SOUTH CAROLINA
Healthy Connections
MEDICAID

Nikki Haley GOVERNOR
Anthony Keck DIRECTOR
P.O. Box 8206 > Columbia, SC 29202
www.scdhhs.gov

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MEDICAID BULLETIN

ALL

TO: All Providers

SUBJECT: Claim Reconsideration Policy-Fee For Service (FFS) Medicaid

Effective January 1, 2015 the South Carolina Department of Health and Human Services (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. Claim Reconsideration Policy directives will be located in all Provider Manuals in Section 3, Billing Procedures. 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 thirty (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 the Provider Manual Appendices.
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 sixty (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 thirty (30) days from receipt of the decision to file an Appeal in accordance with the Appeal policy in Section 1 of all Provider Manuals.

Submit Claim Reconsiderations to the following fax or mailing address:

Fax:
1-855-563-7086

or

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

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 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.

If you have any questions regarding this process, please contact the Provider Service Center 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.

Thank you for your continued support of the South Carolina Healthy Connections Medicaid program.

/s/
Anthony E. Keck
Director