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MEDICAID BULLETIN

TO: **Providers Indicated**

SUBJECT:
I. Spacers for Metered Dose Inhalers
II. Modification to Prior Authorization (PA) Requirements for Organ Transplants
III. Delivery in Cases of Prolonged Labor

I. Spacers for Metered Dose Inhalers

Effective immediately, the South Carolina Department of Health and Human Services (SCDHHS) is covering spacer devices under the Medicaid Pharmacy Program. A quantity limit of two (2) spacers per fiscal year has been established for this device. Requests for more than two spacers per year will require a Prior Authorization (PA) through the pharmacy contractor. These devices for use with metered dose inhalers may be billed by pharmacy providers through the Point-of-Sale (POS) system.

The SCDHHS will make the following changes effective with dates of service on or after January 1, 2012.

II. Modification to PA Requirements for Organ Transplants

The SCDHHS will remove the PA requirements for the Group I Kidney transplants and the Group II Matched Bone Marrow (Autologous Inpatient and Outpatient, Allogeneic Related and Unrelated, and Cord) transplants. For all other Group II Transplants including: Mismatched Bone Marrow, Pancreas, Heart, Liver, Liver/Small Bowel, Liver/Pancreas, Liver/Kidney, Kidney/Pancreas, Lung, Heart/Lung, Multivisceral , and Small Bowel, the current PA requirements will remain in place.

SCDHHS will only reimburse for transplant services that have been referred to Centers for Medicare and Medicaid Services (CMS) certified transplant centers. This will include certified facilities that are contracted with SCDHHS, as well as certified facilities that are located outside of the South Carolina medical service area. SCDHHS will establish a quarterly post payment review process for Kidney and Matched Bone Marrow transplants to monitor utilization and other policy guidelines. All claims are subject to review by the Agency's Division of Program Integrity.

III. Delivery in Cases of Prolonged Labor

SCDHHS is modifying the delivery policy in cases of prolonged labor when a vaginal delivery with failure to progress converts to a cesarean section. For beneficiaries that have been admitted to the hospital and have been in active labor for at least six hours, the Current Procedural Terminology (CPT) code 59514 and modifier UA should be used when billing for the cesarean delivery. The patient records must indicate the time the patient was admitted to the hospital with active labor and the start time of the cesarean section. All claims and reimbursements are subject to an audit by the Division of Program Integrity. The reimbursement rate for the prolonged labor cesarean delivery will be $1,150.00.

This bulletin affects fee-for-service policy and applies to those beneficiaries enrolled in a Medical Homes Network (MHN) or in the fee-for-service option. For questions concerning the Managed Care Organization (MCO) policy regarding billing, please contact the appropriate MCO. MCOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

For a complete copy of the most current policy, please refer to the Physician, Laboratories, and Other Medical Professionals Provider Manual located on the SCDHHS website at http://www.scdhhs.gov. If you have any questions, please contact your Program Representative in the Office of Physician, Pharmacy, and Enhanced Care Services at (803) 898-2660.

/s/
Anthony E. Keck
Director