT HEALTH
265	TODAY'S OPTION	PO BOX 391883	CAMBRIDGE	MA	02139	(866) 222-5137	MEDICARE ADVANTAGE PLAN
797	TODAY'S OPTIONS UNIVERSAL AMERICAN	PO BOX 742528	HOUSTON	TX	77274	(866) 422-5009	MEDICARE ADVANTAGE PLAN
E46	TOLEDO FIREFIGHTERS HEALTH PLAN	PO BOX 5810	TROY	MI	480075810	(419) 255-5314	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
755	TOTAL BENEFIT SERVICES, INC.	PO BOX 30180	NEW ORLEANS	LA	70190	-	
D69	TOTAL CARE/HEALTHSPRING	PO BOX 20000	NASHVILLE	TN	372024070	(800) 743-7141	MEDICARE ADVANTAGE PLAN
D55	TOTAL CAROLINA CARE, INC.	1441 MAIN ST.	COLUMBIA	SC	29210	(866) 433-6031	MEDICAID HMO
B40	TOTAL CLAIMS SOLUTION (TCS)	PO BOX 10888	GREEN BAY	WI	543070888	(800) 376-0110	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B46	TOTAL CLAIMS SOLUTION (TCS)	PO BOX 10888	GREEN BAY	WI	54307	(800) 376-0110	
C03	TOTAL PLAN SERVICES, INC.	PO BOX 251369	PLANO	TX	75025	(800) 969-5238	
A80	TOTAL SCRIPT	10901 WEST 120TH AVE. STE 110	BROOMFIELD	CO	80021	(800) 752-2211	
D47	TOUCHSTONE HEALTH PSO	PO BOX 33519	INDIANAPOLIS	IN	462030519	(888) 777-0204	MEDICARE ADVANTAGE PLAN
A76	TOWER LIFE INS. CO.	310 S. MARY ST.	SAN ANTONIO	TX	78205	(800) 660-6077	
X3B	TPA EXCHANGE	PO BOX 4363	ST AUGUSTINE	FL	32085	(888) 502-2789	
C52	TPA OF GEORGIA	4574 LAWRENCEVILLE HWY, STE 201	LILBURN	GA	30047	(770) 451-7550	
788	TRANSAMERICA LIFE INSURANCE CO.	PO BOX 97	SCRANTON	PA	185040097	(800) 820-3372	CODE ASSIGNED BY SCHA
856	TRANSAMERICA OCCIDENTAL LIFE	PO BOX 2101 TERMINAL ANNEX	LOS ANGELES	CA	90051	(213) 742-2111	
112	TRAVELERS INSURANCE COMPANY	PO BOX 473500	CHARLOTTE	NC	282473500	(704) 544-3665	USE CODE 113 UNITED HEALTHCARE INACTIVE 8-02
642	TRICARE FOR LIFE	PO BOX 7890	MADISON	WI	537077890	(866) 773-0404	
819	TRICARE OVERSEAS PROGRAM	PO BOX 7985	MADISON	WI	537077985	(800) 982-6257	CODE ASSIGNED BY SCHA 6/07/10
614	TRICARE SOUTH REGION	PO BOX 7031	CAMDEN	SC	290217031	(800) 403-3950	INTERNET WWW.MYTRICARE.COM
E73	TRISTAR BENEFIT ADMINISTRATORS	PO BOX 65887	WEST DES MOINES	IA	50265	(800) 456-4584	
C29	TRUE CHOICE USA	PO BOX 251369	PLANO	TX	75025	(800) 251-9665	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
E42	TRUE RX	4 WILLIAMS BROTHERS DR.	WASHINGTON	IN	47501	(866) 921-4047	
E95	TRUESCRIPTS	PO BOX 921	WASHINGTON	IN	47501	(844) 257-1955	RX
212	TRUSTMARK INSURANCE CO.	PO BOX 2942	CLINTON	IA	52733	(847) 615-1500	USE THIS CARRIER FOR GROUPS WITH MORE THAN 50

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
							EMPLOYEES. USE CCA03 FOR GROUPS LESS THAN 50 EMPLOYEES
703	TUCKER COMPANY & ADMINISTRATORS	9140 ARROW POINT BLVD. #200	CHARLOTTE	NC	282738102	(704) 525-9666	
B85	TUFTS HEALTHCARE	PO BOX 9185	WATERTOWN	MA	02471	(800) 423-8080	
376	TUFTS HEATH PLAN	PO BOX 9171	WATERTOWN	MA	024719171	(800) 462-0224	
729	U.A. LOCAL 446 PLUMBERS AND PIPEFITTERS	PO BOX 191030	SACRAMENTO	CA	958191030	(916) 457-0821	CODE IN OPEN STATUS BY SCHA
261	UICI ADMINISTRATORS	PO BOX 30087	RENO	NV	895203087	(800) 315-3440	
B17	ULTRA BENEFITS	PO BOX 763	WESTBORO	MA	01581	(866) 858-7223	
143	UMR	PO BOX 30541	SALT LAKE CITY	UT	841300541	(800) 826-9781	
356	UMR	PO BOX 2697	WICHITA	KS	67201	(800) 826-9781	USE CODE 139
812	UMR	PO BOX 30541	SALT LAKE CITY	UT	841300541	(800) 826-9781	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
139DN	UMR	PO BOX 30541	SALT LAKE CITY	UT	84130	(800) 826-9781	WAS WAUSAU INS. CO.
143DN	UMR	PO BOX 30541	SALT LAKE CITY	UT	841300541	(800) 826-9781	
B42	UMR	PO BOX 266	ONALASKA	WI	546568764	(800) 236-8672	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
967	UNDERWRITERS SAFETY AND CLAIMS	PO BOX 23507	LOUISVILLE	KY	40223	(800) 678-1536	
701	UNI-CARE CHOICE HEALTH BENEFITS	PO BOX 51130	SPRINGFIELD	MA	01151	(800) 288-8630	
160DN	UNICARE HEALTH AND LIFE INSURANCE	PO BOX 659444	SAN ANTONIO	TX	75265	(877) 217-9677	
160	UNI-CARE HEALTH AND LIFE INSURANCE CO	PO BOX 4458	CHICAGO	IL	606804458	(877) 217-9677	WAS MASS MUTUAL
D29	UNICARE LIFE & HEALTH INS. CO (PFFS)	233 S WACKER DR. STE. 3900	CHICAGO	IL	68606	(312) 324-7000	MEDICARE ADVANTAGE PLAN
556	UNIFIED GROUP SERVICES	PO BOX 10	PENDLETON	IN	46064	(765) 778-1535	
566	UNIFIED GROUP SERVICES	PO BOX 10	PENDLETON	IN	46064	(765) 778-1535	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
E45	UNIFIED LIFE INSURANCE	PO BOX 25326	OVERLAND	KS	662255326	(913) 685-2233	
517	UNIFORM MEDICAL PLAN	PO BOX 34850	SEATTLE	WA	98124	(800) 762-6004	CODE NOT REQUESTED BY

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
							MEDICAID. ASSIGNED BY SCHA
195	UNION BANKERS INSURANCE COMPANY	PO BOX 655433	DALLAS	TX	752655433	(214) 954-7840	
693	UNION COUNTY	-	-	-	-	-	
501	UNION FIDELITY INSURANCE COMPANY	4850 ST. RD.	TREVOSE	PA	19049-	(800) 523-6599	
306	UNION LABOR LIFE INSURANCE	111 MASSACHUSETTS AVE., NW	WASHINGTON	DC	20001	(800) 443-8087	
C73	UNION PACIFIC RAILROAD EMPLOYEES HEALTH	795 NORTH 400 WEST	SALT LAKE	UT	84103	(800) 547-0421	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
439	UNION SECURITY INSURANCE CO	PO BOX 981602	EL PASO	TX	79998	(800) 444-6254	USE 386 ASSURANT HEALTH
E38	UNISON HEALTH PLAN	250 BERRYHILL RD.	COLUMBIA	SC	29210	(803) 798-5852	HEALTHY KIDS CONNECTION
638	UNISON HEALTH PLAN HMO	250 BERRYHILL RD.	COLUMBIA	SC	29210	(803) 798-5852	MEDICAID HMO
449	UNITED SERVICE ASSO. FOR HEALTHCARE	PO BOX 6080-288	MISSION VAIEJO	CA	926906080	(800) 872-1187	CODE ASSIGNED BY SCHA
277	UNITED AMERICAN INSURANCE COMPANY	PO BOX 8080	MCKINNEY	TX	750708080	(972) 529-5085	
871	UNITED BEHAVIORAL HEALTH	PO BOX 169053	DULUTH	MN	55816	(800) 877-6003	CODE ASSIGNED BY SCHA
A37	UNITED BEHAVIORAL/DENTAL SYSTEMS	PO BOX 30755	SALT LAKE CITY	UT	84130	(800) 557-5745	
196	UNITED BENEFIT LIFE INSURANCE	3909 HULEN ST.	FT. WORTH	TX	76107	(800) 732-0657	
565	UNITED BENEFITS	PO BOX 2480	DAYTONA BEACH	FL	321152480	(800) 434-4890	WAS POE & BROWN
103	UNITED CLAIMS SOLUTIONS	10835 N. 25TH AVE. 105	PHOENIX	AZ	85029	(866) 744-8482	CODE ASSIGNED BY SCHA
124	UNITED COMMERICAL TRAVELERS OF AMERICA	PO BOX 159019	COLUMBUS	OH	43215	(800) 848-0123	
737	UNITED CONCORDIA	PO BOX 69421	HARRISBURG	PA	17106	(800) 332-0366	
794	UNITED FAMILY LIFE INSURANCE COMPANY	PO BOX 2204	ATLANTA	GA	30371	(404) 659-3300	
704	UNITED FOOD & COMMERICAL WORKERS (UFCW)	1800 PHOENIX BLVD. STE. 310	ATLANTA	GA	30349	(800) 241-7701	
421	UNITED FOOD & COMMERICAL WORKER HEALTH&WELFARE	911 RIDGEBROOK RD	SPARKS	MD	211529451	(800) 638-2972	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
340	UNITED HEALTHCARE PLAN OF RIVER VALLEY	3800 23RD AVE. OF THE CITIES, STE. 200	MOLINE	IL	61265	(800) 224-6602	THIS COMPANY BOUGHT OUT JOHN DEERE INS. CO. 6/29/07
715	UNITED HEALTH & LIFE INSURANCE COMPANY	PO BOX 169050	DULUTH	MN	558168200	(800) 526-2414	USE CC113 UNITED HEALTHCARE

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
E90	UNITED HEALTH (MEDICARE SOLUTIONS)	PO BOX 30436	SALT LAKE CITY	UT	84130	(877) 842-3210	MEDICARE ADVANTAGE
584	UNITED HEALTH ONE	PO BOX 31374	SALT LAKE CITY	UT	841310374	(800) 657-8205	FORMALLY GOLDEN RULE
113	UNITED HEALTHCARE	PO BOX 740800	ATLANTA	GA	303740800	(877) 842-3210	
113DN	UNITED HEALTHCARE	PO BOX 30567	SALT LAKE CITY	UT	84130	(800) 521-5505	
963	UNITED HEALTHCARE CLAIMS	PO BOX 29130	HOT SPRINGS	AR	71903	(888) 201-4111	
825	UNITED HEALTHCARE COMMUNITY PLAN	PO BOX 8207	KINGSTON	NY	12402	(800) 600-9007	MEDICARE ADVANTAGE PLAN
923	UNITED HEALTHCARE COMMUNITY PLAN	PO BOX 6170	COLUMBIA	SC	292606170	(800) 868-2528	MEDICAID MCO PLAN
927	UNITED HEALTHCARE HERITAGE PLUS	UHC OF RIVER VALLEY PO BOX 5230	KINGSTON	NY	124025230	(800) 224-6602	
A82	UNITED HEALTHCARE INDEMNITY	PO BOX 740801	ATLANTA	GA	303740801	(800) 848-8406	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D30	UNITED HEALTHCARE INS. CO (PPO)	PO BOX 150450	HARTFORD	CT	061150450	(860) 702-5000	MEDICARE ADVANTAGE PLAN
A38	UNITED HEALTHCARE OF NC	PO BOX 2604	GREENSBORO	NC	274386304	(800) 999-1147	
B77	UNITED HEALTHCARE PLAN ADMINISTRATORS	PO BOX 121212	MARIETTA	GA	300670092	(800) 562-7079	USE CODE 985 BENESIGHT
872	UNITED HEALTHCARE PLAN OF RIVER VALLEY	3800 23RD AVE. #200	MOLINE	IL	61215	(800) 224-6602	CODE ASSIGNED BY SCHA THESE COMPANY BOUGHT OUT JOHN DEERE INS. CO. THIS WAS THE HMO FOR JOHN DEERE 6/29/07
279	UNITED INSURANCE COMPANY OF AMERICA	1 E WACKER DR.	CHICAGO	IL	60601	(800) 777-8467	
B64	UNITED MEDICAL RESOURCES, INC.	PO BOX 30541	SALT LAKE CITY	UT	84130	(513) 619-3000	
720	UNITED MINE WORKERS HEALTH & RETIREMENT FUND	ROUTE 2 BOX 218A	BIG STONE GAP	VA	24219	(800) 654-9763	
C81	UNITED PAYORS & UNITED PROVIDERS	2273 RESEARCH BLVD.	ROCKVILLE	MD	20850	(800) 247-4144	
994	UNITED PROVIDER SERVICES	PO BOX 820277	FORT WORTH	TX	76182	(800) 519-8374	CARRIER BOUGHT OUT BY CC 740 PHARMACARE
721	UNITED RESOURCE NETWORK	PO BOX 30758	SALT LAKE CITY	UT	84130	(877) 801-3507	CODE ASSIGNED BY SCHA
810	UNITED RESOURCE NETWORK	PO BOX 30758	SALT LAKE CITY	UT	84130	-	CODE ASSIGNED BY SCHA
X3A	UNITED TEACHERS ASSO. INS. CO.	PO BOX 30010	AUSTIN	TX	78755	(800) 880-8824	
493	UNITED TEACHERS ASSOCIATION	PO BOX 30010	AUSTIN	TX	787553010	(866) 880-8824	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
217	UNITED WORLD LIFE INS. CO.	3316 FARNAM ST.	OMAHA	NE	68175	(877) 617-5587	
791	UNITEDHEALTH INTEGRATED SERVICES	PO BOX 30783	SALT LAKE CITY	UT	841300786	(866) 596-8447	
A31	UNITY HEALTH INSURANCE	PO BOX 610	SAUK CITY	WI	535831374	(800) 362-3308	
989	UNIVERA HEALTHCARE	PO BOX 23000	ROCHESTER	NY	14692	(877) 242-9464	
D63	UNIVERA SENIOR CHOICE SECURE	PO BOX 23000	ROCHESTER	NY	15692	(800) 617-1114	MEDICARE ADVANTAGE PLAN
530	UNIVERSAL BENEFITS CORPORATION	PO BOX 97	SCRANTON	PA	185040097	(800) 747-0622	CODE ASSIGNED BY SCHA
198	UNIVERSAL FIDELITY LIFE INS. CO.	PO BOX 1428	DUNCAN	OK	735344	(800) 366-8355	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D34	UNIVERSAL HEALTH CARE	PO BOX 3211	ST. PETERSBURG	FL	33731	(866) 690-4842	MEDICARE ADVANTAGE PLAN
B93	UNIVERSITY HEALTH ALLIANCE	700 BISHOP ST., STE. 300	HONOLULU	HI	968134100	(800) 532-4000	
855	UNIVERSITY HEALTH PLANS	PO BOX 830926 DEPT 003	BIRMINGHAM	AL	35283	(877) 878-0914	
B68	UPMC HEALTH BENEFITS, INC.	PO BOX 2999	PITTSBURGH	PA	15230	(877) 381-3764	
D05	UPMC HEALTH BENEFITS, INC.	PO BOX 2999	PITTSBURGH	PA	15230	(877) 381-3764	MEDICARE ADVANTAGE PLAN
409	UPSTATE ADMINISTRATIVE SERVICES	PO BOX 6589	SYRACUSE	NY	132176589	(315) 422-1533	
D85	US FIRE INSURANCE COMPANY	3195 LINWOOD RD., STE. 201	CINCINNATI	OH	45208	(800) 513-2981	
777	US HEALTH AND LIFE	PO BOX 37504	OAK PARK	MI	482370504	(800) 225-9674	THIS CODE NOT REQUESTED BY SCHA. ASSIGNED BY SCHA
B55	US SCRIPTS	2425 WEST SHAW AVE.	FRESNO	CA	93711	(800) 460-8988	
717	USA HEALTH CARE (MVP HEALTH CARE)	PO BOX 22920	ROCHESTER	NY	146922920	(800) 999-3920	CODE ASSIGNED BY SCHA
953	USA HEALTHCARE ORGANIZATION	7301 N. 16TH ST. STE 201	PHOENIX	AZ	85020	(800) 872-3860	CODE ASSIGNED BY SCHA
582	USAA GENERAL INDEMNITY CO.	PO BOX 15506	SACRAMENTO	CA	958521506	(800) 531-8222	
131	USI	PO BOX 9888	SAVANNAH	GA	31412	(912) 691-1551	THIS CARRIER BOUGHT JONES, HILL & MERCER INS.
513	VALUE OPTIONS	PO BOX 1347	LATHAM	NY	12110	(800) 288-0882	
466	VALUE RX	PO BOX 421150	PLYMOUTH	MN	554420150	(800) 955-4879	USE CODE 333 EXPRESS SCRIPTS
633	VETERANS ADMINISTRATION	-	-	-	-	-	
962	VICARE PLUS	PO BOX 1710	SUFFOLK	VA	23439	(877) 934-4403	
491	VISION SERVICE PLAN	PO BOX 997100	SACRAMENTO	CA	958997100	(800) 622-7444	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
606	VOCA.REHAB GENERAL					-	
608	VOCATIONAL REHAB DISABILITY					-	
E20	VRX PHARMACY SERVICES	PO BOX 9780	SALT LAKE CITY	UT	84109	(877) 879-9722	
A56	VULCAN MATERIALS COMPANY	PO BOX 530187	BIRMINGHAM	AL	352530187	(864) 277-2371	DORMANT 8/06
B41	VYTRA HEALTHCARE	PO BOX 9091	MELVILLE	NY	11747	(866) 808-9399	
549	WAL-MART STORES GROUP HEALTH PLAN	922 W. WALNUT STE. A	ROGERS	AR	72756 320	(501) 621-2929	USE CODE 401 BLUE CROSS BLUE SHIELD OF SC
282	WASHINGTON NATIONAL INSURANCE COMPANY	PO BOX 1934	DES PLAINES	IL	60017	(800) 947-0319	
841	WATKINS ASSOCIATED INDUSTRIES	PO BOX 1738	ATLANTA	GA	30301	(800) 333-3841	CODE ASSIGNED BY SCHA
139RX	WAUSAU INSURANCE COMPANY	PO BOX 8013	WAUSAU	WI	544028013	(800) 826-9781	
B13	WEB TPA	PO BOX 99906	GRAPEVINE	TX	760999706	(800) 758-2851	
B13DN	WEB TPA	PO BOX 99906	GRAPEVINE	TX	76099	(800) 758-2851	
779	WEB-TPA AMERICAN FIDELITY ASSURANCE CO	PO BOX 99906	GRAPEVINE	TX	760999706	(866) 393-2872	DORMANT 8/06
C32	WELL FARGO INSURANCE	PO BOX 2801	CHARLESTON	WV	253302801	(800) 435-4351	
D17	WELLCARE	PO BOX 795184	SAN ANTONIO	TX	78279	(866) 235-2770	MEDICARE ADVANTAGE PLAN
D52	WELLCARE OF GEORGIA	PO BOX 31224	TAMPA	FL	33531	(866) 231-1821	MEDICARE ADVANTAGE PLAN
292	WELLMARK ADMINISTRATORS	PO BOX 9901	SIOUX CITY	IO	51102	(800) 526-5710	
X1O	WELLMARK BLUE CROSS BLUE SHIELD OF IOWA	PO BOX 5023	SIOUX FALLS	SD	57104	(515) 245-4500	USE CARRIER CODE X2A
X2A	WELLMARK BLUE CROSS BLUE SHIELD OF IOWA	PO BOX 5023	SIOUX FALLS	SD	571175023	(800) 526-8995	
X2ADN	WELLMARK BLUE CROSS BLUE SHIELD OF IOWA	PO BOX 9354	DES MOINES	IA	503069354	(877) 333-0164	DENTAL
252	WELLNET HEALTHCARE	57 STREET RD.	SOUTH HAMPTON	PA	18966	(800) 727-1733	
A24	WELLPOINT NEXT RX	PO BOX 2902	CLINTON	IA	527332902	(800) 962-7378	USE CARRIER 333 EXPRESS SCRIPTS
912	WELLS FARGO TPA-NC OFFICES	PO BOX 2857	FAYETTEVILLE	NC	28302	(800) 337-6288	
991	WEST PORT BENEFITS	PO BOX 66743	ST. LOUIS	MO	63166	(888) 306-5299	
D37	WEST VIRGINIA LOCAL 152 HEALTH & WELFARE	5 HOT METAL ST., STE. 200	PITTSBURGH	PA	15203	(866) 825-8152	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C76	WESTERN AND SOUTHERN GROUPS	PO BOX 5735	CINCINNATI	OH	45201	(800) 424-8622	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
415	WEYCO, INC.	PO BOX 30132	LANSING	MI	48909	(517) 349-7010	
415DN	WEYCO, INC.	PO BOX 30132	LANSING	MI	48909	(517) 349-7010	
969	WHP HEALTH INITIATIVE	PO BOX 968022	SCHAUMBERG	IL	601968022	(800) 207-2568	
694	WILLIAMSBURG COUNTY	-	-	-	-	-	
116	WILLIS CORROON ADMINISTRATIVE SERVICES	PO BOX 305154	NASHVILLE	TN	372305154	(800) 255-8109	
826	WILLSE & ASSOCIATES, INC.	PO BOX 1196	BALTIMORE	MD	21203	(410) 547-0454	
D75	WINDSOR MEDICARE EXTRA	PO BOX 269025	PLANO	TX	750269025	(866) 270-5223	MEDICARE ADVANTAGE PLAN
A88	WINDSOR STERLING	PO BOX 269003	PLANO	TX	750269003	(888) 858-8551	
575	WISCONSIN ELECTRICAL EMPLOYEES	PO BOX 2430	BROOKFIELD	WI	53008	(608) 276-9111	CODE IN OPEN STATUS BY SCHA
768	WISCONSIN PHYSICIANS SERVICES	1717 WEST BROADWAY ST.	MADISON	WI	53708	(888) 915-4158	
598	WJB DORN VA MEDICAL CENTER	6439 GARNERS FERRY RD	COLUMBIA	SC	292091639	(803) 776-4000	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
285	WOODMAN OF THE WORLD LIFE INSURANCE SOCIETY	1700 FARNAM ST.	OMAHA	NE	68102	(800) 225-3108	
A34	WOODS & GROOM	2549 17TH ST.	COLUMBUS	IN	47202	(800) 368-3429	DORMANT 8/06
622	WORKMEN'S COMP					-	
580	WORLD INSURANCE COMPANY	PO BOX 3160	OMAHA	NE	681030160	(402) 496-8000	
C57	WORLD TRAVEL PROTECTION	4600 WITMER INDUSTRIAL ESTATES #2	NIAGARA FALLS	NY	14305	(800) 456-4553	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
607	WPS TRICARE FOR LIFE	PO BOX 7889	MADISON	WI	537077889	(866) 773-0404	
C51	YALE HEALTH PLAN	PO BOX 208217	NEW HAVEN	CT	065208217	(203) 432-0250	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
470	YODER BROTHERS	1001 LEBANON RD	PENDLETON	SC	29670	(864) 646-8331	
695	YORK COUNTY	-	-	-	-	-	
C10	ZAVATA	PO BOX 1208	AMERICUS	GA	31709	(800) 841-7735	WAS PARADIGM CARE PLAN
977	ZENITH ADMINISTRATION	26359	LAS VEGAS	NV	89126	(800) 426-5980	DORMANT 8/06

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
100	AETNA US HEALTHCARE	PO BOX 14079	LEXINGTON	KY	40512	(800) 333-4432	
101	INTERNATIONAL CLAIMS SERVICES	27092 BURBANK ST.	FOOTHILL RANCH	CA	92610	(877) 916-7920	ASSIGNED BY SCHA
102						-	
103	UNITED CLAIMS SOLUTIONS	10835 N. 25TH AVE. 105	PHOENIX	AZ	85029	(866) 744-8482	CODE ASSIGNED BY SCHA
104	KAISER FOUNDATION HEALTH PLAN OF SOUTHERN CA.	PO BOX 7004	DOWNEY	CA	90242	(800) 390-3510	CODE ASSIGNED BY SCHA
105	ATHENE ANNUITY AND LIFE ASSURANCE COMPANY	PO BOX 19038	GREENVILLE	SC	29602	(864) 609-1000	
106	AMERICAN FIDELITY ASSURANCE BENEFITS	PO BOX 25160	OKLAHOMA CITY	OK	731250160	(800) 654-8489	
107	MUTUAL OF OMAHA	MUTUAL OF OMAHA PLAZA	OMAHA	NE	68175	(800) 228-9090	DO NOT USE FOR MED ADV. THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE.
108	METROPOLITAN LIFE INSURANCE COMPANY	PO BOX 981282	EL PASO	TX	79998	(800) 638-6626	
109	JEFFERSON PILOT INSURANCE COMPANY	PO BOX 26011	GREENSBORO	NC	27420	(336) 691-3000	
110	AMERIHEALTH HMO, INC.	PO BOX 41574	PHILADELPHIA	PA	191011574	(888) 632-3862	CODE ASSIGNED BY SCHA
111	PRUDENTIAL INSURANCE COMPANY OF AMERICA	841 PRUDENTIAL DR.	JACKSONVILLE	FL	32207	(800) 346-3778	THIS CARRIER BOUGHT OUT BY AETNA CC100
112	TRAVELERS INSURANCE COMPANY	PO BOX 473500	CHARLOTTE	NC	282473500	(704) 544-3665	USE CODE 113 UNITED HEALTHCARE INACTIVE 8-02
113	UNITED HEALTHCARE	PO BOX 740800	ATLANTA	GA	303740800	(877) 842-3210	
114	CLAIMEDIX, INC.	PO BOX 140067	KANSAS CITY	MO	64114	(800) 922-4262	CODE ASSIGNED BY SCHA
115	ALLSTATE INSURANCE	PO BOX 7068	COLUMBIA	SC	29202	(800) 366-8997	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
116	WILLIS CORROON ADMINISTRATIVE SERVICES	PO BOX 305154	NASHVILLE	TN	372305154	(800) 255-8109	
117	HEWITT COLEMAN AND ASSOCIATES	PO BOX 6708	GREENVILLE	SC	29606	(864) 240-5840	
118	AMERICAN HEALTH & LIFE INSURANCE	300 ST. PAUL PLACE	BALTIMORE	MD	21202	(301) 332-3000	
119	AMERICAN HERITAGE LIFE INSURANCE	1776 AMERICAN HERITAGE LIFE DR.	JACKSONVILLE	FL	32224	(800) 535-8086	
120	AMERICAN NATIONAL INSURANCE COMPANY	PO BOX 1790	GALVESTON	TX	77553	(800) 899-6803	
121	GREATER HEALTHCARE	PO BOX 3400	MONROE	NC	28110	(704) 225-8887	
122	ATLANTIC COAST LIFE INSURANCE COMPANY	PO BOX 20010	CHARLESTON	SC	294130010	(843) 763-8680	
123	BANKERS LIFE & CASUALTY	PO BOX 66927	CHICAGO	IL	606660927	(800) 621-3724	
124	UNITED COMMERICAL TRAVELERS OF AMERICA	PO BOX 159019	COLUMBUS	OH	43215	(800) 848-0123	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
125	AMERICAN TRAVELERS LIFE INSURANCE COMPANY	3220 TILLMAN DR.	BEN SALEM	PA	19020	(215) 244-1600	
126	HEALTH PLAN SERVICES (COVENTRY HEALTH CARE)	PO BOX 24146	SEATTLE	WA	98124	(800) 861-0056	CODE ASSIGNED BY SCHA
127	BENEFITSOURCE, INC.	PO BOX 240	MONROE	MI	48161	(800) 423-1028	CODE ASSIGNED BY SCHA
128	CAPITOL LIFE INSURANCE COMPANY	PO BOX 1200	DENVER	CO	80201	(800) 525-2115	PER HOSP. ASSO. 07/02, THIS IS STILL A VALID CARRIER
129	INTERGROUP SERVICES CORPORATION	101 LINDENWOOD DR., STE. 150	MALVERN	PA	19355	(800) 537-9389	
130	EMPLOYERS LIFE INSURANCE COMPANY	PO BOX 6305	SPARTANBURG	SC	29304	(888) 962-8437	CARRIER WAS COASTAL STATE LIFE INS. CO.
131	USI	PO BOX 9888	SAVANNAH	GA	31412	(912) 691-1551	THIS CARRIER BOUGHT JONES, HILL & MERCER INS.
132	COLONIAL LIFE AND ACCIDENT INSURANCE COMPANY	PO BOX 1365	COLUMBIA	SC	29202	(803) 798-7000	
133	COMBINED INSURANCE COMPANY OF AMERICA	PO BOX 6700	SCRANTON	PA	18505	(800) 225-4500	
134	CIGNA CONN GENERAL LIFE INSURANCE	PO BOX 182223	CHATTANOOGA	TN	374227223	(800) 882-4462	DO NOT USE FOR MEDICARE. THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE
135	ALLIED NATIONAL, INC.	PO BOX 419233	KANSAS CITY	MO	641416233	(800) 825-7531	CARRIER WAS ALLIED GROUP INSURANCE TRUST
136	CIGNA FLEXCARE	PO BOX 30575	CHARLOTTE	NC	282303211	-	CODE ASSIGNED BY SCHA
137	EDUCATORS MUTUAL LIFE INSURANCE COMPANY	PO BOX 3149	LANCASTER	PA	17601	(717) 397-2751	
138	LIFEWELL HEALTH PLANS	PO BOX 16203	LUBBOCK	TX	79490	(877) 543-3935	SUBSIDIARY OF HEALTHSCOPE
139	FISERV HEALTH	PO BOX 30541	SALT LAKE CITY	UT	841300541	(800) 826-9781	WAS WAUSAU INS. CO.
140	STERLING OPTION I (PFFS)	PO BOX 5348	BELLINGHAM	WA	982270010	-	MEDICARE ADVANTAGE PLAN
141	NEOA HEALTH BENEFITS FUND	428 E SCOTT AVE. - PO BOX 3070	KNOXVILLE	TN	37927		
142	SC DEPT OF DISABILITIES AND SPECIAL NEEDS	PO BOX 4706	COLUMBIA	SC	29240	(803) 898-9795	CODE ASSIGNED BY SCHA
143	UMR	PO BOX 30541	SALT LAKE CITY	UT	841300541	(800) 826-9781	
144	GLOBE LIFE & ACCIDENT INSURANCE	204 N. ROBINSON	OKLAHOMA CITY	OK	73102	(972) 540-6542	
145	GMP EMPLOYERS RETIREE TRUST	5245 BIG PINE WAY SE	FORT MYERS	FL	33907	(941) 936-6242	
146	HARTFORD INSURANCE GROUP	PO BOX 25600	CHARLOTTE	NC	28212	(704) 536-6230	
147	STATE MUTUAL INSURANCE	PO BOX 10811	CLEARWATER	FL	337578811	(888) 780-6388	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
148	MONUMENTAL LIFE INSURANCE COMPANY	PO BOX 61	DURHAM	NC	27702	(800) 444-5431	
149	INSURANCE COMPANY OF NORTH AMERICA (INA)	195 BROADWAY 11TH FLOOR	NEW YORK	NY	100073100	(212) 618-4000	
150	AMERICAN GENERAL LIFE AND ACCIDENT INS CO	PO BOX 1500	NASHVILLE	TN	372021500	(800) 888-2452	
151	CARELINK	PO BOX 7373	LONDON	KY	40742	(800) 348-2922	MEDICAID HMO
152	MEDICA	PO BOX 30990	SALT LAKE CITY	UT	84130	(800) 952-3455	CODE NOT REQUESTED BY MEDICAID ASSIGNED BY SCHA
153	KANAWHA LIFE INSURANCE COMPANY	PO BOX 6000	LANCASTER	SC	29721	(803) 286-2440	
154	CONSUMER DRN BENEFITS ASSO.	PO BOX 6080-228	MISSION VIEIO	CA	926906080	(888) 411-4208	CODE ASSIGNED BY SCHA
155	CROSSAMERICA HEALTH PLAN	PO BOX 5778	PARSIPPANY	NJ	07054	(866) 302-7332	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
156	LIFE INSURANCE COMPANY OF GEORGIA	PO BOX 105006	ATLANTA	GA	303485006	(770) 980-5100	
157	LIFE INSURANCE COMPANY OF VIRGINIA, THE	PO BOX 27601	RICHMOND	VA	23230	(804) 281-6000	
158	LINCOLN NATIONAL LIFE INSURANCE COMPANY	PO BOX 614008	ORLANDO	FL	32861	(800) 423-2765	
159	MAKSIN MANAGEMENT CORP	CN98000	PENNSAUKEN	NJ	08110	(800) 257-0625	
160	UNI-CARE HEALTH AND LIFE INSURANCE CO	PO BOX 4458	CHICAGO	IL	606804458	(877) 217-9677	WAS MASS MUTUAL
161	AMA INSURANCE AGNECY, INC.	200 N. LASALLE ST., STE. 400	CHICAGO	IL	606819785	(800) 458-5736	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
162	HARVARD PILGRIM HEALTHCARE	PO BOX 656653	SAN ANTONIO	TX	82655	(800) 421-3550	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
163	NATIONWIDE LIFE INSURANCE COMPANY	PO BOX 182202	COLUMBUS	OH	432182202	(614) 249-7111	
164	AMERICAN PROGRESSIVE INSURANCE	PO BOX 130	PENSACOLA	FL	325910130	(800) 626-8913	
165	NEW YORK LIFE INSURANCE COMPANY	PO BOX 105095	ATLANTA	GA	30348	(800) 388-4580	
166	CAPITOL AMERICAN LIFE INSURANCE COMPANY	PO BOX 94953	CLEVELAND	OH	441014953	(216) 696-6400	
167	AMERICAN INTERNATIONAL GROUP (AIG) ACCIDENT	PO BOX 26050	OVERLAND PARK	KS	66225	(888) 722-1668	
168	PRECISE BENEFIT ADMINISTRATORS	PO BOX 9064	JERICHO	NY	11753	(516) 390-6000	
169	CROWN CORK & SEAL COMPANY, INC.	930 BEAUMONT AVE.	SPARTANBURG	SC	29303	(864) 585-6456	
170	OCCIDENTAL LIFE INSURANCE COMPANY OF NC	PO BOX 10324	RALEIGH	NC	27605	(919) 831-8189	
171	AON	PO BOX 66	WINSTON-SALEM	NC	27102	(800) 368-3804	
172	PAUL REVERE LIFE INSURANCE COMPANY	PO BOX 15118	WORCESTER	MA	016150118	(508) 799-4441	
173	PENNSYLVANIA LIFE INSURANCE COMPANY	PO BOX 130	PENSACOLA	FL	325910100	(800) 275-7366	
174	NMU PENSION & WELFARE FUND	360 WEST 31ST ST., 3RD FL	NEW YORK	NY	10001	(212) 337-4900	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
175	COLUMBIA UNIVERSAL LIFE INSURANCE CO.	PO BOX 200225	AUSTIN	TX	787200225	(512) 345-3200	
176	GUIDESTAR HEALTH SYSTEMS	PO BOX 35238	BIRMINGHAM	AL	35238	(800) 595-6949	
177	CINERGY HEALTH PREFERRED PLAN	144 N BEVERWYCK RD. #332	LAKE HIAWATHA	NJ	080341997	(800) 847-1148	CODE IN OPEN STATUS BY SCHA
178	INSURANCE & BENEFIT ADVOCATE, INC.	5838 W BRICK RD STE. 106	SOUTH BEND	IN	46628	(866) 200-6700	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
179	DESERET MUTUAL BENEFIT ADMINISTRATOR	PO BOX 45530	SALT LAKE CITY	UT	84145	(800) 777-3622	
180	ESIS	PO BOX 31122	TAMPA	FL	33631	(800) 884-7975	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
181	GROUP ADMINISTRATORS, LTD.	450 E. REMINGTON RD.	SCHAUMBURG	IL	60173	(847) 519-1880	
182	PENN TREATY NETWORK AMERICA INS. CO.	PO BOX 7066	ALLENTOWN	PA	181057066	(800) 362-0700	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
183	GILSBAR INSURANCE COMPANY	PO BOX 2947	COVINGTON	LA	70434	(800) 234-2643	
184	SECURITY LIFE INSURANCE CO. OF AMERICA	PO BOX 3199	WINSTON-SALEM	NC	27102	(800) 300-9566	
185	S&S HEALTHCARE STRATEGIES	PO BOX 46511	CINCINNATI	OH	45216	(888) 800-8717	
186	SOUTHLAND LIFE INSURANCE COMPANY	PO BOX 105006	ATLANTA	GA	303485006	(770) 980-5100	
187	RELIANCE STANDARD LIFE INS. CO.	PO BOX 82510	LINCOLN	NE	68501	(800) 497-7044	
188	STANDARD LIFE & CASUALTY INSURANCE COMPANY	PO DRAWER 1514	FORT MILL	SC	29716	(803) 548-3657	
189	INTERNATIONAL EDUCATION EXCHANGE SERVICES	PO BOX 370	ITHACA	NY	148510307	(866) 433-7462	
190	BOILERMAKERS NATIONAL HEALTH & WELFARE FUND	754 MINNESOTA AVE., STE. 522	KANSAS CITY	KS	661012762	(913) 342-6555	
191	COVENTRY HEALTHCARE OF DELAWARE, INC.	PO BOX 7713	LONDON	KY	40742	(800) 833-7423	
192	CONVENTRY HEALTHCARE OF NEBRASKA, INC.	PO BOX 7705	LONDON	KY	40742	(800) 288-3343	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
193	ALLSTATE WORKPLACE DIVISION	PO BOX 853916	RICHARDSON	TX	750853916	(800) 937-7039	
194	DAKOTACARE	PO BOX 7406	SIOUX FALLS	SD	571177406	(800) 325-5598	CODE ASSIGNED BY SCHA
195	UNION BANKERS INSURANCE COMPANY	PO BOX 655433	DALLAS	TX	752655433	(214) 954-7840	
196	UNITED BENEFIT LIFE INSURANCE	3909 HULEN ST.	FT. WORTH	TX	76107	(800) 732-0657	
197	RELIANCE STANDARD SPECIALTY PRODUCTS ADM	505 S LENOLA RD., STE. 231	MOORESTOWN	NJ	08057	(866) 375-0775	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
198	UNIVERSAL FIDELITY LIFE INS. CO.	PO BOX 1428	DUNCAN	OK	735344	(800) 366-8355	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
199	ALL OTHER CARRIERS	-	-	-	-	-	
200	ALL AMERICAN LIFE INSURANCE CO.	8501 WEST HIGGINS RD.	CHICAGO	IL	60631	(773) 399-6645	
201	HCH ADMINISTRATORS	PO BOX 1986	PEORIA	IL	61656	(800) 322-1516	
202	JOHN HANCOCK INSURANCE COMPANY	PO BOX 852	BOSTON	MA	02117	(800) 233-1449	
203	HEALTH CARE SUPPORT/PRIVATE HEALTH CARE SYSTEM	29 COLUMBIA HEIGHTS	BROOKLYN	NY	11201	(800) 554-4022	CODE ASSIGNED BY SCHA
204	SELF INSURED BENEFIT ADMINISTRATORS	18167 US HWY 19N	CLEARWATER	FL	33764	(727) 532-0400	
205	FIDELITY LIFE SECURITY	3130 BROADWAY	KANSAS CITY	MO	641112406	(800) 648-8624	
206	MED COST BENEFITS SERVICES	PO BOX 25307	WINSTON-SALEM	NC	271145307	(800) 795-1023	
207	MEDICAL SAVINGS HEALTH PLAN	419 E. MAIN ST.	MIDDLETON	NY	10940	(317) 329-8222	
208	SIEBA, LTD	PO BOX 5000	ENDICOTT	NY	13761	(800) 252-4624	
209	SUMMIT AMERICA INSURANCE SERVICES	PO BOX 25936	OVERLAND PARK	KS	662255936	(877) 246-6997	
210	AMERITAS LIFE INSURANCE	PO BOX 82520	LINCOLN	NE	68501	(800) 255-9678	
211	COORDINATED BENEFIT PLANS, INC.	PO BOX 853925	RICHARDSON	TX	750853925	(800) 753-1000	
212	TRUSTMARK INSURANCE CO.	PO BOX 2942	CLINTON	IA	52733	(847) 615-1500	USE THIS CARRIER FOR GROUPS WITH MORE THAN 50 EMPLOYEES. USE CCA03 FOR GROUPS LESS THAN 50 EMPLOYEES
213	COVENANT ADMINISTRATORS	PO BOX 105738	ATLANTA	GA	30348	(770) 239-6230	
214	RISK BENEFIT MANAGEMENT SERVICES, LLC (RBMS)	PO BOX 241569	ANCHORAGE	AK	99524	(800) 770-3740	
215	OXFORD LIFE INSURANCE COMPANY	PO BOX 46518	MADISON	WI	53744	(877) 469-3073	
216	HUMANA HEALTH INSURANCE OF FLORIDA	PO BOX 19080-F	JACKSONVILLE	FL	32245	(800) 457-4708	
217	UNITED WORLD LIFE INS. CO.	3316 FARNAM ST.	OMAHA	NE	68175	(877) 617-5587	
218	ROCKY MOUNTAIN HEALTH PLAN (RMHP)	PO BOX 4517	ENGLEWOOD	CO	80155	(888) 479-2000	
219	CLAIMS PRO	PO BOX 577	SOUTHFIELD	MI	48075	(800) 837-9600	RX CARRIER ONLY
220	HEALTH NEW ENGLAND	ONE MONARCH PLACE,STE 1500	SPRINGFIELD	MA	011441500	(800) 310-2835	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
221	QUAL CARE	PO BOX 249	PISCATHAWAY	NJ	08855	(800) 992-6613	
222	MEDICA	PO BOX 30990	SALT LAKE CITY	UT	84107	(800) 952-3455	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
223	MED COST PREFERRED	PO BOX 25437	WINSTON-SALEM	NC	27114	(800) 824-7406	CODE ASSIGNED BY SCHA
224	SOUTHERN ELEC. HEALTH FUND	3928 VOLUNTEER DR.	CHATTANOOGA	TN	37416	(423) 899-2593	
225	HEALTH SERVICES FOUNDATION	PO BOX 2109	LIVERMORE	CA	94551	(510) 449-7070	
226	MASTER HEALTH PLAN	PO BOX 16367	AUGUSTA	GA	303919123	(706) 863-5955	
227	MONUMENTAL GENERAL INSURANCE COMPANY	1111 N CHARLES ST.	BALTIMORE	MD	20201	(800) 752-9797	
228	PHYSICIANS PLUS INS. CO.	PO BOX 909953	MILWAUKEE	WI	53209	(800) 545-5015	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
229	SELF INSURED PLANS LLC	1016 COLLIER CENTER WAY STE. 200	LOS ANGELES	CA	90080	(800) 421-2342	CODE ASSIGNED BY SCHA
230	PYRAMID LIFE INSURANCE COMPANY	PO BOX 772	SHAWNEE MISSION	KS	66201	(800) 444-0321	
231	SAVERS LIFE INSURANCE COMPANY	8064 NORTH POINT BLVD., STE. 201	WINSTON-SALEM	NC	27106	(800) 642-0483	
232	GENERAL ADJUSTMENT BUREAU	PO BOX 81808	ATLANTA	GA	30366	(404) 457-9555	CODE ASSIGNED BY SCHA
233	STERLING LIFE INSURANCE	PO BOX 5348	BELLINGHAM	WA	98227	(800) 688-0010	
234	ALWAYSCARE BENEFITS, INC.	PO BOX 80139	BATON ROUGE	LA	70898	(888) 729-5433	DENTAL PLAN
235	SHAW INDUSTRIES	PO BOX 10	DALTON	GA	30722	(800) 321-1855	
236	GUARANTEE TRUST LIFE INSURANCE	1275 MILWAUKEE AVE.	GLENVIEW	IL		(847) 699-0600	
237	GUARDIAN LIFE INSURANCE COMPANY OF AMERICA	PO BOX 8019	APPLETON	WI	54913	(800) 873-4542	
238	HORIZON HEALTHCARE	PO BOX 1028	WEST TRENTON	NJ	08628	(800) 792-3666	
239	HORACE MANN LIFE INSURANCE COMPANY	1 HORACE MANN PLAZA	SPRINGFIELD	IL	62715	(217) 789-2500	
240	STARBRIDGE	PO BOX 55270	PHOENIX	AZ	85078	(800) 308-5948	POLICIES BEGINNING WITH"R" NEED TO BE "E" INDICATORS AND GO TO PO BOX 188004, CHATTANOOGA, TN 37422 POLICIES WITH PH SSN STAYS AS "C".
241	LIFE REINSURANCE CO.	PO BOX 792070	SAN ANTONIO	TX	78279	(800) 229-1024	
242	HELLER ASSOCIATES	8228 MAYFIELD RD. STE 5B	CHESTERLANDE	OH	44026	(440) 527-2955	CODE IN OPEN STATUS BY SCHA
243	LIFE & CASUALTY INSURANCE COMPANY OF TENNESSEE	AMERICAN GENERAL CENTER	NASHVILLE	TN	37250	(615) 749-1000	
244	STERLING INVESTORS LIFE INS. CO.	PO BOX 10844	CLEARWATER	FL	337578844	(877) 604-5240	
245	COVENTRY OF THE CAROLINA'S	PO BOX 7102	LONDON	KY	40742	(800) 935-7284	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
246	COVENTRY HEALTH CARE RX	PO BOX 8400	LONDON	KY	40742	(800) 947-6824	
247	EMPLOYERS DIRECT HEALTH	5050 SPRING VALLEY RD.	DALLAS	TX	752443909	(800) 872-9934	CARRIER WAS FIRST INTEGRATED HEALTH
248	NEW ENGLAND LIFE INSURANCE	25145 COUNTRY CLUB BLVD.	NORTH OLMSTED	OH	440705300	(800) 255-8063	
249	FIRST HEALTH WORKERS COMP ONLY	PO BOX 23070	TUCSON	AZ	85735	(800) 554-4954	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
250	IDEAL SCRIPTS	50 WHITE CAP DR.	NORTH KINGSTOWN	RI	02886	(800) 717-6614	
251	PYRAMID LIFE INSURANCE CO.	PO BOX 12922	PENSACOLA	FL	325912922	(800) 658-1413	CODE IN OPEN STATUS BY SCHA MEDICARE SUPPLEMENTAL PLAN G
252	WELLNET HEALTHCARE	57 STREET RD.	SOUTH HAMPTON	PA	18966	(800) 727-1733	
253	AMERICAN STERLING INSURANCE SERVICES	PO BOX 26103	OVERLAND PARK	KS	66225	(877) 292-6037	
254	PACIFIC MUTUAL LIFE INSURANCE COMPANY	700 NEWPORT CENTER DR.	NEWPORT BEACH	CA	92660	(800) 451-2513	
255	PAN-AMERICAN LIFE INSURANCE COMPANY	PO BOX 981644	EL PASO	TX	79998	(800) 694-9888	
256	BENICOMP	8310 CLINTON PARK DR.	FT. WAYNE	IN	46825	(800) 837-7400	CODE ASSIGNED BY SCHA
257	PHARMACY NETWORK NATIONAL OF N.C.	4000 OLD WAKEFOREST RD., STE. 101	RALEIGH	NC	27609	(800) 331-7108	SEE CARRIER 366 CATALYST RX
258	DIVERSIFIED ADMINISTRATION CORPORATION	PO BOX 299	MARLBOROUGH	CT	06447	(888) 322-2524	
259	CNA HEALTHCARE PARTNERS	PO BOX 34197	LITTLE ROCK	AK	72203	(800) 508-3772	
260	NATIONAL CLAIMS ADMINISTRATIVE SERVICES	PO BOX 10136	FAIRFAX	VA	220388022	(866) 219-9292	CODE IN OPEN STATUS BY SCHA
261	UICI ADMINISTRATORS	PO BOX 30087	RENO	NV	895203087	(800) 315-3440	
262	CAIC (CONTINENTAL AMERICAN INS. CO)	PO BOX 6080226	MISSION VIEJO	CA	926906080	(888) 730-2244	
263	NATIONAL FINANCIAL COMPANY	110 WEST 7TH ST., STE. 300	FT WORTH	TX	76102	(800) 725-1407	
264	HEALTH AMERICA	PO BOX 7089	LONDON	KY	40742	(800) 788-8445	
265	TODAY'S OPTION	PO BOX 391883	CAMBRIDGE	MA	02139	(866) 222-5137	MEDICARE ADVANTAGE PLAN
266	ACMG ADMINISTRATORS OF SOUTH CAROLINA	2570 TECHNICAL DR.	MIAMISBURG	OH	45342	(800) 232-6242	
267	NATIONAL CLAIMS ADMINISTRATIVE SERVICES	PO BOX 220887	CHARLOTTE	NC	282220887	(704) 364-3865	CODE ASSIGNED BY SCHA
268	MARQUETTE NATIONAL LIFE INS. CO.	PO BOX 130	PENSACOLA	FL	32591	(800) 934-8203	
269	THE EPOCH GROUP	PO BOX 12170	OVERLAND PARK	KS	66212	(800) 255-6065	
270	PREFERRED HEALTH PLAN OF THE CAROLINAS	PO BOX 220397	CHARLOTTE	NC	28222	(866) 636-0239	
271	AMERICAN BENEFIT PLAN ADMINISTRATOR	22OO-B ROSSELLE ST.	JACKSONVILLE	FL	32204	(800) 468-5126	
272	ALLIANCE HEALTH BENEFIT PLAN	PO BOX 6443	ROCKVILLE	MD	20850	(800) 342-3289	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
273	CENTRAL BENEFITS USA (CENBEN USA)	PO BOX 619059	DALLAS	TX	85261	(800) 772-5924	CODE ASSIGNED BY SCHA
274	CAPITAL DISTRICT PHYSICIANS PLAN	PO BOX 66602	ALBANY	NY	122066602	(800) 926-7526	
275	AMERICAN TRUST ADMINISTRATORS	PO BOX 87	SHAWNEE MISSION	KS	66201	(913) 451-4900	
276	PLAN HANDLERS	930 CANTERBURY PLACE	ESCONDIDO	CA	92025	(800) 538-5512	
277	UNITED AMERICAN INSURANCE COMPANY	PO BOX 8080	MCKINNEY	TX	750708080	(972) 529-5085	
278	ROCKY MOUNTAIN HEALTH PLAN	PO BOX 10600	GRAND JUNCTION	CO	81502	(800) 854-4558	
279	UNITED INSURANCE COMPANY OF AMERICA	1 E WACKER DR.	CHICAGO	IL	60601	(800) 777-8467	
280	CAREMARK PRESCRIPTION SERVICES	PO BOX 52188	PHOENIX	AZ	850722196	(800) 841-5550	USE CARRIER 471
281	HEALTH NETWORK AMERICA/TRIVERIS	PO BOX 307	EATONTOWN	NJ	07724	(800) 337-1421	CODE ASSIGNED BY SCHA
282	WASHINGTON NATIONAL INSURANCE COMPANY	PO BOX 1934	DES PLAINES	IL	60017	(800) 947-0319	
283	GUARDIAN HEALTHCARE	PO BOX 4197	SCRANTON	PA	77010	(866) 850-1256	MEDICARE ADVANTAGE PLAN
284	AMERIHEALTH ADMINISTRATORS	720 BLAIR RD.	HORSHAM	PA	19044	(800) 345-4017	
285	WOODMAN OF THE WORLD LIFE INSURANCE SOCIETY	1700 FARNAM ST.	OMAHA	NE	68102	(800) 225-3108	
286	HEALTH EXCHANGE (TPA FOR CERNER HEALTH)	PO BOX 165750	KANSAS CITY	MO	64116	(800) 231-4015	CODE IN OPEN STATUS BY SCHA
287	COMMUNITY HEALTH PLAN	PO BOX 14467	CINCINNATI	OH	45250	(888) 800-8717	
288	FIRST ADMINISTRATORS, INC.	PO BOX 9900	SIOUX CITY	IA	51102	(800) 206-0827	
289	AFTRA HEALTH FUND	261 MADISON AVE.	NEW YORK	NY	10016	(800) 562-4690	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
290	FEDERATED MUTUAL INSURANCE COMPANY (REGIONAL)	PO BOX 31716	TAMPA	FL	336313716	(813) 496-8100	
291	NALC HEALTH BENEFIT PLAN	20547 WAVERLY CT.	ASHBURN	VA	20149	(703) 729-4677	
292	WELLMARK ADMINISTRATORS	PO BOX 9901	SIOUX CITY	IO	51102	(800) 526-5710	
293	PARAMOUNT HEALTH CARE	PO BOX 497	TOLEDO	OH	43697	(888) 891-2564	
294	BRIDGESTONE/FIRESTONE COMPANIES	PO BOX 26605	AKRON	OH	44319	(800) 237-8447	
295	MEDICAL BENEFIT ADMINISTRATORS	5940 SEMINOLE CENTER CT.	MADISON	WI	53711	(608) 273-1776	
296	RESERVE NATIONAL INSURANCE	PO BOX 26620	OKLAHOMA CITY	OK	73126	(800) 654-9106	
297	AMALGAMATED LIFE INSURANCE	PO BOX 1451	NEW YORK	NY	101161451	(212) 473-5700	
298	SMITH PREMIERE PHARMACY PLAN	PO BOX 5824	SPARTANBURG	SC	29304	(800) 247-4526	
299	ALICARE	PO BOX 1447	NEW YORK	NY	10116	(212) 539-5115	
300	BENEFIT ADMINISTRATORS, INC.	PO BOX 6279	ERIE	PA	16512	(800) 777-2524	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
301	BENEFIT PLAN ADMINISTRATORS	2145 FORD PARKWAY, STE. 300	ST. PAUL	MN	55116	(800) 277-8973	
302	GOVERNMENT EMPLOYEE HOSP. ASSN (GEHA)	PO BOX 4665	INDEPENDENCE	MO	640514665	(816) 257-5500	
303	PREFERRED HEALTH PLAN, INC.	PO BOX 24125	LOUISVILLE	KY	40224	(502) 339-7500	
304	BUTLER BENEFIT SERVICE, INC.	PO BOX 3310	DAVENPORT	IA	528083310	(866) 927-2200	
305	HEALTHSMART	PO BOX 3262	CHARLESTON	WV	25332	(866) 869-5597	
306	UNION LABOR LIFE INSURANCE	111 MASSACHUSETTS AVE., NW	WASHINGTON	DC	20001	(800) 443-8087	
307	STANDARD SECURITY LIFE INS. CO OF NEW YORK	PO BOX 828	PARK RIDGE	IL	60068	(866) 513-1479	
308	GREAT WEST LIFE	PO BOX 188061	CHATTANOOGA	TN	374228061	(800) 663-8081	GREAT WEST/CIGNA
309	AMERICAN ADMINISTRATIVE GROUP	PO BOX 5227	LISLE	IL	605325227	(630) 493-9252	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
310	ADVANCED DATA SOLUTIONS	PO BOX 723097	ATLANTA	GA	31139	(800) 742-5246	
311	BENEFIT PLANNERS, INC.	PO BOX 682010	SAN ANTONIO	TX	78269	(210) 699-1872	
312	NATIONAL BENEFIT ADMINISTRATORS	PO BOX 690903	CHARLOTTE	NC	282277016	(800) 482-6736	
313	GREAT WEST HEALTHCARE	1000 GREAT WEST DR.	KENNETT	MO	63857	(800) 663-8081	
314	PHARMACY ADVANTAGE NETWORK	50 LENNOX POINTE	ATLANTA	GA	30324	(888) 727-5560	SEE CARRIER 366 CATALYST RX
315	THOMAS COOPER AND COMPANY	PO BOX 22557	CHARLESTON	SC	29413	(843) 722-2115	
316	PROFESSIONAL INSURANCE CORPORATION	2610 WYCLIFF RD.	RALEIGH	NC	27607	(800) 289-1122	
317	EMPLOYEE BENEFITS MANAGEMENT CORPORATION	4789 RINGS RD.	DUBLIN	OH	43017	(800) 552-0455	
318	KLAIS & COMPANY	1867 WEST MARKET ST.	AKRON	OH	443136977	(330) 867-8443	
319	BENEFIT CONCEPTS	PO BOX 60608	KING OF PRUSSIA	PA	19406	(800) 220-2600	
320	LAMAR LIFE INSURANCE COMPANY	PO BOX 880	JACKSON	MS	39201	(601) 949-3100	
321	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	PO BOX 188004	CHATTANOOGA	TN	37422	(800) 222-2798	
322	TIME INSURANCE COMPANY	PO BOX 981602	EL PASO	TX	799980624	(800) 553-7654	USE 386 ASSURANT HEALTH
323	LINCOLN HERITAGE LIFE INSURANCE CO	PO BOX 10843	CLEARWATER	FL	337578843	(888) 586-8810	
324	HEALTH REIMBURSEMENT MANAGEMENT PARTNERSHIP	5 HUTCHINSON DR.	DANVERS	MA	01923	(888) 999-4767	CODE IN OPEN STATUS BY SCHA
325	PERSONAL CARE	PO BOX 7141	LONDON	KY	40742	(800) 431-1211	
326	PHYSICIANS HEALTH PLAN OF MID MICHIGAN	PO BOX 247	ALPHARETTA	GA	300090247	(800) 832-9186	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
327	MAIL HANDLERS BENEFIT PLAN	PO BOX 8402	LONDON	KY	40742	(800) 410-7778	
328	PROVIDER SELECT, INC.	PO BOX 330070	FORT WORTH	TX	76163	(866) 774-7766	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
329	SMITHFIELD FOODS HEALTHCARE	PO BOX 158	SMITHFIELD	VA	23431	(800) 809-5916	
330	ANNUITY BOARD OF SOUTHERN BAPTIST CONVENTION	PO BOX 2190	NASHVILLE	TN	37234	(214) 720-0511	
331	CONSECO HEALTH INS. CO	PO BOX 66904	CHICAGO	IL	606660904	(800) 541-2254	
332	HEALTH PLANS, INC.	PO BOX 5199	WESTBOROUGH	MA	01581	(800) 532-7575	
333	EXPRESS SCRIPTS	PO BOX 2902	CLINTON	IA	527332902	(800) 451-6245	
334	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	1750 PENNSYLVANIA AVE., NW	WASHINGTON	DC	20006	(800) 638-8432	
335	J.P. FARLEY CORP.	PO BOX 458022	WESTLAKE	OH	441468022	(440) 250-4300	
336	CASEBP (CATSKILL AREA SCHOOLS EMPLOYEE PLAN)	PO BOX 968022	SCHAUMBERG	IL	60196	(800) 962-6294	
337	BOARD OF PENSIONS OF THE PRESBYTERIAN CHURCH OF	PO BOX 13896	PHILADELPHIA	PA	19101	(800) 773-7752	
338	PITTMAN & ASSOCIATES, INC.	PO BOX 111047	MEMPHIS	TN	38111	(800) 238-1344	
339	CELTIC INDIVIDUAL HEALTH	PO BOX 33839	INDIANAPOLIS	IN	462030839	(800) 477-7870	
340	UNITED HEALTHCARE PLAN OF RIVER VALLEY	3800 23RD AVE. OF THE CITIES, STE. 200	MOLINE	IL	61265	(800) 224-6602	THIS COMPANY BOUGHT OUT JOHN DEERE INS. CO. 6/29/07
341	ADMINISTRATIVE CONCEPTS, INC.	994 OLD EAGLE SCHOOL RD., STE. 1005	WAYNE	PA	19087	(888) 293-9229	
342	SUN LIFE INSURANCE COMPANY OF CANADA	ONE SUN LIFE EXECUTIVE PARK	WELLESLEY	MA	02181	(800) 225-3950	
343	GROUP BENEFITS ADMINISTRATORS	70 GRAND AVE.	RIVEREDGE	NJ	07661	(201) 343-3003	
344	ALIA CLAIMS DEPARTMENT	PO BOX 9060	PHOENIX	AZ	850689060	(800) 882-5707	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
345	EMPLOYEE BENEFIT SERVICES, INC.	PO BOX 1929	FORT MILL	SC	29716	(800) 242-1510	
346	ADMINISTRATIVE SERVICES, INC.	2187 NORTHLAKE PARKWAY STE. 106 BLD #9	TUCKER	GA	30084	(770) 934-3953	
347	PREFERRED CARE, INC. (PCI)	1300 VIRGINIA DR., STE. 315	FORT WASHINGTON	PA	19034	(800) 222-3085	
348	FIRST AGENCY, INC.	5071 WEST H AVE.	KALAMAZOO	MI	490098501	(269) 381-6630	THIS CODE ASSIGNED BY SCHA 8/28/07
349	HEALTH PLAN SELECT	PO BOX 382767	BIRMINGHAM	AL	352382767	(800) 293-6260	
350	NORTH AMERICA ADMINISTRATORS	PO BOX 1984	NASHVILLE	TN	37203	(615) 256-3561	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
351	FISERV	PO BOX 8077	WAUSAU	WI	544028077	(866) 684-8090	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
352	FISERV HEALTH-COLORADO	PO BOX 720	PUEBLO	CO	810020720	(800) 446-8182	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
353	ONE HEALTH PLAN OF SC	PO BOX 190019	N CHARLESTON	SC	29419	(800) 314-9010	CODE ASSIGNED BY SCHA
354	FIRST BENEFITS CORP	PO BOX 879	ANDERSON	IN	46015	-	CODE ASSIGNED BY SCHA
355	ACTIVA HEALTH GROUP	4350 E. CAMELBACK RD. # 200	PHOENIX	AZ	85018	(602) 468-9500	
356	UMR	PO BOX 2697	WICHITA	KS	67201	(800) 826-9781	USE CODE 139
357	HEALTH PLAN SERVICES	PO BOX 30298	TAMPA	FL	33630	(800) 237-7767	
358	BAKERY & CONFECTIONERY UNION	10401 CONNECTICUT AVE. STE 300	KENSINGTON	MD	208953960	(301) 468-3742	
359	NORTH CAROLINA MUTUAL LIFE INSURANCE	411 W. CHAPEL HILL ST.	DURHAM	NC	27701	(919) 682-9201	
360	NEW ENGLAND FINANCIAL	PO BOX 190019	N. CHARLESTON	SC	29419	(800) 408-7681	USE CARRIER 859 NEW ENGLAND GROUP TRUST
361	MDI GOVERNMENT HEALTH SERVICES	822 HIGHWAY A1A NORTH STE 310	PONTE VEDRA BEACH	FL	32082	(800) 841-6288	CODE ASSIGNED BY SCHA
362	GUARDIAN HEALTHCARE	PO BOX 4197	SCRANTON	PA	18505	(866) 850-1253	MEDICARE ADVANTAGE PLAN
363	PEARCE ADMINISTRATION	PO BOX 2437	FLORENCE	SC	29503	(888) 622-6001	GM SOUTHWEST IS THE CLAIMS PROCESSOR FOR PEARCE ADMINISTRATION
364	CORESTAR	PO BOX 1195	MINNEAPOLIS	MN	55440	(800) 444-6965	
365	GERBER CHILDRENS WEAR, INC.	PO BOX 2126	GREENVILLE	SC	29602	(864) 987-5200	
366	CATALYST RX	PO BOX 968022	SCHAUMBERG	IL	601968022	(800) 997-3784	
367	LOOMIS INSURANCE COMPANY	PO BOX 7011	WYOMISSING	PA	196107011	(800) 782-0392	
368	MED BENEFITS SYSTEM	PO BOX 177	SOUTH BEND	IN	46601	(219) 237-0560	
369	AMERICAN INTERNATIONAL GROUP	PO BOX 25050	WILMINGTON	DE	19899	(800) 468-7077	
370	DELTAHEALTH SYSTEMS	PO BOX 9554	SALT LAKE	UT	84109	(877) 474-0605	WAS P5 HEALTH PLUS SOLUTIONS
371	ICON BENEFIT ADMINISTRATORS, INC.	PO BOX 53010	LUBBOCK	TX	794533070	(800) 658-9777	
372	MEDIPLAN	502 VALLEY RD.	WAYNE	NJ	07410	(973) 696-3111	
373	STATE FARM INSURANCE COMPANIES	7401 CYPRESS GARDENS BLVD.	WINTER HAVEN	FL	338880007	(863) 318-3000	
374	STONEBRIDGE LIFE INSURANCE CO.	2700 W. PLANO PARKWAY	PLANO	TX	75075	(800) 331-9955	
375	RESTAT	11900 WESTLAKE PARK DR.	MILWAUKEE	WI	53224	(800) 926-5858	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
376	TUFTS HEATH PLAN	PO BOX 9171	WATERTOWN	MA	024719171	(800) 462-0224	
377	MERITAIN HEALTH	PO BOX 27267	MINNEAPOLIS	MN	554270267	(800) 925-2272	WAS NORTH AMERICAN ADMINISTRATORS, INC.
378	SELF INSURERS SERVICE, INC.	2218 SOUTH PRIEST DR.	TEMPE	AZ	85282	-	
379	GOODYEAR TIRE & RUBBER COMPANY	PO BOX 677 DEPT. 609	AKRON	OH	44309	(216) 796-6531	
380	BENMARK, INC.	PO BOX 16767	JACKSON	MS	39236	(601) 366-0596	
381	PROVIDENT INDEMNITY LIFE INSURANCE COMPANY	PO BOX 511	NORRISTOWN	PA	19404	(800) 519-9175	
382	HEALTH PLAN OF NEVADA	PO BOX 15645	LAS VEGAS	NV	891145615	(800) 777-1840	MEDICARE ADVANTAGE PLAN
383	AMERICAN HEALTHCARE ALLIANCE	PO BOX 8530	KANSAS CITY	MO	641140530	(877) 284-0102	
384	NORTH AMERICAN BENEFIT NETWORK	PO BOX 94928	CLEVELAND	OH	441014928	(800) 321-4085	
385	POSTMASTERS BENEFIT PLAN	1019 N. ROYAL ST.	ALEXANDRIA	VA	22314	(703) 683-5585	
386	ASSURANT HEALTH	PO BOX 2806	CLINTON	IA	527332806	(800) 553-7654	WAS FORTIS INSURANCE COMPANY
387	HEALTHGRAM	PO BOX 11088	CHARLOTTE	NC	28220	(800) 446-5439	HEALTHGRAM FORMERLY PRIMARY PHYSICIAN CARE
388	NATIONALWAY HEALTHCARE ASSOCIATES	PO BOX 682708	HOUSTON	TX	77268	(800) 810-7856	
389	GROUP LINK	PO BOX 20593	INDIANAPOLIS	IN	46220	(800) 359-7408	
390	BOARD OF PENSIONS EVANGELICAL LUTHERAN CHURCH	PO BOX 59093	MINNEAPOLIS	MN	554590093	(612) 333-7651	
391	POMCO	PO BOX 6329	SYRACUSE	NY	13217	(800) 234-4393	
392	SELF FUNDED GROUP INSURANCE ADMINISTRATORS	PO BOX 1719	KALAMAZOO	MI	490051790	(800) 342-1895	
393	FOUNTAINHEAD ADMINISTRATORS, INC.	PO BOX 13188	BIRMINGHAM	AL	35202	(800) 991-9155	
394	P5 HEALTH PLAN SOLUTIONS	PO BOX 9554	SALT LAKE CITY	UT	84109	(877) 474-0605	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
395	PINNACLE CLAIMS MANAGEMENT, INC.	1630 E SHAW AVE., STE. 190	FRESNO	CA	93710	(800) 649-9121	CODE ASSIGNED BY SCHA
396	MACY'S HR SERVICES	PO BOX 850958	RICHARDSON	TX	75085	(800) 337-2363	CODE ASSIGNED BY SCHA
397	PRIME THERAPEUTIC	PO BOX 25136	LEHIGH VALLEY	PA	18002	(800) 423-1973	
398	RIGHT CHOICE BENEFITS ADMINISTRATORS	12250 WEBER HILL RD., STE. 100	ST. LOUIS	MO	63127	(800) 365-9036	CODE ASSIGNED BY SCHA
399	PACIFIC LIFE AND ANNUITY	PO BOX 34799	PHOENIX	AZ	85067	(800) 733-2285	
400	STATE EMPLOYEES HEALTH PLAN BLUE CROSS	4101 PERCIVAL RD.	COLUMBIA	SC	29219	(800) 868-2520	CLAIMS SHOULD BE SENT TO THE ATTN OF SARAH TOWNES AX-B10

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
401	BLUE CROSS AND BLUE SHIELD OF SC	PO BOX 100300	COLUMBIA	SC	29202	(803) 788-3860	DO NOT USE FOR MEDICARE.THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE. STREET ADDRESS 4101 PERVICAL RD. COLA 29219
402	FEDERAL EMPLOYEE PLAN BLUE CROSS	I-20 AT ALPINE RD.	COLUMBIA	SC	29260	(803) 788-3860	
403	BLUE CHOICE/MEDICAID	PO BOX 6170	COLUMBIA	SC	29260	(877) 275-3256	MEDICAID HMO
404	BOB JONES UNIVERSITY	1700 WADE HAMPTON BLVD.	GREENVILLE	SC	29614	(864) 370-1800	
405	MARSH(INSURANCE TRUST PLAN-DELTA RETIREES)	PO BOX 10432	DES MOINES	IA	503060432	(877) 325-7265	CODE ASSIGNED BY SCHA
406	RURAL CARRIER BENEFIT PLAN	PO BOX 7404	LONDON	KY	40742	(800) 638-8432	
407	CINERGY HEALTH INS.	1844 N. NOB HILL RD. #623	PLANTATION	FL	33322	(800) 847-1148	
408	LIFE INVESTORS INSURANCE COMPANY OF AMERICA	PO BOX 8043	LITTLE ROCK	AR	72203	(501) 376-0426	AKA AEGON
409	UPSTATE ADMINISTRATIVE SERVICES	PO BOX 6589	SYRACUSE	NY	132176589	(315) 422-1533	
410	SAFECO INSURANCE COMPANY	PO BOX 34699	REDMOND	WA	981241699	(206) 867-8000	
411	INTERPLAN HEALTH GROUP	PO BOX 90613	ARLINGTON	TX	76006	-	CODE ASSIGNED BY SCHA
412	CONNECTICARE	PO BOX 546	FARRINGTON	CT	06034	(800) 251-7722	
413	ALLIED BENEFITS SYSTEM	PO BOX 909786-60690	CHICAGO	IL	606909786	(800) 288-2078	
414	NATIONAL TELEPHONE COOP. ASSN.	1 WEST PACK SQUARE, STE. 600	ASHEVILLE	NC	28801	(828) 252-9776	
415	WEYCO, INC.	PO BOX 30132	LANSING	MI	48909	(517) 349-7010	
416	COMPANION BENEFIT ALTERNATIVES	PO BOX 100185	COLUMBIA	SC	29202	(800) 868-1032	THIS CARRIER ASSIGNED BY SCHA NOT REQUESTED OR USED BY DHHS.
417	JULY PRODUCTS	5 GATEWAY CENTER STE 60	PITTSBURG	PA	15222	(866) 900-8322	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
418	GUARDIAN INSURANCE COMPANY	PO BOX 8007	APPLETON	WI	549128007	(800) 685-4542	CODE ASSIGNED BY SCHA
419	GEORGIA STATE HEALTH BENEFIT PLAN	PO BOX 38151	ATLANTA	GA	30334	(800) 626-6402	
420	CUNA MUTUAL INSURANCE GROUP	PO BOX 391	MADISON	WI	53701	(608) 238-5851	
421	UNITED FOOD & COMMERICAL WORKER HEALTH&WELFARE	911 RIDGEBROOK RD	SPARKS	MD	211529451	(800) 638-2972	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
432	M-PLAN CARDINAL HEALTH	PO BOX 357	LINTHICUM	MD	210900357	(800) 675-2605	CODE ASSIGNED BY SCHA
433	COMPANION LIFE	PO BOX 100102	COLUMBIA	SC	29202	(803) 788-0500	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
434	PIEDMONT HEALTH ALLIANCE	116 BONHAM CT.	ANDERSON	SC	29621	(864) 375-9661	
435	SEABURY AND SMITH COMPANY, INC.	PO BOX 2545	NASHVILLE	TN	37219	(800) 582-2498	
436	DAVIS-GARVIN AGENCY	#1 FERNANDINA CT.	COLUMBIA	SC	29212	(803) 732-0060	
437	NEW ERA LIFE INSURANCE CO	PO BOX 4884	HOUSTON	TX	772104884	(281) 368-7200	
438	MAMSI LIFE AND HEALTH INSURANCE CO	PO BOX 993	FREDRICKS	MD	21705	(800) 257-6458	
439	UNION SECURITY INSURANCE CO	PO BOX 981602	EL PASO	TX	79998	(800) 444-6254	USE 386 ASSURANT HEALTH
440	HEALTHNET	PO BOX 14702	LEXINGTON	KY	40512	(800) 641-7761	
441	FEDERAL MOGUL HEALTHCARE	PO BOX 1999	DETROIT	MI	48235	(800) 522-0041	
442	GE LIFE & ANNUITY ASSURANCE CO.	PO BOX 6700	LYNCHBURG	VA	24505	(800) 253-0856	
443	COVENTRY HEALTHCARE OF KANSAS	PO BOX 7109	LONDON	KY	39026	(866) 785-8077	CODE ASSIGNED BY SCHA
444	NATIONAL DISASTER MEDICAL SYSTEM					-	
445	CAROLINA CARE PLAN/MEDICAL MUTUAL INS. CO. OF OHIO	PO BOX 6018	CLEVELAND	OH	441011018	(800) 315-3143	ALSO KNOWN AS SUPERMED ANOTHER PHONE # 800-232-3143
446	EMPLOYEE BENEFIT SERVICES	PO BOX 9888	SAVANNAH	GA	314120088	(803) 577-8051	USE CODE 345 EMPLOYEE BENEFIT SERVICES
447	HEALTH NET	PO BOX 14700	LEXINGTON	KY	405125225	(900) 438-7886	MEDICARE ADVANTAGE PLAN
448	ASSURANT HEALTH INSURANCE	PO BOX 42033	HAZELWOOD	MD	63042	(800) 553-7654	CODE ASSIGED BY SCHA
449	UNITED SERVICE ASSO. FOR HEALTHCARE	PO BOX 6080-288	MISSION VAIEJO	CA	926906080	(800) 872-1187	CODE ASSIGNED BY SCHA
450	DESERET SECURE	PO BOX 45530	SALT LAKE CITY	UT	841450530	(877) 220-0110	MEDICARE ADVANTAGE PLAN
451	ASSURECARE RISK MANAGEMENT	340 QUANRINGLE BLVD.	BOILING BROOK	IL	60440	(800) 759-7422	
452	CIGNA INTERNATIONAL EXPATRIATE BENEFITS	PO BOX 15050	WILMINGTON	DE	19850	(800) 441-2668	
453	BLUE CROSS ANTHEM MEDICARE ADVANTAGE	2100 CORPORATE CENTER	NEWBURY PARK	CA	913201431	(800) 676-2583	MEDICARE ADVANTAGE PLAN
454	INTERNATIONAL UNION OF OPERATING ENGINEERS	166 WEST KELLY ST.	METUCHEN	NJ	08840	(908) 548-6662	
455	ALASKA TEAMSTER TRUST	520 E 34TH AVE., STE. 107	ANCHORAGE	AK	995034116	(800) 478-4450	CODE ASSIGNED BY SCHA
456	FIRST HEALTH (A COVENTRY HEALTH CARE CO)	PO BOX 21680	EAGAN	MN	551210680	(866) 477-5465	
457	COMMERICAL TRAVELERS	70 GENESSE ST.	UTICA	NY	13502	(800) 756-3702	CODE ASSIGNED BY SCHA
458	ASSOCIATION BENEFIT PLAN (MEDICARE)	PO BOX 668587	CHARLOTTE	NC	282668587	(800) 634-0069	CODE ASSIGNED BY SCHA
459	GLASS MOTORS & PLASTIC (GMPA)	5245 BIG PINE WAY, SE 33907	FORT MYERS	FL	33907	(813) 936-6242	
460	MORRIS ASSOCIATES	PO BOX 50440	INDIANAPOLIS	IN	462500440	(317) 554-9000	
461	EVERCARE	PO BOX 31350	SALT LAKE CITY	UT	841310350	(888) 866-8298	MEDICARE ADVANTAGE PLAN
462	1ST MEDICAL NETWORK	PO BOX 724317	ATLANTA	GA	31139	(888) 980-6676	CODE ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
463	TIM BAR CORP	PO BOX 449	HANOVER	PA	17331	(717) 632-4727	
464	INTERNATIONAL MEDICAL GROUP	407 N. FULTON ST.	INDIANAPOLIS	IN	46202	(800) 628-4664	
465	INTER CARE BENEFIT SYSTEMS	PO BOX 3559	ENGLEWOOD	CO	801553559	(303) 770-5710	
466	VALUE RX	PO BOX 421150	PLYMOUTH	MN	554420150	(800) 955-4879	USE CODE 333 EXPRESS SCRIPTS
467	FIRSERV HEALTH	PO BOX 182173	COLUMBUS	OH	432182173	(800) 848-2664	USE CODE 139
468	PHOENIX HEALTHCARE	PO BOX 150809	ARLINGTON	TX	76015	(800) 397-6241	
469	AMERICAN ASSOCIATION OF RETIRED PERSONS (AARP)	PO BOX 740819	ATLANTA	GA	30374	(800) 523-5880	
470	YODER BROTHERS	1001 LEBANON RD	PENDLETON	SC	29670	(864) 646-8331	
471	CAREMARK	PO BOX 52195	PHOENIX	AZ	850722195	(800) 303-0187	
472	NATIONAL HEALTH CARE HEALTH BENEFITS PLAN(NHC)	PO BOX 1398	MURFREESBORO	TN	371331398	(615) 890-2020	
473	INTERNATIONAL MISSION BOARD (IMB)	PO BOX 6767	RICHMOND	VA	232300767	(804) 219-1585	CODE ASSIGNED BY SCHA
474	DIVERSIFIED PHARMACUETICAL	PO BOX 169052	DULUTH	MN	55816	(800) 233-8065	USE CODE 333 EXPRESS SCRIPTS
475	BENEFIT ASSISTANCE CORP.	PO BOX 950	HURRICANE	WV	25526	(304) 562-1913	
476	CENTRAL STATES, SOUTHEAST & SOUTHWEST	PO BOX 5116	DEPLAINES	IL	60017	(800) 323-5000	
477	MEGA LIFE AND HEALTH INSURANCE COMPANY	PO BOX 981606	EL PASO	TX	79998	(800) 527-2845	
478	SMITH ADMINISTRATORS	PO BOX 163289	FORT WORTH	TX	76161	(800) 867-2582	
479	PRIMEXTRA	PO BOX 1088	TWINSBURG	OH	44087	(800) 433-4893	
480	COVENTRY HEALTH CARE OF THE CAROLINAS	PO BOX 7715	LONDON	KY	40742	(800) 889-1947	COVENTRY HEALTH CARE IS PARENT CO. OF SOUTHERN HEALTH AND WELLPATH
481	BENOVATION	3481 CENTRAL PARKWAY, STE 200	CINCINNATI	OH	45223	(800) 681-6912	CODE ASSIGNED BY SCHA
482	COVENTRY HEALTHCARE OF GEORGIA	PO BOX 7711	LONDON	KY	40742	(866) 732-1017	
483	COOPERATIVE BENEFITS ADMINISTRATORS	PO BOX 6249	LINCOLN	NE	68506	(402) 483-9250	
484	INTEGRITY BENEFITS NETWORK	PO BOX 4537	MARIETTA	GA	30061	(770) 428-1604	
485	PROVIDENT HEALTH PLAN	PO BOX 3125	PORTLAND	OR	972083125	(800) 628-3912	CODE ASSIGNED BY SCHA
486	PREFERRED CARE	PO BOX 22920	ROCHESTER	NY	146922920	(800) 999-3920	MEDICARE ADVANTAGE PLAN
487	PIEDMONT INS COMPANY	PO BOX 979	MARION	SC	29571	(843) 423-5541	
488	AMERICAN BENEFITS MANAGEMENT	8310 PORT JACKSON AVE. NORTHWEST	NORTH CANTON	OH	44720	(330) 966-5500	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
489	SAVRX	PO BOX 8	FREEMONT	NE	68026	(800) 350-6714	
490	SHEET METAL LOCAL 20	PO BOX 42489	INDIANAPOLIS	IN	43242	(800) 248-2141	CODE ASSIGNED BY SCHA
491	VISION SERVICE PLAN	PO BOX 997100	SACRAMENTO	CA	958997100	(800) 622-7444	
492	LT11-LIFETRAC NETWORK	111100 WAYZATA BLVD.	MINNEAPOLIS	MN	55305	-	CODE ASSIGNED BY SCHA
493	UNITED TEACHERS ASSOCIATION	PO BOX 30010	AUSTIN	TX	787553010	(866) 880-8824	
494	AVESIS PHARMACY NETWORK	3724 N 3RD ST. STE 300	PHOENIX	AZ	85012	(602) 241-3400	
495	NATIONAL PRESCRIPTION ADMINISTRATORS	PO BOX 1981	EAST HANOVER	NJ	079361981	(800) 522-6727	BOUGHT OUT BY EXPRESS SCRIPTS CC333
496	AMERICAN VETERINARIAN MEDICINE ASSN.	PO BOX 909720	CHICAGO	IL	606049720	(800) 621-6360	
497	TEXAS INTERNATIONAL	PO BOX 11007	WINSTON-SALEM	NC	27116	(866) 307-4711	
498	CAROLINA BENEFIT ADMINISTRATORS	PO BOX 3257	SPARTANBURG	SC	29304	(864) 573-6937	
499	EMPLOYEE BENEFIT CONSULTANTS	PO BOX 928	FINDLAY	OH	45839	(800) 558-7798	
500	DELTA DENTAL	PO BOX 1809	ALPHARETTA	GA	30023	(800) 521-2651	
501	UNION FIDELITY INSURANCE COMPANY	4850 ST. RD.	TREVOSE	PA	19049-	(800) 523-6599	
502	HIP HEALTH PLAN	PO BOX 2803	NEW YORK	NY	101162803	(800) 447-8255	MEDICARE ADVANTAGE PLAN
503	AMERICAN SPECIAL RISK MANAGEMENT	509 SOUTH LENOLA RD., BLDG. TWO	MOORESTOWN	NJ	08057	(800) 359-7475	
504	M CARE	PO BOX 130799	ANN ARBOR	MI	481130779	(215) 657-8920	CODE IN OPEN STATUS BY SCHA
505	ASSOCIATED ADMINISTRATORS	PO BOX 27806	BALTIMORE	MD	212857806	(800) 638-2972	
506	EMPLOYEE BENEFIT PLAN ADMINISTRATORS	PO BOX 2000	EXETER	NH	03833	(800) 258-7298	
507	CENTRAL STATES HEALTH & LIFE CO. OF OMAHA	PO BOX 34350	OMAHA	NE	68134	(402) 397-1111	
508	GROUP HEALTH, INC. /EMBLEM HEALTH COMPANY	PO BOX 3000	NEW YORK	NY	101163000	(212) 501-4444	
509	EQUITABLE LIFE AND CASUALTY	PO BOX 2460	SALT LAKE CITY	UT	84110	(800) 352-5150	
510	EQUITABLE PLAN SERVICES	PO BOX 720460	OKLAHOMA	OK	73172	(800) 749-2631	
511	CIGNA BEHAVIORAL HEALTH	PO BOX 188022	CHATTANOOGA	TN	37422	(800) 336-4091	
512	ST11-STRATEGIC HEALTH	9501 NE 2ND AVE.	MIAMI SHORES	FL	33138	-	CODE ASSIGNED BY SCHA
513	VALUE OPTIONS	PO BOX 1347	LATHAM	NY	12110	(800) 288-0882	
514	JLT SERVICES (TPA FOR NY LIFE)	PO BOX 1511	LATHAM	NY	12110	(800) 793-3773	NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
515	LIFE OF THE SOUTH INSURANCE COMPANY	PO BOX 45237	JACKSONVILLE	FL	32232	(800) 661-6385	THIS CODE ASSIGNED BY SCHA NOT A MEDICAID REQUEST

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
516	DIRECT REIMBURSEMENT BENEFIT PLANS	1111 ALDERMAN DR., STE. 420	ALPHARETTA	GA	30202	(770) 664-5594	
517	UNIFORM MEDICAL PLAN	PO BOX 34850	SEATTLE	WA	98124	(800) 762-6004	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
518	NAT'L ASBESTOS WORKERS MED FUND	PO BOX 188004	CHATTANOOGA	TN	37422	(800) 386-3632	
519	HEALTHSOURE ADMINISTRATORS	PO BOX 382617	BIRMINGHAM	AL	35238	(877) 893-9294	
520	NEW JERSEY CARPENTERS	PO BOX 7818	EDISON	NJ	088180846	(800) 624-3096	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
521	ALLIANCE PPO, INC.	PO BOX 934	FREDERICK	MD	21705	(800) 235-0123	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
522	NATIONAL AUTOMATIC SPRINKLER INDUSTRY	800 CORPORATE DR.	LANDOVER	MD	20785	(301) 577-1700	
523	APA PARTNERS, INC.	PO BOX 1506	LATHAM	NY	121108006	(800) 833-3650	
524	HEALTHFIRST	PO BOX 130217	TYLER	TX	75713	(800) 477-8957	CODE ASSIGNED BY SCHA TPA
525	CONSECO MEDICAL INSURANCE CO.	PO BOX 1205	ROCKFORD	IL	61105	(800) 947-0319	USE CODE 282 WASHINGTON NATIONAL
526	AULTCARE	PO BOX 6910	CANTON	OH	44706	(800) 344-8858	
528	KAISER PERMANENTE	PO BOX 190849	ATLANTA	GA	31119	(800) 611-1811	MEDICARE ADVANTAGE PLAN
529	ANTHEM HEALTH	3575 KROGER BLVD. , STE. 400	DULUTH	GA	30316	(800) 888-1966	
530	UNIVERSAL BENEFITS CORPORATION	PO BOX 97	SCRANTON	PA	185040097	(800) 747-0622	CODE ASSIGNED BY SCHA
531	MARY BLACK HEALTHNETWORK	1690 SKYLYN DR., STE.,130	SPARTANBURG	SC	29307	(864) 573-3535	
532	AMERICAN MEDICAL SECURITY	PO BOX 19032	GREEN BAY	WI	543079032	(800) 232-5432	
533	PHYSICIANS CARE NETWORK	PO BOX 101111	COLUMBIA	SC	292111111	(888) 323-9271	
534	PROVANTAGE PRESCRIPTION BENEFIT MANAGEMENT SERVICE	PO BOX 1662	WAUKEHA	WI	53187	(262) 784-4600	
535	CHP DIRECT/SUPERMED	PO BOX 94648	CLEVELAND	OH	441014648	(800) 773-1445	
536	CLAIMSWARE MANAGEMED	PO BOX 6125	GREENVILLE	SC	29606	(864) 234-8200	
537	KAISER PERMANENTE-OHIO REGION	PO BOX 5316-9774	CLEVELAND	OH	441010316	(800) 634-8816	CODE ASSIGNED BY SCHA
538	PENN GENERAL SERVICES	PO BOX 72077	ATLANTA	GA	303581535	(800) 444-1535	CODE ASSIGNED BY SCHA
539	MEDICAL MUTUAL INSURANCE OF OHIO	PO BOX 94648	CLEVELAND	OH	44101	(800) 362-1279	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
540	LIBERTY NATIONAL LIFE INSURANCE COMPANY	PO BOX 2612	BIRMINGHAM	AL	35202	(205) 325-2722	
541	CHILDRENS REHAB SERVICES	PO BOX 4217	SPARTANBURG	SC	293054217	(864) 596-2227	CODE ASSIGNED BY SCHA
542	THIRD PARTY ADMINISTRATORS/AMERICAN BENEFIT	1733 PARK ST.	NAPERVILLE	IL	60563	(800) 631-5917	
543	ACHA/CAREINGTON INTERNATIONAL CORP	PO BOX 2568	FRISCO	TX	75034	(800) 290-0523	CODE ASSIGNED BY SCHA
545	MOLINA HEALTHCARE OF OHIO	PO BOX 22712	LONGBEACH	CA	90801	(800) 642-4148	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
546	RISK MANAGEMENT SERVICES	PO BOX 6309	SYRACUSE	NY	13217	(315) 448-9000	
547	HARRINGTON HEALTH	PO BOX 30544	SALT LAKE CITY	UT	841300544	(877) 737-0769	
548	COMPBENEFITS INSURANCE CO.	PO BOX 804483	CHICAGO	IL	606804106	(800) 594-0977	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
549	WAL-MART STORES GROUP HEALTH PLAN	922 W. WALNUT STE. A	ROGERS	AR	72756 320	(501) 621-2929	USE CODE 401 BLUE CROSS BLUE SHIELD OF SC
550	EMPLOYEE SECURITY, INC.	7125 THOMAS EDISON DR., STE. 105	COLUMBIA	MD	21046	(800) 638-1134	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
551	COOPERATIVE MANAGED CARE SERVICES LLC	PO BOX 502530	INDIANAPOLIS	IN	46250	(866) 873-4516	CODE IN OPEN STATUS BY SCHA
552	CORESOURCE, INC.	PO BOX 2920	CLINTON	IA	52733	(800) 327-5462	
553	HEALTHSCOPE BENEFITS, INC..	PO BOX 99005	LUBBOCK	TX	79490	(888) 373-6102	
554	DIAMOND G EMPLOYEE BENEFIT TRUST	PO BOX 1298	GREENVILLE	TN	37744	(423) 639-6145	
555	PHILADELPHIA AMERICAN LIFE INSURANCE CO	PO BOX 4884	HOUSTON	TX	772104882	(800) 552-7879	CODE ASSIGNED BY SCHA
556	UNIFIED GROUP SERVICES	PO BOX 10	PENDLETON	IN	46064	(765) 778-1535	
557	AMERICORP INS. CO	PO BOX 3430	CARMEL	IN	46082	(866) 699-4186	
558	NATIONAL TRAVELERS LIFE INS. CO.	PO BOX 9197	DES MOINES	IA	50306	(800) 232-5818	INACTIVE 8/02
559	CAROLINA HOSPITAL SYSTEMS BENEFIT PLAN	PO BOX 100569	FLORENCE	SC	295010659	(843) 661-3875	
560	ALLEN MEDICAL CLAIMS ADMINISTRATORS	PO BOX 978	FT. VALLEY	GA	310300978	(800) 825-5406	
561	PHOENIX MUTUAL LIFE INSURANCE COMPANY	ONE AMERICAN ROW	HARTFORD	CT	06115	(800) 451-2513	THIS CARRIER PURCHASED BY CC864 GE GROUP ADMINISTRATORS
562	HEALTH CLAIMS SERVICES,INC.	PO BOX 9615	DEERFIELD BEACH	FL	33442	(800) 222-3560	
563	ADMINISTRATIVE SERVICE CONSULTANTS	3301 E ROYALTON RD. BLDG. D	BROADVIEW HEIGHTS	OH	44147	-	
564	MULTINATIONAL UNDERWRITERS	PO BOX 863	INDIANAPOLIS	IN	46206	(800) 605-2282	CODE ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
565	UNITED BENEFITS	PO BOX 2480	DAYTONA BEACH	FL	321152480	(800) 434-4890	WAS POE & BROWN
566	UNIFIED GROUP SERVICES	PO BOX 10	PENDLETON	IN	46064	(765) 778-1535	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
567	EASTERN BENEFIT SYSTEMS	200 FREEWAY DR. E.	EAST ORANGE	NJ	07018	(800) 524-0227	
568	SIMPLIFI	PO BOX 922043	HOUSTON	TX	772922043	(888) 446-5710	FORMERLY CBCA ADMINISTRATORS
569	MARYLAND PHYSICIANS CARE	PO BOX 61778	PHOENIX	AZ	85082	(800) 953-8854	CODE IN OPEN STATUS BY SCHA
570	SAMBA HEALTH BENEFIT PLAN	11301 OLD GEORGETOWN RD	ROCKVILLE	MD	20852	(800) 638-6589	
571	CORESOURCE, INC.	PO BOX 8215	LITTLE ROCK	AR	722218215	(888) 604-9397	CODE IN OPEN STATUS BY SCHA
572	CATAMARAN	PO BOX 968022	SCHAUMBERG	IL	601968022	(877) 839-8119	FORMERLY HEALTH TRANS
573	ST JOHN'S CLAIMS ADMINISTRATION	PO BOX 14409	SPRINGFIELD	MO	65814	(877) 875-7700	
574	CITY OF AMARILLO GROUP HEALTH	PO BOX 15130	AMARILLO	TX	79105	(806) 378-4235	CODE IN OPEN STATUS BY SCHA
575	WISCONSIN ELECTRICAL EMPLOYEES	PO BOX 2430	BROOKFIELD	WI	53008	(608) 276-9111	CODE IN OPEN STATUS BY SCHA
576	SIOUX VALLEY HEALTH	PO BOX 91110	SIOUX FALLS	SD	57109	(800) 752-5863	
577	HEALTHMARKETS CARE ASSURED	PO BOX 69349	HARRISBURG	PA	17110	(877) 219-5460	CODE ASSIGNED BY SCHA
578	PROFESSIONAL ADMINISTRATORS, INC.	3751 MAGUIRE BLVD., STE. 100	ORLANDO	FL	32814	(800) 741-0521	
579	ANTHEM PRESCRIPTION MANAGEMENT	PO BOX 145433	CINCINNATI	OH	45250	(800) 662-0210	USE CARRIER A24
580	WORLD INSURANCE COMPANY	PO BOX 3160	OMAHA	NE	681030160	(402) 496-8000	
581	ALTA RX	PO BOX 30081	SALT LAKE CITY	UT	84130	(800) 998-5033	
582	USAA GENERAL INDEMNITY CO.	PO BOX 15506	SACRAMENTO	CA	958521506	(800) 531-8222	
583	ONE NATION BENEFIT ADMINISTRATORS	PO BOX 528	COLUMBUS	OH	43216	(800) 824-6796	NAME CHANGE WAS ANTHEM BENEFIT ADMINISTRATORS
584	UNITED HEALTH ONE	PO BOX 31374	SALT LAKE CITY	UT	841310374	(800) 657-8205	FORMALLY GOLDEN RULE
585	PLUMBERS & STEAMFITTERS WELFARE FUND	1024 MCKINLEY ST.	PEEKSILL	NY	10566	(914) 737-7220	
586	MCA ADMINISTRATORS (MANAGED CARE OF AMERICA)	MANOR OAK TWO, STE 605 1910 COCHRAN RD	PITTSBURGH	PA	15220	(412) 922-0780	WAS DIVERSIFIED GROUP ADMINISTRATORS
587	FUTURE SCRIPTS	PO BOX 419019	KANSAS CITY	MO	64141	(888) 678-7012	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
588	AUTOMATED BENEFIT SERVICES, INC.	PO BOX 321223	DETROIT	MI	482321223	(800) 275-1896	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
589	POLY AMERICA LP	2000 W MARSHALL DR.	GRAND PRAIRIE	TX	75051	(800) 785-5301	CODE IN OPEN STATUS BY SCHA
590	PHYSICIANS HEALTH SERVICES	PO BOX 981	BRIDGEPORT	CT	06601	(800) 848-4747	
591	OLD AMERICAN INSURANCE COMPANY	PO BOX 418573	KANSAS CITY	MO	64141	(816) 753-4900	
592	CONTEC	525 LOCUS GROVE RD.	SPARTANBURG	SC	29303	(864) 503-8333	CODE ASSIGNED BY SCHA
593	MUTUAL ASSURANCE ADMINISTRATORS, INC.	PO BOX 42096	OKLAHOMA CITY	OK	73123	(800) 648-9652	
594	NORWEST FINANCIAL	206 EIGHTH ST.	DES MOINES	IA	50309	(515) 243-2131	CODE ASSIGNED BY SCHA
595	AFLAC -AMERICAN FAMILY LIFE ASSO CO	1932 WYNNTON RD.	COLUMBUS	GA	31999	(800) 992-3522	
596	SECURE HORIZONS	PO BOX 659787	SAN ANTONIO	TX	782659787	(866) 579-8811	MEDICARE ADVANTAGE PLAN
597	MONARCH DIRECT	PO BOX 9004	SPRINGFIELD	MA	01101	(800) 628-9000	
598	WJB DORN VA MEDICAL CENTER	6439 GARNERS FERRY RD	COLUMBIA	SC	292091639	(803) 776-4000	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
599	NATIONAL ELEVATOR INDUSTRY HEALTH BENEFITS	PO BOX 477	NEWTOWN SQUARE	PA	190730477	(800) 523-4702	
603	OTHER INDIGENT (HOSPITAL CHARITY)			SC		-	
604	CHAMPVA	PO BOX 469064	DENVER	CO	80246	(303) 331-7599	
606	VOCA.REHAB GENERAL					-	
607	WPS TRICARE FOR LIFE	PO BOX 7889	MADISON	WI	537077889	(866) 773-0404	
608	VOCATIONAL REHAB DISABILITY					-	
609	COMM FOR BLIND					-	
610	DHEC CANCER					-	
611	DHEC C. CHILDREN					-	
612	DHEC LOW RISK MATERNITY					-	
613	DHEC HIGH RISK MATERNITY					-	
614	TRICARE SOUTH REGION	PO BOX 7031	CAMDEN	SC	290217031	(800) 403-3950	INTERNET WWW.MYTRICARE.COM
615	DHEC STERILIZATION					-	
616	MEDICAID-OUT-OF-STATE					-	
617	MEDICARE RAILROAD (PGBA) PROFESSIONAL PART B	PO BOX 10066	AUGUSTA	GA	30999	(877) 288-7600	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
618	MEDICARE PART A					-	
619	MEDICAID, SC					-	
620	MEDICARE PART B ONLY					-	
621	DEPT CORRECTIONS					-	
622	WORKMEN'S COMP					-	
623	CAROLINA MEDICARE PRIME HMO	201 EXECUTIVE CENTER DR.	COLUMBIA	SC	29210	(803) 750-7473	MEDICARE ADVANTAGE PLAN
624	OTHER SPONSOR					-	
625	DHEC MIGRANT HEALTH					-	
626	DHEC SICKLE CELL					-	
627	DHEC HEART	-	-	-	-	-	
628	DHEC HEMOPHILIA	-	-	-	-	-	
629	DHEC FAMILY PLANNING	-	-	-	-	-	
630	DHEC TB	-	-	-	-	-	
631	SHRINERS	-	-	-	-	-	
632	CRIME VICTIMS	-	-	-	-	-	
633	VETERANS ADMINISTRATION	-	-	-	-	-	
635	MUTUAL OF OMAHA	MUTUAL OF OMAHA PLAZA	OMAHA	NE	68175	(402) 342-7600	MEDICARE INTERMEDIARY PART A
636	MUTUAL OF OMAHA	MUTUAL OF OMAHA PLAZA	OMAHA	NE	68175	-	MEDICARE INTERMEDIARY PART B
637	SELECT HEALTH/FIRST CHOICE	PO BOX 7120	LONDON	KY	40742	(888) 276-2020	MEDICAID HMO
638	UNISON HEALTH PLAN HMO	250 BERRYHILL RD.	COLUMBIA	SC	29210	(803) 798-5852	MEDICAID HMO
639	HEALTHFIRST HMO	255 ENTERPRISE BLVD.. STE. 20	GREENVILLE	SC	29615	(864) 455-1100	MEDICAID HMO
642	TRICARE FOR LIFE	PO BOX 7890	MADISON	WI	537077890	(866) 773-0404	
643	BCBS OF TENNESSEE	730 CHESTNUT ST.	CHATTANOOGA	TN	37402	(877) 296-6189	MEDICARE INTERMEDIARY
644	BCBS OF GEORGIA	PO BOX 9907	COLUMBUS	GA	31908	(800) 441-2273	MEDICARE INTERMEDIARY
645	STERLING MEDICARE CHOICE HMO	PO BOX 70	LINTHIEUM	MD	21900	(615) 244-5600	MEDICARE ADVANTAGE PLAN
646	CIGNA-MEDICARE	PO BOX 671	NASHVILLE	TN	37202	(615) 244-5600	MEDICARE INTERMEDIARY
648	HUMANA GOLD CHOICE (PFFS)	PO BOX 7060	CAMDEN	SC	29020	(877) 511-5000	MEDICARE ADVANTAGE PLAN
650	ABBEVILLE COUNTY	-	-	-	-	-	
651	AIKEN COUNTY	-	-	-	-	-	
652	ALLENDALE COUNTY	-	-	-	-	-	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
653	ANDERSON COUNTY	-	-	-	-	-	
654	BAMBERG COUNTY	-	-	-	-	-	
655	BARNWELL COUNTY	-	-	-	-	-	
656	BEAUFORT COUNTY	-	-	-	-	-	
657	BERKELEY COUNTY	-	-	-	-	-	
658	CALHOUN COUNTY	-	-	-	-	-	
659	CHARLESTON COUNTY	-	-	-	-	-	
660	CHEROKEE COUNTY	-	-	-	-	-	
661	CHESTER COUNTY	-	-	-	-	-	
662	CHESTERFIELD COUNTY	-	-	-	-	-	
663	CLARENDON COUNTY	-	-	-	-	-	
664	COLLETON COUNTY	-	-	-	-	-	
665	DARLINGTON COUNTY	-	-	-	-	-	
666	DILLON COUNTY	-	-	-	-	-	
667	DORCHESTER COUNTY	-	-	-	-	-	
668	EDGEFIELD COUNTY	-	-	-	-	-	
669	FAIRFIELD COUNTY	-	-	-	-	-	
670	FLORENCE COUNTY	-	-	-	-	-	
671	GEORGETOWN COUNTY	-	-	-	-	-	
672	GREENVILLE COUNTY	-	-	-	-	-	
673	GREENWOOD COUNTY	-	-	-	-	-	
674	HAMPTON COUNTY	-	-	-	-	-	
675	HORRY COUNTY	-	-	-	-	-	
676	JASPER COUNTY	-	-	-	-	-	
677	KERSHAW COUNTY	-	-	-	-	-	
678	LANCASTER COUNTY	-	-	-	-	-	
679	LAURENS COUNTY	-	-	-	-	-	
680	LEE COUNTY	-	-	-	-	-	
681	LEXINGTON COUNTY	-	-	-	-	-	
682	MARION COUNTY	-	-	-	-	-	
683	MARLBORO COUNTY	-	-	-	-	-	
684	MCCORMICK COUNTY	-	-	-	-	-	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
685	NEWBERRY COUNTY	-	-	-	-	-	
686	OCONEE COUNTY	-	-	-	-	-	
687	ORANGEBURG COUNTY	-	-	-	-	-	
688	PICKENS COUNTY	-	-	-	-	-	
689	RICHLAND COUNTY	-	-	-	-	-	
690	SALUDA COUNTY	-	-	-	-	-	
691	SPARTANBURG COUNTY	-	-	-	-	-	
692	SUMTER COUNTY	-	-	-	-	-	
693	UNION COUNTY	-	-	-	-	-	
694	WILLIAMSBURG COUNTY	-	-	-	-	-	
695	YORK COUNTY	-	-	-	-	-	
696	OUT-OF-STATE GA	-	-	-	-	-	
697	OUT-OF-STATE NC	-	-	-	-	-	
698	OUT-OF-STATE OTHER	-	-	-	-	-	
700		-	-	-	-		
701	UNI-CARE CHOICE HEALTH BENEFITS	PO BOX 51130	SPRINGFIELD	MA	01151	(800) 288-8630	
702	BOON CHAPMAN BENEFIT ADMINISTRATORS	PO BOX 9201	AUSTIN	TX	787669201	(800) 252-9653	CODE ASSIGNED BY SCHA
703	TUCKER COMPANY & ADMINISTRATORS	9140 ARROW POINT BLVD. #200	CHARLOTTE	NC	282738102	(704) 525-9666	
704	UNITED FOOD & COMMERICAL WORKERS (UFCW)	1800 PHOENIX BLVD. STE. 310	ATLANTA	GA	30349	(800) 241-7701	
705	APS HEALTHCARE, INC.	PO BOX 1307	ROCKVILLE	MD	20849	(800) 221-8699	
706	PLUMBERS & PIPEFITTERS LOCAL NO. 421	PO BOX 840	MACON	GA	312020840	(888) 741-2673	
707	DILLON YARN MEDICAL BENEFITS	1019 TITAN RD	DILLON	SC	29536	(843) 774-7353	
708	PERFORMAX	PO BOX 61505	KING OF PRUSSIA	PA	19406	(888) 554-7629	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
709	MERCER ADMINISTRATION	PO BOX 4546	IOWA CITY	IA	52244	(800) 868-7526	
710	21ST CENTURY HEALTH AND BENEFITS, INC.	PO BOX 5037	CHERRY HILL	NJ	08034	(800) 323-4890	
711	LABORERS DISTRICT COUNCIL OF GA AND SC	PO BOX 607	JONESBORO	GA	302370607	(404) 477-1888	
712	TDI MANAGED CARE SERVICES	620 EPSILON DR.	PITTSBURG	PA	15238	(800) 581-5300	CARRIER BOUGHT OUT BY PHARMACARE CC 740

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
713	HEALTH CARE CREDIT UNION ASSOC. HCCUA	PO BOX 260957	PLANT	TX	750260957	(866) 373-6366	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
714	STOWE ASSOCIATES	2872 WOODCOCK BLVD. #200	ATLANTA	GA	30341	(800) 533-7896	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
715	UNITED HEALTH & LIFE INSURANCE COMPANY	PO BOX 169050	DULUTH	MN	558168200	(800) 526-2414	USE CC113 UNITED HEALTHCARE
716	INDECS CORP	PO BOX 668	LYNDHURST	NJ	07071	(888) 446-3327	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
717	USA HEALTH CARE (MVP HEALTH CARE)	PO BOX 22920	ROCHESTER	NY	146922920	(800) 999-3920	CODE ASSIGNED BY SCHA
718	CIGNA PHARMACY SERVICES	PO BOX 188053	CHATTANOOGA	TN	374228053	(800) 622-5579	
719	FLORIDA HEALTH ALLIANCE	PO BOX 10269	JACKSONVILLE	FL	322470269	(904) 354-8335	
720	UNITED MINE WORKERS HEALTH & RETIREMENT FUND	ROUTE 2 BOX 218A	BIG STONE GAP	VA	24219	(800) 654-9763	
721	UNITED RESOURCE NETWORK	PO BOX 30758	SALT LAKE CITY	UT	84130	(877) 801-3507	CODE ASSIGNED BY SCHA
722	AMERICAN REPUBLIC INSURANCE COMPANY	PO BOX 21670	EAGAN	MN	55121	(800) 247-2190	
723	CAROLINA CONTINENTAL INSURANCE	PO BOX 427	COLUMBIA	SC	29202	(803) 256-6265	
724	MUTUAL MEDICAL PLANS	PO BOX 689	PEORIA	IL	61652	(800) 448-4689	CODE ASSIGNED BY SCHA
725	DIALYSIS CLINIC, INC.	203 FREEMONT AVE.	SPARTANBURG	SC	29303	(864) 585-2046	
726	INSURANCE SERVICE AND BENEFITS	3218 HIGHWAY 67 STE. 218	MESQUITE	TX	75150	(800) 878-3157	
727	GUARANTEE MUTUAL LIFE CO.	8801 INDIAN HILLS DR.	OMAHA	NE	68114	(800) 462-4660	
728	GENERAL PRESCRIPTION PROGRAMS, INC.	305 MADISON AVE. STE 1166B	NEW YORK	NY	10165	(800) 341-2234	
729	U.A. LOCAL 446 PLUMBERS AND PIPEFITTERS	PO BOX 191030	SACRAMENTO	CA	958191030	(916) 457-0821	CODE IN OPEN STATUS BY SCHA
730	GEORGIA HEALTHCARE PARTNERSHIP	PO BOX 16388	SAVANNAH	GA	314163088	(800) 566-6710	
731	ADOVA HEALTH	PO BOX 725549	ATLANTA	GA	31139	(866) 470-4959	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
732	HERTZ CLAIM MANAGEMENT	PO BOX 726	PARK RIDGE	NJ	07656	(201) 307-2177	
733	MOUNTAIN CLAIMS MANAGEMENT	PO BOX 1008	FRUITLAND	ID	83619	(208) 452-7979	CODE IN OPEN STATUS BY SCHA
734	STRATEGIC OUTBURSTING, INC.	PO BOX 241508	CHARLOTTE	NC	28224	(888) 836-7764	CODE NOT REQUESTED BY MEDICAID ASSIGNED BY SCHA
735	INTEGRITAS BENEFIT GROUP	PO BOX 1447	CORDOVA	TN	38088	(901) 685-8980	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
736	SPECTERA	2811 LORD BALTIMORE DR.	BALTIMORE	MD	212442644	(800) 638-3120	
737	UNITED CONCORDIA	PO BOX 69421	HARRISBURG	PA	17106	(800) 332-0366	
738	FHA-TPA DIVISION	PO BOX 327810	FT. LAUDERDALE	FL	333329711	(803) 798-8698	CODE IN OPEN STATUS BY SCHA
739	BOLLINGER, INC.	PO BOX 727	SHORT HILLS	NJ	07078	(866) 267-0092	
740	PHARMACARE	PO BOX 52188	PHOENIX	AZ	850722196	(800) 237-6184	AS OF 1/1/08 CO. MERGED WITH CAREMARK (471) ADD NEW POLICIES WITH 471
741	SPENCER & ASSOCIATES INS.	1 S. LIMESTONE ST. STE 301	SPRINGFIELD	OH	45502	(866) 766-9016	CODE ASSIGNED BY SCHA
742	MIDA DENTAL PLAN	2000 TOWN CENTER, STE. 2200	SOUTHFIELD	MI	48075	(800) 937-6432	
743	EMPLOYEE PLANS, INC.	PO BOX 2362	FT. WAYNE	IN	468012362	(260) 625-7500	
744	SENIOR DIMENSIONS	PO BOX 15645	LAS VAGAS	NV	891145645	(800) 925-7455	
745	GROUP BENEFIT SERVICES	1312 BELLONE AVE.	LUTHERVILLE	MD	21093	(800) 638-6085	
746	MED-TAC CLAIMS	PO BOX 9110	NEWTON	MA	02160	(800) 347-9355	
747	PACIFICARE	PO BOX 6099	CYPRESS	CA	90630	(866) 316-9776	CODE ASSIGNED BY SCHA
748	HEALTH CARE SAVINGS, INC.	4530 PARK RD	CHARLOTTE	NC	28209	-	CODE ASSIGNED BY SCHA
749	GERBER LIFE INSURANCE COMPANY	PO BOX 2088	GRAND RAPIDS	MI	49501	(800) 253-3074	
750	BENEFIT ADMINISTRATIVE SERVICES	PO BOX 4509	ROCKFORD	IL	61110	(815) 969-9663	
751	POLARIS BENEFIT ADMINISTRATORS	PO BOX 2010	WESTERVILLE	OH	43086-	(800) 234-0225	
752	HYGEIA CORPORATION	15500 NEW BARN RD.	MIAMI LAKES	FL	33014	(800) 591-2650	CODE ASSIGNED BY SCHA
753	HEALTHNET	PO BOX 2226	AUGUSTA	GA	309032226	(900) 977-8221	
754	1199 SEIU NATIONAL BENEFIT FUND	PO BOX 1007	NEW YORK	NY	101081007	(646) 473-9200	
755	TOTAL BENEFIT SERVICES, INC.	PO BOX 30180	NEW ORLEANS	LA	70190	-	
756	INSURANCE MANAGEMENT ADMINISTRATORS (IMA)	PO BOX 71120	BOSSIER CITY	LA	711719944	(800) 742-9944	
757	J C PENNEY LIFE INSURANCE COMPANY	PO BOX 869090	PLANO	TX	750860909	(972) 881-6000	
758	HEALTHCHOICE	PO BOX 24870	OKLAHOMA	OK	731270870	(800) 489-2974	CODE ASSIGNED BY SCHA
759	MEDIPLUS	PO BOX 9126	DES MOINES	IA	50309	(800) 247-2192	AKA TROA
760	KEY BENEFIT ADMINISTRATORS	PO BOX 55230	INDIANAPOLIS	IN	46205	(800) 331-4757	
761	EMPLOYEE BENEFIT STRATEGIES	229 EAST MICHIGAN AVE., STE. 235	KALAMAZOO	MI	49007	(800) 325-7477	
762	ROYAL NEIGHBORS OF AMERICA	PO BOX 10850	CLEARWATER	FL	337578850	(877) 815-8857	CODE ASSIGNED BY SCHA
763	THE PROVIDENT	PO BOX 31499	TAMPA	FL	33631	(800) 525-7268	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
764	CARE LINK HEALTH PLAN	PO BOX 7373	LONDON	KY	407427373	(800) 348-2922	
765	FREEDOM HEALTH	PO BOX 151348	TAMPA	FL	33684	(800) 401-2740	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
766	PALMER & CAY/CARSWELL, INC.	PO BOX 1286	SAVANNAH	GA	31402	(912) 234-6621	
767	HEALTHSCOPE BENEFITS	PO BOX 619055	DALLAS	TX	752619055	(800) 600-6212	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
768	WISCONSIN PHYSICIANS SERVICES	1717 WEST BROADWAY ST.	MADISON	WI	53708	(888) 915-4158	
769	FEDEX FREIGHTWAYS	PO BOX 840	HARRISON	AR	72602	(800) 874-4723	
770	PEOPLES BENEFIT LIFE INSURANCE	PO BOX 484	VALLEY FORGE	PA	19493	(800) 523-7900	
771	PACIFIC FIDELITY LIFE INSURANCE CO (P.F.L.)	PO BOX 982009	N RICHLAND HILLS	TX	761828009	(817) 656-6040	USE CODE 477 MEGA LIFE
772	BENEFIT SYSTEMS, INC.	PO BOX 6001	INDIANAPOLIS	IN	462066001	(800) 824-3216	
773	PHYSICIANS MUTUAL INSURANCE COMPANY	PO BOX 2018	OMAHA	NE	681032018	(800) 228-9100	DO NOT USE THIS CODE FOR MEDICARE ADVANTAGE PLANS OFFERED BY THIS CARRIER
774	MOLINA MEDICARE OPTIONS PLUS	PO BOX 22811	LONG BEACH	CA	90801	(800) 665-1328	MEDICARE ADVANTAGE PLAN
775	FIRST CHOICE BENEFITS MANAGEMENT	PO BOX 658	BELOIT	WI	535120658	(800) 303-5770	
776	AFID (ASSO. OF FRANCHISE AND INDEPENDENT DIST.	1 S. LIMESTONE ST., STE. 301	SPRINGFIELD	OH	45502	(866) 766-9016	CODE IN OPEN STATUS BY SCHA
777	US HEALTH AND LIFE	PO BOX 37504	OAK PARK	MI	482370504	(800) 225-9674	THIS CODE NOT REQUESTED BY SCHA. ASSIGNED BY SCHA
778	AMERICAN CONTINENTAL INSURANCE CO	PO BOX 5008	BRENTWOOD	TN	37024	(800) 264-4000	
779	WEB-TPA AMERICAN FIDELITY ASSURANCE CO	PO BOX 99906	GRAPEVINE	TX	760999706	(866) 393-2872	DORMANT 8/06
780	CORPORATE SYSTEMS ADMINISTRATION, INC.	PO BOX 4985	JOHNSON CITY	TN	376024985	(800) 275-2847	
781	MEDICAL CLAIMS MANAGEMENT CORP	PO BOX 25307	WINSTON-SALEM	NC	271145307	(800) 334-0609	
782	HOUSING BENEFIT PLAN	PO BOX 542077	DALLAS	TX	753542077	(800) 937-2036	
784	PACIFIC HEALTH ADMINISTRATORS	PO BOX 620123	ORLANDO	FL	328620123	(800) 776-6070	CODE ASSIGNED BY SCHA
785	THE HARVEST INSURANCE CO.	PO BOX 956003	LAKE MARY	FL	327950856	(800) 253-0856	CODE ASSIGNED BY SCHA
786	ACS BENEFIT SERVICES, INC.	PO BOX 2000	WINSTON-SALEM	NC	271022000	(800) 849-5370	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
787	PACIFICARE SENIOR SUPPLEMENT PLAN	PO BOX 6072	CYPRESS	CA	906300072	(800) 851-3802	
788	TRANSAMERICA LIFE INSURANCE CO.	PO BOX 97	SCRANTON	PA	185040097	(800) 820-3372	CODE ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
789	FIRST COMMUNITY HEALTH PLAN, INC.	PO BOX 382947	BIRMINGHAM	AL	35238	(800) 734-7826	CODE IN OPEN STATUS BY SCHA
790	MHNET BEHAVIORAL HEALTH	PO BOX 7802	LONDON	KY	40742	(800) 752-7242	
791	UNITEDHEALTH INTEGRATED SERVICES	PO BOX 30783	SALT LAKE CITY	UT	841300786	(866) 596-8447	
792	PIONEER LIFE INSURANCE COMPANY OF ILLINOIS	PO BOX 1250	ROCKFORD	IL	611051250	(815) 987-5000	USE CODE 282 WASHINGTON NATIONAL
793	HUMANA GOLD PLUS	PO BOX 14601	LEXINGTON	KY	405124601	(800) 457-4708	MEDICARE ADVANTAGE PLAN
794	UNITED FAMILY LIFE INSURANCE COMPANY	PO BOX 2204	ATLANTA	GA	30371	(404) 659-3300	
795	REGIONAL MEDICAL ADMINISTRATORS, INC.	PO BOX 4128	GLEN RAVEN	NC	272150901	(336) 226-7950	
796	LINECO	821 PARKVIEW BLVD.	LOMBARD	IL	601483230	(800) 323-7268	CODE ASSIGNED BY SCHA
797	TODAY'S OPTIONS UNIVERSAL AMERICAN	PO BOX 742528	HOUSTON	TX	77274	(866) 422-5009	MEDICARE ADVANTAGE PLAN
798	MEDCARE INTERNATIONAL	12480 WEST ATLANTIC BLVD., STE. 2	CORAL SPRINGS	FL	33071	-	
799	GENWORTH FINANCIAL	PO BOX 8021	SAN RAFAEL	CA	949129974	(800) 876-4582	WAS GE FINANCIAL SERVICES
800	NEBCO (TENNECO)	PO BOX 97	SCRANTON	PA	185040097	(800) 717-7562	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
801	IMERICA LIFE AND HEALTH INS. CO	PO BOX 3287	ENGLEWOOD	CO	80155	(888) 273-8020	
802	CONSTITUTION LIFE INSURANCE CO	PO BOX 130	PENSACOLA	FL	325910130	(800) 789-6364	
803	FIRST CONTINENTAL LIFE INSURANCE	PO BOX 1911	CARMEL	IN	46032	(800) 538-1235	
804	PIEDMONT COMMUNITY HEALTHCARE, INC.	PO BOX 14408	CINCINNATI	OH	452500408	(800) 400-7247	
805	PENN TREATY NETWORK AMERICA (PTNA)	PO BOX 130	PENSACOLA	FL	325910130	(800) 635-7418	CODE ASSIGNED BY SCHA
806	NETWORK HEALTH PLAN	PO BOX 568	MENASHA	WI	54952	(920) 720-1300	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
807	OPTIMA HEALTH PLAN	PO BOX 5028	TROY	MI	460071199	(800) 229-1199	
808	NEW MARKET DIMENSION	PO BOX 1338	COCKEYVILLE	MD	21031	(800) 570-6745	
809	INTER VALLEY HEALTH PLAN	300 SOUTH PARK PO BOX 6002	POMONA	CA	917696002	(800) 251-8191	CODE ASSIGNED BY SCHA
810	UNITED RESOURCE NETWORK	PO BOX 30758	SALT LAKE CITY	UT	84130	-	CODE ASSIGNED BY SCHA
811	SPARTANBURG REGIONAL HEALTHCARE SYSTEM	PO BOX 1000	LANCASTER	SC	29721	-	CODE ASSIGNED BY SCHA
812	UMR	PO BOX 30541	SALT LAKE CITY	UT	841300541	(800) 826-9781	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
813	CENTURY PLANNER	9201 WATSON RD, STE. 350	ST. LOUIS	MO	631261509	(800) 776-2453	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
814	HEALTHCOMP ADMINISTRATORS	PO BOX 45018	FRESNO	CA	93718	(800) 442-7247	
815	BANKERS FIDELITY LIFE INSURANCE COMPANY	PO BOX 260040	PLANO	TX	75026	(866) 458-7499	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
816	ARCADIAN MEMBER CARE	PO BOX 4946	COVINA	CA	91723	(800) 573-8597	MEDICARE ADVANTAGE PLAN
817	PRIORITY HEALTH	PO BOX 232	GRAND RAPIDS	MI	49501	(800) 446-5674	
818	SEAFARERS HEALTH & BENEFIT PLAN (SHBP)	PO BOX 380	PINEY POINT	MD	20674	(800) 252-4674	
819	TRICARE OVERSEAS PROGRAM	PO BOX 7985	MADISON	WI	537077985	(800) 982-6257	CODE ASSIGNED BY SCHA 6/07/10
820	MMSI MAYO MANAGEMENT SERVICES	4001 41ST ST. WEST	ROCHESTER	NM	41154	(800) 635-6671	CODE ASSIGNED BY SCHA SEE CARRIER CODE 536
821	ODS HEALTH PLAN ADVANTAGE	PO BOX 4030	PORTLAND	OR	972084030	(877) 337-0650	
822	MEDICAL MUTUAL	PO BOX 6018	CLEVELAND	OH	44101	(800) 258-2873	CODE ASSIGNED BY SCHA
823	HEALTH ALLIANCE PLAN	PO BOX 02459	DETROIT	MI	48202	(800) 422-4641	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
824	ENVISION RX OPTIONS	2181 EAST AURORA RD STE 201	TWINSBURG	OH	44087	(800) 361-4542	
825	UNITED HEALTHCARE COMMUNITY PLAN	PO BOX 8207	KINGSTON	NY	12402	(800) 600-9007	MEDICARE ADVANTAGE PLAN
826	WILLSE & ASSOCIATES, INC.	PO BOX 1196	BALTIMORE	MD	21203	(410) 547-0454	
827	J. SMITH LANIER	PO BOX 72749	NEWNAN	GA	30271	(888) 295-4864	
828	NATIONAL PHARMACUETICAL SERVICES	PO BOX 407	BOYSTOWN	NE	68017	(800) 546-5677	
829	ADMINISTRATIVE SOLUTIONS	PO BOX 2490	ALPHARETTA	GA	30023	(678) 339-0211	
830	CONTRACTORS EMPLOYEE BENEFIT ADM. (CEBA)	PO BOX 559017	AUSTIN	TX	78755	(800) 247-7724	
831	CORPORATE BENEFIT SOLUTIONS, INC.	PO BOX 8215	LITTLE ROCK	AR	72221	(888) 604-9397	
832	CAMERON AND ASSOCIATES	6100 LAKE FOREST DR.	ATLANTA	GA	30328	(800) 387-9919	
833	MERCY HEALTH PLANS	PO BOX 4568	SPRINGFIELD	MO	658084568	(800) 647-2240	
834	DEFINITY HEALTH	PO BOX 9525	AMHERST	NY	14226	(866) 333-4648	BROUGHT OUT BY UNITED HEALTHCARE CARRIER 113
835	MANAGED PHARMACY BENEFITS	1100 NORTH LINDBERGH	ST. LOUIS	MO	63132	(800) 672-9540	THIS CARRIER BOUGHT OUT BY EXPRESS SCRIPTS.
836	HUMANA	PO BOX 14601	LEXINGTON	KY	40512	(800) 558-4444	
837	HEALTH ADMINISTRATION SERVICES	PO BOX 6724208	HOUSTON	TX	77267	(800) 865-5440	
838	SHESFIELD, OLSON & MCQUEEN	PO BOX 16608	ST. PAUL	MN	55116	(888) 330-8408	
839	CITIZENS SECURITY LIFE INS.	PO BOX 436149	LOUISVILLE	KY	402536149	(502) 244-2420	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
840	AMERICAN, INCOME LIFE INSURANCE COMPANY	PO BOX 2608	WACO	TX	76797	(817) 772-3050	
841	WATKINS ASSOCIATED INDUSTRIES	PO BOX 1738	ATLANTA	GA	30301	(800) 333-3841	CODE ASSIGNED BY SCHA
842	GARDNER AND WHITE, INC.	PO BOX 40619	INDIANAPOLIS	IN	462400619	(317) 257-9131	
843	CORE MANAGEMENT RESOURCES GROUP	PO BOX 840	MACON	GA	31202	(888) 741-2673	
844	PRIME TIME HEALTH PLAN	PO BOX 6905	CANTON	OH	44706	(800) 617-7446	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
845	GEISINGER HEALTH PLAN GOLD	PO BOX 8200	DANVILLE	PA	178218200	(800) 498-9731	MEDICARE ADVANTAGE PLAN
846	SCRIPT CARE, INC.	6380 FOLSOM DR.	BEAUMONT	TX	77706	(800) 880-9988	
847	MAHONEY BENEFIT ADMINISTRATORS	PO BOX 7260	FORT LAUDERDALE	FL	33338	(800) 280-7093	
848	HERITAGE	PO BOX 1730	AUBURNDALE	FL	33823	(800) 282-2460	
849	E.O.S. HEALTH	PO BOX 27088	TEMPE	AZ	85285	(888) 456-8417	
850	ONENET PPO	PO BOX 934	FREDERICK	MD	217050934	(800) 342-3289	CODE ASSIGNED BY SCHA
852	BUILDERS MUTUAL INSURANCE CO	PO BOX 150006	RALEIGH	NC	276240006	(800) 809-4861	
853	COMPSYCH CORP.	PO BOX 8379	CHICAGO	IL	60680	(877) 595-5282	
854	BOYD CARE (BOYD BROTHERS TRANSPORTATION)	PO BOX 70	CLAYTON	AL	36016	(334) 775-1284	
855	UNIVERSITY HEALTH PLANS	PO BOX 830926 DEPT 003	BIRMINGHAM	AL	35283	(877) 878-0914	
856	TRANSAMERICA OCCIDENTAL LIFE	PO BOX 2101 TERMINAL ANNEX	LOS ANGELES	CA	90051	(213) 742-2111	
857	CORPORATE BENEFIT SERVICES, INC.	PO BOX 211778	EAGAN	MN	55121	(704) 373-0447	
858	DENTAQUEST	PO BOX 2136	COLUMBIA	SC	29202	(800) 307-6553	NAIC 52040 MEDICAID DENTAL CLAIMS PROCESSOR
859	NEW ENGLAND GROUP TRUST	PO BOX 30466	TAMPA	FL	33630	(800) 654-1731	
860	MANAGED HEALTH NETWORK	PO BOX 209010	AUSTIN	TX	78720	(800) 835-2094	
861	SUPERIOR ESSEX	PO BOX 724907	ATLANTA	GA	31139	(877) 291-7920	
862	PERFORMAX	300 CORPORATE PARKWAY	AMHERST	NY	11226	(877) 777-6076	
863	INSURANCE ADMINISTRATION CORP.	PO BOX 39119	PHOENIX	AZ	85069	(800) 843-3106	
864	GE GROUP ADMINISTRATORS	PO BOX 150809	ARLINGTON	TX	76015	(888) 255-8961	
865	SECURIAN DENTAL PLANS	PO BOX 9385	MINNEAPOLIS	MN	554409385	(800) 234-9009	NAIC 93742
866	OLYMPIC HEALTH MANAGEMENT	PO BOX 5348	BELLINGHAM	WA	98227	(360) 734-9888	
867	BCBS OF NC	PO BOX 30087	DURHAM	NC	27702	(919) 489-7431	
868	KANSAS CITY LIFE	PO BOX 9040	AUSTIN	TX	78766	(800) 874-5254	
869	EMPLOYEE BENEFIT MANAGEMENT SERVICES	PO BOX 21367	BILLINGS	MT	59104	(800) 777-3575	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
870	FOUNDATION HEALTH	PO BOX 453219	SUNRISE	FL	33345	(800) 441-5501	
871	UNITED BEHAVIORAL HEALTH	PO BOX 169053	DULUTH	MN	55816	(800) 877-6003	CODE ASSIGNED BY SCHA
872	UNITED HEALTHCARE PLAN OF RIVER VALLEY	3800 23RD AVE. #200	MOLINE	IL	61215	(800) 224-6602	CODE ASSIGNED BY SCHA THESE COMPANY BOUGHT OUT JOHN DEERE INS. CO. THIS WAS THE HMO FOR JOHN DEERE 6/29/07
873	MEDCO HEALTH	PO BOX 8190	MADISON	WI	537088190	(800) 221-7006	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY THE SCHA
874	HEALTH NET	PO BOX 14700	LEXINGTON	KY	40512	(888) 747-7823	THIS CODE NOT REQUESTED BY SCHA. ASSIGNED BY SCHA
875	AMERICAN SENTINEL	PO BOX 61140	HARRISBURG	PA	171061140	(800) 692-7338	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
876	HEALTHSOURCE OF NC, INC.	PO BOX 28087	RALEIGH	NC	27611	(800) 849-9000	USE CODE 134 CIGNA HEALTHCARE
877	PRE-EXISTING CONDITION INSURANCE PLAN (PCIP)	PO BOX 300	INDEPENDENCE	MO	640510300	(800) 220-7898	
878	HRM CLAIM MANAGEMENT	PO BOX 4022	KALAMAZOO	MI	490034022	(800) 253-0966	
879	COVENTRY OF THE CAROLINAS	PO BOX 7102	LONDON	KY	40742	(866) 208-3610	FORMALLY WELLPATH
880	OPTIMUM HEALTH PARTNERS	PO BOX 2243	GREENVILLE	SC	29602	(864) 213-4992	
881	BEHAVIORAL HEALTH SYSTEMS	PO BOX 830724	BIRMINGHAM	AL	352830724	(800) 245-1150	
882	CONNECTICARE	PO BOX 4000	FARMINGTON	CT	06034	(877) 224-8230	CODE ASSIGNED BY SCHA
883	SELECT HEALTH OF SOUTH CAROLINA, INC.	7410 NORTHSIDE DR. STE. 208	CHARLESTON	SC	29420	(843) 569-1759	CODE IN OPEN STATUS BY SCHA
884	HEALTH FIRST HEALTH PLANS	PO BOX 565001	ROCKLEDGE	FL	329565001	(800) 716-7737	CODE IN OPEN STATUS BY SCHA
885	JOHN ALDEN INSURANCE COMPANY	PO BOX 020270	MIAMI	FL	33102	(800) 328-4316	
886	PLANNED ADMINISTRATORS, INC.	PO BOX 6927	COLUMBIA	SC	29260	(803) 754-0041	
887	CNIC HEALTH SOLUTIONS	PO BOX 3559	ENGLEWOOD	CO	80155	(800) 426-7453	
888	SOUTHEASTERN BENEFIT PLANS, INC.	335 ARCHDALE DR.	CHARLOTTE	NC	282174246	(704) 529-5400	
889	GROUP INSURANCE ADMINISTRATION, INC.	3350 PEACHTREE RD NE STE. 1040	ATLANTA	GA	30326	(800) 621-0683	
890	PARTNERS NATIONAL HEALTH PLANS OF NORTH CAROLINA	PO BOX 17368	WINSTON-SALEM	NC	271167368	(800) 942-5695	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
891	OPTIMUM CHOICE OF THE CAROLINAS, INC.	4 TAFT CT.	ROCKVILLE	MD	20850	(800) 343-8205	
892	INDEPENDENT HEALTH	PO BOX 9066	BUFFALO	NY	14231	(800) 247-1466	
893	KEYSTON HEALTH PLAN EAST	PO BOX 8339	PHILADELPHIA	PA	19101	(800) 227-3116	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
894	AMERIHEALTH MERCY HEALTH PLAN	PO BOX 7118	LONDON	KY	40742	(888) 991-7200	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
895	CONTINENTAL LIFE INS. OF TENNESSEE	PO BOX 1188	BRENTWOOD	TN	37024	(800) 264-4000	
896	OPTIMED HEALTH PLAN	4 TERRY DR., STE. 1	NEWTOWN	PA	18940	(800) 482-8770	
897	SOUTHERN BENEFIT ADM.	PO BOX 188006	CHATTANOOGA	TN	37422	(800) 678-4656	
898	ASSOCIATION & SOCIETY INS. CORP	PO BOX 2510	ROCKVILLE	MD	20847	(800) 638-2610	
899	AETNA HEALTH PLANS OF THE CAROLINAS, INC.	3 CENTERVIEW DR.	GREENSBORO	NC	27407	(800) 459-1466	HMO PLAN ONLY
900	KOHLER COMPANY	444 HIGHLAND DR.	KOHLER	WI	530441515	(920) 457-4441	
901	DENTAL CARE PLUS	100 CROWNE POINT PLACE	CINCINNATI	OH	45241	(800) 367-9466	
902	BLUE CARE NETWORK OF MI	PO BOX 68710	GRAND RAPID	MI	49516	(800) 658-8878	CODE ASSIGNED BY SCHA. THIS IS THE HMO TO CC 504 WHICH IS THE POS
903	CAREPLUS HEALTH PLAN	PO BOX 31286	TAMPA	FL	336313286	(800) 867-4445	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
904	BEST CHOICE HEALTH PLAN	PO BOX 21128	FORT LAUDERDALE	FL	33335	(800) 867-4446	
905	GERBER LIFE MEDICARE SUPPLEMENT	PO BOX 2271	OMAHA	NE	68103	(877) 656-5425	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
906	GROUP HEALTH ADMINISTRATOR, INC.	PO BOX 6244	CHARLOTTE	NC	282071018	(800) 222-5790	
907	CELTIC LIFE INSURANCE CO.	PO BOX 46337	MADISON	WI	53744	(800) 766-2525	
909	PREFERRED HEALTH ALLIANCE CORP.	PO BOX 382048	BIRMINGHAM	AL	35238	(800) 722-8477	
910	AMERICAN ADMINISTRATIVE GROUP	PO BOX 5227	LISLE	IL	605325227	(800) 354-5112	WAS GALLAGER & BASSETT SERVICES
911	COMMUNITY HEALTH PARTNERS	PO BOX 5787	SPARTANBURG	SC	29304	(888) 962-8437	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
912	WELLS FARGO TPA-NC OFFICES	PO BOX 2857	FAYETTEVILLE	NC	28302	(800) 337-6288	
913	FLORIDA HOSPITAL HEALTHCARE SYSTEM	PO BOX 536847	ORLANDO	FL	328536847	(800) 741-4810	
914	NATIONAL TEACHERS ASSO LIFE INSURANCE CO.	PO BOX 2369	ADDISON	TX	75001	(888) 671-6771	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
915	MANAGED HEALTH RESOURCES	PO BOX 30742	CHARLOTTE	NC	28208	(704) 355-5200	
916	MHEALTH	PO BOX 742567	HOUSTON	TX	77274	(888) 642-5040	
919	AMERICAN HEALTH GROUP, INC.	PO BOX 1500	MAUMEE	OH	43537	(800) 872-8276	
920	HEALTHSMART PREFERRED CARE	PO BOX 53010	LUBBOCK	TX	794533010	(806) 473-2500	
922	BLUE CHOICE HEALTHPLAN	PO BOX 6170	COLUMBIA	SC	292606170	(803) 786-8466	WAS COMPANION HEALTHCARE NAME CHANGE EFFECTIVE 7/1/05
923	UNITED HEALTHCARE COMMUNITY PLAN	PO BOX 6170	COLUMBIA	SC	292606170	(800) 868-2528	MEDICAID MCO PLAN
927	UNITED HEALTHCARE HERITAGE PLUS	UHC OF RIVER VALLEY PO BOX 5230	KINGSTON	NY	124025230	(800) 224-6602	
928	COOK INSURANCE	PO BOX 1029	BLOOMINGTON	IN	47402	(800) 593-2080	
929	NATIONAL HEALTH INSURANCE COMPANY	PO BOX 619999	DALLAS/FORT WORTH AIRPORT	TX	752619999	(800) 237-1900	
930	SENTRY LIFE INSURANCE COMPANY	PO BOX 8025	STEVENS POINT	WI	54481	(800) 426-7234	
931	GOOD SAMARITAN PROGRAM	5151 WEST HWY 40	BEACHGROVE	IN	46140	(317) 894-2000	
932	MANHATTAN INSURANCE GROUP	PO BOX 925309	HOUSTON	TX	772925309	(800) 669-9030	CODE ASSIGNED BY SCHA. NOT REQUESTED BY MEDICAID
933	PREFERRED HEALTHCARE SYSTEMS	620 HOWARD AVE.	ALTOONA	PA	166014899	-	CODE ASSIGNED BY SCHA
934	ASSOCIATION & SOCIETY INS. CORP	PO BOX 2510	ROCKVILLE	MD	20847	(800) 638-2610	
936	KEY BENEFITS-TRANSCHOICE PLUS	PO BOX 3252	MILWAUKEE	WI	53201	(866) 867-6883	
937	MVP HEALTH CARE	PO BOX 2207	SCHENECTADY	NY	12301	(800) 229-5851	NAME CHANGE ONLY 4/09. WAS PREFERRED CARE
939	PREMIER HEALTH SYSTEMS	PO BOX 1640	COLUMBIA	SC	292021640	(803) 296-8999	CODE ASSIGNED BY SCHA
940	PRIVATE HEALTH CARE SYSTEMS (PHCS)	PO BOX 2914	DES PLAINES	IL	600172914	(800) 531-7662	CODE ASSIGNED BY SCHA 6/18/07
941	FIDELITY SECURITY LIFE INSURANCE CO	419 E MAIN ST.	MIDDLETOWN	NY	10940	(800) 826-7531	THE CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
942	PRINCIPAL FINANCIAL GROUP	PO BOX 10357	DES MOINES	IA	503060357	(800) 247-4695	
943	LIBERTY MUTUAL LIFE INSURANCE	5 HUTCHINSON DR.	DANVERS	MA	01923	(888) 999-4767	CODE IN OPEN STATUS BY SCHA
945	CAROLINA ATLANTIC MEDICAL SERVICES ORGANIZATION	PO BOX 22528	CHARLESTON	SC	29413	(800) 810-0906	DORMANT 8/06
946	FIRST HEALTH	PO BOX 1377	THOMASVILLE	GA	31799	(866) 847-8235	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
948	PHILADELPHIA AMERICAN LIFE INS. CO.	PO BOX 2465	HOUSTON	TX	77252	(800) 552-7879	
951	AMERICAN GROUP ADMINISTRATORS	101 CONVENTION CENTER DR. STE. 200	LAS VEGAS	NE	89109	(800) 842-4742	
952	STARK TRUSS CO., INC.	PO BOX 2080C	STOW	OH	44224	(800) 456-4002	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
953	USA HEALTHCARE ORGANIZATION	7301 N. 16TH ST. STE 201	PHOENIX	AZ	85020	(800) 872-3860	CODE ASSIGNED BY SCHA
954	MULTIPLAN	115 5TH AVE.	NEW YORK	NY	100031004	(800) 546-3887	
955	DESIGN SAVERS PLAN	2814 SPRING RD., STE. 122	ATLANTA	GA	30339	(800) 616-5709	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
958	ITPE-NMU HEALTH AND WELFARE FUND	PO BOX 13817	SAVANNAH	GA	31416	(912) 352-7169	
960	HEALTH EOS	PO BOX 6090	DER PERE	WI	541156090	(800) 435-5694	CODE ASSIGNED BY SCHA. NOT REQUESTED BY MEDICAID
961	MHN (MANAGED HEALTH NETWORK)	PO BOX 27018	LAS VEGAS	NV	89126	(800) 458-4642	CODE ASSIGNED BY SCHA
962	VICARE PLUS	PO BOX 1710	SUFFOLK	VA	23439	(877) 934-4403	
963	UNITED HEALTHCARE CLAIMS	PO BOX 29130	HOT SPRINGS	AR	71903	(888) 201-4111	
964	PHARMACUETICAL CARE NETWORK	9343 TECH CENTER DR.	SACRAMENTO	CA	95826	(800) 777-0074	
965	PROFESSIONAL BENEFIT ADMINISTRATORS, INC. (PBA)	PO BOX 4687	OAKBROOK	IL	605223755	(630) 655-3755	
966	CAPITOL ADMINISTRATORS OF THE SOUTHEAST	PO BOX 188061	CHATTANOOGA	TN	37422	(888) 650-6566	
967	UNDERWRITERS SAFETY AND CLAIMS	PO BOX 23507	LOUISVILLE	KY	40223	(800) 678-1536	
968	AMERICAN BENEFIT ADMINISTRATIVE SERVICES	PO BOX 0928	BROOKFIELD	WI	53008	(630) 416-1111	
969	WHP HEALTH INITIATIVE	PO BOX 968022	SCHAUMBERG	IL	601968022	(800) 207-2568	
970	CONSOLIDATED WORKERS ASSOCIATION (CWA)	PO BOX 2647	CHINO HILLS	CA	91709	(800) 919-5514	CODE ASSIGNED BY SCHA
971	ATLANTA ADMINISTRATIONS	135 BEAVER ST.	WALTHAM	MA	02452	(800) 548-1256	
972	ASR CORP (ADMINISTRATION SYSTEM RESEARCH)	PO BOX 6392	GRAND RAPIDS	MI	49516	(800) 968-2449	
973	CAMBRIDGE INTERGRATED SERVICES GROUP, INC.	PO BOX 1687	GRAND RAPIDS	MI	49501	(800) 766-9780	USE CARRIER 171 AON
974	COMMERCE BENEFIT GROUP	PO BOX 900	ELYRIA	OH	44036	(800) 223-9941	
975	INFORMED RX	PO BOX 968022	SCHAUMBURG	IL	601968022	(800) 645-3332	WAS NATIONAL MEDICAL HEALTH CARD
976	PARAGON BENEFITS, INC.	PO BOX 12288	COLUMBUS	GA	31917	(706) 277-6710	
977	ZENITH ADMINISTRATION	26359	LAS VEGAS	NV	89126	(800) 426-5980	DORMANT 8/06

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
978	LEGGETT & PLATT	PO BOX 7687	HIGH POINT	NC	27264	(877) 311-2150	
979	MEDICAL REIMBURSEMENT OF AMERICA	113 SEABOARD LANE	FRANKLIN	TN	37067	(615) 963-3826	THIS CODE IS USED BY SCHA NOT AN ACTIVE MEDICAID CODE
980	BENEFIT SUPPORT, INC.	PO BOX 2977	GAINSVILLE	GA	30503	(800) 777-4782	
981	ARGUS HEALTH SYSTEMS	PO BOX 419019	KANSAS CITY	MO	64141	(800) 522-7487	
982	OFFICE OF GROUP BENEFITS STATE OF LOUISIANA	PO BOX 44036	BATON ROUGE	LA	708044036	(800) 272-8451	
983	INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS	3901 E. WINSLOW AVE.	PHOENIX	AZ	85040	(602) 234-0497	
984	HOMELAND HEALTHCARE	PO BOX 3726	SEATTLE	WA	98124	(800) 493-4240	
985	BENESIGHT	PO BOX 340	PUEBLO	CO	81002	(800) 362-1116	
986	COMMONWEALTH BENEFIT ADMINISTRATORS	115 HANOVER ST.	ASHLAND	VA	23005	(800) 526-1677	
987	BANKERS FIDELITY LIFE INS CO	PO BOX 105652	ATLANTA	GA	30348	(404) 266-5500	
988	MID WEST NATIONAL LIFE INS. CO.	PO BOX 981606	EL PASO	TX	799981610	(800) 733-1110	
989	UNIVERA HEALTHCARE	PO BOX 23000	ROCHESTER	NY	14692	(877) 242-9464	
990	SOUTHERN GROUP ADMINISTRATORS, INC.	200 SOUTH MARSHALL ST.	WINSTON-SALEM	NC	27101	(800) 334-8159	
991	WEST PORT BENEFITS	PO BOX 66743	ST. LOUIS	MO	63166	(888) 306-5299	
992	CHESTERFIELD RESOURCES, INC.	PO BOX 1884	AKRON	OH	44309	(800) 321-0935	
993	MPI INTERNATIONAL, INC.	PO BOX 81913	ROCHESTER	MI	483081913	(248) 853-9010	
994	UNITED PROVIDER SERVICES	PO BOX 820277	FORT WORTH	TX	76182	(800) 519-8374	CARRIER BOUGHT OUT BY CC 740 PHARMACARE
995	MEDIMPACT	10680 TREENA ST., STOP 5	SAN DIEGO	CA	92131	(800) 788-2949	
996	J.F. MOLLOY & ASSO.	PO BOX 68947	INDIANAPOLIS	IN	46268	(800) 331-3287	SEE CARRIER 942 PRINCIPAL FINANCIAL GROUP
997	GENWORTH FINANCIAL	PO BOX 10821	CLEARWATER	FL	33757	(877) 825-9337	CODE IN OPEN STATUS BY SCHA
998	CANADA LIFE ASSURANCE CO.	6201 POWERS FERRY RD., STE. 100	ATLANTA	GA	30348	(800) 333-2542	
999	CIGNA HEALTHCARE OF SC/HEALTHSOURCE SC	PO BOX 190024	CHARLESTON	SC	294199024	(800) 720-3150	BOUGHT BY CIGNA HEALTHCARE CC 134
100DN	AETNA US HEALTHCARE	PO BOX 14094	LEXINGTON	KY	40512	(800) 451-7715	
100RX	AETNA PHARMACY	PO BOX 52444	PHOENIX	AZ	850722444	(800) 238-6279	
110RX	PROVIDENT/CAREMARK	PO BOX 686005	SAN ANTONIO	TX	78268	(800) 841-5550	USE CODE 280 CAREMARK
113DN	UNITED HEALTHCARE	PO BOX 30567	SALT LAKE CITY	UT	84130	(800) 521-5505	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
134DN	CIGNA CONN GENERAL LIFE INSURANCE	PO BOX 188037	CHATTANOOGA	TN	37422	(800) 244-6224	DO NOT USE FOR MEDICARE.THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE
134RX	CIGNA CONN GENERAL LIFE INSURANCE	PO BOX 188053	CHATTANOOGA	TN	374228053	(800) 622-5579	USE CARRIER CODE 718
139DN	UMR	PO BOX 30541	SALT LAKE CITY	UT	84130	(800) 826-9781	WAS WAUSAU INS. CO.
139RX	WAUSAU INSURANCE COMPANY	PO BOX 8013	WAUSAU	WI	544028013	(800) 826-9781	
143DN	UMR	PO BOX 30541	SALT LAKE CITY	UT	841300541	(800) 826-9781	
153DN	KANAWHA LIFE INSURANCE COMPANY	PO BOX 6000	LANCASTER	SC	29721	(803) 286-2440	
160DN	UNICARE HEALTH AND LIFE INSURANCE	PO BOX 659444	SAN ANTONIO	TX	75265	(877) 217-9677	
201DN	HCH ADMINISTRATORS	PO BOX 1986	PEORIA	IL	61656	(800) 322-1516	
206DN	MED COST BENEFITS SERVICES	PO BOX 25987	WINSTON-SALEM	NC	27114	(800) 795-1023	
237DN	GUARDIAN LIFE INSURANCE CO. OF AMERICA	PO BOX 2459	SPOKANE	WA	99210	(800) 541-7846	
245RX	FIRST HEALTH	PO BOX 23070	TUCSON	AZ	85734	(800) 554-4954	
300DN	BENEFIT ADMINISTRATORS, INC.	PO BOX 6279	ERIE	PA	16512	(800) 777-2524	
302DN	GOVERNMENT EMPLOYEE HOSP. ASSOC. (GEHA)	PO BOX 2336	INDEPENDENCE	MO	64051	-	DENTAL COVERAGE
308DN	GREAT WEST LIFE	PO BOX 188037	CHATTANOOGA	TN	37422	(877) 631-4227	
312DN	NATIONAL BENEFIT ADMINISTRATORS	PO BOX 690903	CHARLOTTE	NC	282277016	(800) 482-6736	
315DN	THOMAS COOPER AND COMPANY	PO BOX 22557	CHARLESTON	SC	29413	(843) 722-2115	
321DN	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	PO BOX 1358	GLEN BURNIE	MD	21060	(800) 222-2798	
345DN	EMPLOYEE BENEFIT SERVICES, INC.	PO BOX 1929	FORT MILL	SC	29716	(800) 242-1510	
370DN	DELTAHEALTH SYSTEMS	PO BOX 702500	WEST VALLEY	UT	84170	(877) 474-0605	
386DN	ASSURANT HEALTH	PO BOX 2940	CLINTON	IA	527332940	(800) 442-7742	DHHS INTERNAL RECOVERY CLAIMS BILLING MUST BE FAX TO: 414-224-0472
387DN	HEALTHGRAM	PO BOX 11088	CHARLOTTE	NC	28220	(800) 446-5439	DENTAL - HEALTHGRAM FORMERLY PRIMARY PHYSICIANS CARE
401DN	BLUE CROSS AND BLUE SHIELD OF SC	4101 PERCIVAL RD.	COLUMBIA	SC	29219	(803) 788-3860	THIS CODE USED ONLY FOR DENTAL CLAIMS WHERE BCBS IS THE INSURANCE CARRIER
415DN	WEYCO, INC.	PO BOX 30132	LANSING	MI	48909	(517) 349-7010	
445DN	CAROLINA CARE PLAN/MEDICAL MUTUAL INS. CO.	PO BOX 6018	CLEVELAND	OH	441011018	(80) 031-5314	DENTAL ONLY
476DN	CENTRAL STATES, SOUTHEAST & SOUTHWEST	PO BOX 5116	DEPLAINES	IL	60017	(800) 323-5000	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
536DN	CLAIMSWARE MANAGEMED	PO BOX 6125	GREENVILLE	SC	29606	(864) 234-8200	
552DN	CORESOURCE, INC.	6100 FAIRVIEW RD.	CHARLOTTE	NC	28210	(800) 327-5462	
553DN	HEALTHSCOPE BENEFITS, INC.	PO BOX 99005	LUBBOCK	TX	79490	(800) 967-6831	
709DN	MARSH ADVANTAGE AMERICA	501 NORTH BROADWAY, STE. 500	ST. LOUIS	MO	63102	(800) 868-7526	FORMERLY BENEFIT PLAN SERVICES
751DN	POLARIS BENEFIT ADMINISTRATORS	PO BOX 1008	DELAWARE	OH	43015-	(800) 234-0225	
751RX	POLARIS BENEFIT ADMINISTRATORS	PO BOX 1008	DELAWARE	OH	43015-	(800) 234-0225	
766DN	PALMER & CAY/CARSWELL, INC.	PO BOX 1286	SAVANNAH	GA	31402	(912) 234-6621	
781DN	MEDICAL CLAIMS MANAGEMENT CORP	PO BOX 12995	CHARLOTTE	NC	282202995	(800) 334-0609	
836DN	HUMANA	PO BOX 14601	LEXINGTON	KY	40512	(800) 558-4444	
842DN	GARDNER AND WHITE, INC.	PO BOX 40619	INDIANAPOLIS	IN	462400619	(317) 257-9131	
857DN	CORPORATE BENEFIT SERVICES, INC.	PO BOX 12954	CHARLOTTE	NC	28220	(704) 373-0447	
879DN	DENEX DENTAL	111 ROCKVILLE PIKE STE. 700	ROCKVILLE	MD	20850	(866) 690-4908	DENEX DENTAL IS A PLAN UNDER WELLPATH SELECT/COVENTRY
885DN	JOHN ALDEN INSURANCE COMPANY	PO BOX 020270	MIAMI	FL	33102	(800) 328-4316	
886DN	PLANNED ADMINISTRATORS, INC.	PO BOX 6927	COLUMBIA	SC	29260	(803) 754-0041	
889DN	GROUP INSURANCE ADMINISTRATION, INC.	3350 PEACHTREE RD NE STE. 1040	ATLANTA	GA	30326	(800) 621-0683	
897DN	SOUTHERN BENEFITS ADMINISTRATORS DENTAL	5305 VIRGINIA BEACH BLVD.	NORFOLK	VA	23502	(757) 461-8091	
909DN	PREFERRED HEALTH ALLIANCE CORP.	PO BOX 382048	BIRMINGHAM	AL	35238	(205) 969-1155	
937DN	MVP HEALTH CARE	PO BOX 763	SCHENECTADY	NY	12301	(800) 480-5640	
958DN	ITPE-NMU HEALTH AND WELFARE FUND	PO BOX 13817	SAVANNAH	GA	31416	(912) 352-7169	
A01	THRIVENT FINANCIAL FOR LUTHERANS	4341 N. BALLARD RD.	APPLETON	WI	54919	(800) 847-4836	
A02	ALTERNATIVE BENEFITS PLANS, INC.	2920 BRANDYWINE RD. STE. 106	ATLANTA	GA	30341	(800) 241-7319	
A03	STARMARK	PO BOX 2942	CLINTON	IA	52733	(800) 522-1246	THIS CARRIER HANDLES GROUPS WITH LESS THAN 50 EMPLOYEES. SEE CC212 FOR GROUPS OVER 50 EMPLOYEES.
A04	CONSULTEC PRESCRIPTION BENEFITS MANAGEMENT	9040 ROSWELL RD., STE. 700	ATLANTA	GA	303501853	(800) 365-4944	
A05	AMERICAN PUBLIC LIFE INSURANCE CO.	PO BOX 925	JACKSON	MS	39205	(800) 256-8606	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
A06	COLONIAL PENN FRANKLIN LIFE INSURANCE COMPANY	1818 MARKET ST.	PHILADELPHIA	PA	191811250	(800) 523-4000	THIS CARRIER PART OF CONSECO INSURANCE GROUP
A07	CONTINENTAL LIFE INSURANCE CO. OF SOUTH CAROLINA	PO BOX 6138	COLUMBIA	SC	29260	(803) 782-4947	
A08	INDEPENDENCE AMERICAN INS. CO. (IHC HEALTH SOLUTION)	PO BOX 21456	EAGON	MN	55121	(866) 429-0608	
A09	RX AMERICA	221 N CHARLES LINDBERG DR.	SALT LAKE CITY	UT	84116	(800) 770-8014	
A10	AMERISCRIPT	4301 DARROW RD. STE. 4200	STOW	OH	44224	(800) 681-6912	
A11	PREFERRED ADMINISTRATORS	15560 NORTH FLW BLVD.	SCOTTSDALE	AZ	85260	(877) 276-7198	
A12	MOUNTAIN CLAIMS MANAGEMENT	PO BOX 1008	FRUITLAND	ID	83616	(866) 952-7979	
A13	HOLDEN & COMPANY	PO BOX 10411	SAVANNAH	GA	31412	(800) 404-3344	
A14	EB RX	2045 MIDWAY DR.	TWINSBURG	OH	44087	(800) 800-7153	
A15	MANAGED PRESCRIPTIONS SERVICES (MPS)	ONE CITY CENTRE STE. 1100	ST. LOUIS	MO	631016922	(800) 759-6959	
A16	FCE BENEFIT ADMINISTRATOR	4615 WALZEM RD. STE 300	SAN ANTONIO	TX	782181610	(800) 899-9355	
A17	NOVA HEALTHCARE ADMINISTRATORS	2680 GRAND ISLAND BLVD.	GRAND ISLAND	NY	140720308	(800) 333-3195	
A18	MSH MOBILITY BENEFITS	PO BOX 77	BEEBE PLAIN	VT	05823	(888) 842-1530	CODE ASSIGNED BY SCHA
A19	ISLAND GROUP ADMINISTRATION, INC.`	3 TOILSOME LANE	EAST HAMPTON	NY	11937	(800) 926-2306	CODE ASSIGNED BY SCHA
A20	PROFESSIONAL CLAIMS MANAGEMENT	PO BOX 35276	CANTON	OH	443155276	(800) 325-8424	
A20DN	PROFESSIONAL CLAIMS MANAGEMENT	PO BOX 35276	CANTON	OH	443155276	(800) 325-8424	
A21	PC HEALTH PLAN ADMINISTRATION	PO BOX 1377	THOMASVILLE	GA	31799	(888) 426-1937	CODE ASSIGNED BY SCHA
A22	PIEDMONT ADMINISTRATORS	PO BOX 25307	WINSTON-SALEM	PA	271145307	(800) 852-7040	
A23	SERV U PRESCRIPTION	PO BOX 26096-0096	MILWAUKEE	WI	53226	(800) 759-3203	
A24	WELLPOINT NEXT RX	PO BOX 2902	CLINTON	IA	527332902	(800) 962-7378	USE CARRIER 333 EXPRESS SCRIPTS
A25	BENESCRIPT	8300 E. MAPLEWOOD AVE.	GREENWOOD VILLAGE	CO	80111	(800) 345-3189	
A26	MARKEL SMART STM	PO BOX 15953	LUBBOCK	TX	79490	(800) 279-2290	
A27	HEALTHCARE SUPPORT	25 COLUMBIA HEIGHTS	BROOKLYN HEIGHTS	NY	112012482	(800) 554-4022	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A28	SHENANDOAH LIFE INSURANCE CO	PO BOX 12847	ROANOKE	VA	24029	(800) 848-5433	
A29	MERITAN HEALTH	PO BOX 80884	INDIANAPOLIS	IN	46280	(800) 606-4841	
A30	RMSCO, INC.	PO BOX 678	LIVERPOOL	NY	130880678	(877) 204-7086	
A30DN	RMSCO, INC.	PO BOX 678	LIVERPOOL	NY	130880678	(877) 204-7086	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
A31	UNITY HEALTH INSURANCE	PO BOX 610	SAUK CITY	WI	535831374	(800) 362-3308	
A32	MAGELLAN BEHAVIORAL HEALTH	PO BOX 1659	MARYLAND HEIGHTS	MO	63043	(800) 359-2422	
A33	ALLIANT HEALTH PLANS, INC.	PO BOX 21109	ROANOKE	VA	24108	(800) 283-4927	
A34	WOODS & GROOM	2549 17TH ST.	COLUMBUS	IN	47202	(800) 368-3429	DORMANT 8/06
A35	FABRI-KAL CORPORATION	PO DRAWER C	PIEDMONT	SC	29773	(864) 299-1720	CODE IN OPEN STATUS BY SCHA
A36	FIELDCREST CANNON (CANNON MILLS)	PO BOX 5000	EDEN	NC	272895000	(800) 222-3693	
A37	UNITED BEHAVIORAL/DENTAL SYSTEMS	PO BOX 30755	SALT LAKE CITY	UT	84130	(800) 557-5745	
A38	UNITED HEALTHCARE OF NC	PO BOX 2604	GREENSBORO	NC	274386304	(800) 999-1147	
A39	COMPLETE BENEFITS SOLUTIONS	6071 CARMEL RD. STE 305	CHARLOTTE	NC	28226	(866) 270-2316	
A40	STRATEGIC RESOURCE COMPANY	PO BOX 14079	LEXINGTON	KY	40512	(888) 772-9682	
A41	CLAIMS MANAGEMENT SERVICES	PO BOX 10888	GREEN BAY	WI	54307	(800) 472-7130	
A42	PRIMERICA LIFE INSURANCE COMPANY	3120 BRECKINRIDGE BLVD.	DULUTH	GA	30199	(404) 381-1000	
A43	PREMIER BENEFIT MANAGEMENT, INC.	7070-A KAIGHN AVE.	PENSAUKEN	NJ	08109	-	CODE ASSIGNED BY SCHA
A44	GLOBAL MEDICAL MANAGEMENT, INC.	7901 SW 36TH ST. STE 100	DAVIE	FL	33328	(954) 370-6404	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A45	INTEQ GROUP	5445 LASIERRA DR., STE. 400	DALLAS	TX	75231	(800) 959-3953	
A46	STANDARD INSURANCE COMPANY	PO BOX 82622	LINCOLN	NE	68501	(503) 321-7000	
A47	STATESMAN NATIONAL LIFE INSURANCE COMPANY	3815 MONTROSE BLVD.	HOUSTON	TX	77006	(713) 526-6000	
A48	QUALMED OF OREGON	PO BOX 286	CLACKMAS	OR	970150286	(800) 568-5628	DORMANT 8/06
A49	ARIZONA FOUNDATION FOR MEDICAL CARE	PO BOX 2909	PHOENIX	AZ	850622909	(602) 231-8855	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A50	FEDERAL EMPLOYEES COMPENSATION ACT	PO BOX 8300	LONDON	KY	407428300	(866) 335-8319	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A51	COAL MINE WORKERS COMP PROGRAM	PO BOX 8300	LONDON	KY	407428300	(866) 335-8319	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A52	NATIONWIDE SPECIALTY HEALTH CLAIMS	PO BOX 420	SPRINGFIELD	MA	01101	(800) 517-4791	
A53	LONGSHORE & HARBOR WORKERS COMP PROGRAM	PO BOX 8300	LONDON	KY	407428300	(866) 335-8319	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
A54	CENTURY HEALTHCARE	PO BOX 2256	GRAPEVINE	TX	76099	(888) 444-1995	NEIC 30018
A55	AETNA LIFE AND CASUALTY	PO BOX 36890	LOUISVILLE	KY	40232	(800) 423-3289	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A56	VULCAN MATERIALS COMPANY	PO BOX 530187	BIRMINGHAM	AL	352530187	(864) 277-2371	DORMANT 8/06
A57	AMERICAN GROUP ADMINISTRATORS, INC.	101 CONVENTION CENTER DR. STE 200	LAS VEGAS	NV	89109	(800) 842-4742	CODE ASSIGNED BY SCHA
A58	COMPREHENSIVE BENEFITS	PO BOX 8955	MELVILLE	NY	11747	(800) 828-3605	
A60						-	
A61	SUMMACARE HEALTH PLAN	PO BOX 3620	AKRON	OH	743893628	(800) 996-8701	
A62	AMERICAN MEDICAL AND LIFE INSURANCE (AMLI)	PO BOX 1353	CHICAGO	IL	60690	(888) 264-1512	
A63	CITIZENS INSURANCE	PO BOX 1627	ANDERSON	SC	29622	(864) 334-0090	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A64	NTCA (NAT'L TELECOMMUNICATIONS COOPERATIVE ASSO.)	ONE WEST PACK SQUARE STE 600	ASHEVILLE	NC	288013459	(828) 281-9000	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A65	DATARX	5920 ODELLE ST.	CUMMINGS	GA	30040	(877) 823-1273	
A66	PRAIRIE STATES ENTERPRISES, INC.	PO BOX 23	SHEBOYGAN	WI	530820023	(800) 815-7020	
A67	HEALTHSCOPE BENEFITS	PO BOX 99005	LUBBOCK	TX	794906831	(800) 967-6831	
A68	HOLLINGSWORTH SACO LOWELL CORP.	PO DRAWER 2327	GREENVILLE	SC	29602	(864) 859-3211	DORMANT 8/06
A69	KAISER FOUNDATION HEALTH PLAN OF SOUTHERN CA	PO BOX 7004	DOWNEY	CA	902427004	(800) 331-0420	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A70	NATIONAL EMPLOYEE BENEFIT ADMINISTRATORS	1920 N. FLORIDA MANGO RD	WEST PALM BEACH	FL	33409	(800) 822-5899	
A71	CAROLINA BEHAVIORAL HEALTH ALLIANCE	PO BOX 571137	WINSTON-SALEM	NC	271571137	(800) 475-7900	
A72	BABB, INC.	850 RIDGE AVE.	PITTSBURGH	PA	15212	(800) 245-6102	
A73	CLAIMS TECHNOLOGY, INC.	100 COURT AVE., STE. 306	DES MOINES	IA	50309	(800) 245-8813	
A74	FIRST CAROLINA CARE, INC.	PO BOX 381686	BIRMINGHAM	AL	35238	(800) 811-3298	
A75	HEALTH COST SOLUTIONS	PO BOX 1439	HENDERSONVILLE	TN	37077	(888) 229-5020	WAS LIFECARE CENTERS OF AMERICA
A76	TOWER LIFE INS. CO.	310 S. MARY ST.	SAN ANTONIO	TX	78205	(800) 660-6077	
A77	SISCO	PO BOX 389	DUDUQUE	IA	52004	(800) 457-4725	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
A78	HIGHWAY TO HEALTH (HTH)	PO BOX 968	HORSHAM	PA	19044	(888) 350-2002	THIS CODE ASSIGNED BY SCHA. NOT REQUESTED BY MEDICAID
A79	HEALTH SPECIAL RISK	4001 N. JOSEY LANE	CARROLLTON	TX	75007	(972) 492-6474	
A80	TOTAL SCRIPT	10901 WEST 120TH AVE. STE 110	BROOMFIELD	CO	80021	(800) 752-2211	
A81	BENESYS	PO BOX 90082	LUBBOCK	TX	79402	(337) 234-1789	
A82	UNITED HEALTHCARE INDEMNITY	PO BOX 740801	ATLANTA	GA	303740801	(800) 848-8406	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A83	GROUP RESOURCES, INC.	PO BOX 100043	DULUTH	GA	300969343	(770) 623-8383	
A84	HCC LIFE INSURANCE COMPANY	PO BOX 2005	FARMINGTON HILLS	MI	48333	(866) 400-4102	
A85	QUALCHOICE	PO BOX 25610	LITTLE ROCK	AR	722219914	(800) 235-7111	
A86	BENEFIT MANAGEMENT CO	PO BOX 269000	WESTON	FL	333269000	(800) 262-9175	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A87	SOUTHEAST COMMUNITY CARE (ARCADIAN HEALTH)	PO BOX 4946	COVINA	CA	91723	(800) 573-8597	
A88	WINDSOR STERLING	PO BOX 269003	PLANO	TX	750269003	(888) 858-8551	
A89	SPECIAL INSURANCE SERVICES (SIS)	PO BOX 250349	PLANO	TX	750250349	(800) 767-6811	CODE ASSIGNED BY SCHA
A90	EMPLOYEE BENEFIT CLAIMS, INC.	9501 WEST DEVON	ROSEMONT	IL	60018	(312) 696-3660	
A91	STATES GENERAL LIFE INS. CO	115 WEST 7TH ST., STE. 1200	FORT WORTH	TX	761027012	(800) 782-8375	
A92	PROVIDENT AMERICAN LIFE & HEALTH INS.	PO BOX 29158	SHAWNEE MISSION	KS	66201915	(800) 753-5133	
A93	AMERICAN COLLEGE OF SURGEONS	PO BOX 2522	FORT WORTH	TX	761132522	(800) 433-1672	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A94	FORETHOUGHT LIFE INSURANCE COMPANY	PO BOX 981721	EL PASO	TX	79998	(877) 492-5870	
A95	REYNOLDS & REYNOLDS	PO BOX 1272	DAYTON	OH	45401	(800) 736-3539	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A96	HAMRICKS, INC.	742 PEACHOID RD.	GAFFNEY	SC	29340	(864) 487-7505	
A97	EMPLOYER PLAN SERVICES, INC.	2180 NORTH LOOP WEST, STE. 400	HOUSTON	TX	77018	(800) 447-6588	
A98	CORPORATE BENEFIT SERVICES OF AMERICA, INC.	PO BOX 738	HOPKINS	MN	55343	(800) 765-4224	
A99	CHEROKEE INSURANCE	PO BOX 853925	RICHARDSON	TX	750853925	(800) 201-0450	
B01	HEALTH PARTNERS	PO BOX 1289	MINNEAPOLIS	MN	554401289	(888) 922-2313	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
B01DN	HEALTH PARTNERS DENTAL	PO BOX 1172	MINNEAPOLIS	MN	55440	(888) 922-2313	
B02	LIFE INSURANCE CO. OF ALABAMA	PO BOX 349	GADSDEN	AL	35902	(800) 226-2371	
B03	CHESAPEAKE LIFE INS. CO.	PO BOX 809025	DALLAS	TX	753809025	(888) 756-3534	
B04	CARITEN HEALTHCARE	PO BOX 22987	KNOXVILLE	TN	37933	(800) 284-0042	CODE IN OPEN STATUS BY SCHA
B05	FOCUS HEALTHCARE MANAGEMENT, INC.	720 COOL SPRINGS BLVD.	FRANKLIN	TN	37067	(615) 778-4000	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B06	SOUTHCARE HEALTHCARE PREFERRED	1100 CIRCLE 75 PARKWAY, STE 1400	ATLANTA	GA	30339	(800) 470-2004	
B07	MAGNACARE	PO BOX 1001	GARDEN CITY	NY	11530	(866) 624-6259	
B08	AMFIRST INSURANCE CO	PO BOX 16708	JACKSON	MS	39236	(888) 888-2519	
B09	DEARBORN NATIONAL	PO BOX 23060	BELLEVILLE	IL	62223	(800) 348-4512	
B10	PILGRIM HEALTH & LIFE INSURANCE	PO BOX 897	ATLANTA	GA	30303	(404) 659-2100	CODE IN OPEN STATUS BY SCHA
B11	CBCA ADMINISTRATORS, INC.	PO BOX 1339	MINNEAPOLIS	MN	55440	(800) 824-3882	
B12	JOHN HANCOCK LIFE AND HEALTH INSURANCE	JOHN HANCOCK B5-03 200 BERKELEY ST.	BOSTON	MA	02116	(800) 377-7311	
B13	WEB TPA	PO BOX 99906	GRAPEVINE	TX	760999706	(800) 758-2851	
B13DN	WEB TPA	PO BOX 99906	GRAPEVINE	TX	76099	(800) 758-2851	
B14	A.C.S. CONSULTING SERVICES, INC.	PO BOX 2000	WINSTON-SALEM	NC	271022000	(336) 759-2013	
B14DN	A.C.S. CONSULTING SERVICES, INC.	PO BOX 2000	WINSTON-SALEM	NC	271022000	(336) 759-2013	
B15	HILLCREST BENEFIT ADMINISTRATORS	PO BOX 1516	MT. DORA	FL	32756	(800) 743-9264	
B16	MAGELLAN RX	11013 WEST BROAD ST., STE. 500	GLEN ALLEN	VA	23060	(800) 659-4112	
B17	ULTRA BENEFITS	PO BOX 763	WESTBORO	MA	01581	(866) 858-7223	
B18	LUMENOS	PO BOX 69309	HARRISBURG	PA	17106	(877) 495-7223	
B19	RENAISSANCE DENTAL	PO BOX 17250	INDIANAPOLIS	IN	46217	(888) 358-9484	
B20	FMH BENEFIT SERVICES, INC.	PO BOX 25946	OVERLAND PARK	KS	66225	(800) 990-9058	
B21	PIONEER HEALTH	PO BOX 6600	HOLYOKE	MA	01041	(800) 423-4586	
B22	COVENTRY HEALTHCARE OF VIRGINIA	PO BOX 7704	LONDON	KY	40742	(800) 627-4872	
B23	LINCOLN FINANCIAL GROUP	PO BOX 614008	ORLANDO	FL	32861	(800) 423-2765	
B24	EMBLEM HEALTH CARE CO.	PO BOX 3000	NEW YORK	NY	10116	(212) 501-4444	
B25	HEALTH AND WELFARE FUND LOCAL 218	PO BOX 115027	ATLANTA	GA	30310	(404) 755-5665	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
B26	IMSCO HEALTH PLAN	PO BOX 697	BUCKEYSTOWN	MD	217170697	(800) 944-2833	IMSCO - INTERNATIONAL MANAGEMENT SERVICE CO.
B27	HEALTH FIRST (PPO)	PO BOX 17709	GREENVILLE	SC	29606	(864) 289-3000	
B28	THE STANDARD	PO BOX 82622	LINCOLN	NE	68501	(800) 547-9515	
B29	PANAMERICAN BENEFIT SOLUTIONS	PO BOX 981644	EL PASO	TX	799981644	(800) 694-9888	WAS US NOW INSURANCE GROUP
B30	SOUTHERN BENEFITS, SOUTHEASTERN PIPE TRADERS	PO BOX 1449	GOODLETTSVILLE	TN	370701449	(800) 831-4914	
B31	GREAT AMERICAN LIFE INS. CO (GALIC)	PO BOX 559002	AUSTIN	TX	787553010	(800) 880-2745	
B32	MAXCARE	PO BOX 16430	OKLAHOMA CITY	OK	73113	(800) 259-7765	
B33	PHARMAVAIL DRUG COMPANY	3380 TRICKHUM RD., BLDG. 400, UNIT 100	WOODSTOCK	GA	30188	(800) 933-3734	
B34	ATLANTA LIFE INSURANCE COMPANY	100 AUBURN AVE., NE	ATLANTA	GA	30303	(404) 659-2100	
B35	PROCARE RX PBM	1267 PROFESSIONAL PARKWAY	GAINSVILLE	GA	30507	(800) 699-3542	
B36	COMMONWEALTH INDEMNITY PLAN	PO BOX 9016	ANDOVER	MA	01810	(800) 442-9033	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B37	BENEFIT ADMINISTRATORS	PO BOX 21308	COLUMBIA	SC	29221	(877) 840-0936	
B37DN	BENEFIT ADMINISTRATORS	PO BOX 1957	BEATTYVILLE	KY	41311	(800) 325-8424	
B38	MEDBEN	PO BOX 1009	NEWARK	OH	43058	(800) 686-8425	
B39	MEDICAL SAVINGS INSURANCE CO.	5835 WEST 74TH ST.	INDIANAPOLIS	IN	462781758	(317) 329-8222	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B40	TOTAL CLAIMS SOLUTION (TCS)	PO BOX 10888	GREEN BAY	WI	543070888	(800) 376-0110	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B41	VYTRA HEALTHCARE	PO BOX 9091	MELVILLE	NY	11747	(866) 808-9399	
B42	UMR	PO BOX 266	ONALASKA	WI	546568764	(800) 236-8672	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B43	AFFINITY HEALTH PLAN	PO BOX 981726	EL PASO	TX	799981726	(866) 247-5678	
B44	AMERICAN CHOICE HEALTH PLAN, LLC	PO BOX 922043	HOUSTON	TX	77292	(800) 633-4226	
B44DN	AMERICAN CHOICE HEALTH PLAN, LLC	PO BOX 922009	HOUSTON	TX	77292	(800) 598-9799	
B45	ATLANTICARE	PO BOX 613	HAMMONTON	NJ	08037	(888) 328-2287	
B46	TOTAL CLAIMS SOLUTION (TCS)	PO BOX 10888	GREEN BAY	WI	54307	(800) 376-0110	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
B47	PHARMACY DATA MANAGEMENT, INC.	1170 E WESTERN RESERVE RD	POLAND	OH	44514	(800) 774-0890	
B48	SELECT HEALTH	PO BOX 30192	SALT LAKE CITY	UT	84123	(800) 538-5038	
B49	FALLON COMMUNITY HEALTH PLAN	PO BOX 15121	WORCHESTER	MA	01615	(800) 868-5200	
B50	MEMBER HEALTH	PO BOX 391180	CLEVELAND	OH	44139	(888) 868-5854	
B51	INNOVIANT	PO BOX 8082	WAUSAU	WI	54402	(877) 559-2955	
B52	SOUTHERN PLANNED ADMINISTRATORS	PO BOX 218180	HOUSTON	TX	77218	(281) 829-1033	
B53	NATIONAL FOUNDATION LIFE INSURANCE COMPANY	110 WEST 7TH ST., STE. 300	FORT WORTH	TX	76102	(800) 221-9039	
B54	NGS AMERICAN, INC.	PO BOX 2310	CLEMENS	MI	48046	(810) 779-7676	
B55	US SCRIPTS	2425 WEST SHAW AVE.	FRESNO	CA	93711	(800) 460-8988	
B56	MEDSAVE USA	3035 LAKELAND HILLS BLVD.	LAKELAND	FL	33805	(800) 226-3155	
B57	SOUTHERN FARM BUREAU LIFE INS. CO.	PO BOX 78	JACKSON	MS	39205	(800) 457-9611	
B58	AVMED HEALTH	PO BOX 569000	MIAMI	FL	332569000	(800) 452-8633	
B59	LDI INTEGRATED PHARMACY SERVICES	701 EMERSON RD., STE. 301	CREVE COEUR	MO	63141	(866) 516-3121	
B60	STATE MUTUAL LIFE ASSURANCE COMPANY OF AMERICA	1100 31ST ST.	DOWNERS GROVE	IL	60515	(800) 323-3359	CODE IN OPEN STATUS BY SCHA
B61	AMERICAN BEHAVIORAL	3680 GRANDVIEW PARKWAY STE 100	BIRMINGHAM	AL	35243	(800) 925-8327	
B62	LIBERTY DENTAL	PO BOX 26110	SANTA ANNA	CA	92799	(888) 902-0349	
B63	EASTERN LIFE AND HEALTH INSURANCE	PO BOX 10188	LANCASTER	PA	17605	(800) 233-0307	
B64	UNITED MEDICAL RESOURCES, INC.	PO BOX 30541	SALT LAKE CITY	UT	84130	(513) 619-3000	
B65	COMPASS ROSE HEALTH PLAN	PO BOX 141501	NASHVILLE	TN	37214	(877) 531-1159	
B66	KIRKE-VAN ORSDEL, INC.	PO BOX 9126	DES MOINES	IA	503069126	(800) 247-2192	USE CODE 759 MEDIPLUS PER SCHA
B67	NAVITUS HEALTH SOLUTIONS LLC	PO BOX 999	APPLETON	WI	549120999	(866) 268-2501	
B68	UPMC HEALTH BENEFITS, INC.	PO BOX 2999	PITTSBURGH	PA	15230	(877) 381-3764	
B69	AMERICAN INSURANCE ADMINISTRATORS	PO BOX 2348	COLUMBUS	OH	432162348	(800) 922-1245	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA.
B70	DECARE DENTAL	PO BOX 1348	MINNEAPOLIS	MN	55440	(800) 371-6561	
B71	CHCS SERVICES, INC.	PO BOX 12467	PENSACOLA	FL	325912457	(888) 803-1780	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B72	INTEGRITY NATIONAL LIFE INS.	PO BOX 32350	LOUISVILLE	KY	40232	(502) 426-1843	CODE ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
B73	SOUTHERN CALIFORNIA PIPE TRADES TRUST FUND	501 SHATTO PLACE, 5TH FLOOR	LOS ANGELES	CA	90020	(213) 385-6161	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B74	STAR HRG	PO BOX 54150	PHOENIX	AZ	850784150	(800) 288-1474	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B75	HEALTH DESIGN PLUS	PO BOX 2584	HUDSON	OH	442362584	(800) 893-0777	
B76	INTERNATIONAL ASSO. BENEFITS	1747 PENNSYLVANIA AVE. NORTH WEST	WASHINGTON	DC	20006	(800) 275-1171	
B77	UNITED HEALTHCARE PLAN ADMINISTRATORS	PO BOX 121212	MARIETTA	GA	300670092	(800) 562-7079	USE CODE 985 BENESIGHT
B78	ARM GROUP (OMNICARE)	340 QUADRANGLE DR.	BOILINGBROOK	IL	60440	(800) 968-7222	
B79	FOX-EVERETT, INC.	PO BOX 6012	RIDGELAND	MI	39158	(877) 476-6327	
B80	INTEGRATED BEHAVIORAL HEALTH/IBH	PO BOX 30018	LAGUNA NIGUEL	CA	92607	(800) 395-1616	
B81	HM BENEFITS ADMINISTRATORS, INC.	PO BOX 535078	PITTSBURGH	PA	152535078	(800) 279-2624	
B82	AVANTE HEALTH	1111 E. HERNDON AVE. STE. 308	FRESNO	CA	93720	(866) 416-3617	
B83	STATE OF LOUISIANA EMPLOYEES	PO BOX 44036	BATON ROUGE	LA	70804	(800) 272-8451	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B84	HEALTH CARE CORPORATION	203 JANDERS RD.	CARY	IL	60013	-	CODE IN OPEN STATUS BY SCHA
B85	TUFTS HEALTHCARE	PO BOX 9185	WATERTOWN	MA	02471	(800) 423-8080	
B86	PREFERRED ONE ADMINISTRATIVE SERVICES	PO BOX 59212	MINNEAPOLIS	MN	55459	(800) 997-1750	
B87	HEALTH ALLIANCE	PO BOX 6003	URBANA	IL	616036003	(800) 322-7451	
B88	GETTYSBURG HEALTH ADMINISTRATORS	PO BOX 1169	FREDERICK	MD	21702	(800) 497-4474	
B89	RXEDO	7800 DALLAS PARKWAY STE 460	PLANO	TX	75024	(888) 879-7336	
B90	FIRST CHOICE VIP CARE	PO BOX 307	LINTHICUM	MD	210900307	(800) 575-0418	THIS IS A MEDICARE ADVANTAGE PLAN.
B91	CHRISTIAN BROTHERS EMPLOYEE BENEFIT TRUST	1205 WINDHAM PARKWAY	ROMEOVILLE	IL	60446	(800) 807-0400	
B92	CARE SOURCE	ONE SOUTH MAIN	DAYTON	OH	45402	(800) 488-0134	
B93	UNIVERSITY HEALTH ALLIANCE	700 BISHOP ST., STE. 300	HONOLULU	HI	968134100	(800) 532-4000	
B94	THE CAPELLA GROUP	PO BOX 200368	ARLINGTON	TX	76006	(888) 411-3888	
B95	SINCLAIR HEALTH SERVICES	PO BOX 30827	SALT LAKE CITY	UT	84130	(888) 800-2230	
B96	ALTERNATIVE RISK MANAGEMENTS (ARM LTD)	814 N.W. HIGHWAY	ARLINGTON HEIGHTS	IL	60004	(800) 392-1770	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
B97	NIPPON LIFE INSURANCE CO.	PO BOX 25951	SHAWNEE MISSION	KS	662255951	(800) 374-1835	
B98	AMERICAN PIONEER LIFE INSURANCE COMPANY	PO BOX 130	PENSACOLA	FL	32591	(800) 538-1053	
B99	GROUP & PENSION ADMINISTRATORS, INC.	PO BOX 749075	DALLAS	TX	75374	(866) 206-3224	
C01	TERMINIX SERVICE	PO BOX 2627	COLUMBIA	SC	29202	(803) 772-1783	CODE ASSIGNED BY SCHA
C02	FOUNDATION BENEFITS ADMINISTRATORS	6300 BRIDGEPOINT PKWAY, BLDG. 3 #400	AUSTIN	TX	78730	(888) 368-7910	
C03	TOTAL PLAN SERVICES, INC.	PO BOX 251369	PLANO	TX	75025	(800) 969-5238	
C04	CBA BLUE	PO BOX 2365	SOUTH BURLINGTON	VT	03036	(888) 222-9206	
C05	STRATEGIC OUTSOURCING, INC. (SOI)	PO BOX 241508	CHARLOTTE	NC	28224	(888) 836-7764	
C06	MISSIONARY MEDICAL	PO BOX 45730	SALT LAKE CITY	UT	84145	(800) 777-1647	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C07	AMERIBEN SOLUTIONS	PO BOX 7186	BOISE	ID	83707	(800) 786-7930	
C08	BENECARD	PO BOX 2187	CLIFTON	NJ	07015	(800) 737-9528	
C09	HEALTH PLAN ADMINISTRATORS	PO BOX 2638	ROCKFORD	IL	61132	(815) 633-5800	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C10	ZAVATA	PO BOX 1208	AMERICUS	GA	31709	(800) 841-7735	WAS PARADIGM CARE PLAN
C11	BENEFIT MANAGEMENT SERVICES, INC.	PO BOX 1317	MATTHEWS	NC	28106	(800) 228-1803	
C11DN	BENEFIT MANAGEMENT SERVICES, INC.	PO BOX 1178	MATTHEWS	NC	28106	(800) 228-1813	
C12	BENEFIT MANAGEMENT, INC.	PO BOX 1090	GREAT BEND	KS	66210	(800) 290-1368	
C13	CENTRAL RESERVE LIFE OF NORTH AMERICA INSURANCE CO	17800 ROYALTON RD.	STRONGSVILLE	OH	441365197	(800) 321-3997	
C14	COASTAL LUMBER CO	PO BOX 1576	WALTERBORO	SC	29488	(843) 538-2876	CODE IN OPEN STATUS BY SCHA
C15	ADVANCE PCS	PO BOX 52188	PHOENIX	AZ	850722196	(480) 391-4600	SEE CARRIER 471
C16	CONSOLIDATED BENEFITS, INC.	PO BOX 23686	COLUMBIA	SC	29224	(803) 736-5088	
C17	NATIONAL BENEFITS	110 GIBRALTAR RD.	HORSHAM	PA	19044	(215) 443-0404	
C18	EVOLUTIONS HEALTHCARE SYSTEMS	PO BOX 5001	NEW PORT RICHEY	FL	34656	(800) 881-4474	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C19	TAYLOR BENEFIT RESOURCES, INC.	PO BOX 6580	THOMASVILLE	GA	31758	(888) 352-5246	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
C20	SCREEN ACTORS GUILD-PRODUCERS HEALTH PLAN	PO BOX 7830	BURBANK	CA	915107830	(800) 777-4013	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C22	BOSTON MUTUAL LIFE INSURANCE COMPANY	120 ROYALL ST.	CANTON	MA	02021	(617) 828-7000	
C23						-	
C24	ENCOMPASS HEALTH MANAGEMENT SYSTEM	6000 WEST TOWN PARKWAY STE 350	DES MOINES	IA	50266	(800) 511-3389	
C25	MEDICAL CLAIMS SERVICES	1 WALL ST.. STE. 2A	RAVENSWOOD	WV	26164	(888) 225-0522	
C26	INTERACTIVE MEDICAL SYSTEMS, INC.	PO BOX 19108	RALEIGH	NC	27619	(919) 846-8400	
C27	SELECT BENEFIT ADMINISTRATORS	PO BOX 3245	MILWAUKEE	WI	53201	(800) 497-3699	
C27DN	SELECT BENEFIT ADMINISTRATORS	PO BOX 440	ASHLAND	WI	54806	(800) 497-3699	
C28	BENEFIT PLAN MANAGEMENT	PO BOX 536	ROCKLYN	MA	02370	(877) 642-7500	
C29	TRUE CHOICE USA	PO BOX 251369	PLANO	TX	75025	(800) 251-9665	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C30	KEENAN AND COMPANY	PO BOX 11431	TORRANCE	CA	90510	(800) 653-3626	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C31	CONSUMER HEALTH SOLUTIONS	PO BOX 3492	SPARTANBURG	SC	29304	(864) 573-9541	THE CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C32	WELL FARGO INSURANCE	PO BOX 2801	CHARLESTON	WV	253302801	(800) 435-4351	
C32DN	HEALTHSMART	PO BOX 3262	CHARLESTON	WV	25332	(800) 435-4351	FORMALLY WELLS FARGO
C33	THE DESTINY HEALTH PLAN	PO BOX 4628	OAKBROOK	IL	60522	(866) 826-9345	
C34	HTH HIGHWAY TO HELP	1 RADNOR CORP CTR., STE. 100	RADNOR	PA	19087	(866) 510-8780	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C35	MUTUAL PROTECTIVE MEDICO LIFE INSURANCE COMPANIES	1515 S 75TH ST.	OMAHA	NE	68124	(800) 228-6080	SEE CODE C99
C36	NORTH AMERICAN INSURANCE COMPANY	PO BOX 44160	MADISON	WI	53744	(608) 662-1232	
C37	OLD SURETY LIFE INSURANCE CO	PO BOX 54407	OKLAHOMA CITY	OK	731541407	(800) 272-5466	
C38	STANDARD LIFE & ACCIDENT INSURANCE COMPANY	PO BOX 1800	GALVESTON	TX	775531800	(888) 350-1488	
C39	CONTINENTAL GENERAL INSURANCE COMPANY	PO BOX 247007	OMAHA	NE	681247007	(402) 397-3200	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
C40	AVERA HEALTH PLANS	PO BOX 381506	BIRMINGHAM	AL	35238	(888) 322-2115	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C41	INSUREX BENEFITS ADMINISTRATORS, INC.	PO BOX 41779	MEMPHIS	TN	381741799	(901) 725-6435	
C41DN	INSUREX BENEFITS ADMINISTRATORS, INC.	PO BOX 41779	MEMPHIS	TN	381741799	(901) 725-6435	
C42	STANDARD CORPORATION	1400 MAIN ST. STE 1300	COLUMBIA	SC	29201	(803) 771-6785	
C43	EMPLOYEE BENEFIT ADMINISTRATORS	PO BOX 5150	GREENVILLE	SC	29606	(864) 235-6474	
C44	S C MEDICAL ASSOCIATION-MEMBERS INSURANCE TRUST	PO BOX 6927	COLUMBIA	SC	29260	(803) 798-6207	
C45	TALL TREE ADMINISTRATORS	PO BOX 71747	SALT LAKE CITY	UT	841710747	(877) 453-4201	
C46	MEDCO HEALTH SOLUTIONS	PO BOX 2902	CLINTON	IA	527332902	(800) 272-7243	USE CARRIER 333 EXPRESS SCRIPTS
C47	KANAWHA BENEFIT SERVICES	PO BOX 50098	KNOXVILLE	TN	379500098	(800) 822-1274	
C47DN	KANAWHA BENEFIT SERVICES	PO BOX 50098	KNOXVILLE	TN	379500098	(800) 822-1274	
C48	SOUTHERN ADMINISTRATIVE SERVICES	PO BOX 8069	COLUMBUS	GA	31908	(800) 426-8803	
C49	ACS CONSULTING SERVICES, INC.	PO BOX 2000	WINSTON-SALEM	NC	27102	(800) 849-5370	WAS PENN WESTERN
C49DN	PENN WESTERN BENEFITS, INC.	PO BOX 2000	WINSTON-SALEM	NC	27102	(800) 846-5370	
C50	TENNESSEE BENEFIT ADMINISTRATORS	PO BOX 3257	SPARTANBURG	SC	29304	-	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C51	YALE HEALTH PLAN	PO BOX 208217	NEW HAVEN	CT	065208217	(203) 432-0250	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C52	TPA OF GEORGIA	4574 LAWRENCEVILLE HWY, STE 201	LILBURN	GA	30047	(770) 451-7550	
C53						-	
C54	INTER-AMERICAS INS. CORP. (OOIDA)	PO BOX 9510	WICHITA	KS	672770510	-	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C55	PLAN ADMINISTRATORS (MATURE AMERICAN)	734 15TH ST. NW STE. 500	WASHINGTON	DC	20005	(202) 393-6600	
C56	COMPDENT	1930 BISHOP LANE STE. 132	LOUISVILLE	KY	40218	(800) 633-1262	
C57	WORLD TRAVEL PROTECTION	4600 WITMER INDUSTRIAL ESTATES #2	NIAGARA FALLS	NY	14305	(800) 456-4553	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C59	HUMANA CHOICE (PPO)	PO BOX14605	LEXINGTON	KY	405784602	(800) 457-4708	MEDICARE ADVANTAGE PLAN
C60	INSTILL HEALTH SYSTEMS (FFS)	PO BOX 7061	CAMDEN	SC	290207845	(877) 446-7845	MEDICARE ADVANTAGE PLAN

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
C61	INSTILL HEALTH SYSTEMS (PPO)	PO BOX 7061	CAMDEN	SC	290207845	(877) 446-7845	MEDICARE ADVANTAGE PLAN
C62	BCBS OF SC MEDICARE BLUE PRIVATE (PFFS)	PO BOX 100133	COLUMBIA	SC	29202	(800) 605-3256	MEDICARE ADVANTAGE PLAN
C63	BCBS OF SC MEDICARE BLUE&MEDICARE BLUE PLUS (PPO)	PO BOX 100133	COLUMBIA	SC	29202	(800) 605-3256	MEDICARE ADVANTAGE PLAN
C64	BLUE CHOICE HEALTH PLAN (PPO)	PO BOX 6170	COLUMBIA	SC	29260	(877) 275-3256	MEDICARE ADVANTAGE (PPO)
C65	PRESBYTERIAN HEALTHCARE SERVICES	PO BOX 27489	ALBUQUERQUE	NM	87125	(800) 356-2219	
C66	CATERPILLAR, INC.	PO BOX 62920	COLORADO SPRINGS	CO	809622920	(309) 494-2363	
C67					-	-	
C68	DENTAL BENEFIT PROVIDERS	PO BOX 389	ROCKVILLE	MD	20848	(800) 445-9090	
C69						-	
C70	AMERICAN RETIREMENT LIFE	PO BOX 30010	AUSTIN	TX	757553010	(866) 459-1755	REQUESTED BY THE SCHA
C71	JOHNS HOPKINS HEALTHCARE	6704 CURTIS CT.	GLEN BURNIE	MD	21060	(800) 261-2393	
C72	ADVANCED INSURANCE ADMINISTRATION	125 MERRILL DR. STE. 2000	LITTLE ROCK	AR	72211	(888) 242-4800	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C73	UNION PACIFIC RAILROAD EMPLOYEES HEALTH	795 NORTH 400 WEST	SALT LAKE	UT	84103	(800) 547-0421	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C74	NATIONAL CLAIMS ADMINISTRATIVE SERVICES	PO BOX 981610	EL PASO	TX	799981610	(704) 364-3865	
C74DN	NATIONAL CLAIMS ADMINISTRATIVE SERVICES	PO BOX 220887	CHARLOTTE	NC	28222	(704) 364-3865	
C75	FLORIDA 1ST SERVICE ADMINISTRATORS, INC.	PO BOX 3607	WINTER HAVEN	FL	338853067	(800) 226-3155	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C76	WESTERN AND SOUTHERN GROUPS	PO BOX 5735	CINCINNATI	OH	45201	(800) 424-8622	
C77	CARPENTERS HOSPITALIZATION PLAN	3611 CHESTER AVE.	CLEVELAND	OH	44114	(800) 421-3959	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C78	KAISER PERMANENTE	PO BOX 190849	ATLANTA	GA	31119	(404) 261-2590	
C79	BENEFIT ADMINISTRATIVE SYSTEM, LTD	PO BOX 17475 JOVANNA DR., STE. 1B	HOMEWOOD	IL	60430	(708) 799-7400	
C80	ELDER HEALTH (MHN/HMC)	PO BOX 4433	BALTIMORE	MD	21223	(888) 776-8851	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C81	UNITED PAYORS & UNITED PROVIDERS	2273 RESEARCH BLVD.	ROCKVILLE	MD	20850	(800) 247-4144	
C82	AMERICAN STANDARD LIFE & ACCIDENT INS. CO.	PO DRAWER 3248, 224 NORTH INDEPENDENT	ENID	OK	73701	(405) 233-4000	CODE IN OPEN STATUS BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
C83	FREEDOM LIFE INSURANCE CO. OF AMERICA	PO BOX 1468	ARLINGTON	TX	76004	(866) 973-4647	
C84	CENTRAL UNITED & CHRISTIAN MUTUAL LIFE INS. CO.	2727 ALLEN PARKWAY	HOUSTON	TX	770192115	(713) 529-0045	
C85	LOYAL AMERICAN LIFE INSURANCE COMPANY	PO BOX 559004	AUSTIN	TX	78755	(800) 633-6752	
C86	NATIONAL STATES INSURANCE COMPANY	PO BOX 27321, 1830 CRAIG PARK CT.	ST. LOUIS	MO	63141	(314) 878-0101	
C87	SIHO INSURANCE SERVICES	PO BOX 1787	COLUMBUS	IN	47202	(800) 873-2022	
C88	ADVENTIST RISK MANAGEMENT	PO BOX 1928	GRAPEVINE	TX	76099	(800) 638-0589	
C89	NEW SOURCES BENEFITS	PO BOX 6305	SPARTANBURG	SC	29304	(800) 476-1555	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C92	AMERICAN HEALTH CARE	3850 ATHERTON RD.	ROCKLIN	CA	95765	(800) 872-8276	
C92DN	AMERICAN HEALTH CARE	3001 DOUGLAS ST.	ROSEVILLE	CA	95661	(800) 872-8276	
C93	STUDENT ASSURANCE INSURANCE SERVICES	PO BOX 196	STILL WATER	MN	55085	(800) 328-2739	
C94	ERIN GROUP ADMINISTRATORS	PO BOX 7777	LANCASTER	PA	17604	(800) 433-3746	ANOTHER PHONE NUMBER 717-581-1300
C94DN	ERIN GROUP ADMINISTRATORS	PO BOX 7777	LANCASTER	PA	17604	(800) 433-3746	ANOTHER PHONE NUMBER 717-581-1300
C95	MIDWEST SECURITY	2700 MIDWEST DR.	ONALASKA	WI	54650	(800) 236-8672	
C96	MEDTRACK SERVICES	7101 COLLEGE BLVD., STE. 1000	OVERLAND PARK	KS	66210	(800) 771-4648	
C97	GEM GROUP	1200 THREE GATEWAY CENTER	PITTSBURGH	PA	15222	(800) 242-8923	
C98	MEDICAL BENEFIT ADM. OF MARYLAND, INC.	PO BOX 950	FORREST HILL	MA	60631	(888) 532-3467	
C99	MUTUAL PROTECTIVE MEDICO LIFE INS. CO.	1515 S. 75TH ST.	OMAHA	NE	68124	(800) 228-6080	CARRIER WAS PREVIOUSLY C35.
CAS	CASUALTY CASE	-	-	-	-	-	
CO5						-	
CO9	EMPLOYEE BENEFITS TRUST	PO BOX 1431	WICHITA FALLS	TX	76307	(817) 761-7611	CODE ASSIGNED WITH LETTER O INSTEAD OF NUMERIC ZERO.
D01	INTERLINK HEALTH SERVICES	4950 NE BELNAP CT. #205	HILLSBORO	OR	97124	(503) 640-2000	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D02	INSURANCE ADMINISTRATOR OF AMERICA	PO BOX 5082	MT. LAUREL	NJ	08054	(800) 989-6739	
D03	PACIFIC SOURCE	PO BOX 7068	EUGENE	OR	97401	(800) 624-6052	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
D04	LBA HEALTH PLANS, INC./PRIMARY SELECT	PO BOX 17098	OWINGS MILL	MD	211177098	(800) 815-8240	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D05	UPMC HEALTH BENEFITS, INC.	PO BOX 2999	PITTSBURGH	PA	15230	(877) 381-3764	MEDICARE ADVANTAGE PLAN
D06	SOUTHERN CALIFORNIA BAKERY & CONFECTIONARY	PO BOX 22041	COMMERCE	CA	90022	(323) 722-7171	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D08	BIG LOTS ASSOCIATE BENEFIT PLAN	PO BOX 9071	DUBLIN	OH	430170971	(877) 254-2363	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D09	JM FAMILY ENTERPRISES	8019 BAYBERRY RD.	JACKSONVILLE	FL	32256	(800) 892-0059	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D10	SEVEN CORNERS, INC.	PO BOX 3430	CARMEL	IN	46082	(866) 699-4186	
D11	ADVANCED BENEFIT SOLUTIONS	PO BOX 71490	PHOENIX	AZ	85050	(888) 419-1094	CODE NOT REQUESTED BY MEDICAID ASSIGNED BY SCHA MEDICARE SUPPLEMENTAL PLAN
D12	SECUREHORIZONS DIRECT PFFS	PO BOX 12466	PENSACOLA	FL	325912466	(888) 202-4340	MEDICARE ADVANTAGE PLAN
D13	ARCADIAN	PO BOX 4946	COVINA	CA	91723	(800) 775-6490	CODE ORIGINALLY ASSIGNED AS MA IN ERROR USE CODE 816 FOR MA PLAN
D14	MEDICARE PLUS BLUE (BCBS OF MICHIGAN)	27000 ELEVEN MILE RD	SOUTHFIELD	MI	48034	(800) 249-5103	MEDICARE ADVANTAGE PLAN
D15	SECURITYCHOICE ENHANCED PLUS	PO BOX 795180	SAN ANTONIO	TX	78279	(888) 445-8916	MEDICARE ADVANTAGE PLAN
D16	AETNA MEDICARE OPEN PLAN	PO BOX 14079	LEXINGTON	KY	405124079	(800) 624-0756	MEDICARE ADVANTAGE PLAN
D17	WELLCARE	PO BOX 795184	SAN ANTONIO	TX	78279	(866) 235-2770	MEDICARE ADVANTAGE PLAN
D18	COMMUNITY CARE SENIOR HEALTH PLAN	PO BOX 3249	TULSA	OK	741013249	(800) 642-8065	MEDICARE ADVANTAGE PLAN
D19	HEALTHFIRST 65 PLUS	PO BOX 5196	NEW YORK	NY	10274	(888) 260-1010	MEDICARE ADVANTAGE PLAN
D20	EXCELLUS MEDICARE BLUE CHOICE OPTIMUM	PO BOX 41915	ROCHESTER	NY	14604	(877) 883-9577	MEDICARE ADVANTAGE PLAN
D21	CARITEN SENIOR HEALTH	PO BOX 22885	KNOXVILLE	TN	37933	(865) 670-7790	MEDICARE ADVANTAGE PLAN
D22	SMART VALUE (BC OF GA) (PFFS)	PO BOX 3897	SCRANTON	PA	18505	(866) 865-9329	MEDICARE ADVANTAGE PLAN
D23	AMERICA'S HEALTH CHOICE MEDICAL PLANS,(HMO)	762 SOUTH US HWY. ONE PMB 224	VERO BEACH	FL	32962	(800) 308-9823	MEDICARE ADVANTAGE PLAN
D24	MOUNT CARMEL HEALTH PLAN (MCHP) MEDIGOLD (HMO)	PO BOX 6111	WESTERVILLE	OH	43086	(800) 240-3870	
D25	ELDER PLAN, INC. (HMO)	PO BOX 199100	BROOKLYN	NY	11219	(718) 921-8818	MEDICARE ADVANTAGE

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
D26	OXFORD MEDICARE ADVANTAGE (HMO)	PO BOX 7082	BRIDGEPORT	CT	06601	(800) 234-1228	MEDICARE ADVANTAGE PLAN
D27	SECURE HORIZONS PACIFICARE	PO BOX 25032	SANTA ANA	CA	927995032	(714) 825-3828	MEDICARE ADVANTAGE PLAN
D28	PYRAMID LIFE INSURANCE CO (PFFS)	PO BOX 958465	LAKE MARY	FL	327958465	(407) 628-1776	MEDICARE ADVANTAGE PLAN
D29	UNICARE LIFE & HEALTH INS. CO (PFFS)	233 S WACKER DR. STE. 3900	CHICAGO	IL	68606	(312) 324-7000	MEDICARE ADVANTAGE PLAN
D30	UNITED HEALTHCARE INS. CO (PPO)	PO BOX 150450	HARTFORD	CT	061150450	(860) 702-5000	MEDICARE ADVANTAGE PLAN
D31	LEON MEDICAL CENTER HEALTH PLAN	PO BOX 65-9006	MIAMI	FL	33265	(305) 559-5366	MEDICARE ADVANTAGE PLAN
D32	MEDICARE COMPLETE (UNITED HEALTH CARE)	PO BOX 659735	SAN ANTONIO	TX	782659735	(877) 842-3210	MEDICARE ADVANTAGE PLAN
D33	ADVANTRA FREEDOM	PO BOX 7154	LONDON	KY	407427154	(800) 713-5095	MEDICARE ADVANTAGE PLAN
D34	UNIVERSAL HEALTH CARE	PO BOX 3211	ST. PETERSBURG	FL	33731	(866) 690-4842	MEDICARE ADVANTAGE PLAN
D36	HOP/PSERS HEALTH ADMINISTRATION UNIT	PO BOX 2921	CLINTON	IA	52733	(800) 773-7725	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D37	WEST VIRGINIA LOCAL 152 HEALTH & WELFARE	5 HOT METAL ST., STE. 200	PITTSBURGH	PA	15203	(866) 825-8152	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D38	AMERICAN INSURANCE ADMINISTRATORS	PO BOX 2348	COLUMBUS	OH	43216	(800) 922-1245	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D39	NEW YORK WELFARE FUND	101-49 WOOKHAVEN BLVD.	OZONE PARK	NY	11416	(718) 845-5800	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D40	MINNESOTA POWER HEALTH PLANS	30 W SUPERIOR ST.	DULUTH	MN	55802	(888) 812-8800	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D41	BLUEGRASS FAMILY HEALTH	PO BOX 22738	LEXINGTON	KY	40522	(800) 787-2680	
D42	CARE IMPROVEMENT PLUS	PO BOX 4347	SCRANTON	PA	18505	(866) 686-2506	MEDICARE ADVANTAGE PLAN
D43	SOUTHEAST COMMUNITY CARE BY ARCADIAN HEALTH	PO BOX 4946	COVINA	CA	91723	(800) 573-8597	MEDICARE ADVANTAGE PLAN
D44	INDEPENDENT HEALTH	PO BOX 9066	BUFFALO	NY	14231	(866) 617-8585	MEDICARE ADVANTAGE PLAN
D45	HIGHMARK SECURITY BLUE	120 5TH AVE.	PITTSBURGH	PA	15222309	(800) 547-3627	MEDICARE ADVANTAGE PLAN
D46	GROUPHEALTH OPTIONS, INC.	PO BOX 34585	SEATTLE	WA	98124	(888) 767-4670	MEDICARE ADVANTAGE PLAN
D47	TOUCHSTONE HEALTH PSO	PO BOX 33519	INDIANAPOLIS	IN	462030519	(888) 777-0204	MEDICARE ADVANTAGE PLAN
D48	AMERICAN CONTINENTAL INSURANCE CO	PO BOX 2368	BRENTWOOD	TN	37024	(615) 337-1300	MEDICARE ADVANTAGE PLAN
D51	AMERIGROUP COMMUNITY CARE	PO BOX 61010	VIRGINIA BEACH	VA	234661010	(800) 600-4441	MEDICAID HMO
D52	WELLCARE OF GEORGIA	PO BOX 31224	TAMPA	FL	33531	(866) 231-1821	MEDICARE ADVANTAGE PLAN
D53	SIERRA OPTIMA PLUS CLAIMS	PO BOX 15645	LAS VEGAS	NV	891145645	(888) 274-2207	MEDICARE ADVANTAGE PLAN

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
D54	GATEWAY HEALTH PLAN MEDICARE ASSURED	PO BOX 11560	ALBANY	NY	122110655	(800) 685-5209	MEDICARE ADVANTAGE PLAN
D55	TOTAL CAROLINA CARE, INC.	1441 MAIN ST.	COLUMBIA	SC	29210	(866) 433-6031	MEDICAID HMO
D56	CITRUS HEALTH CARE, INC.	PO BOX 20547	TAMPA	FL	33622	(866) 769-1157	MEDICARE ADVANTAGE PLAN
D57	CIGNA MEDICARE ACCESS	PO BOX 22174	TEMPE	AZ	852852174	(800) 577-9410	MEDICARE ADVANTAGE PLAN
D58	BRAVO HEALTH MEDICARE ADVANTAGE	PO BOX 4433	BALTIMORE	MD	21223	(800) 556-1570	MEDICARE ADVANTAGE PLAN
D60	AMERIGROUP COMMUNITY CARE OF SC	PO BOX 31789	VIRGINIA BEACH	VA	234661789	(800) 600-4441	CODE ASSIGNED BY SCHA
D61	AMERICA'S 1ST CHOICE	PO BOX 210769	COLUMBIA	SC	29210	(866) 321-3947	MEDICARE ADVANTAGE PLAN
D62	SECURE HORIZONS DIRECT (UNITED HEALTHCARE)	PO BOX 31353	SALT LAKE CITY	UT	84131	(866) 579-8774	MEDICARE ADVANTAGE PLAN
D63	UNIVERA SENIOR CHOICE SECURE	PO BOX 23000	ROCHESTER	NY	15692	(800) 617-1114	MEDICARE ADVANTAGE PLAN
D64	EMPIRE HEALTHCHOICE ASSURANCE, INC.	PO BOX 100300 CLAIMS PROCESSING	COLUMBIA	SC	29204	(803) 788-8562	MEDICARE ADVANTAGE PLAN
D65	ANTHEM SENIOR ADVANTAGE	PO BOX 37690	LOUISVILLE	KY	402337180	(888) 290-9160	MEDICARE ADVANTAGE PLAN
D66	CHCCARES OF SOUTH CAROLINA	140 STONE RIDGE DR.	COLUMBIA	SC	29210	(866) 802-2474	MEDICAID HMO
D67	BLUE CROSS OF FLORIDA HEALTH OPTIONS	PO BOX 1798	JACKSONVILLE	FL	32231	(877) 352-2583	MEDICARE ADVANTAGE PLAN
D69	TOTAL CARE/HEALTHSPRING	PO BOX 20000	NASHVILLE	TN	372024070	(800) 743-7141	MEDICARE ADVANTAGE PLAN
D71	KEYSTONE 65	PO BOX 7799	PHILADELPHIA	PA	191017799	(800) 227-3116	MEDICARE ADVANTAGE PLAN
D74	DART MANAGEMENT CORP	PO BOX 318	MASON	MI	488540318	(800) 248-0457	
D75	WINDSOR MEDICARE EXTRA	PO BOX 269025	PLANO	TX	750269025	(866) 270-5223	MEDICARE ADVANTAGE PLAN
D79	EMPLOYEE HEALTH INSURANCE MANAGEMENT (EHIM)	26711 NORTHWESTERN HWY STE 400	SOUTHFIELD	MI	48033	(800) 311-3446	
D81	HEARTLAND NATIONAL LIFE INSURANCE CO.	PO BOX 2878	SALT LAKE CITY	UT	84110	(800) 872-3860	REQUESTED BY THE SCHA
D82	SOLSTICE	PO BOX 14009	LEXINGTON	KY	40512	(877) 760-2247	
D85	US FIRE INSURANCE COMPANY	3195 LINWOOD RD., STE. 201	CINCINNATI	OH	45208	(800) 513-2981	
D87	LIFESTYLE HEALTHCARE	345 N. RIVERVIEW STE. 600	WICHITA	KS	67203	(866) 827-6607	FORMERLY MEDOVA HEALTHCARE
D94	AMERIGROUP COMMUNITY CARE	PO BOX 61010	VIRGINIA BEACH	VA	234661010	(800) 600-4441	MEDICAID HMO
D99	MEDICARE ADVANTAGE					-	MEDICARE ADVANTAGE PLAN GENERIC CODE
E102	PROTECTIVE LIFE INSURANCE	PO BOX 12687	BIRMINGHAM	AL	35202	(205) 268-7055	CANCER POLICY ONLY
E12	CAROLINA CRESCENT	1201 MAIN ST. STE. 970	COLUMBIA	SC	29201	(803) 251-6630	HEALTHY KIDS CONNECTION
E20	VRX PHARMACY SERVICES	PO BOX 9780	SALT LAKE CITY	UT	84109	(877) 879-9722	
E23	MAINE SENSE	PO BOX 1959	GRAY	ME	04039	(800) 290-8559	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
E24	PBM PLUS	300 TECHNECENTER DR. STE. C	MILFORD	OH	45150	(800) 263-2178	
E29	BEST LIFE AND HEALTH INSURANCE CO.	PO BOX 890	MERIDIAN	ID	836800890	(800) 433-0088	
E30	BUSINESS ADMINISTRATORS AND CONSULTANTS, INC.	PO BOX 107	REYNOLDSBURG	OH	43068	(800) 521-2654	
E37	SELECT HEALTH	PO BOX 7120	LONDON	KY	40742	(888) 276-2020	HEALTHY KIDS CONNECTION
E38	UNISON HEALTH PLAN	250 BERRYHILL RD.	COLUMBIA	SC	29210	(803) 798-5852	HEALTHY KIDS CONNECTION
E41	MEDTRAK	7101 COLLEGE BLVD., STE. 1000	OVERLAND PARK	KS	66210	(800) 771-4648	
E42	TRUE RX	4 WILLIAMS BROTHERS DR.	WASHINGTON	IN	47501	(866) 921-4047	
E43	THE HEALTH PLAN INSURANCE CO.	52160 NATIONAL RD. EAST	ST. CLAIRSVILLE	OH	43950	(740) 699-6273	
E44	ALTERNATIVE INSURANCE RESOURCE, INC.	PO BOX 680787	BIRMINGHAM	AL	352660787	(800) 451-4318	
E45	UNIFIED LIFE INSURANCE	PO BOX 25326	OVERLAND	KS	662255326	(913) 685-2233	
E46	TOLEDO FIREFIGHTERS HEALTH PLAN	PO BOX 5810	TROY	MI	480075810	(419) 255-5314	
E51	CHOICE BENEFITS	3801 OLD GREENWOOD RD.	FT. SMITH	AR	75278	(800) 451-6907	
E54	ALLEGIANCE BENEFIT PLAN MANAGEMENT	PO BOX 3018	MISSOULA	MT	598063018	(800) 781-7204	
E55	AG ADMINISTRATORS	PO BOX 979	VALLEY FORGE	PA	19482	(800) 634-8628	
E61	HEALTHEZ	PO BOX 398220	MINNEAPOLIS	MN	55439	(855) 280-9638	
E66	CHCCARE OF SOUTH CAROLINA	140 STONE RIDGE DR.	COLUMBIA	SC	29210	(866) 802-2474	
E73	TRISTAR BENEFIT ADMINISTRATORS	PO BOX 65887	WEST DES MOINES	IA	50265	(800) 456-4584	
E80	KANSAS INDEPENDENT PHARMACY (KPSC)	4125 SOUTH WEST GAGE CENTER DR., STE. 203	TOPEKA	KS	66604	(800) 279-3022	
E81	SELECT ADMINISTRATIVE SERVICES (SAS)	PO BOX 3209	GULFPORT	MS	39503	(800) 847-6621	
E82	SIMPLE BENEFIT PLANS	2810 PREMIER PARKWAY STE. 400	DULUTH	GA	30097	(800) 270-4158	
E87	BENEFIT ADMINISTRATIVE SYSTEMS	PO BOX 2920	MILWAUKEE	WI	53201	(800) 525-0582	
E89	BROADREACH MEDICAL RESOURCES	1350 BROADWAY #410	NEW YORK	NY	10018	(888) 718-2375	
E90	UNITED HEALTH (MEDICARE SOLUTIONS)	PO BOX 30436	SALT LAKE CITY	UT	84130	(877) 842-3210	MEDICARE ADVANTAGE
E91	SCOTT AND WHITE HEALTH PLAN	PO BOX 21800	EAGAN	MN	55121	(800) 321-7947	
E93	CUSTOM DESIGN BENEFITS	5589 CHEVIOT RD.	CINCINNATI	OH	45247	(800) 598-2929	
E95	TRUESCRIPTS	PO BOX 921	WASHINGTON	IN	47501	(844) 257-1955	RX
E96	MEDPARTNERS ADMINISTRATIVE	6920 POINT INVERNESS WAY	FORT WAYNE	IN	46804	(888) 312-9744	
E97	SIGNATURE CARE	PO BOX 5548	FORT WAYNE	IN	46895	(800) 666-4449	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
E99	MAXORPLUS	320 SOUTH POLK ST., STE. 200	AMARILLO	TX	79101	(800) 687-0707	
E99RX	MAXORPLUS	320 SOUTH POLK ST., STE. 200	AMARILLO	TX	79101	(800) 687-0707	RX ONLY
X01	BLUE CROSS & BLUE SHIELD OF MARYLAND, INC.	PO BOX 14115	LEXINGTON	KY	40512	(800) 524-4555	
X0A	BLUE CROSS OF GEORGIA/COLUMBUS, INC.	PO BOX 9907	COLUMBUS	GA	319089907	(800) 441-2273	POLICIES SHOULD BE ADDED WITH XOB. BCBS OF OF GA.
X0ARX	BLUE CROSS OF GEORGIA/COLUMBUS, INC.	PO BOX 9907	COLUMBUS	GA	319089907	(800) 441-2273	DO NOT USE FOR MEDICARE.THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE.
X0B	BLUE CROSS & BLUE SHIELD OF GEORGIA/ATLANTA, INC.	PO BOX 9907	COLUMBUS	GA	319086007	(404) 842-8000	FOR GEORGIA STATE EMPLOYEES USE CARRIER 419 GEORGIA STATE HEALTH BENEFIT PLAN
X0BDN	BCBS OF GEORGIA DENTAL	PO BOX 659444	SAN ANTONIO	TX	78265	(404) 842-8000	
X0C	BLUE CROSS & BLUE SHIELD OF NORTH CAROLINA	PO BOX 35	DURHAM	NC	27702	(800) 214-4844	
X0CDN	BLUE CROSS & BLUE SHIELD OF NORTH CAROLINA	PO BOX 2100	WINSTON-SALEM	NC	271022100	(919) 489-7431	
X0D	BLUE CROSS AND BLUE SHIELD OF FLORIDA	PO BOX 1798	JACKSONVILLE	FL	322310014	(800) 727-2227	
X0E	EMPIRE BLUE CROSS AND BLUE SHIELD	PO BOX 1407 CHURCH ST. STATION	NEW YORK	NY	10008	(800) 342-9816	
X0EDN	EMPIRE BCBS DENTAL	PO BOX 791	MINNEAPOLIS	MN	554400791	(800) 722-8879	
X0F	BLUE CROSS & BLUE SHIELD OF VIRGINIA	PO BOX 27401	RICHMOND	VA	23279	(800) 991-6061	
X0G						-	
X0H	BLUE CROSS & BLUE SHIELD UNITED OF WISCONSIN	PO BOX 2025	MILWAUKEE	WI	53201	(414) 224-6100	
X0I	BLUE CROSS & BLUE SHIELD OF MARYLAND, INC.	PO BOX 9836	BALTIMORE	MD	21204	(800) 524-4555	USE CARRIER X01
X0J	PENNSYLVANIA BLUE SHIELD	PO BOX 890089	CAMP HILL	PA	17089	(800) 637-3493	
X0K	REGENCE BLUE CROSS BLUE SHIELD OF OREGON	PO BOX 1271	PORTLAND	OR	97207	(503) 225-5221	
X0KRS	REGENCE BCBS OF OREGON	PO BOX 12625 MAILSTOP S4P	SALEM OREGON	OR	97309	(888) 437-1508	RX PLAN ONLY MM CODE X0K
X0KRX	REGENCE BCBS OF OREGON	PO BOX 12625 MAILSTOP S4P	SALEM	OR	97309	(888) 437-1508	
X0L	BLUE CROSS & BLUE SHIELD OF DELAWARE, INC.	PO BOX 1991	WILMINGTON	DE	19899	(302) 421-0260	
X0M	BLUE CROSS OF MASSACHUSETTS, INC.	PO BOX 986020	BOSTON	MA	022986020	(800) 253-5210	
X0MDN	BCBS OF MASSACHUSETTS	PO BOX 986005	BOSTON	MA	02298	800-253-5210	DENTAL ONLY
X0N	BLUE CROSS AND BLUE SHIELD OF TEXAS	PO BOX 660044	DALLAS	TX	752660044	(800) 451-0287	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
X0NDN	BLUE CROSS AND BLUE SHIELD OF TEXAS	PO BOX 660247	DALLAS	TX	75266	(800) 494-7218	
X0O	BLUE CROSS AND BLUE SHIELD OF ALABAMA	PO BOX 2294	BIRMINGHAM	AL	35201	(800) 517-6425	DO NOT USE FOR MEDICARE.THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE.
X0ODN	BLUE CROSS AND BLUE SHIELD OF ALABAMA	PO BOX 830389	BIRMINGHAM	AL	352830389	(800) 517-6425	
X0P	BLUE CROSS & BLUE SHIELD OF TENNESSEE	1 CAMERON HILL CIRCLE	CHATTANOOGA	TN	374020002	(800) 468-9736	
X0PDN	BLUE CROSS & BLUE SHIELD OF TENNESSEE	1 CAMERON HILL CIRCLE STE. 0002	CHATTANOOGA	TN	374020002	(800) 565-9140	
X0Q	BLUE CROSS & BLUE SHIELD OF MICHIGAN	PO BOX 312500	DETROIT	MI	48231	(800) 482-0898	
X0QDN	BLUE CROSS & BLUE SHIELD OF MICHIGAN	PO BOX 49	DETROIT	MI	48231	(888) 826-8152	
X0R	MEDICAL MUTUAL OF OHIO	PO BOX 6018	CLEVELAND	OH	44101	(216) 687-7000	
X0RDN	MEDICAL MUTUAL OF OHIO	PO BOX 981800	EL PASO	TX	79998	(216) 687-7000	
X0S	BLUE CROSS & BLUE SHIELD OF NEW JERSEY, INC.	PO BOX 1219	NEWARK	NJ	07101	(800) 624-1110	AKA HORIZON BCBS OF NEW JERSEY
X0SDN	BLUE CROSS & BLUE SHIELD OF NEW JERSEY, INC.	PO BOX 1311	MINNEAPOLIS	MN	55440	(800) 355-2583	AKA HORIZON BCBS OF NEW JERSEY
X0T	BLUE CROSS OF ILLINOIS	PO BOX 805107	CHICAGO	IL	60680	(800) 634-8644	
X0TDN	BLUE CROSS OF ILLINOIS	PO BOX 23059	BELLEVILLE	IL	62223	(866) 826-0914	
X0U	BLUE CROSS & BLUE SHIELD OF KENTUCKY, INC.	9901 LINN STATION RD.	LOUISVILLE	KY	40223	(502) 423-2011	
X0V	BLUE SHIELD OF NORTHEASTERN NEW YORK	PO BOX 15013	ALBANY	NY	12212	(518) 453-4600	
X0W	BLUE CROSS OF CALIFORNIA	PO BOX 60007	LOS ANGELES	CA	90060	(800) 677-6669	
X0X	CENTRAL BENEFITS MUTUAL INSURANCE COMPANY	PO BOX 16526	COLUMBUS	OH	43216	(614) 464-5870	
X0Y	ANTHEM BLUE CROSS AND BLUE SHIELD	PO BOX 105187	ATLANTA	GA	30348	(800) 622-4822	
X0YDN	ANTHEM BLUE CROSS AND BLUE SHIELD	PO BOX 659444	SAN ANTONIO	TX	78265	(800) 622-4822	
X0YRX	ANTHEM BLUE CROSS AND BLUE SHIELD	PO BOX 37010	LOUISVILLE	KY	40233	(800) 622-4822	
X0Z	BLUE CROSS & BLUE SHIELD OF MISSISSIPPI, INC.	PO BOX 1043	JACKSON	MS	39215	(601) 932-3800	
X1A	BLUE CROSS BLUE SHIELD OF NEW MEXICO	PO BOX 27630	ALBUQUERQUE	NM	87125	(800) 711-3795	
X1D	BLUE CROSS /BLUE SHIELD OF NATIONAL CAPITAL AREA	550 12TH ST. SW	WASHINGTON	DC	20024	(202) 479-8000	
X1E	BLUE CROSS OF PUERTO RICO	PO BOX 366068	SAN JUAN	PR	009366068	(809) 759-9898	
X1F	BLUE CROSS & BLUE SHIELD OF RHODE ISLAND	500 EXCHANGE ST.	PROVIDENCE	RI	02903	(401) 831-7300	
X1FDN	BLUE CROSS BLUE SHIELD OF RHODE ISLAND	PO BOX 69427	HARRISBURG	PA	171069427	(800) 831-2400	DENTAL ONLY

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CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
X1G	INDEPENDENCE BLUE CROSS	PO BOX 219669	KANSAS CITY	MO	641219669	(800) 275-2583	
X1H	BLUE CROSS & BLUE SHIELD OF CONNECTICUT, INC.	PO BOX 533	NORTH HAVEN	CT	06473	(203) 239-4961	
X1I	ARKANSAS BLUE CROSS AND BLUE SHIELD, INC.	PO BOX 2181	LITTLE ROCK	AR	72203	(501) 378-2010	
X1J	BLUE CROSS & BLUE SHIELD OF WESTERN NEW YORK, INC.	PO BOX 80	BUFFALO	NY	142400080	(800) 888-0757	
X1K	BLUE CROSS & BLUE SHIELD OF MEMPHIS	85 NORTH DANNY THOMAS BLVD.	MEMPHIS	TN	38103	(901) 529-3111	
X1L	BLUE CROSS & BLUE SHIELD OF LOUISIANA	PO BOX 98029	BATON ROUGE	LA	708989029	(504) 291-5370	
X1M	BLUE CROSS & BLUE SHIELD OF KANSAS	1133 SOUTHWEST TOPEKA BLVD.	TOPEKA	KS	66629	(785) 291-4180	
X1N	MEDICAL SERVICE CORPORATION OF EASTERN WASHINGTON	PO BOX 3048	SPOKANE	WA	99220	(509) 536-4900	
X1O	WELLMARK BLUE CROSS BLUE SHIELD OF IOWA	PO BOX 5023	SIOUX FALLS	SD	57104	(515) 245-4500	USE CARRIER CODE X2A
X1P	BLUE CROSS & BLUE SHIELD OF MINNESOTA	PO BOX 64338	ST. PAUL	MN	55164	(800) 382-2000	
X1Q	BLUE CROSS & BLUE SHIELD OF MAINE	2 GANNETT DR.	SOUTH PORTLAND	ME	041066911	(207) 775-1550	
X1R	HIGHMARK BLUE CROSS BLUE SHIELD	PO BOX 890062	CAMPHILL	PA	170890062	(412) 544-7000	
X1S	COMMUNITY MUTUAL INSURANCE COMPANY	1351 WILLIAM HOWARD TAFT RD.	CINCINNATI	OH	45206	(513) 282-1016	CODE IN OPEN STATUS BY SCHA
X1T						-	
X1U	BLUE CROSS & BLUE SHIELD OF NEBRASKA	PO BOX 3248, MAIN P.O. STATION	OMAHA	NE	681800001	(402) 390-1820	
X1V	BLUE CROSS & BLUE SHIELD OF COLORADO	700 BROADWAY	DENVER	CO	80273	(303) 831-2131	
X1W	BLUE CROSS & BLUE SHIELD OF UTAH	PO BOX 30270	SALT LAKE CITY	UT	841300270	(801) 333-2100	
X1X	BLUE CROSS OF OHIO	PO BOX 956	TOLEDO	OH	43696	(800) 362-1279	
X1Y	BLUE SHIELD OF CALIFORNIA	PO BOX 272540	CHICO	CA	95927	(888) 235-1765	
X1YDN	BLUE SHIELD OF CALIFORNIA	PO BOX 272590	CHICO	CA	959272590	(888) 702-4171	
X1Z						-	
X20						-	
X21						-	
X25						-	
X2A	WELLMARK BLUE CROSS BLUE SHIELD OF IOWA	PO BOX 5023	SIOUX FALLS	SD	571175023	(800) 526-8995	
X2ADN	WELLMARK BLUE CROSS BLUE SHIELD OF IOWA	PO BOX 9354	DES MOINES	IA	503069354	(877) 333-0164	DENTAL
X2B	BLUE CROSS & BLUE SHIELD OF KANSAS CITY	PO BOX 419169	KANSAS CITY	MO	641416169	(800) 892-6048	

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CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
X2C						-	
X2D						-	
X2E						-	
X2F	BLUE CROSS AND BLUE SHIELD OF THE ROCHESTER AREA	PO BOX 22999	ROCHESTER	NY	14692	(716) 325-3630	TO VERIFY DENTAL COVERAGE CALL 1-800-724-1675
X2FDN	BLUE CROSS AND BLUE SHIELD OF THE ROCHESTER AREA	PO BOX 22999	ROCHESTER	NY	14692	(716) 325-3630	DENTAL
X2G	BLUE CROSS & BLUE SHIELD CENTRAL NEW YORK, INC.	PO BOX 4809	SYRACUSE	NY	132214809	(315) 448-3801	
X2H	BLUE CROSS & BLUE SHIELD OF UTICA-WATERTOWN, INC.	12 RHOADS DR., UTICA BUSINESS DISTRICT	UTICA	NY	13501	(315) 798-4238	
X2I						-	
X2J	BLUE CROSS & BLUE SHIELD OF NORTH DAKOTA	4510 13TH AVE. SW	FARGO	ND	581210001	(800) 368-2312	
X2K	CAPITAL BLUE CROSS	PO BOX 211457	EAGAN	MN	551213057	(800) 962-2242	
X2L	BLUE CROSS OF NORTHEASTERN PENNSYLVANIA	PO BOX 890179	CAMP HILL	PA	170890179	(800) 829-8599	
X2M	BLUE CROSS OF WASHINGTON AND ALASKA	PO BOX 91059	SEATTLE	WA	981119159	(800) 722-1471	
X2N						-	
X2O	BLUE CROSS & BLUE SHIELD OF WEST VIRGINIA, INC.	PO BOX 1353	CHARLESTON	WV	25325	(304) 347-7709	
X2P	MOUNTAIN STATE BLUE CROSS & BLUE SHIELD, INC.	PO BOX 1948	PARKERSBERG	WV	26102	(304) 424-7700	
X2Q						-	
X2R						-	
X2S	BLUE CROSS & BLUE SHIELD OF VERMONT	PO BOX 2365	SOUTH BURLINGTON	VT	54072365	(802) 247-2583	
X2T	BLUE CROSS & BLUE SHIELD OF OKLAHOMA	PO BOX 3283	TULSA	OK	74102	(918) 560-3535	
X2U	BLUE CROSS & BLUE SHIELD OF MISSOURI	1831 CHESTNUT ST.	ST. LOUIS	MO	63103	(314) 923-4444	AKA ALLIANCE BLUE CROSS BLUE SHIELD
X2V	BLUE CROSS OF IDAHO HEALTH SERVICE, INC.	PO BOX 7408	BOISE	ID	83707	(208) 344-7411	
X2W	BLUE CROSS & BLUE SHIELD OF ARIZONA, INC.	PO BOX 13466	PHOENIX	AZ	850023466	(602) 864-4100	
X2X	BLUE CROSS BLUE SHIELD OF HAWAII	PO BOX 44500	HONOLULU	HI	96801	(800) 776-4672	
X2Y	BLUE CROSS BLUE SHIELD OF MONTANA	PO BOX 5004	GREAT FALLS	MT	59403	(406) 791-4000	
X3A	UNITED TEACHERS ASSO. INS. CO.	PO BOX 30010	AUSTIN	TX	78755	(800) 880-8824	
X3B	TPA EXCHANGE	PO BOX 4363	ST AUGUSTINE	FL	32085	(888) 502-2789	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
XOKRX	REGENCE BCBS OF OREGON RX PLAN	PO BOX 12625 MAILSTOP S4P	SALEM	OR	97309	(888) 437-1508	RX PLAN ONLY MM PLAN IS X0K
XOV	BLUE CROSS OF NORTHEASTERN NEW YORK, INC.	PO BOX 15013	ALBANY	NY	12212	(518) 438-5500	
XYZ	OPTUM RX	PO BOX 29044	HOT SPRINGS	AR	71093	(800) 788-7871	FORMERLY PRESCRIPTION SOLUTIONS

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APPENDIX 3 COPAYMENT SCHEDULE

The Copayment schedule reflects amounts the beneficiary is expected to pay to the provider at the time services are received. The current amounts are effective for dates of service on and after July 11, 2011 per Medicaid bulletin dated July 8, 2011, unless otherwise noted.

Service	Procedure Code/ Frequency	Amount
Physician Office Visits (Physician/Nurse Practitioner)	90791-90792 92002-92014 99201-99205 99212-99215 99241-99245	$3.30
*Durable Medical Equipment and Supplies	Services per day	$3.40
Optometrist	92002-92014 99201-99205 99212-99215 99241-99245	$3.30
Chiropractor	98940 98941 98942	$1.15
Podiatrist	99201-99205 99212-99215 99241-99245	$1.15
Home Health	S9128 S9129 S9131 T1021 T1028 T1030 T1031	$3.30
Federally Qualified Health Center (FQHC)	T1015	$3.30
Rural Health Clinic (RHC)	T1015	$3.30
Ambulatory Surgical Center	Services per day	$3.30
Dental	Services per day	$3.40

APPENDIX 3 COPAYMENT SCHEDULE

Service	Procedure Code/ Frequency	Amount
Pharmacy (The prescription copayment will apply to ages 19 and above only.)	Per prescription/refill	$3.40
Note: Effective for dates of service on and after July 1, 2015, the copayment will be $0 for certain medications for the treatment of diabetes, behavioral health disorders and smoking cessation products. Refer to the Pharmacy Co-Payment Waiver Medicaid bulletin dated May 26, 2015.		
Inpatient Hospital	Per admission	$25.00
Outpatient Hospital **(non-emergency)**	Per claim	$3.40

*__Note__: Durable Medical Equipment that is under a rent to purchase payment plan will have the $3.40 copayment split evenly among the 10-month rental payment schedule.

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MANAGED CARE 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) to offer health care services. An MCO must receive a Certificate of Authority from the SC Department of Insurance and must be licensed as a domestic insurer by the State to render Medicaid managed care services. MCO model contracts are approved by the Centers for Medicare and Medicaid Services (CMS) and Medicaid.

This Managed Care supplement is intended to provide an overview of the Managed Care program. Providers should review the MCO Policy and Procedure Guides for detailed program-specific requirements. The guide is located on the SCDHHS Web site at www.scdhhs.gov within the Managed Care section.

The Exhibits section of this supplement provides contact information for MCOs currently participating in the Medicaid Managed Care program as MCOs are subject to change at any time. Providers are encouraged to visit the SCDHHS website (www.scdhhs.gov) for the most current listing of health plans, the counties in which they are authorized to operate, and the number of managed care enrollees within a county.

MANAGED CARE SUPPLEMENT

MANAGED CARE OVERVIEW

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 DESCRIPTION

Managed Care Organizations (MCOs)

A Managed Care Organization (MCO) is commonly referred to as an HMO (Health Maintenance Organization) in the private sector. MCOs are required to operate under a contract with SCDHHS to provide healthcare services to beneficiaries through a network of healthcare professionals, both primary and specialty care, as well as hospitals, pharmacies, etc. This network is developed by contracting with the various healthcare professionals. Providers wanting to contract with an MCO must be enrolled in South Carolina Medicaid with SCDHHS.

Primary care providers (PCP) must be accessible within a 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.

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 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

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MANAGED CARE OVERVIEW

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) - Medically Complex Children's Waiver

SCDHHS administers one MHN specifically for individuals that are enrolled in the Medically Complex Children's Waiver program. Medical Homes Networks (MHNs) are Primary Care Case Management (PCCM) programs that link beneficiaries with a primary care provider (PCP). An MHN is a group of physicians who have agreed to serve as PCCM providers for this specific population. They work in partnership with the 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.

The outcome of this medical home is 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.

MHN Program Identification (ID) Card - Medically Complex Children's Waiver

A separate identification card is not issued for members enrolled in this program. Beneficiaries enrolled in this MHN will have only one identification card, the one issued by SC Medicaid. This card does not contain the name or phone number of the assigned PCP. Such information can only be obtained by checking eligibility.

Core Benefits - Medically Complex Children's Waiver

Services provided under this MHN program are all paid on a FFS basis. As such, all claims are submitted to and processed by SCDHHS. Benefits offered in the MHN program mirror those offered in FFS with the following exceptions:

- All beneficiaries in this program receive unlimited ambulatory visits

MANAGED CARE SUPPLEMENT

MANAGED CARE OVERVIEW

Prior Authorizations and Referrals - Medically Complex Children's Waiver

The PCP is contractually required to either provide medically necessary services or authorize another provider to treat the 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. 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

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- Speech Therapist Services
- Therapeutic Foster Care Services

Referrals for a Second Opinion - Medically Complex Children's Waiver

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

Referral Documentation - Medically Complex Children's Waiver

All referrals must be documented in the 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 - Medically Complex Children's Waiver

Beneficiaries can obtain the following services from Medicaid providers without obtaining a prior authorization from their PCP:

- Ambulance Services
- Dental Services
- Dialysis/End Stage Renal Disease Services
- Emergency Room Services (billed by the hospital)
- Family Planning Services
- Home- and Community-Based Waiver Services
- Independent Laboratory and X-ray Services[1]
- Medical Transportation Services
- Nursing Home Services
- Obstetrician and Gynecologist Services
- Optician Services
- Optometrist Services
- Pharmacy Services

[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.

MANAGED CARE SUPPLEMENT

MANAGED CARE OVERVIEW

- State Agency Services[2]

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 support representative will respond to you directly.

Primary Care Provider Requirements - Medically Complex Children's Waiver

The primary care provider is required to either provide services or authorize another provider to treat the 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

24-Hour Coverage Requirements - Medically Complex Children's Waiver

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.

[2] Agencies exempt from prior authorization are the Department of Mental Health, the Continuum of Care, the Department of Alcohol and Other Drug Abuse, the Department of Disabilities and Special Needs, the Department of Juvenile Justice, and the Department of Social Services.

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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

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

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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.

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 loses 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. 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.

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.

MANAGED CARE SUPPLEMENT

MANAGED CARE ENROLLMENT

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 is selected by a Quality Weighted Automated Assignment Algorithm 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.

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.

MANAGED CARE SUPPLEMENT

MANAGED CARE ENROLLMENT

Providers should refer to the appropriate Medicaid provider manual for additional limitations when providing services to newborns.

Primary Care Provider Selection and Assignment

Upon enrolling into a managed care plan, all beneficiaries are "assigned" to a primary care provider (PCP). When the beneficiary is assigned to an MCO, the MCO 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. 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 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 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 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 NETWORKS (MHNS) FOR THE MEDICALLY COMPLEX CHILDREN'S WAIVER

The following MHN participates with the Medically Complex Children's waiver and South Carolina Healthy Connections (Medicaid). MHN beneficiaries should present their South Carolina Healthy Connections Medicaid Insurance card in order to receive health care services. No additional card is necessary.

South Carolina Solutions

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

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.

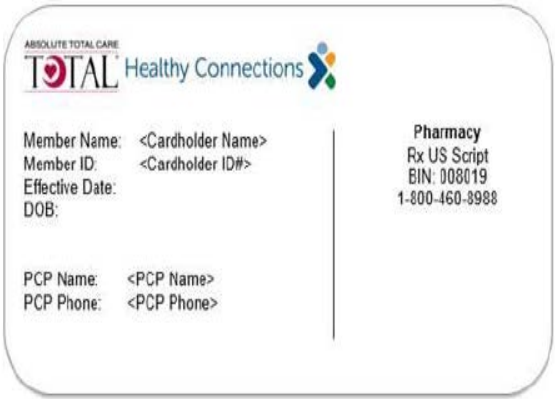
SAMPLE MEDICAID MCO CARDS

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.

MANAGED CARE SUPPLEMENT

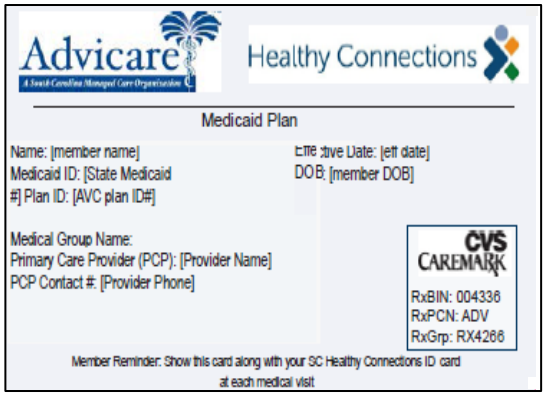
Absolute Total Care

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



Advicare

Provider and Member Services
1-888-781-4371
www.advicarehealth.com



BlueChoice

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

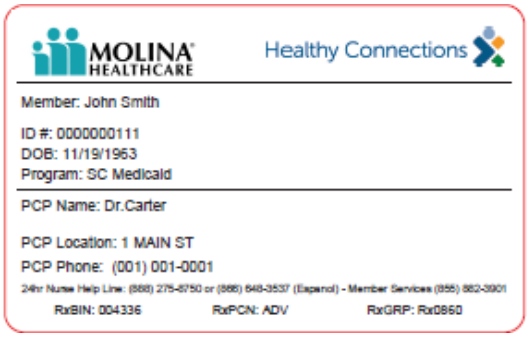
First Choice by Select Health

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

MANAGED CARE SUPPLEMENT

Molina Healthcare, Inc.

1-855-237-6178 (Provider Services)
1-855-882-3901 (Member Services)
www.molinahealthcare.com



WellCare Health Plans, Inc.

200 Center Point, Suite 180
Columbia, SC 29210
(888) 588-9842
www.southcarolina.wellcare.com

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PROVIDER MANUAL SUPPLEMENT

THIRD-PARTY LIABILITY

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THIRD-PARTY LIABILITY SUPPLEMENT

INTRODUCTION

"Third-party liability" (TPL) refers to the responsibility of parties other than Medicaid to pay for health insurance costs. Medicaid is always the payer of last resort, which means that Medicaid will not pay a claim for which someone else may be responsible until the party liable before Medicaid has been billed. For the most part, this means providers are responsible for billing third parties before billing Medicaid.

Third parties can include:

- Private health insurance
- Medicare
- Employment-related health insurance
- Medical support from non-custodial parents
- Long-term care insurance
- Other federal programs
- Court judgments or settlements from a liability insurer
- State workers' compensation
- First party probate-estate recoveries

Private health insurers and Medicare are the most common types of third party that providers are required to bill. For information on casualty cases and estate recovery, see Section 1 of your provider manual.

HEALTH INSURANCE RECORDS

Medicaid Insurance Verification Services (MIVS), Medicaid's TPL contractor, researches third-party insurance information. Sources of information include providers, eligibility offices, long-term care workers, private insurers, other government agencies, and beneficiaries themselves.

It can take up to 25 days for a new policy record to be added to a beneficiary's eligibility file and five days for corrections and updates of an existing record. New policy information and updates are added to the Medicaid Management Information System (MMIS) every working day.

ACCESS TO CARE

As a provider, your role in the TPL process begins as soon as you agree to treat a Medicaid-eligible patient. You should ask every patient and/or the patient's responsible party about other insurance coverage.

According to 42 CFR 447.20(b), **you cannot refuse to treat a Medicaid patient simply because he or she has other health insurance**. You and the patient should work together to decide whether you will consider the individual a Medicaid patient or a private-pay patient. If you accept the individual as a Medicaid patient, you are obligated to follow Medicaid's third-party liability guidelines and other policies. Remember, you agree to treat a patient as a Medicaid

patient for an entire spell of illness; you cannot change a beneficiary's status in the midst of a course of treatment.

When you first accept a Medicaid beneficiary, and at every service encounter thereafter, you will check to see whether the patient is eligible for Medicaid. At the same time, you will check for any other insurers you may need to bill. You should also perform a Medicaid eligibility check again when entering a claim, as eligibility and TPL information are constantly being updated.

South Carolina Healthy Connections (Medicaid) does not require you to obtain copies of other insurance cards from the beneficiary. You can obtain from South Carolina Healthy Connections (Medicaid) all the information you need to file with another insurer or to code TPL information on a Medicaid claim, including policy numbers, policy types, and contact information for the insurer, as long as Medicaid has that information on file.

Health Insurance Premium Payment Project

The Health Insurance Premium Payment (HIPP) project allows SCDHHS to pay private health insurance premiums for Medicaid beneficiaries who may be at risk of losing the private insurance coverage. SCDHHS will pay such premiums if the payment is deemed cost effective; see Section 1 of your provider manual for more information on qualifying situations. Maintaining good communication with your patients will help you identify candidates for referral to the HIPP program.

Eligibility Verification

- **Medicaid Card:** Possession of a Medicaid card means only that a beneficiary was eligible for Medicaid when the card was issued. You must use other eligibility resources for up-to-date eligibility and TPL information.
- **Point-of-Sale Devices and Eligibility Verification Vendors:** Check with your vendor to see how TPL information is reported.
- **Web Tool:** The Eligibility Verification function of the South Carolina Healthy Connections (Medicaid) Web-based Claims Submission Tool provides information about third-party coverage. See the Web Tool User Guide for instructions on checking eligibility.

REPORTING TPL INFORMATION TO MEDICAID

Providers are an important source of information from beneficiaries about third-party insurers. You can report this information to Medicaid in two ways: enter the information on claims submitted to Medicaid, or submit Health Insurance Information Referral Forms to Medicaid. When primary health insurance information appears on a claim form, the insurance information is passed to MIVS electronically for verification. This referral process is conducted weekly and contributes to timely additions and updates to the policy file.

THIRD-PARTY LIABILITY SUPPLEMENT

Health Insurance Information Referral Forms

The SCDHHS Health Insurance Information Referral Form is used to document third-party insurance coverage, policy changes, beneficiary coverage changes, carrier changes, and policy lapse information. You should fill out this form when you discover third-party coverage information that Medicaid does not know about, or when you have insurance documentation that indicates the TPL health insurance record needs an update.

A copy of the form is included in the Forms section of your provider manual, and samples appear at the end of this supplement. Send or fax the completed forms to:

South Carolina Healthy Connections
PO Box 101110
Columbia, SC 29211-9804
Fax: (803) 252-0870

COORDINATION OF BENEFITS

Health insurers adhere to "coordination of benefits" provisions to avoid duplicating payments. The health plan or payer obligated to pay a claim first is called the "primary" payer, the next is termed "secondary," and the third is called "tertiary." Together, the payers coordinate payments for services up to 100% of the covered charges at a rate consistent with the benefits.

Medicaid does not participate in coordination of benefits in the same way as other insurers. Medicaid is never primary, and it will only make payments up to the Medicaid allowable. However, you should understand how other companies coordinate payments.

COST AVOIDANCE VS. PAY & CHASE

South Carolina Healthy Connections (Medicaid) is required by the federal government to reject claims for which another party might be liable; this policy is known as "cost avoidance." Providers must report primary payments and denials to Medicaid to avoid rejected claims. The majority of services covered by Medicaid are subject to cost avoidance.

For certain services, Medicaid does not cost-avoid claims and will pursue recovery under a policy known as "Pay & Chase." Medicaid remains the payer of last resort in all cases; however, under Pay & Chase it temporarily behaves like a primary payer.

Services that fall under Pay & Chase are:

- Preventive pediatric services
- Dental EPSDT services
- Maternal health services
- Title IV – Child Support Enforcement insurance records
- Certain Department of Health and Environmental Control (DHEC) services under Title V

While providers of such services are encouraged to file with any liable third party before Medicaid, if they choose not to do so, SCDHHS will pay the claims and bill liable third parties directly through the Benefit Recovery program. More information on recovery appears later in

this supplement. If you choose to bill both a third party and Medicaid, you must enter the TPL filing information on your Medicaid claim as outlined in this supplement – rendering Pay & Chase-eligible services does not exempt you from the requirement to correctly code for TPL.

Resources Secondary to Medicaid

Certain programs funded only by the state of South Carolina (*i.e.*, without matching federal funds) should be billed secondary to Medicaid. The TPL claim processing subsystem does not reject claims for resources that may pay after Medicaid. These resources are:

- BabyNet
- Best Chance Network
- Black Lung
- Commission for the Blind
- Community Health
- Crime Victims Compensation Fund
- CRS (Children's Rehabilitative Services)
- Department of Corrections
- DHEC Cancer
- DHEC Family Planning (DHEC Maternal Child Health)
- DHEC Heart
- DHEC Hemophilia
- DHEC Migrant Health
- DHEC Sickle Cell
- DHEC TB
- Indian Health
- Other Indigent (hospital charity)
- Other Sponsor
- Ryan White Program
- State Aid Cancer Program
- Vaccine Injury Compensation
- Veterans Administration
- Vocational Rehabilitation Services

COPAYMENTS AND TPL

For certain services, Medicaid beneficiaries must make a Medicaid copayment. SCDHHS deducts this amount from what Medicaid pays the provider. Copayments are described in detail in Section 3 of your provider manual (if they apply to the services you provide).

Remember, as a Medicaid provider you have agreed to accept Medicaid's payment as payment in full. You can never balance bill a beneficiary receiving Medicaid-covered services for anything other than the Medicaid copayment. (You may, however, bill a beneficiary for services that Medicaid does not cover.)

When a beneficiary has Medicare or private insurance, he or she is still responsible for the Medicaid copayment. However, if the sum of the copayment and the Medicare/third-party payment would exceed the Medicaid-allowed amount, you must adjust or eliminate the copayment. In other words, though you may accept a primary insurance payment higher than what Medicaid would pay, the beneficiary's copayment cannot contribute to the excess revenue.

Medicaid beneficiaries with private insurance are **not** charged the copayment amount of the primary plan(s). When you accept a patient as a Medicaid patient, all Medicaid rules, including the Medicaid copayment rules, apply to that individual. These rules are federal law; they protect the Medicaid beneficiary by limiting his or her liability for payment for medical services.

THIRD-PARTY LIABILITY SUPPLEMENT

Medicaid determines payment in full and the patient's liability. Therefore, when you file a secondary claim with Medicaid, you can only apply the Medicaid copayment and cannot require the primary plan copayment as you would for a private pay patient.

DENIALS AND EOBS

When you bill a primary health insurer, you should obtain either a payment or a denial. You should also receive an Explanation of Benefits (EOB) that explains how the payment was calculated and any reasons for non-payment. Once you have received a reply from all potentially liable parties, if there are still charges that are not paid in full that might be covered by Medicaid, you may then bill Medicaid. This process is known as sequential billing.

Note that you must receive a *valid* denial before billing Medicaid. A request for more information or corrected information does not count as a valid denial.

POLICY TYPES

Each private policy listed in a patient's insurance record has an entry for "policy type," the most common of which is Health No Restrictions (HN). Another policy type you may encounter is HI, Health Indemnity; such policies pay per diem for hospital stays, surgeries, anesthesia, etc. HS, Health Supplemental, refers to policies that cover Medicare coinsurance and deductibles. Other policy types include Accident (HA) and Cancer (HC).

The policy type HN may be applied to a pharmacy carve-out, a mental health claim administrator, or a dental policy. The policy type does not provide specific information about the types of services covered, so you may have to take extra steps to determine whether to bill a particular carrier:

1. Ask the beneficiary. He or she should be able to tell you what kind of policy it is.
2. Look at the name of the carrier in the full list of carrier codes. The name may help you figure out the type of coverage (*e.g.*, ABC Dental Insurers).
3. Call SCDHHS Provider Service Center (PSC). Providers can also submit an online inquiry at http://scdhhs.gov/contact-us and a provider support representative will respond to you directly. He or she can look up more details of the plan in the TPL policy file.

TIMELY FILING REQUIREMENTS

Providers must file claims with Medicaid within a year of the date of service. If a claim is rejected, you must file a new claim within that year, and Void/Replacement adjustments must be made within that year as well – all activity related to the claim must occur within a year of the date of service in order for you to be paid.

Because of this timely filing requirement, you should bill third parties as soon as possible after service delivery. SCDHHS recommends that you file a claim with the primary insurer within 30 days of the date of service.

THIRD-PARTY LIABILITY SUPPLEMENT

Regardless of how long the third party takes to reply, providers must still meet Medicaid's timeliness requirements. Delays by other insurers are not a sufficient excuse for timeliness extensions.

Timely Filing	
Medicaid claims	One year
Medicare-primary claims to Medicaid	Two years or within six months from Medicare adjudication
Primary health insurance	30 days recommended

Late claim filing to the primary insurer and gaps in activity related to obtaining payment from a primary carrier are not reasonable practices. SCDHHS will not consider payment if a claim is not successfully adjudicated by the MMIS within the time frames above.

REASONABLE EFFORT

Providers occasionally encounter difficulties in obtaining documentation and payment from third parties and beneficiaries. For example, the third-party insurer may refuse to send a written denial or explanation of benefits, or a beneficiary may be missing or uncooperative. It is your responsibility as a provider to seek a solution to such problems.

"Reasonable effort" consists of taking logical, timely steps at each stage of the billing process. Such steps may include submitting new claims, making follow-up phone calls, and sending additional requested information. Many resources are available to help you pursue third-party payments. The PSC can work with you to explore these options.

Reasonable Effort and Insurance Companies

Below is a suggested process for filing to insurance companies. A flowchart based on this process can be found at the end of this supplement.

A. Send a claim to the insurance company.

If after **thirty days** you have received no response:

B. Call the company's customer service department to determine the status of the claim.

- **If the company has not received the claim:**
  1. Refile the claim. Stamp the claim as a repeat submission or send a cover note.
  2. Repeat follow-up steps as needed.
- **If the company has received the claim but considers the billing insufficient:**
  1. Supply all additional information requested by the company.
  2. Confirm that all requested information has been submitted.

THIRD-PARTY LIABILITY SUPPLEMENT

3. Allow thirty more days for the claim to be processed.
4. If there is no response within thirty days and all information has been supplied as requested, proceed as instructed below.

- **If the company has received the claim, considers the billing valid, and has not suspended the claim:**
  1. Make a note in your files.
  2. Follow up with a written request for a response.

C. If after two more weeks you have still received no response:

1. Write to the company citing this history of difficulties. Copy the South Carolina Department of Insurance Consumer Division on your letter.

Remember, difficulties with insurance companies do not exempt you from timely filing requirements. It is important that you file a claim as soon as possible after providing a service so that, should you encounter any difficulty, you have time to pursue the steps described above.

Once the Department of Insurance has resolved an issue (which usually takes about 90 days), you should have adequate information to bill Medicaid correctly. Following all the steps above should take no more than 180 days, well within the Medicaid timely filing limit of one year.

Reasonable Effort and Beneficiaries

Difficulties can arise when a beneficiary does not cooperate with an insurer's request for information. For example, U.S. military beneficiaries must report changes in their status and eligibility to the Defense Eligibility and Enrollment Reporting System (DEERS); a delay by a beneficiary may delay a provider's response from the insurer. An insurer may also need a beneficiary to send in subrogation forms related to a hospitalization.

It is in your interest to contact the beneficiary, whether by phone, certified letter, or otherwise. You may offer to help the beneficiary understand and fill out forms. Be sure to document all your attempts at contact and inform the insurer of such actions.

Occasionally insurers will pay a beneficiary instead of a provider. If you know an insurance payment will be made to a patient, you should consider having the patient sign an agreement indicating that the total payment will be turned over to the provider, and that failure to cooperate with the agreement will result in the beneficiary no longer being accepted as a Medicaid patient.

Reasonable Effort Documentation Form

In cases where you have made all reasonable efforts to resolve a situation, you can submit a Reasonable Effort Documentation form. The form must demonstrate that you have made sustained efforts to contact the insurance company or beneficiary. This document is used only as a last resort, when all other attempts at contact and payment collection have failed.

Attach the form to a claim filed as a denial. Attach copies of all documents that demonstrate your efforts (correspondence with the insurer and the Department of Insurance, notes from your files, etc.). If you are filing electronically, you must keep the Reasonable Effort Documentation form

and all supporting documentation on file. A blank Reasonable Effort Documentation form can be found in the Forms section of your provider manual, and examples appear at the end of this supplement.

Reporting TPL Information on Claims

When you file a claim that includes TPL information, you will report up to five pieces of TPL information, depending on the type of claim:

For each insurer:

1. The carrier code
2. The insured's policy number
3. A payment amount or "0.00"

For the whole claim:

4. A denial indicator when at least one payer has not made payment
5. The total of all payments by other insurers

Carrier Codes

Medicaid, in conjunction with the South Carolina Hospital Association (SCHA), assigns every third-party insurer a unique three-digit alphanumeric code. Among the SCHA carrier codes are a few five-digit codes created by SCDHHS to satisfy carrier-specific claim filing requirements; these are identified by the suffix RX (pharmacy plans). SCHA carrier codes are used to identify insurers and other payers (including the Medicare Advantage plans) on dental, professional, and institutional claims. A complete list of carrier codes can be found in Appendix 2 of those provider manuals.

SCDHHS maintains an entirely separate list of five-digit carrier codes for pharmacy claims submission. Providers should visit http://southcarolina.fhsc.com or the SCDHHS Provider Information page at http://provider.scdhhs.gov/ to view the pharmacy carrier codes list.

With very few exceptions, the alphanumeric carrier codes assigned by the SCHA are three digits, alpha-numeric-alpha. However, if you file hard copy, you may want to indicate a zero as Ø to ensure it is keyed correctly.

If you cannot find a particular carrier or carrier code in your manual, please visit the SCDHHS Provider Information page at http://provider.scdhhs.gov/ to view the most current carrier codes list.

If you are billing a company for which you cannot find a code, you may use 199, the generic carrier code. MIVS will then call you to ask about the new insurer. You may prefer to submit a Health Insurance Information Referral Form to MIVS while you have the carrier information easily accessible, as MIVS may call you up to one month after the claim has been processed.

You may encounter the "CAS" carrier code when checking a beneficiary's eligibility. This code represents an open casualty case. Medicaid does not cost avoid claims with casualty coverage. You may decide to bill Medicaid directly and forgo participation in the case, or you may take

action with the liable party and not bill Medicaid. Timely filing requirements still apply even where there is a possible casualty settlement, so you must make your decision prior to the one-year Medicaid timely filing deadline.

Policy Numbers

Many insurance companies use Social Security numbers (SSNs) as policy numbers, but some are transitioning to policy numbers that do not rely on confidential information. You should use the number that appears on the beneficiary's health insurance card.

SCDHHS has begun adding these new policy numbers to beneficiary records. If one of your claims is rejected for failure to file to a private insurer (edit 150) and you have already filed to that insurer, there may be a policy number discrepancy; you should code the claim with the beneficiary's SSN. Edit codes and rejected claims are discussed in more detail below.

Pharmacy Claims

TPL policies apply to all Medicaid services. Like other providers, pharmacists must bill all other potentially liable parties, including Medicare, before billing Medicaid. However, pharmacists' billing procedures differ from those of other providers. Pharmacists do not use the carrier codes assigned by the SCHA; South Carolina Healthy Connections (Medicaid) maintains separate carrier codes for pharmacy claims submission. Providers should visit the SCDHHS Provider Information page at http://provider.scdhhs.gov for pharmacy carrier codes. These unique codes may also be found at http://southcarolina.fhsc.com.

Pharmacists receive two-character NCPDP edit codes rather than South Carolina Healthy Connections (Medicaid) edit codes. Code 41 indicates that you need to file to a third-party payer, to include Medicare Parts B and D, if applicable.

Pharmacy services are generally cost-avoided; however, SCDHHS performs Pay & Chase billing for insurance resources that are Child Support Enforcement-ordered and in situations where the insurance company will not pay the Medicaid-assigned claim and instead makes payment to the subscriber. Pharmacists who file to primary plans but do not receive the insurance payment should report that fact to MIVS or SCDHHS so that Pay & Chase may be implemented instead of cost avoidance.

The point-of-sale contractor's Pharmacy Provider Manual contains complete instructions on how to submit TPL information on Medicaid claims.

Nursing Facility Claims

Nursing facilities are required to follow Medicaid's TPL policies by billing other liable parties before billing Medicaid. The nursing facility claim form, the Turn Around Document, does not provide fields for coding TPL information. In order to have TPL payments calculated, you will report TPL payments and denials on a Health Insurance Information Referral Form and/or submit the insurance EOB with a new DHHS Form 181.

If you discover third-party coverage that Medicaid does not yet have on file, bill the third party and send a Health Insurance Information Referral Form to MIVS so that the insurance record

may be put online. If Medicaid has already paid, you are responsible for refunding the insurance payment. Failure to report insurance that will likely be subsequently discovered may result in the claim being put into benefit recovery and recouped in a recovery cycle (see the section on recovery for more information).

To initiate Medicaid billing for a resident also covered by a third-party payer, submit a claim to Medicaid and receive a rejection (edit code 156 for commercial insurance) for having failed to file with the other liable third parties. This establishes your willingness to accept a resident as a Medicaid beneficiary. It also shows that you intend to adhere to Medicaid's timely filing requirements.

When you receive a rejected claim, attach all EOBs and submit a new DHHS Form 181 to the Medicaid Claims Control System (MCCS); they will route it to the Medicaid TPL department for processing. If you are subsequently paid by a third party, use Form 205 to refund part or all of your Medicaid payment. Mark "health insurance" as the reason for the refund, supply the insurance information, and attach a check for the amount being refunded.

Remember that claims in recovery have timely filing requirements. SCDHHS suggests that as soon as you receive a 156 edit and/or discover that a resident has third-party coverage, you check your records and bill the third party for previous claims for the current calendar year and for one year prior for which Medicaid should not have paid primary. If you wait for the next recovery cycle, you may run into timely filing deadlines. All previously paid claims that were not filed with the insurance company or third parties are subject to recovery by Medicaid.

Should MIVS mail you a letter of recovery, make sure you follow all procedures and timelines as required. The PSC will be able to assist you in completing all requirements from MIVS in order to avoid a take-back or to reverse a previous take-back.

If you have any other questions or concerns about third-party liability issues, call the PSC. Because nursing home billing cycles are often longer than those of other providers, it is essential that you contact SCDHHS early in the TPL billing process, before timely filing requirements become a concern.

The Nursing Facility Services Provider Manual contains complete billing instructions for nursing facilities. Please see also the following sections of this supplement: Eligibility Verification, Reporting TPL Information to Medicaid, Cost Avoidance vs. Pay & Chase, Timely Filing Requirements, and Reasonable Effort.

PROFESSIONAL, INSTITUTIONAL, AND DENTAL CLAIMS

The CMS-1500 and UB-04 claim forms have space to report two payers other than Medicaid. If there are three or more insurers, you will need to code your claim with the payers listed that pay primary and secondary. When your claim receives edit 151, you must submit a new claim and write in the carrier code, policy number, and amount paid in the third occurrences of fields 24, 25, and 26 of the CMS-1500, Claims submitted electronically will be processed automatically with up to ten primary payers.

THIRD-PARTY LIABILITY SUPPLEMENT

Professional Paper Claims

The CMS-1500 has two areas for entering other insurers: block 9 (fields 9a, 9c, and 9d) and block 11 (fields 11, 11b, and 11c). If there is only one primary insurer, you can use either block. If there are two insurers, use both blocks.

CMS-1500 TPL Fields

9a Other Insured's Policy or Group Number Enter the policy number.	**11 Insured's Policy Group or FECA Number** Enter the policy number.
9c Reserved for NUCC Use If the insurance has paid, indicate the amount paid in this field. If the insurance has denied payment, enter "0.00" in this field.	**11b Other Claim ID (Designated by NUCC)** If the insurance has paid, indicate the amount paid in this field. If the insurance has denied payment, enter "0.00" in this field.
9d Insurance Plan Name or Program Name Enter the three-character carrier code.	**11c Insurance Plan Name or Program Name** Enter the three-character carrier code.

10d Claim Codes (Designated by NUCC)
Enter the appropriate TPL indicator for this claim.

The valid TPL indicators are:

1 Insurance denied

6 Crime victim

8 Uncooperative beneficiary

If either insurer denied payment, you will put the TPL indicator "1" in field 10d. "6" is used to alert SCDHHS to potential criminal proceedings and restitution. "8" is used in conjunction with the Reasonable Effort Documentation form to show that you have been unable to contact a beneficiary from whom you need information and/or payment.

29 Amount Paid
Enter the total amount paid from all insurance sources. This amount is the sum of 9c and 11b.

Complete instructions for filling out CMS-1500 claim forms can be found in Section 3 of provider manuals for professional services. Sample CMS-1500s with TPL information appear at the end of this supplement.

THIRD-PARTY LIABILITY SUPPLEMENT

Institutional Paper Claims

Unlike other claim types, the UB claim form has a section for listing all parties being billed, **including Medicaid**. Medicaid's carrier code, 619, must be entered on all UB claims submitted to Medicaid.

Fields 50, 54, and 60 are the main fields for coding TPL information.

- Identify all other payers, with the primary payer on line A.
- For each payer other than Medicaid, enter the three-digit carrier code in field 50 and the corresponding payment in field 54.
- For denials, enter the carrier code in field 50 and "0.00" in field 54. Then, enter occurrence code 24 and the date of denial in item 31, 32, 33, or 34.
- You are not required to enter a provider number for payers other than Medicaid, though doing so will not affect your claim.
- Enter Medicaid (619) on line B or C. Leave field 54 of the Medicaid line blank; there will never be a prior payment.
- Enter the patient's 10-digit Medicaid ID number on the lettered line (A, B, or C) that corresponds to the Medicaid line in fields 50 – 54. Enter the other policy numbers on the same lettered line as the code and payment for that carrier.

UB-04 TPL Fields

	50 PAYER	51 PROVIDER NO	54 PRIOR PAYMENTS
A	618/620 (Medicare carrier code)		$33.01
B	401 (BCBS carrier code)		$255.39
C	619 (Medicaid carrier code)		

60 CERT.-SSN-HIC.-ID NO.
ABQ1111222
123456789-1212
1234567890

If one claim spans multiple claim forms, fields 50, 51, and 54 must be completed in exactly the same way on each page of the claim.

Complete instructions for filling out UB claim forms can be found in the Hospital Services and Psychiatric Hospital Services provider manuals, and a sample UB-04 with TPL information appears at the end of this supplement.

Dental Paper Claims

For samples and complete instructions for filling out the ADA and CMS-1500 claim forms, refer to the DentaQuest Dental Office Reference Manual (ORM) at http://www.DentaQuest.com

THIRD-PARTY LIABILITY SUPPLEMENT

Web-Submitted Claims

The Web Tool User Guide contains instructions for entering TPL information for all claim types except Dental using the Web Tool. The basic steps are the same as for paper claims.

REJECTED CLAIMS

If you file a claim to Medicaid for which you should have first billed a third-party insurer, your claim will be rejected unless 1) the policy has not yet been uploaded to the MMIS, or 2) the service is in Pay & Chase. The Eligibility section on the Web Tool will supply information you need to file with the third-party payer.

Insurance Edits

There are six edit codes indicating that a claim has not been filed to other insurers:

- 150: TPL coverage verified/filing not indicated on claim
- 151: Multiple insurance policies/not all filed – call TPL
- 155: Possible, not positive, insurance match/other errors
- 156: TPL verified/filing not indicated on claim
- 157: TPL coverage; no amount other sources on claim
- 953: Buy-in indicated – possible Medicare payer

If you receive one of these edit codes and have not filed a claim with all third parties listed under the Eligibility section on the Web Tool, you must do so. **Whenever you receive one of these edits, your subsequent attempts to obtain Medicaid payment must have at least one TPL carrier code and policy number even when there is no primary payment.** If a policy has lapsed by the time a claim is processed, SCDHHS will be unable to correctly identify the claim as TPL-related unless you enter the TPL information on a new claim.

The insurance carrier code, the policy number, and the name of the policyholder are all listed under the Eligibility section on the Web Tool, while the carrier's address and telephone number may be found in Appendix 2 of your provider manual or on the SCDHHS Web site. Because of timely filing requirements, you should file with the primary insurer as soon as possible.

If you have already filed a claim with all third parties listed on the Web Tool, check to see that all the information you entered is correct. Compare the carrier code and policy number you entered on the rejected claim and submit a new claim. You must re-enter all TPL information when filing a new claim.

Other TPL-related edit codes include:

165: TPL balance due/patient responsibility must be present and numeric

316: Third party code invalid

317: Invalid injury code

390: TPL payment amount not numeric

400: TPL carrier and policy number must both be present

THIRD-PARTY LIABILITY SUPPLEMENT

401: Amount in other sources, but no TPL carrier code

555: TPL payment is greater than payment due from Medicaid

557: Carrier payments must equal payments from other sources

565: Third-party payment, but no third-party ID

690: Amount from other sources more than Medicaid amount

732: Payer ID number not on file

733: Insurance information coded, but payment or denial indicator missing

953: Buy-in indicated on CIS – possible Medicare

Resolution instructions for these edit codes can be found in Appendix 1 of your provider manual.

CLAIM ADJUSTMENTS AND REFUNDS

If you are paid by a third-party insurer after you have been paid by Medicaid, you should initiate a claim adjustment if you wish to refund the original paid claim in full. You must use the Void/Replacement rather than the Void Only option. Unless there is a replacement claim, new TPL information will not be available to MIVS for investigation and addition to the policy file in the MMIS.

If the refund is for an amount less than the original Medicaid payment, contact MIVS for a manual TPL debit or send a refund check for the appropriate amount. Complete instructions for filing adjustments are in Section 3 of your provider manual, and sample Adjustment Form 130s appear at the end of this supplement. Please remember that hospital providers, pharmacists, and nursing facilities do not use the Form 130.

If you submit a refund to SCDHHS and subsequently discover that it was in error, SCDHHS must receive your credit adjustment request within 90 days of the refund.

Remember: you should not send a check when you make a claim-level adjustment. However, if you need to send a reimbursement check for any reason, fill out the Form for Medicaid Refunds (Form 205 – see the Forms section of your provider manual) and send it with the check to the following address:

South Carolina Healthy Connections
Cash Receipts
PO Box 8355
Columbia, SC 29202

RECOVERY

"Recovery" refers to all situations where Medicaid or the provider pursues third parties who are liable for claims that Medicaid has already paid. Recovery categories include Retro Medicare, Retro Health, and Pay & Chase.

MIVS is responsible for mailing recovery invoices and posting benefit recovery responses. If you have questions about recovery, please contact them directly. See the contact list at the end of the supplement.

THIRD-PARTY LIABILITY SUPPLEMENT

Retro Medicare

SCDHHS invoices institutional and professional medical providers at the beginning of each month for retroactive Medicare coverage (Retro Medicare). You will receive a letter indicating that your account will be debited. The letter identifies Medicare-eligible beneficiaries, claim control numbers, and dates of service, as well as the check date of the automated adjustment and an “own reference number” to identify the debit(s).

You are expected to file the affected claims to Medicare within 30 days of the invoice. After filing to Medicare, you have the option of filing a claim to Medicaid for consideration of an additional payment toward the coinsurance and deductible. Requests for reconsideration of the debit must be received within 90 days of the debit.

If Medicare has denied, you may submit a claim to Medicaid. Provider adjustments will not be submitted for payment in order to eliminate the possibility of duplicate payments. Certain claims for patients with Medicare Part B only, when it is impossible to file them within the one-year timely filing limit, may be an exception.

Despite the extended timely filing deadlines for Medicare-primary claims (six months from Medicare payment or two years from the date of service), you may encounter difficulties with timely filing when Medicare does not make a payment and a claim is in Retro Medicare. If a claim sent to Medicaid is denied with edit 510 for being more than one year after the date of service or six months after the Medicare remittance date, mail, or fax the rejected claim, with supporting documentation to MIVS. If the patient is Part B-only and a UB claim form has received edit 510, the rejected claim, with supporting documentation, should be forwarded or faxed to MIVS. If MIVS determines that the late filing is valid, they will make a credit adjustment.

Claims pulled into Retro Medicare, when filed within 30 days should meet Medicare one year timely filing rule.

Please note that the computer logic also reviews the procedures on the claims and does not pull into recovery procedure codes that are not Medicare covered.

South Carolina Healthy Connections (Medicaid) is responsible for attempting to recover all claims that can be filed within timely filing limits.

Retro Health and Pay & Chase

SCDHHS invoices institutional providers each quarter for Retro Health and Pay & Chase claims. Providers are expected to file the claims to the primary medical plan within the quarter of the invoice and to respond to the recovery letter upon receiving the primary adjudication.

Approximately four months after the recovery letter, providers are notified of any claims for which there has been no response. Six months after the initial invoice, claims for which there was no response are automatically debited. Requests for reconsideration of the debit must be received within 90 days of the debit. SCDHHS will not reconsider requests after the nine-month cycle.

THIRD-PARTY LIABILITY SUPPLEMENT

Retro Health Example

January 2011	Initial invoice
May 2011	Second letter
June 2011	Notification: Automated debit on last check date of the month
September 2011	Deadline for reconsideration

You should submit claims promptly to the primary carriers to avoid receiving timely filing denials from the primary health plans for cost avoidance and for recovery. If you fail to meet timely filing requirements and thus fail to meet a primary carrier's deadline, this is not an acceptable denial; however, when an insurer's timely filing deadline for a date of service is within approximately six weeks of an invoice in Retro Health or possibly before the Medicaid invoice, SCDHHS will accept the insurer's denial and stop a subsequent debit of the Medicaid paid claim from your account.

Insurers occasionally recoup payments made to providers who have put the insurance payment on a Medicaid secondary claim or who have refunded the Medicaid primary payment under Retro Health or Pay & Chase. When the provider submits proof of return of the primary payment, SCDHHS will consider reinstating payment by manual adjustment when the request is received within 90 days of the primary plan request to the provider.

CONCLUSION

Medicaid's ability to fund health care for low-income people relies in part on the success of its cost avoidance measures. For providers, third-party liability responsibilities can be summarized as follows:

- Bill all other liable parties before billing Medicaid.
- Make reasonable, good-faith efforts to get responses from insurers and beneficiaries.
- Code TPL information correctly on claims.

THIRD-PARTY LIABILITY SUPPLEMENT

TPL RESOURCES

The PSC is your first source for questions about third-party liability. Listed below are some other resources.

Dental Claims: Provider questions about third party liability should be directed to the DentaQuest Call Center at 1-888-307-6553 or via e-mail at denclaims@dentaquest.com.

SCDHHS Web site: http://www.scdhhs.gov

- Carrier codes
- Provider manuals
- Edit codes and resolutions

Provider Enrollment and Education Web site: http://MedicaideLearning.com

- Web Tool User Guide and Addenda

Medicaid Insurance Verification Services

South Carolina Healthy Connections
PO Box 101110
Columbia, SC 29211-9804

Main Number	1-888-289-0709 option 5
Health Insurance Premium Payment Project	(803) 264-6847 (803) 462-2580 Fax
Benefit Recovery	(803) 462-2582 Fax
Casualty and Estate Recovery	(803) 462-2579 Fax
General Correspondence	(803) 462-2583 Fax

South Carolina Department of Insurance

300 Arbor Lake Drive, Suite 1200
PO Box 100105
Columbia, SC 29223
http://www.doi.sc.gov/

SCDHHS Division of Third-Party Liability

(803) 898-2630

SCDHHS Casualty Department

(803) 898-2977

SCDHHS Health Insurance Department

(803) 898-2907

THIRD-PARTY LIABILITY SUPPLEMENT

SCDHHS Estate Recovery Department

South Carolina Healthy Connections
PO Box 100127
Columbia, SC 29202
(803) 898-2932

THIRD-PARTY LIABILITY SUPPLEMENT

SAMPLE FORMS

Form
Health Insurance Information Referral Form: Carrier change
Health Insurance Information Referral Form: Coverage ended
Reasonable Effort Documentation Form: Failure to respond – beneficiary
Reasonable Effort Documentation Form: Failure to respond – insurer
Reasonable Effort Flowchart
Adjustment Form 130: Primary insurer paid after the appeal process
Adjustment Form 130: Primary insurer payment received after Medicaid payment
UB-04: Medicare paid; private insurer denied
CMS-1500: Two private insurers; one paid, one denied
CMS-1500: Medicare and private insurer paid

THIRD-PARTY LIABILITY SUPPLEMENT

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID HEALTH INSURANCE INFORMATION REFERRAL FORM

Provider or Department Name: Acme Dental Clinic Provider ID or NPI: 1234560000

Contact Person: Richard Roe Phone #: 803-555-5555 Date: 03/01/10

I ADD INSURANCE FOR A MEDICAID BENEFICIARY WITH NO INSURANCE IN THE MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) – ALLOW 25 DAYS

Beneficiary Name: Jim Smith Date Referral Completed: 02/29/2010

Medicaid ID#: 2222222222 Policy Number: AZ99999999999

Insurance Company Name: OmniCorp Insurers Group Number: 390-OP-777777

Insured's Name: N/A Insured SSN: 777-77-0000

Employer's Name/Address: Retired

II CHANGES TO AN INSURANCE RECORD THAT IS IN THE MMIS – MIVS SHALL WORK WITHIN 5 DAYS

_____ a. beneficiary has never been covered by the policy – close insurance.

__X__ b. beneficiary coverage ended - terminate coverage (date) 12/31/2009

_____ c. subscriber coverage lapsed - terminate coverage (date) _____

_____ d. subscriber changed plans under employer - new carrier is _____

- new policy number is _____

_____ e. beneficiary to add to insurance already in MMIS for subscriber or other family member.

(name) _____

Sample Only

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 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 Columbia, SC 29202-8206

DHHS 931 – Updated January 2008

THIRD-PARTY LIABILITY SUPPLEMENT

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID HEALTH INSURANCE INFORMATION REFERRAL FORM

Provider or Department Name: Acme Dental Clinic Provider ID or NPI: 1234560000

Contact Person: Richard Roe Phone #: 803-555-5555 Date: 03/01/2010

I ADD INSURANCE FOR A MEDICAID BENEFICIARY WITH NO INSURANCE IN THE MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) – ALLOW 25 DAYS

Beneficiary Name: John Doe Date Referral Completed: 02/28/2010

Medicaid ID#: 9999999999 Policy Number: DH123456

Insurance Company Name: National Dental Insurance Group Number: QWE1234

Insured's Name: Jane Doe Insured SSN: 123-45-6789

Employer's Name/Address: South Carolina State Library, 1500 Senate Street, Columbia, SC 29201

II CHANGES TO AN INSURANCE RECORD THAT IS IN THE MMIS – MIVS SHALL WORK WITHIN 5 DAYS

____ a. beneficiary has never been covered by the policy – close insurance.

____ b. beneficiary coverage ended - terminate coverage (date) _____

____ c. subscriber coverage lapsed - terminate coverage (date) _____

__X__ d. subscriber changed plans under employer - new carrier is GloboChem

- new policy number is A1111111110

____ e. beneficiary to add to insurance already in MMIS for subscriber or other family member.

(name) _____

Sample Only

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 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 Columbia, SC 29202-8206

DHHS 931 – Updated January 2008

THIRD-PARTY LIABILITY SUPPLEMENT

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
REASONABLE EFFORT DOCUMENTATION

PROVIDER Acme Orthopedic **DOS** 01/01/10

NPI or MEDICAID PROVIDER ID 1234567890

MEDICAID BENEFICIARY NAME Jane Doe

MEDICAID BENEFICIARY ID# 1111111111

INSURANCE COMPANY NAME Jones Health Insurance

POLICYHOLDER Jane Doe

POLICY NUMBER 987654321J

ORIGINAL DATE FILED TO INSURANCE COMPANY 01/15/10

DATE OF FOLLOW UP ACTIVITY 02/16/10

RESULT:
Called insurer to check claim status. Insurer needs bene to fill out subrogation forms

Sample Only

FURTHER ACTION TAKEN:

Called beneficiary on 02/16/10, 02/18/10, and 02/28/10. No answer and no answering machine. No other contact info on file w/ Medicaid or insurer.

DATE OF SECOND FOLLOW UP 03/05/10

RESULT:

Sent certified letter offering to help bene fill out forms. Bene refused letter. Called insurer 8/10/08; they will not act without forms.

I HAVE EXHAUSTED ALL OPTIONS FOR OBTAINING A PAYMENT OR SUFFICIENT RESPONSE FROM THE PRIMARY INSURER.

Mary Orthopod 03/12/10

(SIGNATURE AND DATE)

ATTACH A COPY OF FORM TO A NEW CLAIM AND FORWARD TO YOUR MEDICAID CLAIMS PROCESSING POST OFFICE BOX.

Revised 04/2014

THIRD-PARTY LIABILITY SUPPLEMENT

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
REASONABLE EFFORT DOCUMENTATION

PROVIDER Dr. Betty Smith **DOS** 03/05/10

NPI or MEDICAID PROVIDER ID 1231231230

MEDICAID BENEFICIARY NAME John Jones

MEDICAID BENEFICIARY ID# 9999999999

INSURANCE COMPANY NAME Global Health

POLICYHOLDER John Jones

POLICY NUMBER 8888888888

ORIGINAL DATE FILED TO INSURANCE COMPANY 03/07/10

DATE OF FOLLOW UP ACTIVITY 04/06/10

RESULT:
Called insurer. They received claim and have not suspended it. Sent follow-up letter requesting a response on 04/10/10.

Sample Only

FURTHER ACTION TAKEN:

04/27/10: No response from insurer. Called again; they could not find claim. Resubmitted on 04/29/10.

DATE OF SECOND FOLLOW UP 05/30/10

RESULT:

Called insurer; no action on claim. Notified Dept. of Insurance 05/31/10. Case is still open; Dept. of Ins. advised that we file with Medicaid now, as decision may take some time.

I HAVE EXHAUSTED ALL OPTIONS FOR OBTAINING A PAYMENT OR SUFFICIENT RESPONSE FROM THE PRIMARY INSURER.

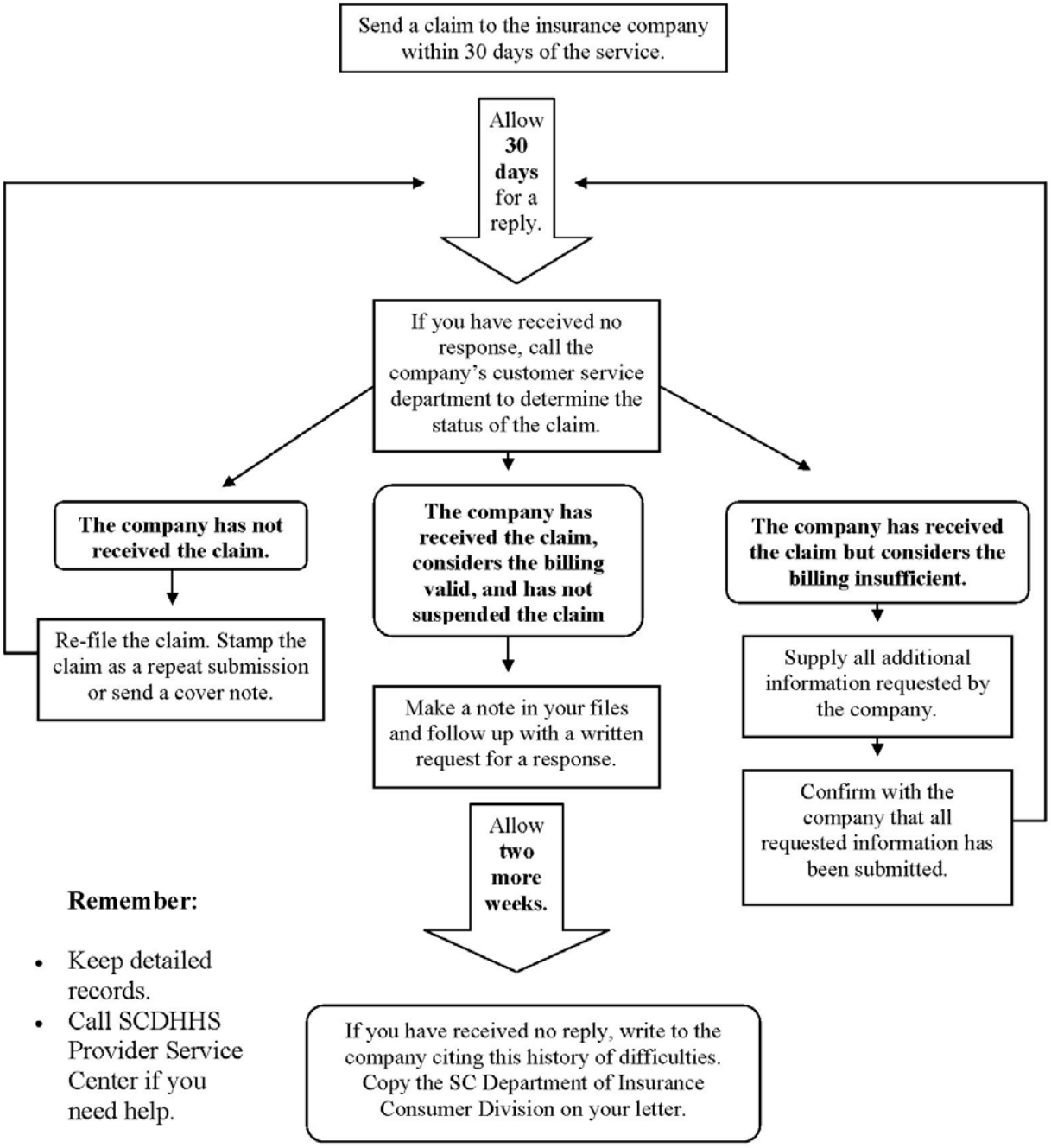
Betty Smith 06/03/10
(SIGNATURE AND DATE)

ATTACH A COPY OF THE FORM TO A NEW CLAIM AND FORWARD TO YOUR MEDICAID CLAIMS PROCESSING POST OFFICE BOX.

Revised 04/2014

THIRD-PARTY LIABILITY SUPPLEMENT

How to Obtain a Response from Insurance Company
A Suggested Third-Party Filing Process



Remember:

- Keep detailed records.
- Call SCDHHS Provider Service Center if you need help.

THIRD-PARTY LIABILITY SUPPLEMENT

South Carolina Department of Health and Human Services - Claim Adjustment Form 130

Provider Name: (Please use black or blue ink when completing form)
Johnson DME Supply

Provider Address :
111 Oak Lane

Provider City , State, Zip:
Anywhere, SC 22222-2222

Total paid amount on the original claim:
$1244.00

Original CCN: 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 A

Provider ID: A B C 1 2 3

NPI: 1 2 3 4 5 6 7 8 9 0

Recipient ID: 2 2 2 2 2 2 2 2 2 2

Adjustment Type:
- ○ Void
- ● Void/Replace

Originator:
- ○ DHHS
- ○ MCCS
- ● Provider
- ○ MIVS

Reason For Adjustment: (Fill One Only)

- ● Insurance payment different than original claim
- ○ Keying errors
- ○ Incorrect recipient billed
- ○ Voluntary provider refund due to health insurance
- ○ Voluntary provider refund due to casualty
- ○ Voluntary provider refund due to Medicare
- ○ Medicaid paid twice - void only
- ○ Incorrect provider paid
- ○ Incorrect dates of service paid
- ○ Provider filing error
- ○ Medicare adjusted the claim
- ○ Other

Sample Only

For Agency Use Only

Analyst ID:

- ○ Hospital/Office Visit included in Surgical Package
- ○ Independent lab should be paid for service
- ○ Assistant surgeon paid as primary surgeon
- ○ Multiple surgery claims submitted for the same DOS
- ○ MMIS claims processing error
- ○ Rate change
- ○ Web Tool error
- ○ Reference File error
- ○ MCCS processing error
- ○ Claim review by Appeals

Comments:
Primary insurer paid after the appeal process.

Signature: Jane Doe

Date: 04/01/10

Phone: (555) 555-5555

DHHS Form 130 Revision date: 03-13-2007

THIRD-PARTY LIABILITY SUPPLEMENT

South Carolina Department of Health and Human Services - Claim Adjustment Form 130

Provider Name: (Please use black or blue ink when completing form)

Dr. Joe Jones

Provider Address :

123 Main Street

Provider City , State, Zip:

Somewhere, SC 22222-0000

Total paid amount on the original claim:

$230

Original CCN: 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 A

Provider ID:

NPI: 9 8 7 6 5 4 3 2 1 0

Recipient ID: 7 7 7 7 7 7 7 7 7 7

Adjustment Type:

- ○ Void
- ● Void/Replace

Originator:

- ○ DHHS
- ○ MCCS
- ● Provider
- ○ MIVS

Reason For Adjustment: (Fill One Only)

- ○ Insurance payment different than original claim
- ○ Keying errors
- ○ Incorrect recipient billed
- ● Voluntary provider refund due to health insurance
- ○ Voluntary provider refund due to casualty
- ○ Voluntary provider refund due to Medicare
- ○ Medicaid paid twice - void only
- ○ Incorrect provider paid
- ○ Incorrect dates of service paid
- ○ Provider filing error
- ○ Medicare adjusted the claim
- ○ Other

Sample Only

For Agency Use Only

Analyst ID:

- ○ Hospital/Office Visit included in Surgical Package
- ○ Independent lab should be paid for service
- ○ Assistant surgeon paid as primary surgeon
- ○ Multiple surgery claims submitted for the same DOS
- ○ MMIS claims processing error
- ○ Rate change
- ○ Web Tool error
- ○ Reference File error
- ○ MCCS processing error
- ○ Claim review by Appeals

Comments:

Primary insurance payment received after Medicaid payment.

Signature: *Mary Smith*

Date: 04/01/10

Phone: (803) 555-5555

DHHS Form 130 Revision date: 03-13-2007

THIRD-PARTY LIABILITY SUPPLEMENT

1 ABC MEDICAL CENTER
111 OAK LANE
ANYWHERE SC 22222-0000

2

3a PAT. CNTL # DOE1234
b. MED. REC. # 654321-654321
4 TYPE OF BILL 111
5 FED. TAX NO. 00-0000000
6 STATEMENT COVERS PERIOD FROM 030910 THROUGH 031010
7

8 PATIENT NAME a
b JANE DOE

9 PATIENT ADDRESS a 222 MAPLE STREET
b COLUMBIA c SC d 22222-2222 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
01011960	F	030910		2	7		01							80	C5					

	31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a	24	033110													
b															

38
MEDICAID
PO BOX 1458
COLUMBIA SC 29202-1458

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	02	00 00				
b						
c						
d						

	42 REV CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	206	ICU/INTERMEDIATE	975.00	031010	5	4875 00		
2	270	MED/SURG SUPPLY		031010	104	1636 23		
3	350	CT SCAN		031010	2	1821 00		
4	450	EMERG ROOM		030910	1	591 00		
22	0001	PAGE 1 OF 1	CREATION DATE	042910	TOTALS	8923 00	0	

Sample Only

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	9876543210
A	618 MEDICARE				6000 00		57 OTHER PRV ID	
B	199 ACME HEALTH				0 00			
C	619 MEDICAID							

	58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A			12345678999		
B			99911111111AZX		
C			1234567890		

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A			
B			
C			

66 DX 288.8 67 A B C D E F G H 68
I J K L M N O P Q

69 ADMIT DX 70 PATIENT REASON DX a b c 71 PPS CODE 72 ECI a b c 73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
4131	031010					
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS

81CC		
a	B3	1212121212
b		
c		
d		

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

THIRD-PARTY LIABILITY SUPPLEMENT

HEALTH INSURANCE CLAIM FORM

One Carrier Paid; One Carrier Denied

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID [X] (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN [X] (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, Jane A

3. PATIENT'S BIRTH DATE MM 01 DD 01 YY 1947 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 123 Windy Lane

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Anytown STATE: SC

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE: 29999 TELEPHONE (Include Area Code): ( )

ZIP CODE TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 012345678

a. OTHER INSURED'S POLICY OR GROUP NUMBER: A111111111122

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC): 10.00

c. RESERVED FOR NUCC USE: 0.00

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: 400

d. INSURANCE PLAN NAME OR PROGRAM NAME: 134

10d. CLAIM CODES (Designated by NUCC): 1

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on File DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. 295.35 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01	31	13	01	31	13	11		99999						20 00	1		ZZ	1212121212
																		NPI	1212121212
2																		NPI	
3																		NPI	
4																		NPI	
5																		NPI	
6																		NPI	

25. FEDERAL TAX I.D. NUMBER: 555555555 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: DOE1234

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE $ 20 00

29. AMOUNT PAID $ 10 00

30. Rsvd for NUCC Use 10 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (555) 5555555

ABC Clinic
111 Main Street
Anytown, SC 22222-2222

a. 1234567890 b. ZZ1212121212

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT-OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

Sample Only

THIRD-PARTY LIABILITY SUPPLEMENT

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

Medicare Paid; Private Carrier Paid

PICA

1. MEDICARE [X] (Medicare#) MEDICAID [X] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [X] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

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3. PATIENT'S BIRTH DATE MM 01 DD 01 YY 1947 SEX M [ ] F [X]

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6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Anytown STATE: SC

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE: 29999 TELEPHONE (Include Area Code): ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 111222333A

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 012345678

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC): 10.00

c. RESERVED FOR NUCC USE: 5.00

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: 620

d. INSURANCE PLAN NAME OR PROGRAM NAME: 400

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on File DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. 295.35 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01	31	13	01	31	13	11		99999						20 00	1		ZZ	1212121212
																		NPI	1212121212
2																		NPI	
3																		NPI	
4																		NPI	
5																		NPI	
6																		NPI	

25. FEDERAL TAX I.D. NUMBER: 555555555 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: DOE1234

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE $ 20 00

29. AMOUNT PAID $ 15 00

30. Rsvd for NUCC Use 5 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (555) 5555555

ABC Clinic
111 Main Street
Anytown, SC 22222-2222

a. 1234567890 b. ZZ1212121212

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Sample Only

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THIRD-PARTY LIABILITY SUPPLEMENT

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