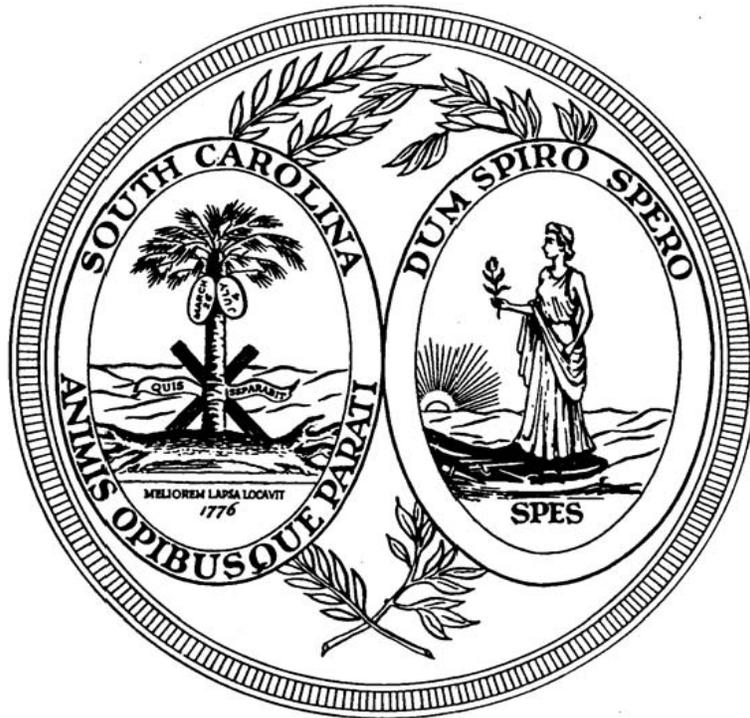




South Carolina
Health & Human Services



SOUTH CAROLINA HEALTHY CONNECTIONS (MEDICAID) PROVIDER MANUAL

PHARMACY SERVICES

February 1, 2005
Updated February 1, 2013

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

January 11, 2005

PHARM 05-02

MEDICAID BULLETIN

TO: Pharmacy Services Providers

SUBJECT: Medicaid Policy Manual for Pharmacy Services Providers

The enclosed revised Department of Pharmacy Services 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.

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

The revised manual is organized 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 Pharmacy Services program.

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

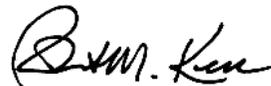
Section 4, **Codes**, provides the **National Council for Prescription Drug Programs (NCPDP) Error Code Listing**.

Section 5, **Administrative Services**, contains general information, contact information for DHHS state and county offices, and examples of all forms referenced throughout the manual.

The **Appendix** provides detailed information regarding the Alternate Reimbursement Methodology (ARM) Program.

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 website. This policy 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 Department of Pharmacy Services staff at (803) 898-2876. Thank you for your continued support of the South Carolina Medicaid program.



Robert M. Kerr
Director

RMK/bgav

Enclosure

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

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FORMS

MANAGED CARE SUPPLEMENT

THIRD-PARTY LIABILITY SUPPLEMENT

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
02-01-13	1	18	Updated URL address for the National Correct Coding Initiative (NCCI)
01-01-13	5	9 12	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	20-21	<ul style="list-style-type: none"> • Updated Electronic Funds Transfer (EFT)
12-01-12	5	5 13	<ul style="list-style-type: none"> • Updated URL for provider information • Updated McCormick county office telephone number
12-01-12	Appendix 1	24, 26, 27, 32, 33 19, 27, 40, 44, 45, 47, 49, 50, 55, 56, 57, 59, 60, 61,	<ul style="list-style-type: none"> • 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
10-01-12	1	4	Replaced back of Healthy Connections Medicaid card

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
08-01-12	1	2, 8, 9, 12, 13, 15, 25, 34	Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012
08-01-12	2	56, 57	Updated program area contact information to reflect Medicaid Bulletin dated June 29
08-01-12	3	20	Updated hyperlink
08-01-12	5	1 5 7	<ul style="list-style-type: none"> • 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	-	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012 • Replaced CARC 141 or CARC A1 for edit codes 52, 053, 517, 600, 924-926, 929, 954, 961, 964, 966, 967, 969, 980, 985-987 • Added edit codes 349, 590, 978, 990, 991-995 • Deleted edit codes 166, 205, 573, 574, 593, 596 • Updated resolution for edit codes 170-172, 171, 174, 210, 321, 711, 798
08-01-12	Managed Care Supplement	1-2 7 11 17 19	<ul style="list-style-type: none"> • Changed Division of Care Management to Bureau of Managed Care • Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012 • Removed language limiting enrollment to 2500 members • Update contact information for Palmetto Physician Connections • Added to “Medicaid” to BlueChoice HealthPlan

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
08-01-12	TPL Supplement	5, 6, 10,17, 24	Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012
04-01-12	1	4	Replaced South Carolina Healthy Connections card
04-01-12	2	24 47	<ul style="list-style-type: none"> • Updated Medicaid Coverage of Tobacco Cessation Products • Updated Copayment
04-01-12	3	3 16	<ul style="list-style-type: none"> • Updated Submission of Claims • Updated Multi-ingredient Compound Claims
04-01-12	5	5 12 13	<ul style="list-style-type: none"> • Updated Universal Claim Form • Updated address for Marion County • Updated phone number for Newberry County
03-01-12	2	40 43 45 50 56	<ul style="list-style-type: none"> • Updated Upper Limits of Payment for Certain Multiple Source Products • Updated Prescription Code Origin • Updated Payment Methodology Information • Updated Medicaid Point-of-Sale Denial Response • Updated Claims Submission for Certain Physician-Injectable Products
03-01-12	3	7 8 10-16 20	<ul style="list-style-type: none"> • Updated Prescription Number • Updated Monthly Prescription Limit Override Procedures • Updated sections starting at Cost Avoidance Claims Processing until Date of Service is More than One Year Old • Added Web-Based Application and Electronic Funds Transfer (EFT)
02-01-12	5	10	Updated the Fairfield county office number
01-01-12	1	2-5, 20, 24	Deleted IVRS Information per “Retirement of Toll Free Eligibility Verification Line” bulletin released 11-18-11
01-01-12	2	7, 64 14 41, 47	<ul style="list-style-type: none"> • Added spacers for metered dose inhalers to DME billables • Updated Prior Authorization section • Added WAC + 0.8% to Upper Limits of Payment

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		52 56 31, 57-59, 61&62	for Certain Multiple Source Products and Payment Methodology Information <ul style="list-style-type: none"> • Updated South Carolina PDPs section to reflect the new annual enrollment period • Updated FPW to reflect current eligible beneficiaries • Deleted IVRS Information per “Retirement of Toll Free Eligibility Verification Line” bulletin released 11-18-11
01-01-12	3	10 12 14 18	<ul style="list-style-type: none"> • Deleted IVRS Information per “Retirement of Toll Free Eligibility Verification Line” bulletin released 11-18-11 • Deleted Medical Home Network under Copayments • Added Risperdal Consta and Invega Sustenna to list of injectable products • Updated hyperlink • Updated EFT information
01-01-12	5	2	Deleted IVRS Information per “Retirement of Toll Free Eligibility Verification Line” bulletin released 11-18-11
01-01-12	Managed Care Supplement	9	Deleted IVRS Information per “Retirement of Toll Free Eligibility Verification Line” bulletin released 11-18-11
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	TPL Supplement	6, 15 12 3, 17, 19	<ul style="list-style-type: none"> • Changed Medicare timely filing requirement to two years and six months • Deleted policy to use Medicaid legacy provider number on the same line as the Medicaid carrier code • Deleted sample legacy number from UB-04 TPL Fields table • Updated TPL contact information

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
09-01-11	1	19	Deleted information regarding National Correct Coding Initiative
09-01-11	5	15	Updated zip code for Spartanburg County office
08-01-11	3	-	Updated language throughout section to reflect the current billing policies including claim processing, claim submission, and copayments
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	48	Deleted "Beneficiaries enrolled in Medical Homes Networks (SC Solutions) are exempt from copayments."
07-01-11	5	15	Deleted PO Box address for the Spartanburg County Office
06-01-11	2	38, 78	Added language to prohibit automatic prescription refills
06-01-11	5	7	Corrected Abbeville County PO Box Zip+4 Code
05-01-11	1	8, 11	Added language prohibiting payment to institutions or entities located outside of the United States
05-01-11	2	3 48	<ul style="list-style-type: none"> • Updated Scope of Coverage to include prohibiting payments to institution or entities located outside of the United States • Updated Copayment exemption to include Federally Recognized Indian Tribe
05-01-11	3	12	Updated Copayment exemption to include Federally Recognized Indian Tribe
04-01-11	2	3 48, 57 55	<ul style="list-style-type: none"> • Corrected the name of the Magellan paper claims unit • Changed outpatient hospital copayment to reflect Medicaid Bulletin dated March 6, 2011 – Copayments • CMS's Contingency Plan for Dual Eligibles, paragraph 2: Removed reference to GAPS or

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		56 57	former SILVERxCARD member <ul style="list-style-type: none"> • Waiver Programs Operated by Division of Community Long Term Care paragraph 1: Removed language exempting CLTC waivers from collection of copayment on Medicaid-covered prescriptions • Family Planning Waiver (FPW), paragraph 4: Added STIs; paragraph 5: Deleted
04-01-11	3	11-12	Changed outpatient hospital copayment to reflect Medicaid Bulletin dated March 6, 2011 – Copayments
04-01-11	5	8	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	17, 18	Updated to reflect Medicaid Bulletin dated February 9, 2011 – Provider Service Center
03-01-11	5	4 7	Updated to reflect Medicaid Bulletin dated February 9, 2011 – Provider Service Center Added toll free number for Aiken County
03-01-11	TPL Supplement	17 24, 25	<ul style="list-style-type: none"> • Changed the name of the Provider Outreach Web site to Provider Enrollment and Education • Updated the descriptions for Form130s
02-01-11	2	33	Changed the prescription limit overrides to three
01-01-11	1	7 19-20	<ul style="list-style-type: none"> • 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	17 18	<ul style="list-style-type: none"> • Updated electronic remittance package information • Updated to reflect Medicaid Bulletin dated December 10, 2010 – Requests for Duplicate Remittance Package

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
01-01-11	5	15	Added toll-free telephone number for Saluda county
01-01-11	Forms	-	Added Duplicate Remittance Request Form
01-01-11	TPL Supplement	8, 10 8 10 13 15 15	<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> ◦ Changed the timely filing requirement from 90 days of the invoice to 30 days ◦ 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	2 Forms	21 -	Added new Proton Pump Inhibitors form
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	3	15	<ul style="list-style-type: none"> • Updated “Patient Paid Amount Submitted” Field (ID-433-DX) section
11-01-10	TPL Supplement	3, 8, 13-14, 18-19 6, 15-17	<ul style="list-style-type: none"> • 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

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
10-01-10	1	- 1 7 10	<ul style="list-style-type: none"> • 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	13	Correct McCormick county office street address
10-01-10	Managed Care Supplement	- 1 2 3 4 5 6 13 17	<ul style="list-style-type: none"> • 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	5	7 11 13	<ul style="list-style-type: none"> • 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	TPL Supplement	12 13 18	<ul style="list-style-type: none"> • 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

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
			DentaQuest contact information for TPL questions
08-01-10	Change Control Record	1	Removed July 1 entries for Appendix 1 and Appendix 2
08-01-10	2	23 52	<ul style="list-style-type: none"> • Updated to reflect Medicaid Bulletin dated July 19, 2010 — Prescription Limit • Removed Gap Assistance Pharmacy Program for Seniors (GAPS) section
08-01-10	3	3	Corrected header
08-01-10	5	7, 11, 13-15 8	<ul style="list-style-type: none"> • 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
07-01-10	2	3 3, 4, 5, 9, 11, 14, 17-19, 22-24, 31, 32, 35-38, 45, 47, 54, 59, 60, 63, 64, 71, 75 33	<ul style="list-style-type: none"> • Changed First Health Services Corporation to Magellan Medicaid Administration, Inc. • Changed First Health to Magellan Medicaid Administration • Updated Monthly Prescription Limit Override Criteria for Adult Beneficiaries section
07-01-10	3	1, 3, 6-11, 13-15 7	<ul style="list-style-type: none"> • Replaced all references to First Health Services with Magellan Medicaid Administration • Added the 340B Providers section under the Special Billing Issues/Instructions section
07-01-10	4	1	Replaced reference to First Health Services with Magellan Medicaid Administration
07-01-10	5	-	Updated telephone numbers and zip codes for multiple county offices

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
07-01-10	Forms	-	Updated the following forms to changed First health to Magellan Medicaid Administration: <ul style="list-style-type: none"> • MedWatch • Prior Authorization Request • Growth Hormone – Adult Treatment • Growth Hormone – Pediatric Treatment • Prior Authorization Request – Adult Treatment • Prior Authorization Request – Antipsychotics • Prior Authorization Request – Hepatitis B • Prior Authorization Request – Hepatitis C
06-01-10	2	33 53 54 58 44	<ul style="list-style-type: none"> • Updated language in Monthly Prescription Limit Override Criteria for Adult Beneficiaries • Updated verbiage under Medicare Part B Drugs • Deleted duplicate paragraph at bottom of page • Added medications Risperdal Consta and Invega Sustenna for Claims Submissions for Certain Physician-Injectable Products • Added Prescription Origin Code
06-01-10	Managed Care Supplement	1 3 17 20, 23, 25	<ul style="list-style-type: none"> • 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	3	<ul style="list-style-type: none"> • 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 entry dated December 1, 2009

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
03-01-10	2	41 & 69 53-54 54 71 20 21-22	<ul style="list-style-type: none"> • Added effective date of February 17, 2010 pharmacists must use DAW code of 1 (changed from 6) • Added policy and language pertaining to Contract X0001 done through LINET under section CMS'S Contingency Plan for Dual Eligibles • Deleted section Additional Contingency Plan for Dual Eligibles • Replaced MedWatch form • Replaced Prior Authorization Request Form • Replaced South Carolina Growth Hormone Prior Authorization Request Form
03-01-10	3	3 6 6-7 7	<ul style="list-style-type: none"> • Updated Physical Address for FIRST HEALTH Services Corporation • Added effective date of December 9, 2009 for requirement for providers to include prescribers NPI number when submitting claims • Deleted language pertaining to FIRST HEALTH website information under the Prescriber Identification Numbers Section • Changed DAW value from 6 to 1
03-01-10	Forms	-	<ul style="list-style-type: none"> • Replaced MedWatch Form • Replaced Prior Authorization Request Form • Replaced South Carolina Medicaid Growth Hormone Prior Authorization Request Form • Added South Carolina Prior Authorization Request Form - Antipsychotics • Added South Carolina Prior Authorization Request Form – Hepatitis B • Added South Carolina Prior Authorization Request Form – Hepatitis C • Updated hyperlinks
02-01-10	2	51 48	<ul style="list-style-type: none"> • Under CMS's Contingency Plan for Dual Eligibles heading, GAPS members are not included • Updated the Gap Assistance Pharmacy Program for Seniors (GAPS) section
02-01-10	3	9	Under Beneficiary ID Number heading, changed the card name to South Carolina Healthy Connections

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
02-01-10	Appendix 1	13 36	<ul style="list-style-type: none"> • 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	8 13 14	<ul style="list-style-type: none"> • Updated Physical Address for Allendale County Office • Replaced Jasper County DSS with Jasper County DHHS • Replaced Orangeburg County DSS with Orangeburg County DHHS
12-01-09	1	8 25	<ul style="list-style-type: none"> • 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 November 24, 2009
12-01-09	2	5-6 9, 11, 13 45 50 60 70 55 57	<ul style="list-style-type: none"> • Updated the following sections: <ul style="list-style-type: none"> o General Exclusions o Prior Authorization o Copayment o Medicaid and Certain PDP-Excluded Drug Categories o Medicaid Coverage of OTC Pharmaceuticals o Quantity of Medication • Deleted Medically Fragile Children’s Program section • Updated Reimbursement Guidelines for Influenza, Rabies, and Pneumococcal to reflect Medicaid Bulletin dated August 14, 2009
12-01-09	3	19-20	Updated policy to reflect Medicaid Bulletin dated November 13, 2009 – Electronic Remittance Package
12-01-09	5	11	Updated the Dorchester County office street address
10-01-09	1	3-4 4-6	<ul style="list-style-type: none"> • Updated the Medicare/Medicaid Eligibility section to include Qualified Medicare Beneficiaries (QMBs) • Updated SC Medicaid Healthy Connections

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		- 26	<ul style="list-style-type: none"> language throughout section • Updated South Carolina Medicaid Bulletins and Newsletters • Changed heading to Medicare Cost Sharing
10-01-09	5	13 14 15	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Removed all references to CHCcares to reflect Medicaid Bulletin dated August 3, 2009 • Updated Absolute Total Care entries as following: <ul style="list-style-type: none"> ○ Changed the company's name to Absolute Total Care ○ Replaced the beneficiary card samples ○ Corrected contact information
08-01-09	2	31	Under Quantity of Medication Limits/DOS Optimization Program, changed the maximum one-month supply from 34-day supply to 31-day supply
08-01-09	5	16	Updated telephone number for York County office
07-01-09	5	10, 14 10 11	<ul style="list-style-type: none"> • 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	2	16-19	Corrected formatting
06-01-09	TPL Supplement	19	Updated Department of Insurance Web site address

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
05-01-09	1	1-6, 11 2 3 5 28-33	<ul style="list-style-type: none"> • 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	2	27 28, 45	<ul style="list-style-type: none"> • Replaced reference to Partners for Health Medicaid card with new Healthy Connections card • Updated to reflect managed care policies and procedures effective May 1, 2009
05-01-09	5	16	Updated telephone number for Union County office
05-01-09	Managed Care Supplement	-	Updated supplement to include general policies and procedures effective May 1, 2009
04-01-09	1	2, 3, 8	Updated hyperlinks
04-01-09	3	11, 15, 19	Updated hyperlinks
04-01-09	5	13	Updated telephone number for Lexington County office
03-01-09	2	3, 8, 12, 31-35, 49- 53, 61 6 52	<ul style="list-style-type: none"> • Updated hyperlinks • Added general exclusion 13 (cough/cold medications) • Deleted cough and cold products from the Medicaid and Certain PDP-Excluded Drug Categories
03-01-09	3	5	Changed 34-days' supply to 31-days'

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
03-01-09	5	1 3, 5 11 11, 14-15	<ul style="list-style-type: none"> • Changed Partners for Health to Healthy Connections • Update hyperlinks • Corrected Dorchester County's Orangeburg Rd telephone number • Change DSS to DHHS in addresses for Abbeville, McCormick, Newberry, and Saluda counties
03-01-09	Managed Care Supplement	1, 7, 10, 17, 23, 25-30, 35	Updated hyperlinks
03-01-09	TPL Supplement	8, 9, 19	Updated hyperlinks
02-01-09	2	50-51	Updated GAPS information and deleted the PDPs participating in GAPS Chart
02-01-09	5	8	Updated Allendale County office PO Box zip code
02-01-09	Forms	-	Updated Authorization Agreement for Electronic Funds Transfer (EFT) form
01-01-09	1	8	Updated hyperlink for bulletin.scdhhs.gov
01-01-09	5	13	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	21	Added EFT information to reflect Medicaid Bulletin dated August 26, 2008
10-01-08	5	11, 15	<ul style="list-style-type: none"> • Updated address for Lake City • Updated address for Sumter County office
09-01-08	5	9	Updated phone number for Berkeley County office
09-01-08	5	13	Updated phone number for Kershaw County office
08-01-08	2	56	Updated Family Planning Wavier information

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
08-01-08	3	6 16	<ul style="list-style-type: none"> • Updated Prescriber Identification Number with NPI info • Added paragraph for Claims Submission for FPW Beneficiaries
08-01-08	5	9	Deleted PO Box for Chester County
08-01-08	Appendix 1	3	Updated Edit Code 062
07-01-08	5	15	Deleted PO Box for Lancaster County
07-01-08	Managed Care Supplement	27	Replaced Web site address for BlueChoice
06-01-08	5	12	Updated telephone number for Orangeburg county office
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
04-01-08	TPL Supplement	2 3, 8, 15 12 29	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	Forms	-	Replaced Form 931 with new version dated January 2008

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
03-01-08	TPL Supplement	9 21-22	<ul style="list-style-type: none"> • Added information on carrier code “CAS” for open casualty cases • Replaced Form 931 samples with new versions
02-01-08	2	19 49-51 50-51	<ul style="list-style-type: none"> • Updated policy on Medicaid Coverage of Tobacco Cessation Products • Removed references to SILVERxCARD • Updated GAPS information for 2008
02-01-08	3	9	Updated NPI policy
01-01-08	5	13	Updated address for Lancaster County office
01-01-08	Managed Care Supplement	1 3	<ul style="list-style-type: none"> • Removed PhyTrust from the list of MHNs • Added Carolina Crescent to the list of MCOs
11-01-07	5	11, 12 12	<ul style="list-style-type: none"> • Updated telephone numbers for Florence and Kershaw counties • Updated Horry County address to 1601 11th Ave., 1st Floor
10-01-07	1	1-2 3 4 12 15 25	<ul style="list-style-type: none"> • 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	2	38-39, 71 68	<ul style="list-style-type: none"> • Added information about tamper-resistant prescription pads to reflect Medicaid Bulletin dated August 30, 2007. • Updated record retention information
10-01-07	-	-	Added Managed Care Supplement
10-01-07	TPL Supplement	15-17	<ul style="list-style-type: none"> • 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

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
07-01-07	1	All	Revised policies and procedures throughout section
06-01-07	4	2 - 4	Updated NCPDP error code definitions
06-01-07	TPL Supplement	All	<ul style="list-style-type: none"> • Updated all sample forms and claims with new versions • Updated form completion instructions to match new form versions
06-01-07	2 & 3	-	<ul style="list-style-type: none"> • Updated policies governing provider numbers to include National Provider Identifier • Changed references to location of forms from “Section 5” to “Forms section”
06-01-07	Forms	-	Updated DHHS forms to add National Provider Identifier field.
06-01-07	5	9, 11 14 -	<ul style="list-style-type: none"> • Added toll-free number for Berkeley, Charleston, and Darlington county offices • Updated phone number for Oconee County • Split forms and exhibits from Section 5 to create separate Forms section
04-01-07	5	10	Updated phone number for Darlington county office
03-01-07	5	8	Updated Barnwell county office address
02-01-07	TPL Supplement	31-32	Updated ECF Samples to show third payer line
10-01-06	5	-	Updated county office addresses
09-01-06	2 & 3	All	Updated policies to reflect Medicaid Bulletins dated November 21, 2005; November 29, 2005; December 15, 2005; March 16, 2006; and June 21, 2006.
09-01-06	4	7	Deleted SILVERxCARD edit
09-01-06	5	-	<ul style="list-style-type: none"> • Updated Web addresses • Updated county office addresses
09-01-06	Appendix 1	All	Deleted Alternate Reimbursement Methodology (ARM) Program Appendix

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
08-01-06	-	-	Added TPL Supplement
01-01-06	1	4 & 5	Removed SILVERxCARD sample and program description
11-01-05	1	6, 7	Removed “HIPAA” from names of S.C. Medicaid Provider Outreach and S.C. Medicaid EDI Support Center
10-10-05	2 & 3	3-70 (Sec. 2); 5-7 (Sec. 3)	Updated policies to reflect bulletins dated April 15, June 3, July 11, and July 20, 2005, and ongoing implementation of PDL. Revised policy topics include multi-ingredient compounds, partial fill prescriptions, voluntary PDL for mental health drugs, H2RAs, OxyContin, NSAIDs, ED drugs, and proper billing procedures. Also added new PA request form for growth hormone.
10-10-05	5	20 3-5 7-15	<ul style="list-style-type: none"> • Added new PA request form for growth hormone. • Updated links • Updated list of DHHS county offices
10-01-05	5	7-15	Updated list of DHHS county offices
10-01-05	Appendix	-	Removed the Change Control Record from the appendix to a separate file

SECTION 1

GENERAL INFORMATION AND ADMINISTRATION

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SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

PROGRAM DESCRIPTION

The Medicaid program, as established by Title XIX of the Social Security Act, as amended, provides quality health care to low income, disabled, and elderly individuals by utilizing state and federal funds to reimburse providers for approved medical services. This care includes the diagnosis, treatment, and management of illnesses and disabilities.

The South Carolina Department of Health and Human Services (SCDHHS) is the single state agency designated to administer the South Carolina Medicaid program in compliance with state and federal laws and regulations and the South Carolina State Plan.

SCDHHS offers two Medicaid Managed Care Programs:

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

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

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION**SOUTH CAROLINA MEDICAID PROGRAM****PROGRAM DESCRIPTION
(CONT'D.)**

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

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

**ELIGIBILITY
DETERMINATION**

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

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

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

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

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION**SOUTH CAROLINA MEDICAID PROGRAM****ELIGIBILITY
DETERMINATION
(CONT'D.)**

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

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

**ENROLLMENT
COUNSELING SERVICES**

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

**MEDICARE / MEDICAID
ELIGIBILITY**

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

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

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

MEDICARE / MEDICAID ELIGIBILITY (CONT'D.)

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

SOUTH CAROLINA HEALTHY CONNECTIONS MEDICAID CARD

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

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



The back of the Healthy Connections Medicaid card includes:

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

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

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

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

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

Beneficiaries who choose to enroll with a Medicaid Managed Care Organization (MCO) will also be issued an identification card by the MCO. This MCO-issued card contains phone numbers for member services and provider billing issues specific to the managed care plan. Please see the Managed Care Supplement for samples of cards from the various managed care plans.

**SC HEALTHY
CONNECTIONS HEALTH
OPPORTUNITY ACCOUNT**

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

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



SECTION 1 GENERAL INFORMATION AND ADMINISTRATION**SOUTH CAROLINA MEDICAID PROGRAM****SC HEALTHY
CONNECTIONS HEALTH
OPPORTUNITY ACCOUNT
(CONT'D.)**

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

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

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

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

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

To learn more about this tool and how to access it, visit the SC Medicaid e-Learning Web site at: <http://Medicaid eLearning.com> or contact the SC Medicaid EDI Support Center via the SCDHHS Provider Service Center at 1-888-289-0709. A list of training opportunities is also located on the Web site. For Web Tool training dates, click on "Training Options."

**SOUTH CAROLINA
MEDICAID BULLETINS AND
NEWSLETTERS**

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

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION**SOUTH CAROLINA MEDICAID PROGRAM****PROVIDER
ENROLLMENT****PROVIDER PARTICIPATION**

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

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

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

PROVIDER PARTICIPATION (CONT'D.)

regulations currently in effect as well as all policies, procedures, and standards required by the Medicaid program.

- Medicaid will not provide any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside the United States

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

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

A provider must immediately report any change in enrollment or contractual information (*e.g.*, mailing or payment address, physical location, telephone number, specialty information, change in group affiliation, ownership, etc.) to SCDHHS Provider Service Center within 30 days of the change. Failure to report this change of information promptly could result in delay of payment and/or termination of enrollment. Mailing information is located in the Correspondence and Inquiries section.

Extent of Provider Participation

Providers have the right to limit the number of Medicaid patients they are willing to treat within their practice; however, providers may not discriminate in selecting the Medicaid beneficiaries they will treat or services they will render. A provider may not refuse to furnish services covered under Medicaid to an eligible individual because of a third party's potential liability for the service(s). A provider who is not a part of a Managed Care

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION**SOUTH CAROLINA MEDICAID PROGRAM****Extent of Provider
Participation (Cont'd.)**

Organization's network may refuse service to a Medicaid MCO member.

A provider and a beneficiary (or the beneficiary's guardian or representative) should determine before treatment is rendered whether the provider is willing to accept the beneficiary as a Medicaid patient. In an emergency, or if a provider cannot determine that a patient is Medicaid-eligible at the time service is rendered, the provider should meet with the beneficiary (or the beneficiary's legal guardian or representative) at the earliest possible date to determine whether the provider is willing to accept the beneficiary as a Medicaid patient for the previously rendered service. To avoid disputes or misunderstandings, providers are encouraged to document the details of their provider-patient agreement in the patient's record.

In furnishing care to beneficiaries who are participating in a Medicaid managed care option, all providers are required to comply with the benefit requirements specified by the applicable managed care program with respect to issues such as the extent of approvals for referrals, etc. Specific questions may be addressed directly to the managed care provider or the Bureau of Managed Care at (803) 898-4614.

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

Non-Discrimination

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

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION**SOUTH CAROLINA MEDICAID PROGRAM****Non-Discrimination
(Cont'd.)**

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

Service Delivery*Freedom of Choice*

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

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

Medical Necessity

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS/ DOCUMENTATION REQUIREMENTS

GENERAL INFORMATION

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

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

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

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS / DOCUMENTATION REQUIREMENTS

GENERAL INFORMATION (CONT'D.)

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

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

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

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

DISCLOSURE OF INFORMATION BY PROVIDER

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

Once a Notice of Privacy Practices is acknowledged by the Medicaid beneficiary, or the beneficiary's authorization to release information is obtained, a provider who uses hard-copy claim forms that require the patient's signature is no

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION**RECORDS / DOCUMENTATION REQUIREMENTS****DISCLOSURE OF
INFORMATION BY
PROVIDER (CONT'D.)**

longer required to have each claim form signed by the beneficiary. Providers who file claims electronically are required under their Trading Partner Agreement (TPA) to ensure ready association of electronic claims with an acknowledged Notice of Privacy Practices or a signed statement from the beneficiary consenting to the release of information necessary to process claims.

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

**SAFEGUARDING
BENEFICIARY
INFORMATION**

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

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

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION**RECORDS / DOCUMENTATION REQUIREMENTS****SAFEGUARDING
BENEFICIARY
INFORMATION (CONT'D.)**

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

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

Regarding the release of beneficiary information to billing/collection agencies, the Centers for Medicare and Medicaid Services (CMS) has instructed the states that the requirements for the release of beneficiary information should parallel the limitations on payments. Agents to whom payments could be made are allowed to obtain relevant beneficiary information, since the sharing of that information is for a purpose directly connected with Medicaid administration. However, if no payment could be made to the agent because the agent's compensation is tied to the amount billed or collected, or is dependent upon the collection of the payment, then Medicaid is not allowed to release beneficiary information to that agent.

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

**Confidentiality of Alcohol
and Drug Abuse Case
Records**

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

**SPECIAL / PRIOR
AUTHORIZATION**

Certain medical services must be authorized by SCDHHS (or its designee) prior to delivery in order to be reimbursable by Medicaid. Some of the services that are

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION**RECORDS / DOCUMENTATION REQUIREMENTS****SPECIAL / PRIOR
AUTHORIZATION (CONT'D.)**

specifically subject to prior authorization and approval are as follows:

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

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION
RECORDS / DOCUMENTATION REQUIREMENTS

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SECTION 1 GENERAL INFORMATION AND ADMINISTRATION**REIMBURSEMENT****CHARGE LIMITS**

Providers may not charge Medicaid any more for services to a beneficiary than they would customarily charge the general public. Providers should bill their usual and customary charges and not the Medicaid reimbursement rate. Retroactive adjustments can only be made up to the billed amount. Medicaid will generally pay the lower of the established Medicaid reimbursement rate, determined by the program, or the provider's charges. The Medicaid program will not pay for services or items that are furnished gratuitously without regard to the beneficiary's ability to pay, or where no payment from any other source is expected, such as free x-rays or immunizations provided by health organizations.

**BROKEN, MISSED, OR
CANCELLED
APPOINTMENTS**

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

**NATIONAL CORRECT
CODING INITIATIVE (NCCI)**

The South Carolina Medicaid program utilizes NCCI edits and its related coding policy to control improper coding.

The CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. The purpose of the NCCI edits is to prevent improper payment when incorrect code combinations or units of service are reported exceeding what is normally considered to be medically necessary. NCCI edits identify procedures/services performed by the same provider for the same beneficiary on the same date of service.

NCCI consist of two types of edits:

- 1) NCCI Procedure to Procedure (PTP) edits: These edits define pairs of HCPCS/CPT codes that should not be reported together for a variety of reasons.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

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

These edits consist of a column one code and a column two code. If both codes are reported, the column one code is eligible for payment and the column two code is denied. In some instances an appropriate modifier may be added to one or both codes of an edit pair to make the code combination eligible for payment.

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

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

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

The CMS web page <http://www.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' capitated payment as payment in full for all services

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

MEDICAID AS PAYMENT IN FULL (CONT'D.)

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

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

If the agent's compensation is tied to the amount billed or collected or is dependent upon the

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION**REIMBURSEMENT****REASSIGNMENT OF CLAIMS (CONT'D.)**

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 Healthy Connections Medicaid Insurance card with a Point of Sale (POS) device or by using the South Carolina Medicaid Web-based Claims Submission Tool. Third-party resources include but are not limited to health benefits under commercial health insurance plans, indemnity contracts, school insurance, Workers' Compensation, and other casualty plans that may provide health insurance benefits under automobile or homeowner's coverages.

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

Health Insurance

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

Should the third-party carrier deny payment or reduce payment to less than the Medicaid approved amount, the provider may then submit the claim to Medicaid. The claim filed to Medicaid must be properly completed with all applicable third-party information entered in the appropriate fields (see Section 3 or other appropriate materials for billing instructions). Under the federally mandated Cost Avoidance program, 42 CFR §433.139,

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION**REIMBURSEMENT****Health Insurance**

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

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

Premium Payment Project

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

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

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

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

Casualty Insurance

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

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

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

Provider Responsibilities – TPL

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

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION**REIMBURSEMENT****Provider Responsibilities –
TPL (Cont'd.)**

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

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

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

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

TIME LIMIT FOR SUBMITTING CLAIMS

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

Medicare Cost Sharing Claims

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

Retroactive Eligibility

Effective December 1, 2009, claims and related ECFs involving retroactive eligibility must meet both of the following criteria to be considered for payment:

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

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

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION**REIMBURSEMENT****Retroactive Eligibility
(Cont'd.)**

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

Payment Information

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION
REIMBURSEMENT

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SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID PROGRAM INTEGRITY

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

PROGRAM INTEGRITY

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

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID PROGRAM INTEGRITY

PROGRAM INTEGRITY (CONT'D.)

exception reports that identify excessive or aberrant billing practices.

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

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

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

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION**MEDICAID PROGRAM INTEGRITY****PROGRAM INTEGRITY
(CONT'D.)**

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

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

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

**RECOVERY AUDIT
CONTRACTOR**

The South Carolina Department of Health and Human Services, Division of Program Integrity, has contracted with a Recovery Audit Contractor to assist in identifying and collecting improper payments paid to providers as a result of billing errors as referenced in 42 CFR 476.71. Section 6411(a) of the Affordable Care Act, Expansion of the Recovery Audit Contractor (RAC) Program amends section 1902(a) (42) of the Social Security Act and requires States to establish a RAC program to enable the auditing of claims for services furnished by Medicaid providers. Pursuant to the statute, these Medicaid RACs must: (1) identify overpayments; (2) recoup overpayments; and (3) identify underpayments. The Centers for Medicare & Medicaid Services (CMS) published the final rule implementing this provision, with an effective date of January 1, 2012. States are required to contract with Medicaid RACs “in the same manner as the Secretary enters into contracts” with the Medicare Recovery Auditors. For example, the contingency fee paid to the Medicaid RAC may not exceed that of the highest fee paid to a Medicare Recovery Auditor.

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

- That each Medicaid RAC hires a minimum of 1.0 FTE Contractor Medical Director who is a Doctor of Medicine or Doctor of Osteopathy licensed to practice in that State.
- That each Medicaid RAC also hires certified coders (unless the State determines that certified coders are

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID PROGRAM INTEGRITY

RECOVERY AUDIT CONTRACTOR (CONT'D.)

not required for the effective review of Medicaid claims)

- An education and outreach program for providers, including notification of audit policies and protocols
- Minimum customer service measures such as a toll-free telephone number for providers and mandatory acceptance of provider submissions of electronic medical records on CD/DVD or via facsimile at the providers' request
- Notifying providers of overpayment findings within 60 calendar days
- A 3 year maximum claims look-back period and
- A State-established limit on the number and frequency of medical records requested by a RAC.

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

BENEFICIARY EXPLANATION OF MEDICAL BENEFITS PROGRAM

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

BENEFICIARY OVERSIGHT

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION**MEDICAID PROGRAM INTEGRITY****BENEFICIARY OVERSIGHT
(CONT'D.)**

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

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

**MEDICAID BENEFICIARY
LOCK-IN PROGRAM**

SCDHHS implemented a Medicaid Beneficiary Lock-In Program in December 2008. The purpose of the Beneficiary Lock-In Program is to address issues such as coordination of care, patient safety, quality of care, improper or excessive utilization of benefits, and potential fraud and abuse associated with the use of multiple pharmacies and prescribers. The policy implements SC Code of Regulations R 126-425. The Division of Program Integrity reviews beneficiary profiles in order to identify patterns of inappropriate, excessive, or duplicative use of pharmacy services, such as using four or more pharmacies in a six-month period. If beneficiaries meet the lock-in criteria established by SCDHHS, they will be placed in the Medicaid Lock-In Program for one year to monitor their drug utilization and to require them to utilize one designated pharmacy. The beneficiary has the opportunity to select a pharmacy and has the right to appeal. The pharmacy provider selected is also notified of the lock-in, so that adequate time is allowed for selection of another provider should the first provider find he or she cannot provide the needed services.

DIVISION OF AUDITS

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

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION**MEDICAID PROGRAM INTEGRITY****DIVISION OF AUDITS
(CONT'D.)**

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

Audits to confirm the accuracy and allowability of costs and other financial information reported to SCDHHS

**PAYMENT ERROR RATE
MEASUREMENT**

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION**MEDICAID ANTI-
FRAUD PROVISIONS /
PAYMENT
SUSPENSION /
PROVIDER
EXCLUSIONS /
TERMINATIONS****FRAUD**

The South Carolina Medicaid program operates under the anti-fraud provisions of 42 US Code §1320a-7b. This federal law relates to both fraud and abuse of the program and identifies illegal acts, penalties for violations, and the individuals and/or entities liable under this section.

The Division of Program Integrity carries out SCDHHS responsibilities concerning suspected Medicaid fraud as required by 42 CFR Part 455, Subpart A. Program Integrity must conduct a preliminary investigation and cooperate with the state and federal authorities in the referral, investigation, and prosecution of suspected fraud in the Medicaid program. SCDHHS refers suspected cases of Medicaid fraud by health care providers to the Medicaid Fraud Control Unit of the State Attorney General's Office for investigation and possible prosecution. SCDHHS also makes referrals to the Bureau of Drug Control for suspected misuse or overprescribing of prescription drugs, especially controlled substances. If a provider suspected of fraud or abuse is also enrolled in a Medicaid Managed Care Organization (MCO), Program Integrity will coordinate the investigation with the MCO(s) involved. Suspected Medicaid fraud on the part of a beneficiary is referred to a Medicaid Recipient Fraud Unit in the State Attorney General's Office for investigation.

PAYMENT SUSPENSION

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

**Suspension of Provider
Payments for Credible
Allegation of Fraud**

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

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

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

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

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

Notice of Suspension

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

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

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

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

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

Referrals to the Medicaid Fraud Control Unit

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION**MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER EXCLUSIONS / TERMINATIONS****Good Cause not to Suspend Payments or to Suspend Only in Part**

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

- Law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation;
- Other available remedies implemented by SCDHHS will more effectively or quickly protect Medicaid funds;
- SCDHHS determines, based upon the submission of written evidence by the individual or entity that is the subject of the payment suspension, that the suspension should be removed;
- SCDHHS determines that beneficiary access to items or services would be jeopardized by a payment suspension for either of the following reasons:
 - An individual or entity is the sole community physician or the sole source of essential specialized services in a community;
 - The individual or entity serves a large number of beneficiary's within a medically underserved area, as designated by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.
- Law enforcement declines to certify that a matter continues to be under investigation;
- SCDHHS determines that payment suspension is not in the best interests of the Medicaid program.

SCDHHS may also find that good cause exists to suspend payments in part, or to convert a payment suspension previously imposed in whole to one only in part, on any individual or entity regarding a credible allegation of fraud, if any of the following are applicable:

- SCDHHS determines that beneficiary access to items or services would be jeopardized by a payment suspension for either of the following reasons:

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

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

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

- o An individual or entity is the sole community physician or the sole source of essential specialized services in a community;
- o 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:
 - o 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
 - o A payment suspension in part would effectively ensure that potentially fraudulent claims were not continuing to be paid. If this determination is made by SCDHHS, it will be documented in writing.
- Law enforcement declines to certify that a matter continues to be under investigation.
- SCDHHS determines that payment suspension is not in the best interest of the Medicaid program.

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

PROVIDER EXCLUSIONS

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION**MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER EXCLUSIONS / TERMINATIONS****PROVIDER EXCLUSIONS
(CONT'D.)**

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

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

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

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

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

The OIG maintains the LEIE (List of Excluded Individuals and Entities), a database accessible to the general public that

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION**MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER EXCLUSIONS / TERMINATIONS****PROVIDER EXCLUSIONS
(CONT'D.)**

provides information about parties excluded from participation in Medicare, Medicaid, and all other Federal health care programs. Visit the OIG Web site at <http://www.oig.hhs.gov/fraud/exclusions.asp> to search and/or download the LEIE.

SCDHHS also maintains its own list of excluded, South Carolina-only Medicaid providers (or those with a South Carolina connection) on our Web site. Visit the Provider Information page at <http://provider.scdhhs.gov> for the most current list of individuals or entities excluded from South Carolina Medicaid.

PROVIDER TERMINATIONS

“Termination” means that the SCDHHS has taken an action to revoke a provider’s Medicaid billing privileges, the provider has exhausted all applicable appeal rights or the timeline for appeal has expired, and there is no expectation on the part of the provider or SCDHHS that the revocation is temporary. Under Federal regulations established by the Affordable Care Act, SCDHHS has established the reasons under which a provider can be terminated from the Medicaid program “for cause”; see SCDHHS PE Policy-03, Terminations.

**ADMINISTRATIVE
SANCTIONS**

State regulations concerning administrative sanctions in the Medicaid program are found in South Carolina Regulations at Chapter 126, Article 4, Subarticle 1. SCDHHS may impose one or more of the following sanctions against a provider who has been determined to have abused the program:

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION**MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER EXCLUSIONS / TERMINATIONS****OTHER FINANCIAL PENALTIES**

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

The United States Department of Health and Human Services (USDHHS), Office of Inspector General (OIG), may also impose civil money penalties and assessments under the provisions of 42 CFR Part 1003

FAIR HEARINGS

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

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

REINSTATEMENT

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

Before a request for re-enrollment in Medicaid will be considered, the provider must have an active, valid license to practice and must not be excluded from Medicaid or Medicare by the federal government (USDHHS OIG). It is the provider's responsibility to satisfy these requirements. If the individual was excluded by the Office of Inspector General (HHS-OIG), then the individual must first apply to HHS-OIG for reinstatement and follow any federal requirements.

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

1. The likelihood that the events that led to exclusion will re-occur.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION**MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER EXCLUSIONS / TERMINATIONS****REINSTATEMENT (CONT'D.)**

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

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

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

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

APPEALS

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

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

In accordance with regulations of SCDHHS, a provider wishing to file an appeal must send a letter requesting a hearing along with a copy of the notice of adverse action or the remittance advice reflecting the denial in question. Letters requesting an appeal hearing should be sent to the following address:

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

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

**MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER
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SECTION 2

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SECTION 2 POLICIES AND PROCEDURES

PROGRAM DESCRIPTION

PHARMACY PRACTICE REQUIREMENTS

The DHHS requires that providers of pharmacy services to South Carolina Medicaid beneficiaries adhere to all state and federal requirements regarding the practice of pharmacy. Additionally, South Carolina Medicaid-enrolled pharmacies located outside of the state of South Carolina must adhere to all federal and state requirements specific to the state in which the pharmacy is located.

PHARMACY

“Pharmacy” means a location for which a pharmacy permit is required from its respective Board of Pharmacy and in which prescription drugs and devices are maintained, compounded, and dispensed for patients by a pharmacist. This definition includes a location where a pharmacist provides pharmacy-related services. All such pharmacies are eligible to apply for participation in the South Carolina Medicaid program. (See Section 1 regarding enrollment procedures.) South Carolina Board of Pharmacy-permitted non-dispensing drug outlets are **INELIGIBLE** for Medicaid participation.

Out-of-state pharmacies *must* be enrolled with the South Carolina Medicaid program in order to be reimbursed for any prescriptions dispensed to South Carolina Medicaid beneficiaries. Non-resident pharmacies (*i.e.*, pharmacies located outside of South Carolina) whose primary business is filling mail-order prescriptions must have a special permit issued by the South Carolina Board of Pharmacy in order to engage in the sale, distribution, or dispensing of legend drugs or devices in South Carolina. This special non-resident South Carolina permit is required in order to be eligible for Medicaid participation.

Providers desiring to enroll in the South Carolina Medicaid program must have a licensed pharmacist on the premises and may not subcontract pharmaceutical services that are to be billed to the Medicaid program.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM DESCRIPTION

PHARMACIST

A “pharmacist” is an individual health care provider licensed by the State to engage in the practice of pharmacy.

A pharmacist is a learned professional authorized to provide patient care services within the scope of their knowledge and skills.

“Practice of Pharmacy” means:

- The interpretation, evaluation, and dispensing of prescription drug orders in the patient’s best interest;
- Participation in drug and device selection, drug administration, prospective drug reviews, and drug or drug-related research;
- Provision of patient counseling and the provision of those acts or services necessary to provide pharmacy care and drug therapy management; and responsibility for compounding and labeling of drugs and devices (except labeling by a manufacturer, re-packager, or distributor of non-prescription drugs and commercially packaged legend drugs and devices);

Proper and safe storage of drugs and devices and maintenance of proper records for them; or the offering or performing of those acts, services, operations or transactions necessary in the conduct, operation, education, management, and control of pharmacy.

SCOPE OF COVERAGE

The basic objective of the Medicaid Pharmacy Services program is to provide needed pharmaceuticals for the purpose of saving lives in an emergency or a short-term illness, for sustaining life in chronic or long-term illness, or for limiting the need for hospitalization. This manual outlines additional requirements and restrictions set forth by the DHHS in its standards for providing services to Medicaid beneficiaries.

Pharmacy services include the dispensing of most *generic* legend (*i.e.*, products that require a prescription in order to be dispensed) and most *generic* non-legend pharmaceuticals to eligible beneficiaries. (See the *Medicaid Coverage of Generic Products* in this section.)

SECTION 2 POLICIES AND PROCEDURES

PROGRAM DESCRIPTION

SCOPE OF COVERAGE (CONT'D.)

Only **rebated** pharmaceuticals that are Food and Drug Administration (FDA) approved may be considered for reimbursement.

(See the *Omnibus Budget Reconciliation Act of 1990-Rebate Requirements* in this section.) For each pharmaceutical dispensed, a valid prescription authorized by a licensed practitioner (physician, dentist, optometrist, podiatrist, or other health care provider authorized by law to diagnose and prescribe drugs and devices) must be on file.

The SC Medicaid pharmacy benefit will not cover drug samples, pharmaceuticals obtained through Patient Assistance Programs (PAP), or any other free pharmaceuticals. Additionally, 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.

NON-FORMULARY PROGRAM

The DHHS maintains an “open,” or non-formulary, pharmacy services program. With certain specified exceptions, most rebated *generic* legend and *generic* non-legend pharmaceuticals are routinely covered by the Medicaid program (see *Medicaid Coverage of Generic Products* in this section for further clarification). However, some drugs require clinical prior authorization (see *Prior Authorization* in this section) in order to be considered for reimbursement by Medicaid. The National Drug Code (NDC) number listed on the product’s stock container or packaging is used for identification and claims filing.

PHARMACY POINT-OF- SALE (POS) SYSTEM

The South Carolina Medicaid program has contracted with Magellan Medicaid Administration, Inc. to process prescription drug claims using a computerized point-of-sale (POS) system. This system gives participating pharmacies on-line, “real time” access to beneficiary eligibility, drug coverage (to include prior authorization requirements), prescription limitations, pricing and payment information, and prospective drug utilization review (ProDUR). Although not mandatory, providers are strongly encouraged to utilize POS transmission in order to avoid potentially costly rejections of submitted claims. Magellan Medicaid Administration only accepts claims from participating pharmacies which have valid provider contracts and who are enrolled with the South Carolina

SECTION 2 POLICIES AND PROCEDURES

PROGRAM DESCRIPTION

PHARMACY POINT-OF-SALE (POS) SYSTEM (CONT'D.)

Medicaid Pharmacy Services Program. For more information on POS claims submission and to request billing specifications, pharmacy providers should contact Magellan Medicaid Administration's Provider Relations Department at 804-965-7619. (Additional claims submission options and requirements are discussed in detail in the Magellan Medicaid Administration Pharmacy Provider Manual; that manual may be accessed at <http://southcarolina.fhsc.com>.)

OMNIBUS BUDGET RECONCILIATION ACT OF 1990 – REBATE REQUIREMENTS

The Omnibus Budget Reconciliation Act (OBRA) of 1990 requires that pharmaceutical manufacturers have a rebate agreement in effect with the Centers for Medicare and Medicaid Services (CMS) in order for their pharmaceuticals to be reimbursed by the Medicaid program.

The pharmaceuticals of those manufacturers who have NOT entered into such an agreement are non-covered by the Medicaid program. However, *devices or supplies* such as insulin syringes and over-the-counter (OTC) family planning products remain as covered items since this limitation in coverage applies only to *medications* dispensed to Medicaid beneficiaries.

South Carolina Medicaid requires the submission of a product's 11-digit National Drug Code (NDC) number. The first five digits of the NDC number comprise the labeler code; it is this labeler code that identifies the manufacturer of the product. The Medicaid pharmacy claims processing system uses this labeler code to determine if the pharmaceutical is rebated and therefore, potentially, Medicaid-covered. It should be noted that manufacturers that utilize several different labeler codes may *not* have rebate agreements in effect with CMS for *all* of their labeler codes. Therefore, the labeler code is the controlling factor rather than the manufacturer's name.

Manufacturer rebate payments to the State are based on prescription claims payment data identified by NDC number. To assure that the appropriate manufacturer is invoiced for the rebate monies due the State, pharmacy providers are required to submit accurate NDC numbers when filing Medicaid claims to Magellan Medicaid Administration, Inc., the POS contractor for South Carolina Medicaid.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM DESCRIPTION

OMNIBUS BUDGET RECONCILIATION ACT OF 1990 – REBATE REQUIREMENTS (CONT'D.)

The NDC number being submitted to Medicaid for reimbursement must be the actual NDC number on the package or container from which the medication was dispensed.

Submitting inaccurate NDC numbers may result in: DHHS' billing the wrong manufacturer for the rebate, disputes in the amount of rebate due, and postpayment review of the records of the pharmacy provider.

Additionally, failure to correctly reflect the actual NDC number dispensed may negatively impact revenues generated for the State and potentially result in a greater expenditure of state funds. Therefore, it is imperative that pharmacists take care to correctly identify the specific NDC number of the pharmaceutical dispensed. Appropriate updates to computer software programs will facilitate the use of accurate NDC numbers.

GENERAL EXCLUSIONS

The following is a listing of products *excluded* from South Carolina Medicaid coverage. These items are considered non-covered, regardless of circumstance.

1. Weight control products (except for lipase inhibitors)
2. Investigational pharmaceuticals or products
3. Immunizing agents (except for influenza, pneumococcal, and hepatitis-B vaccines). See Magellan Medicaid Administration Pharmacy Provider Manual for additional information regarding specific coverage guidelines, particularly as related to hepatitis-B vaccine
4. Pharmaceuticals determined by the Federal Drug Administration (FDA) to be less than effective and identical, related, or similar drugs (frequently referred to as "DESI" drugs)
5. Except for omalizumab (*e.g.*, Xolair®), leuprolide acetate (*e.g.*, Lupron®, Eligard®, and Viadur®), palivizumab (*e.g.*, Synagis®), and Rh₀(D) immune globulin (*e.g.*, RhoGAM®), Risperdal Consta, and Invega-Sustenna, injectable pharmaceuticals administered by the practitioner in the office, in an outpatient clinic or infusion center, or in a mental health center are not covered.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM DESCRIPTION

GENERAL EXCLUSIONS (CONT'D.)

Note: Medicaid reimbursement for Cerezyme® (imiglucerase) or Respigam® is limited solely to physician providers, hospital providers, and infusion centers through their respective Medicaid program area (e.g., Physicians Services, Hospital Services, etc.)

RhoGAM®, Synagis®, Lupron®, Eligard®, Viadur®, and Xolair® may be billed via point-of-sale by the pharmacy services provider if administered in a physician's office or clinic. Due to safety and product stability issues, the pharmacy provider must deliver these pharmaceuticals *directly* to the physician's office or clinic. Additionally, Risperdal Consta® and Invega-Sustenna may be billed via point-of-sale by the Pharmacy Services provider if administered in a South Carolina Department of Mental Health outpatient clinic. (See *Claims Submission for Certain Physician-Injectable Products* elsewhere in this section for additional information.)

6. Products used as flushes to maintain patency of indwelling peripheral or central venipuncture devices. These products are not covered under Pharmacy Services, but are covered through the DHHS Department of Durable Medical Equipment (DME).
7. Fertility products
8. Pharmaceuticals that are not rebated
9. Nutritional supplements (Enteral nutrition therapy administered through a feeding tube and Total Parenteral Nutritional [TPN] therapy may be covered through the DHHS Department of Durable Medical Equipment; however, neither program reimburses for oral nutritional supplements.)
10. Oral hydration therapies for adults
11. Pharmaceuticals used for cosmetic purposes or hair growth

SECTION 2 POLICIES AND PROCEDURES

PROGRAM DESCRIPTION

GENERAL EXCLUSIONS (CONT'D.)

12. Anti-hemophilia factor

Note: *Fee-for-service* reimbursement for anti-hemophilia factor is limited to the South Carolina Department of Health and Environmental Control's CSHCN (formerly CRS) Pharmacy; that state agency administers the SC Hemophilia program. For *beneficiaries enrolled in a Medicaid MCO*, the MCO is responsible for the provision and reimbursement of anti-hemophilia factor.

13. Cough/Cold medications

14. Devices and supplies (*e.g.*, diabetic supplies such as lancets, infusion supplies, etc.). These items may be billed through the DHHS Department of DME. However, certain glucometers, test strips and spacers for metered dose inhalers may also be billed through the Pharmacy POS system by an enrolled DME provider.

15. Erectile dysfunction (ED) products prescribed to treat impotence

SECTION 2 POLICIES AND PROCEDURES

PROGRAM DESCRIPTION

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SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

PROGRAM REQUIREMENTS

PRIOR AUTHORIZATION

Pharmaceuticals requiring prior authorization (PA) are outlined below. South Carolina Medicaid's PA program, administered by Magellan Medicaid Administration, is comprised of a clinical PA process as well as a non-clinical PA process. Regarding *clinical* PA requests, the *prescriber* or the prescriber's designated office personnel must contact Magellan Medicaid Administration's Clinical Call Center (866-247-1181 toll-free) in order to furnish necessary patient-specific medical information. (Although faxed requests from prescribers are permissible [see *Request for Prior Authorization* form in this section], *telephoned PA requests may be processed more expeditiously* since all needed information can be supplied at the time of the telephone call.) Magellan Medicaid Administration employs a clinical staff of pharmacists and pharmacy technicians whose primary responsibilities include responding to prescribers' prior authorization requests. Based on established criteria, Magellan Medicaid Administration makes the determination regarding coverage of the product prescribed for the beneficiary. The Magellan Medicaid Administration Clinical Call Center telephone number is reserved for use by health care professionals and should not be furnished directly to beneficiaries. Magellan Medicaid Administration's *beneficiary call center* telephone number for questions regarding Pharmacy Services-related issues is 800-834-2680; providers may furnish the beneficiary call center telephone number to Medicaid beneficiaries *for Pharmacy Services-related issues only*.

Upon verification that usage is appropriate and in compliance with Medicaid policies, *non-clinical PAs generally may be processed at the point of sale by the pharmacist* by utilizing specific claims filing instructions contained in the Magellan Medicaid Administration Pharmacy Provider Manual. (If additional assistance is needed regarding non-clinical PAs, the provider may contact Magellan Medicaid Administration's Technical Call Center, toll-free, at 866-254-1669.)

It should be noted that for certain categories of drugs, the

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

PRIOR AUTHORIZATION (CONT'D.)

need for prior authorization is based on the age and/or gender of the beneficiary or on the quantity to be dispensed.

[Maximum quantity limitations have been established for certain drugs; these established maximum quantities are based upon a 31-days' supply of medication and have been determined using the drug manufacturers' current dosing recommendations. Effective February 1, 2007, DHHS implemented a Dose Optimization program, an enhancement to the current Quantity Limits program. Listings of drugs subject to quantity limitations may be found at <http://southcarolina.fhsc.com>. See *Quantity of Medication* elsewhere in this section for detailed information.] Furthermore, only *rebated* pharmaceuticals may be considered for possible reimbursement through the PA process.

Note: With few specified exceptions, Medicaid does not routinely cover brand name products for which there are therapeutically equivalent generic products available. See *Medicaid Coverage of Generic Products* elsewhere in this section for further information.

The drugs (or categories of drugs) outlined below require prior authorization. Those products requiring *clinical* prior authorization by the prescriber are designated as such.

1. **Non-preferred drugs:** A Preferred Drug List (PDL) has been implemented by South Carolina Medicaid. Therapeutic classes included in the PDL may also be subject to PA requirements outlined elsewhere in this section. A listing of drugs included in the PDL may be found at <http://southcarolina.fhsc.com>.

Prescribers are strongly encouraged to write prescriptions for "preferred" products. However, if a prescriber deems that the patient's clinical status necessitates therapy with a PA-required drug, the prescriber (or his/her designated office personnel) is responsible for initiating the prior authorization request.

A prospective, approved PA request will prevent rejection of prescription claims at the pharmacy due to the PA requirement.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

PRIOR AUTHORIZATION (CONT'D.)

2. The following **home or self-administered** injectable products (see *Important Note* which follows):
 - Certain specified immunizing agents (*i.e.*, influenza, pneumococcal, and hepatitis-B vaccines; coverage guidelines are outlined in the Magellan Medicaid Administration Pharmacy Provider Manual; also, see *Special Coverage Groups/Issues* information elsewhere in this section).
 - Growth hormone products such as Serostim®, Nutropin®, Norditropin®, Humatrope®, and Genotropin® (the prescriber should contact Magellan Medicaid Administration's Clinical Call Center at 866-247-1181 or complete the *South Carolina Medicaid Growth Hormone Prior Authorization Request* form found elsewhere in this section).

Certain (rebated) injectable products, which are packaged and usually prescribed for home administration, are *routinely covered* by Medicaid. Therefore, those specified home-administered pharmaceuticals are not subject to prior authorization nor do they require any special billing procedures. Routinely covered injectable products are: insulin; diabetic and epinephrine emergency kits; Imitrex®; and Betaseron®, Avonex®, and Copaxone®.

Important Note:

Unless otherwise specified, injectables administered in a physician's office, emergency room, infusion center, or other clinical setting shall not be billed by pharmacy providers to the Medicaid Pharmacy Services program since such products are NOT reimbursable by Pharmacy Services.

In order for an injectable product to be considered for reimbursement by Pharmacy Services, the drug must be rebated and administered in the patient's home (to include long-term care facility settings, boarding homes, etc.). Pharmacy providers may bill for only those injectable products for which the

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

PRIOR AUTHORIZATION (CONT'D.)

pharmacist has verified that the injectable will be self- or home-administered.

Therefore, the submission of a Medicaid pharmacy claim for an injectable product signifies that the pharmacist has verified the Medicaid beneficiary's self- or home-administration of that product. Postpayment-payment reviews will be performed to ensure adherence to this billing policy.

Staff in the facility, infusion center, or office where the injectable drug is to be administered should contact their respective Medicaid program area (*i.e.*, Physicians Services, Hospital Services, etc.) to obtain Medicaid coverage, billing, and reimbursement information. See also *General Exclusions* portion of this section regarding non-covered injectable medications.

Exceptions: RhoGAM®, Synagis®, Lupron®, Eligard®, Viadur®, and Xolair® may be billed via point-of-sale by the pharmacy services provider if administered in a physician's office or clinic. (It should be noted, however, that Xolair® requires prior authorization. The prescriber must contact Magellan Medicaid Administration's Clinical Call Center at 866-247-1181 to request approval.) Due to safety and product stability issues, the pharmacy provider must deliver these pharmaceuticals *directly* to the physician's office or clinic. Additionally, Risperdal Consta® and Invega-Sustenna may be billed via point of sale by the Pharmacy Services provider if administered in a South Carolina Department of Mental Health outpatient clinic. (For additional information regarding these exceptions, see the *Special Groups/Issues* portion of this section.)

3. **Medicare Part B-covered pharmaceuticals** (including their respective generics) for *dually eligible* beneficiaries. These products include:
 - Immunosuppressants (*e.g.*, CellCept®, Imuran®, Neoral®, Prograf®, Sandimmune®, Sangcya®, Simulect®, Zenapax®, Gengraf®, Rapamune®, Orthoclone OKT3®, and Atgam®)

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

PRIOR AUTHORIZATION (CONT'D.)

- Chemotherapy agents (oral)
- Anti-emetics (oral)
- Inhalation drugs
- Interferon Beta-1A (Avonex®)

Providers must have a supplier billing number in order to bill *Medicare Part B* for immunosuppressant drugs. The Medicare supplier billing number may be obtained by calling the National Supplier Clearinghouse at 866-238-9652 (toll-free). For those non-ESRD transplant patients whose surgeries were sponsored by Medicare, coverage of immunosuppressants is a lifetime *Medicare Part B* benefit. Those beneficiaries who have received a kidney transplant and had Medicare entitlement solely due to ESRD, and have not become entitled to Medicare due to age or disability, are NOT eligible for lifetime Medicare Part B coverage of immunosuppressants. However, Medicare Part B does sponsor coverage of these drugs for ESRD patients for a 36-month period following the date of discharge from the hospital stay during which the Medicare-covered transplant surgery was performed. Medicare Part B should continue to be billed for reimbursement of immunosuppressants until the provider receives a denial of coverage. Once Medicare Part B denial of coverage for immuno-suppressive drug therapy is confirmed (or if Medicare Part B denies payment because the drug is considered non-covered for the diagnosis indicated), the pharmacist should then submit the claim to the beneficiary's Part D prescription drug plan (PDP).

Regarding oral chemotherapy agents for dually eligible beneficiaries, if the oral chemotherapy drug being prescribed is used to treat cancer, then the provider should bill *Medicare Part B* for reimbursement. If such a drug is NOT being used to treat cancer but rather some other medical condition, the provider should bill *Medicare Part D* for reimbursement.

Medicare Part B is the primary payer if the oral anti-emetic replaces an intravenous anti-emetic and

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

PRIOR AUTHORIZATION (CONT'D.)

the initial oral anti-emetic dose is administered within two hours of chemotherapy administration.

If Medicare Part B reimburses any portion of the Pharmacy Services provider's submitted charge (or if the claim paid amount was applied to the Medicare Part B annual deductible), the pharmacist may request prior authorization (PA) to bill Medicaid secondarily using Magellan Medicaid Administration's point-of-sale system. Pharmacists may request prior authorization by contacting the Magellan Medicaid Administration Clinical Call Center at 866-247-1181 (toll-free). If the amount paid was applied toward the annual deductible, a copy of the Medicare Part B explanation of benefits (EOB) must be faxed to the Magellan Medicaid Administration Clinical Call Center at 888-603-7696 (toll-free). Pharmacists are encouraged to indicate the beneficiary's 10-digit Medicaid identification number on Medicare EOBs furnished to Magellan Medicaid Administration. While subsequent fills for that specific drug therapy will continue to require PA, faxing additional copies of the Medicare EOB will not be necessary each time the prescription is refilled.

Providers should go to: <http://www.palmettogba.com> for complete Medicare Part B policy and billing codes pertaining to covered outpatient pharmaceuticals (including inhalation drugs).

To facilitate claims submission, it may be necessary for the pharmacist to contact the prescriber for additional diagnostic or patient-specific information in order to determine which payer (Part B or Part D) should be billed as primary. (See Section 3 of this manual for billing instructions.)

4. **Sildenafil when prescribed for the treatment of pulmonary arterial hypertension (PAH).** The prescriber must contact Magellan Medicaid Administration's Clinical Call Center at 866-247-1181 to communicate patient-specific clinical information. If coverage is approved, subsequent PA requests will be necessary at certain intervals for that specified therapy and dosage.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

PRIOR AUTHORIZATION (CONT'D.)

5. **Amphetamines** for patients over the age of 21 to treat: Adult Attention Deficit Disorder (AADD) or narcolepsy.

Note: Pharmaceuticals used as anorexiant are excluded from coverage. Amphetamines for FDA-approved indications for patients from birth to the date of their 21st birthday are routinely covered and do not require prior authorization.

6. **Lactulose** solution used: 1) as an adjunct to protein restriction and supportive therapy for the prevention and treatment of portal-systemic encephalopathy (PSE) including hepatic pre-coma and coma or 2) in the treatment of chronic constipation *if trials with conventional laxative therapies have been unsuccessful*.

Note: Lactulose solution is non-covered if prescribed for the initial treatment of chronic constipation in lieu of trials with conventional laxative therapies.

7. **Tretinoin** used for patients over the age of 21 to treat: 1) acne vulgaris, 2) forms of skin cancer or 3) the following dermatologic conditions: lamellar ichthyosis, mollusca contagiosa, verrucae plantaris, verrucae planae juvenilis, ichthyosis vulgaris bullous congenital ichthyosiform and pityriasis rubra pilaris.

Note: Pharmaceuticals used for cosmetic purposes are excluded from coverage; therefore, tretinoin is non-covered when prescribed for photoaged skin or skin conditions related to the normal aging process (*e.g.*, wrinkles, liver spots). Tretinoin used for FDA-approved indications for patients from birth to the date of their 21st birthday is routinely covered and does not require prior authorization.

8. **Lipase inhibitors** (*e.g.*, **Xenical®**) when prescribed for morbid obesity or hypercholesterolemia; in addition to meeting the conditions specified below, the patient must be at least 18 years of age

(The prescriber must contact Magellan Medicaid Administration's Clinical Call Center at 866-247-1181 to request approval).

SECTION 2 POLICIES AND PROCEDURES**PROGRAM REQUIREMENTS****PRIOR AUTHORIZATION
(CONT'D.)****Xenical® (orlistat) for diagnosis of morbid obesity:**

- Patient must have a diagnosis of obesity in the presence of other risk factors (*e.g.*, hypertension, diabetes, dyslipidemia).
- Patient must have an initial body mass index (BMI) ≥ 30 kg/m².
- Patient must be on a reduced fat and calorie diet with nutritional counseling regarding adherence to dietary guidelines.

Xenical® (orlistat) for diagnosis of hypercholesterolemia:

- Patient must have a diagnosis of hypercholesterolemia with treatment failures.
- Patient must have experienced an adverse reaction as a direct result of EACH of the FDA-approved drug classes for treating hypercholesterolemia.

9. Panretin® (alitretinoin)

The prescriber must contact Magellan Medicaid Administration's Clinical Call Center (866-247-1181) to request approval; if approved, coverage may be granted for a period of four months. (There is a limit of one tube of Panretin® gel on the initial prescription.)

10. Targretin® (bexarotene)

The prescriber must contact Magellan Medicaid Administration's Clinical Call Center (866-247-1181) to request approval; if approved, coverage may be granted for a period of four months.

(On the initial prescription, there is a limit of one tube of Targretin® gel OR a one month's supply of oral medication.)

11. Certain anti-ulcer products [*i.e.*, proton pump inhibitors (PPIs) that are not included on the PDL.]

The prescriber must contact Magellan Medicaid Administration's Clinical Call Center (866-247-1181) to communicate patient-specific clinical information. If coverage of the requested product is

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

PRIOR AUTHORIZATION (CONT'D.)

approved, subsequent PA requests will be necessary at certain intervals for that specified therapy and dosage.

12. **Certain anti-arthritis products** (*i.e.*, cyclooxygenase-2 [COX-2] inhibitors)

The anti-arthritis prior authorization program includes:

- COX-2 inhibitors, all strengths and dosages.

Note: Prior authorization is not required for COX-2 inhibitor prescriptions/refills for patients 60 years of age and greater.

The prescriber must contact Magellan Medicaid Administration's Clinical Call Center (866-247-1181) to communicate patient-specific clinical information. If coverage of the requested product is approved, subsequent PA requests will be necessary at certain intervals for that specified therapy; generally, prior authorization approval for anti-arthritis drugs is in effect for up to one year.

Other Prior Authorization Protocols

Regarding pharmaceuticals dispensed to Medicaid beneficiaries enrolled in a hospice program, only those drugs **not** related to the terminal illness may be billed as fee-for-service to the Medicaid program; such drugs must be prior authorized *by the hospice provider* (rather than by Magellan Medicaid Administration) before delivery. Pharmacists must contact the hospice provider to verify that the services being rendered are for a condition not related to the patient's terminal illness.

(Detailed billing instructions may be found in the Magellan Medicaid Administration Pharmacy Provider Manual. See also *Special Coverage Groups/Issues* elsewhere in this section for additional information regarding Medicaid hospice services.)

Regarding dual eligibles enrolled in a Medicare-approved hospice program, Medicare Part A pays for drugs prescribed for symptom control or pain relief. However, Medicare Part A is not permitted to pay for prescriptions intended to treat the beneficiary's terminal illness. The beneficiary's Medicare Part D prescription drug plan covers drugs unrelated to the terminal illness.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Other Prior Authorization Protocols (Cont'd.)

It is important to note that patients may not be billed for any products for which Medicaid reimbursement may be requested through Magellan Medicaid Administration's prior authorization process. Patients may be billed only in those instances where the request for prior authorization has been denied due to clinical criteria not having been met.

Since non-clinical PAs generally may be processed successfully by the pharmacist at the point of sale, it is the pharmacist's responsibility to submit such claims in a timely and accurate fashion. To facilitate the claims submission process (*e.g.*, to verify place of administration for injectable products), the pharmacist may have to contact the prescriber in order to obtain patient-specific diagnostic or related information.

Prescribers may request prior authorization from Magellan Medicaid Administration via telephone, fax (888-603-7696, toll-free), or mail; requests for prior authorization will be responded to within 24 hours of receipt. (For expediency, telephonic requests are preferred.)

The DHHS requires that PA be requested (and subsequent approval entered into Magellan Medicaid Administration's system) prior to the dispensing of the medication; thus, retroactive PAs may be considered only in cases of retroactive Medicaid eligibility determination.

It should be noted that Magellan Medicaid Administration's prior authorization process does not require a "PA number" to be entered on a POS (or paper) claim; the only requirement is that the PA record is activated in Magellan Medicaid Administration's system prior to claim submission. Clinical prior authorization timelines may vary, depending upon category of drug requested and patient-specific diagnostic information.

If the request for prior authorization is denied, Magellan Medicaid Administration's Clinical Call Center staff will notify the originator of the request verbally at the time of telephonic contact or by fax if the request was made via that method.

For clinical prior authorizations in which a Magellan Medicaid Administration pharmacy technician or

SECTION 2 POLICIES AND PROCEDURES**PROGRAM REQUIREMENTS****Other Prior Authorization
Protocols (Cont'd.)**

pharmacist requests additional information from the prescriber, Magellan Medicaid Administration will deny the PA request if the prescriber does not respond to a request for information within three working days. Denial letters are not issued in such instances.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS



SOUTH CAROLINA MEDICAID PROGRAM PRIOR AUTHORIZATION REQUEST

PREScriBER: NAME: _____ <small>(FIRST) (LAST)</small> National Provider ID # _____ PHONE # (____) _____ FAX # (____) _____ PREScriBER'S OFFICE STAFF MEMBER COMPLETING FORM: _____	BENEFICIARY: NAME: _____ <small>(FIRST) (LAST)</small> MEDICAID #: _____ DATE OF BIRTH: ___/___/___ SEX: <input type="checkbox"/> M <input type="checkbox"/> F REQUEST DATE: ___/___/___
--	---

PHARMACY: _____ **PHONE:** (____) _____

PRIOR AUTHORIZATION REQUESTED FOR: (Please check appropriate prior authorization type)

<input type="checkbox"/> Orlistat (please include information regarding height, weight, diet plans, nutritional counseling, etc., with all orlistat requests)	<input type="checkbox"/> Quantity Limits <input type="checkbox"/> PDE5 Inhibitor for Pulmonary Arterial Hypertension Other: _____	NOTE: "Brand Medically Necessary" PA requests require a <i>South Carolina MedWatch form</i> . "Growth Hormone" PA requests require a <i>Growth Hormone request form</i> .
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DRUG NAME	DOSE	STRENGTH	LENGTH OF THERAPY

DIAGNOSIS: _____

DIAGNOSTIC PROCEDURES AND FINDINGS (please list dates): _____

MEDICAL JUSTIFICATION FOR PRODUCT USE: _____

PREScriBER'S SIGNATURE AND SPECIALTY: _____

MAGELLAN MEDICAID ADMINISTRATION USE ONLY:	<input type="checkbox"/> APPROVED	<input type="checkbox"/> DENIED
DATE: ___/___/___	COMMENTS: _____	
MAP RPh/TECH: _____	_____	
NDC: _____	_____	

SUBMIT REQUESTS TO: **MAGELLAN MEDICAID ADMINISTRATION**
 FAX: (888) 603-7696
 All Fax requests will be processed in one business day To check on the status you may call TELEPHONE: (866) 247-1181
WEB REQUESTS: PA's may be requested on-line see the following website for details: <http://southcarolina.fhsc.com/>

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS



SOUTH CAROLINA MEDICAID PROGRAM PRIOR AUTHORIZATION REQUEST – PROTON PUMP INHIBITORS

PRESCRIBER: NAME: _____ <small>(FIRST) (LAST)</small> National Provider ID # _____ PHONE # (____) _____ FAX # (____) _____	BENEFICIARY: NAME: _____ <small>(FIRST) (LAST)</small> MEDICAID #: _____ DATE OF BIRTH: ___/___/___ SEX: <input type="checkbox"/> M <input type="checkbox"/> F REQUEST DATE: ___/___/___
PREScriBER'S OFFICE STAFF MEMBER COMPLETING FORM: _____	

PHARMACY: _____ PHONE: (____) _____

Patient's Diagnosis: _____

Have any recent GI procedures been performed? (Check and complete ALL that apply.)

Procedure:	Date of Procedure:	Findings:
<input type="checkbox"/> Upper GI Series	____/____/____	_____
<input type="checkbox"/> Barium Swallow	____/____/____	_____
<input type="checkbox"/> Endoscopy	____/____/____	_____

Has the Patient had a failure (4 week trial) on an acute dose of an H2 Receptor Antagonist in the past 2 years? Yes No
 If Yes, Medication Name: _____ Strength: _____ Frequency: _____ Date of trial: ___/___/___

Is the Patient H.Pylori positive? Yes No Date: ___/___/___

Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page. _____

SUBMIT REQUESTS TO: MAGELLAN MEDICAID ADMINISTRATION FAX: (888) 603-7696 All Fax requests will be processed in one business day To check on the status you may call TELEPHONE: (866) 247-1181 WEB REQUESTS: PA's may be requested on-line see the following website for details: http://southcarolina.flusc.com/
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SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS



SOUTH CAROLINA MEDICAID PROGRAM

GROWTH HORMONE PRIOR AUTHORIZATION REQUEST – ADULT TREATMENT

PRESCRIBER: NAME: _____ (FIRST) (LAST) Prescriber Specialty: _____ PHONE # (____) _____ FAX # (____) _____ PRESCRIBER'S OFFICE STAFF MEMBER COMPLETING FORM: _____	BENEFICIARY: NAME: _____ (FIRST) (LAST) MEDICAID #: _____ DATE OF BIRTH: ___/___/___ SEX: <input type="checkbox"/> M <input type="checkbox"/> F REQUEST DATE: ___/___/___
---	---

PHARMACY: _____ PHONE: (____) _____

DRUG NAME	STRENGTH	DURATION

If request is for a non-preferred agent, please include clinical criteria for this particular agent over one of the following: Genotropin®, Norditropin®, Saizen®

Dosage Schedule: _____

Diagnosis: _____ ICD-9 CODE: _____

Initiation of Therapy: Yes No

Continuation of Therapy: Yes No

Provocative Stimulation Test and Findings : _____

Is patient receiving full supplementation of deficient pituitary hormones? Yes No
 If yes, please list _____

Does the patient have reduced bone mineral density (BMD) using the WHO criteria? Yes No
 If yes, please provide T-Score: _____

Does the patient have a high risk lipid profile? Yes No
 If yes, please provide total cholesterol or LDL level: _____

Does the patient have at least 2 pituitary hormone deficiencies other than Growth Hormone? Yes No
 If yes, please list: _____

For renewal, is the patient showing improvement? Yes No
 * Increase in BMD per DEXA scan: Yes No
 * Reduction in lipid panel: Yes No
 Document percent reduction: _____

Prescriber's Signature: _____ Date: ___/___/___

SUBMIT REQUESTS TO:	MAGELLAN MEDICAID ADMINISTRATION
FAX: (888) 603-7696	
All Fax requests will be processed in one business day To check on the status you may call TELEPHONE: (866) 247-1181	
WEB REQUESTS: PA's may be requested on-line see the following website for details: http://southcarolina.flhsc.com/	

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS



SOUTH CAROLINA MEDICAID PROGRAM

GROWTH HORMONE PRIOR AUTHORIZATION REQUEST – PEDIATRIC TREATMENT

PRESCRIBER: NAME: _____ (FIRST) (LAST) Prescriber Specialty: _____ <i>(Note: Requesting prescriber must be a nephrologist or pediatric endocrinologist)</i> PHONE # (____) _____ FAX # (____) _____	BENEFICIARY: NAME: _____ (FIRST) (LAST) MEDICAID #: _____ DATE OF BIRTH: ___/___/___ SEX: <input type="checkbox"/> M <input type="checkbox"/> F REQUEST DATE: ___/___/___
PRESCRIBER'S OFFICE STAFF MEMBER COMPLETING FORM: _____	

PHARMACY: _____ **PHONE:** (____) _____

DRUG NAME	STRENGTH	DURATION

If request is for a non-preferred agent, please include clinical criteria for this particular agent over one of the following: Genotropin®, Norditropin®, Saizen®

Dosage Schedule: _____

Diagnosis: _____ **ICD-9 CODE:** _____

Birth Weight: _____ **Gestational Age at Birth:** _____

Last Recorded Height: _____ **Date of Measurement:** _____

Last Recorded Weight: _____ **Date of Measurement:** _____

Biological Mother's Height: _____ **Biological Father's Height:** _____

Therapy: Initiation Continuation

Bone Age Studies Results: _____

Epiphyses: Open Closed

Has Patient been evaluated by Endocrinologist Pediatric Nephrologist

Current Growth Velocity: _____

PLEASE ATTACH COPIES OF GROWTH CHARTS TO THIS REQUEST.

Prescriber's Signature: _____ **Date:** ___/___/___

SUBMIT REQUESTS TO: FAX: (888) 603-7696 All Fax requests will be processed in one business day To check on the status you may call TELEPHONE: (866) 247-1181 WEB REQUESTS: PA's may be requested on-line see the following website for details: http://southcarolina.fhsc.com/	MAGELLAN MEDICAID ADMINISTRATION
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SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

MEDICAID COVERAGE OF TOBACCO CESSATION PRODUCTS

DHHS reimburses for certain pharmaceuticals used to facilitate the discontinuation of tobacco products. A prescription written for a tobacco cessation product specified below is covered within program limitations (*e.g.*, monthly prescription limit) for all Medicaid beneficiaries. Prior authorization is not required (except where indicated) for reimbursement of the tobacco cessation products listed below, however, there are quantity limitations for these pharmaceuticals as well as a coverage-period limit.

Medicaid coverage of tobacco cessation pharmaceuticals includes prescriptions authorized for any of the following *rebated* drugs:

- Bupropion sustained release products
- Chantix® (varenicline) tablets
- Nicotine Replacement Therapy (NRT) pharmaceutical products: legend and over-the-counter patches and gum. (*NRT lozenges, inhalers and sprays are noncovered unless approved through the prior authorization process.*)

Reimbursement for tobacco cessation products is available for one twelve-week course of treatment consisting of 90 days (three consecutive months) per beneficiary per calendar year. Pregnant beneficiaries are entitled to two twelve-week courses of treatment consisting of 90 days (three consecutive months) per calendar year. Medicaid-covered maximum quantity limitations for tobacco cessation products are:

- Bupropion extended release 150 mg – 180 tablets per 90-day period
- Chantix® (varenicline) tablets – 180 tablets per 90-day period
- Nicotine patches – 90 patches per 90-day period
- Nicotine gum – 1,512 pieces per 90-day period

To request prior authorization for NRT lozenges, nasal inhalers, or sprays, prescribers should contact Magellan Medicaid Administration's Clinical Call Center at 866-247-1181. Documentation verifying the patient's inability to use the patches or gum and the medical necessity of the NRT lozenges, nasal inhaler, or spray will be required.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

LONG-TERM CARE BENEFICIARIES

Regarding *non-dually eligible* long-term care patients (including swing bed patients), with certain specified exceptions, the Medicaid program sponsors payment for up to four prescriptions per month for beneficiaries over the age of 21. However, pharmacists may utilize an override code to exceed the monthly prescription limit for adult Medicaid beneficiaries if certain prescription limit override criteria are met; see *Prescription Limit* elsewhere in this section for further details. (Children from birth to the date of their 21st birthday are allowed unlimited prescriptions per month.)

Providers are advised that, with the exception of insulin, *all* OTC products must be furnished by the nursing facility, and as such, these items may not be billed separately to the Pharmacy Services program. OTC drugs are reimbursed in the per diem rate for all facilities in accordance with procedures established by DHHS. Therefore, OTC products may not be billed to the patient/responsible party, relative, organization, or any other entity.

Nearly all parenteral therapies furnished to non-dually eligible long-term care patients are routinely covered and do not require prior authorization in order to be billed to Medicaid. Furthermore, except for insulin, parenteral therapies do not count toward the adult beneficiary's monthly prescription limit. In addition to non-insulin parenteral therapies, the following items are exempt from the current monthly limit for adult long-term care patients:

- Aerosolized pentamidine
- Clozapine therapy
- Family planning pharmaceuticals and devices

See *Prescription Limit* elsewhere in this section for additional information regarding routine exceptions to the monthly prescription limit for adult beneficiaries.

Deductions for Non-Covered Medical Expenses

Non-dually eligible individuals in nursing facilities, whose cost of care is sponsored by Medicaid and who have monthly recurring income, are allowed deductions from their monthly income if they incur medical expenses which are not covered by Medicaid or another third party.

Non-covered medical expenses are those expenses which are recognized by State law as medical expenses, but

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Deductions for Non-Covered Medical Expenses (Cont'd.)

which are not covered by Medicaid or any other third party payer such as Medicare, TRICARE, private insurance, etc. Non-covered medical services include those items/services that exceed Medicaid limits (for patients over the age of 21, drugs dispensed above the four prescriptions per month limit which do not meet the prescription limit override criteria), less than effective, or non-rebated drugs. Non-covered services do not include items/services that are recognized in allowable costs for Medicaid long-term care rate setting purposes.

A deduction will be allowed when the following information is provided to the nursing facility:

- A bill which states the item/service furnished, the date rendered, and the cost
- A statement or prescription from a licensed practitioner that verifies medical necessity

The deduction(s) will be made in the month in which the required documentation is provided to the nursing facility. Deductions will not be allowed for expenses that were incurred prior to entering the nursing facility. Services/items, which were rendered more than three months prior to the month of the request, will not be allowed as deductions except under the following circumstances:

- When eligibility is determined for a retroactive period; or
- When there is a delay in approving an application on an individual who is a resident of a nursing facility; or
- When there is a delay in a determination by a third party payer regarding coverage of an item/service

Deductions will be allowed for prescription drugs that are noted under *General Exclusions* elsewhere in this section, exceed the monthly prescription limit for adult Medicaid patients (and which do not meet specified override criteria), or are not covered by another third party payer. The amount deducted cannot exceed the lesser of \$12.00 or the actual cost of the prescription.

SECTION 2 POLICIES AND PROCEDURES

DRUG UTILIZATION REVIEW PROGRAM

The DUR program must ensure that prescribed medications are appropriate, medically necessary, and are not likely to result in adverse medical outcomes. The DHHS Drug Utilization Review program is composed of the: 1) retrospective DUR program, 2) prospective DUR component, 3) DUR Panel's responsibilities and drug history reviews, 4) patient counseling for Medicaid beneficiaries receiving prescriptions, and 5) records requirement of a pharmacy patient record system (see *Records Requirements* elsewhere in Section 2 for detailed information regarding this specific component).

RETROSPECTIVE DUR

The DHHS retrospective DUR program involves monthly reviews of patient drug history profiles by a panel of physicians and pharmacists. These monthly reviews seek to assist prescribers by focusing upon the possibility of adverse drug effects. Many clinical factors influence prescription decisions, including the patient's health status, side effects reported by the patient or detected by the prescriber, and available alternative treatments. Non-clinical factors also impact these reviews. To prescribe appropriately, the practitioner needs all relevant clinical and personal information, including the drugs ordered by other prescribers. Upon notification of a potential drug therapy problem, written notification is sent to the prescriber(s) and dispensing pharmacies. This notification describes the potential drug therapy problem and includes the comprehensive drug history profile.

The DUR Panel conducts a retrospective review of the patient drug history profiles and evaluates the drug history information for: therapeutic appropriateness, over and underutilization, appropriate use of generic products, therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect dosage or duration of therapy, and clinical abuse/misuse. Providing practitioners with specific, focused and *comprehensive drug information*

SECTION 2 POLICIES AND PROCEDURES

DRUG UTILIZATION REVIEW PROGRAM

RETROSPECTIVE DUR (CONT'D.)

increases their awareness of potential drug therapy problems.

This allows prescribers to make any necessary prescription changes in order to prevent adverse outcomes.

PROSPECTIVE DUR

Prospective DUR means a review of the patient's drug therapy and prescription drug order as part of a drug regimen review before each prescription is filled or dispensed. As an integral part of the POS system, ProDUR encompasses the detection, evaluation, and counseling components of pre-dispensing drug therapy screening. The point-of-sale ProDUR system assists the pharmacist in these functions by addressing multiple situations in which potential drug problems may exist. Drug utilization review performed prior to dispensing helps pharmacists ensure that beneficiaries receive appropriate medications. This is accomplished by providing information that may not have been previously available to the dispensing pharmacist.

Because the ProDUR system examines previously paid claims from all participating pharmacies as it reviews a beneficiary's Medicaid-reimbursed prescription history, drugs that interact with or are affected by previously dispensed medications can be detected. The ProDUR system is offered as an informational tool to assist the pharmacist in performing his/her professional duties.

The potential problems that the ProDUR system detects include:

- Overutilization (*i.e.*, early refill)
- Underutilization
- Excessive daily dose
- Insufficient daily dose
- Therapeutic duplication
- Drug to drug interaction
- Drug-age contraindication
- Drug-pregnancy contraindication
- Excessive quantity
- Drug-diagnosis contraindication

SECTION 2 POLICIES AND PROCEDURES**DRUG UTILIZATION REVIEW PROGRAM****PROSPECTIVE DUR
(CONT'D.)**

Non-computerized pharmacy providers (or those providers who choose not to utilize the point-of-sale system for claims submission) must manually screen each prescription for certain therapeutic problems, using standards consistent with OBRA 1990 requirements.

If the Medicaid POS ProDUR system is not utilized, DHHS' prospective DUR

program requires that, in compliance with OBRA 1990 requirements, the pharmacist must perform a drug regimen review which includes, but is not limited to, the following activities:

1. Evaluation of prescription drug orders and pharmacy patient records for:
 - Known allergies
 - Rational therapy – contraindications
 - Reasonable dose and route of administration
 - Incorrect dosage or duration of therapy
 - Reasonable directions for use
 - Therapeutic appropriateness
 - Appropriate use of generic products
2. Evaluation of prescription drug orders and pharmacy patient records for duplication of therapy and therapeutic duplication.
3. Evaluation of prescription drug orders and pharmacy patient records for interactions such as:
 - Drug-drug
 - Drug-food
 - Drug-disease (if available)
 - Adverse drug reactions
 - Clinical abuse/misuse
4. Evaluation of prescription drug orders and pharmacy patient records for proper utilization, including overutilization or underutilization, and optimum therapeutic outcomes.

SECTION 2 POLICIES AND PROCEDURES**DRUG UTILIZATION REVIEW PROGRAM****PROSPECTIVE DUR
(CONT'D.)**

See the Prospective Drug Utilization Review section in the Magellan Medicaid Administration Pharmacy Provider Manual for additional information.

DUR PANEL

The DUR Panel is a panel composed of physicians and pharmacists. This panel of health care practitioners has responsibilities pertaining to:

1. The retrospective DUR program, including the retrospective review of patient drug history profiles
2. Criteria used in the retrospective DUR process and subsequent application of standards for both the retrospective and prospective DUR programs
3. Decisions regarding interventions with prescribers and pharmacists in response to therapy problems identified through retrospective DUR

PATIENT COUNSELING

Patient counseling is defined as the oral or written communication by the pharmacist to a patient or caregiver providing information on the proper use of drugs and devices.

South Carolina Medicaid requires that, upon receipt of a prescription drug order for a “new” medication and following review of the patient’s pharmacy record, the pharmacist shall personally offer counseling to the patient or the patient’s agent. Using his or her best professional judgment, the pharmacist’s counseling shall include a discussion of those matters that the pharmacist considers appropriate for the patient or patient’s agent in that particular situation. The discussion must be in person, whenever practicable, or by telephone or written communication and shall include appropriate elements of patient counseling.

SECTION 2 POLICIES AND PROCEDURES

PRESCRIBING/ DISPENSING LIMITATIONS

ELIGIBILITY

The Medicaid program reimburses for covered medical services for individuals who have a valid 10-digit identification number (as printed on the permanent plastic South Carolina Healthy Connections Card) and whose eligibility for that date of service has been verified. For pharmacy providers, eligibility verification may be accomplished by claims submission through Magellan Medicaid Administration's POS system.

It is important to note that *possession of the plastic Medicaid card does not guarantee Medicaid eligibility*; beneficiaries may become ineligible for Medicaid for a given month only to regain eligibility at a later date. Therefore, it is possible that a beneficiary will present a Medicaid card during a period of ineligibility. To avoid such rejections, pharmacy providers are strongly encouraged to submit claims via Magellan Medicaid Administration's "real time" point-of-sale system. Pharmacists are not obligated to dispense medications if the beneficiary (or his/her caregiver) is unable to present the plastic Medicaid card or other appropriate documentation containing the individual's Medicaid health insurance number. (Refer to Section 1 for further information on Medicaid eligibility and for a detailed description of the South Carolina Healthy Connections Medicaid Insurance Card.)

The POS system also facilitates claims processing by identifying those Medicaid beneficiaries enrolled in certain waiver programs who may be eligible for enhanced benefits; conversely, it also alerts the pharmacy provider that, in some instances, Medicaid coverage may be restricted or limited.

Use of the point-of-sale system provides *immediate* verification that the individual is currently eligible for Medicaid coverage and also determines if benefits are restricted or enhanced.

Therefore, if non-POS claims are submitted, the provider is at risk for possible non-payment by

SECTION 2 POLICIES AND PROCEDURES

PRESCRIBING/DISPENSING LIMITATIONS

ELIGIBILITY (CONT'D.)

Medicaid due to beneficiary ineligibility or other factors (including exceeding the monthly prescription limit for an adult beneficiary).

There is no prior authorization mechanism or other method available by which to override the monthly prescription limit if the adult beneficiary's four "slots" have already been utilized for non-essential medications and the rejected prescription is for a pharmaceutical which is also deemed non-essential. Thus, in some instances, providers who submit non-POS claims will be at risk for exceeding the adult beneficiary's monthly prescription limit (see *Prescription Limit* elsewhere for further details). Furthermore, where the Medicaid point-of-sale system is utilized in claims submission, an adult beneficiary may receive services (if necessary) from more than one pharmacy in a given month without compromising his/her monthly prescription limit.

In order to ensure that Magellan Medicaid Administration and DHHS Pharmacy Services staff resources are appropriately utilized, providers should instruct beneficiaries to call the Magellan Medicaid Administration Beneficiary Call Center at 800-834-2680 (toll-free) for inquiries regarding Pharmacy Services-related issues. Other Medicaid inquiries from beneficiaries should be directed to 888-549-0820 (toll-free).

In addition to providing traditional fee-for-service medical care coverage, DHHS has implemented the SC Medicaid Managed Care Program. Providers should refer to the Managed Care Supplement for additional information.

Note: The above requirements are specific to fee-for-service Medicaid. Many beneficiaries are now enrolled in a Medicaid Managed Care program and, as such, are subject to the guidelines as outlined in their specific managed care plan. Providers must verify plan participation prior to rendering services. Providers should refer to the Managed Care Supplement for additional information.

SECTION 2 POLICIES AND PROCEDURES

PRESCRIBING/DISPENSING LIMITATIONS

PRESCRIPTION LIMIT

Medicaid-eligible beneficiaries from *birth to the date of their 21st birthday* are allowed unlimited prescriptions per month.

For patients over the age of 21, unless otherwise specifically allowed, the traditional fee-for-service Medicaid program sponsors reimbursement for a maximum of four prescriptions per beneficiary per month (see monthly prescription limit override criteria outlined below). Current *routine* exceptions to the monthly prescription limit for adult beneficiaries are:

- Insulin syringes used in the administration of home parenteral therapies (not applicable to non-dually eligible long-term care patients; see specific long-term care OTC policy outlined elsewhere in this section)
- Home-administered parenteral therapies (however, *insulin* counts toward the monthly prescription limit, but claims for insulin which reject for exceeding the monthly prescription limit may be overridden if certain criteria are met)
- Aerosolized pentamidine
- Clozapine therapy
- Family planning pharmaceuticals and devices

Monthly Prescription Limit Override Criteria for Adult Beneficiaries

Pharmacists may utilize an override code to exceed the monthly prescription limit for adult Medicaid beneficiaries if the prescription limit override criteria are met. A total of three overrides per beneficiary per month is allowed.

Pharmacists should submit the prescription limit override code, a “5” in the Prior Auth Type Code (PATC) field, if all of the following criteria are met. Adult Medicaid beneficiaries are entitled to four prescriptions per month and up to three overrides for prescriptions that meet the following criteria. Pharmacists should submit the prescription limit override code on the claim if:

1. The monthly prescription limit has been met, *and*
2. The adult patient has one of the following conditions, *and*

SECTION 2 POLICIES AND PROCEDURES

PRESCRIBING/DISPENSING LIMITATIONS

Monthly Prescription Limit Override Criteria for Adult Beneficiaries (Cont'd.)

3. The prescription is for an *essential* drug used in the adult patient's treatment plan for one of these conditions:
 - Acute sickle cell disease
 - Behavioral health disorder
 - Cancer
 - Cardiac disease (including hyperlipidemia)
 - Diabetes
 - End stage lung disease
 - End stage renal disease (ESRD)
 - HIV/AIDS
 - Hypertension
 - Life-threatening illness (not otherwise specified)
 - Organ transplant
 - Terminal stage of an illness

It is inappropriate for pharmacy providers to choose to ignore this particular billing process for all of their adult Medicaid patients. Conversely, it is inappropriate for pharmacy providers to generally promote this particular billing mechanism since not all prescriptions can meet the override criteria.

The override of the monthly prescription limit is reserved for only those prescriptions that, in the clinical judgment of the pharmacist, meet the prescription override criteria outlined above.

Use of the monthly prescription limit override code is systematically restricted for those therapeutic classes that normally do not meet the override criteria (*e.g.*, vitamins, laxatives, and so forth). However, it should be noted that this override restriction does not imply that use of the override code is appropriate for *all* prescriptions for medications in the non-restricted therapeutic classes. Pharmacists are expected to make sound decisions regarding use of the prescription limit override on an individual prescription/patient basis. *If a pharmacist is uncertain as to the appropriateness of a prescription limit*

SECTION 2 POLICIES AND PROCEDURES

PRESCRIBING/DISPENSING LIMITATIONS

Monthly Prescription Limit Override Criteria for Adult Beneficiaries (Cont'd.)

override for a particular medication, the pharmacist should contact the prescriber to obtain additional clinical information so that an informed Medicaid coverage decision may be made. Following careful consideration, if the pharmacist deems a prescription in a restricted therapeutic class to meet the stipulated override criteria, he or she may call the Magellan Medicaid Administration Clinical Call Center at 866-247-1181 (toll-free) to request prior authorization.

- Pharmacists must NOT use the override code for a prescription until after the adult beneficiary's monthly prescription limit has been reached.
- Since children from birth to the date of their 21st birthday are eligible for an unlimited number of Medicaid-covered prescriptions per month, the override mechanism should never be utilized when submitting claims for children.

Pharmacists may reverse pharmacy claims (previously submitted during the given month) that would have met the prescription limit criteria (provided the monthly prescription limit had already been met) in order to submit claims for that month for prescriptions that do not meet the prescription limit override criteria. Subsequently, the reversed claims that meet the override criteria may be resubmitted using the override code. Pharmacies will be audited for appropriate utilization of the prescription limit override code. (See Section 3 for claims submission procedures to be utilized when an allowable override to the monthly prescription limit is necessary.)

Providers are advised that there is no "special authorization" process in effect or other method allowed by which the monthly prescription limit may be overridden when claims for *non-essential* medications are denied for exceeding the limit and *multiple* pharmacy providers are involved. Therefore, providers who submit non-POS claims are at risk for exceeding the monthly prescription limit for adult beneficiaries and are strongly encouraged to consider claims submission via the point-of-sale system. Through use of the POS system, the pharmacy provider has immediate access to the claims adjudication process and receives an on-line, "real time" notification if the monthly prescription limitation is exceeded.

SECTION 2 POLICIES AND PROCEDURES

PRESCRIBING/DISPENSING LIMITATIONS

QUANTITY OF MEDICATION LIMITS / DOSE OPTIMIZATION PROGRAM

Medicaid reimburses for a maximum one-month supply of medication per prescription or refill or for a days' supply commensurate with the smallest package size available. The DHHS defines a one-month supply as a maximum 31-day supply per prescription for non-controlled substances.

Providers should refer to the South Carolina Controlled Substances Regulations promulgated by the South Carolina Department of Health and Environmental Control (DHEC) for maximum quantity limitations on prescriptions for controlled substances.

Furthermore, certain pharmaceuticals are subject to maximum quantity limitations. Those products which have quantity limits may be found at <http://southcarolina.fhsc.com>. The Quantity Limits listing is updated periodically; therefore, providers may find it beneficial to refer to the Web site for the most current information. The established maximum quantities are based upon a month's supply of medication. Prior authorization will be necessary for any quantity exceeding the established per month limitation. Prescribers should contact the Magellan Medicaid Administration Clinical Call Center at 866-247-1181 (toll-free) to request prior authorization.

Effective with dates of service February 1, 2007, DHHS implemented a Dose Optimization program. The focus of the Dose Optimization program is improved patient compliance with drug therapy regimens, reduced potential for exceeding the maximum recommended dose as determined by the Food and Drug Administration, and decreased adverse drug events.

Dose Optimization is an enhancement to the current Quantity Limits program. Medications that may be indicated for once or twice daily dosing are identified and where clinically applicable, Dose Optimization edits limit the number of times the medication is dosed. This editing process does not interfere with the total daily dosage of the medication prescribed for the patient. Prescribers are asked to consider appropriate Dose Optimization guidelines when higher strengths of the drug are commercially available. For example, prescriptions authorized for two Aricept® 5 mg tablets daily should instead be authorized for the commercially available Aricept® 10 mg tablet with instructions of one tablet daily.

SECTION 2 POLICIES AND PROCEDURES

PRESCRIBING/DISPENSING LIMITATIONS

QUANTITY OF MEDICATION LIMITS / DOSE OPTIMIZATION PROGRAM (CONT'D.)

When clinically appropriate, DHHS encourages pharmacy providers to contact prescribers regarding those prescriptions where changes may be appropriate to conform to daily dosing limitations.

For those patients who require unique dosing regimens, pharmacy providers should ask the prescriber or the prescriber's designated office personnel to contact Magellan Medicaid Administration's Clinical Call Center at 866-247-1181 to request prior authorization. Those products subject to Dose Optimization may be found at <http://southcarolina.fhsc.com>. The Dose Optimization listing will be updated periodically; therefore, providers may find it beneficial to refer to the Web site for the most current information.

Providers should note that DHHS requires the use of the "metric decimal" quantity on Medicaid pharmacy claims. **A "rounded" or "rounded up" number must NOT be submitted as the billed quantity when the dispensed amount is a fractional quantity.** *If the dispensed quantity is a fractional amount, then the billed quantity must accurately reflect the specific metric decimal quantity that is dispensed.*

Billing incorrect quantities negatively affects quarterly rebate invoice data and results in under- or overpayment to providers. Furthermore, mispaid claims due to inaccurate quantities are subject to postpayment review and when appropriate, recoupment of monies. Pharmacy providers must evaluate their software and billing processes in order to ensure that the prescription quantity that is billed to Medicaid accurately reflects the dispensed quantity. Billing inquiries should be directed to Magellan Medicaid Administration's Technical Call Center at 866-254-1669. (See *Postpayment Reviews* elsewhere in this section for additional information.)

REFILLS

Refills are to be provided only if authorized by the prescriber, allowed by law, and should be in accordance with the best medical and pharmacological practices. Refill documentation should be accurate and easily accessible for postpayment review purposes. If a refill authorization is received orally, sufficient documentation must be present on the original prescription. However, in those refill instances where a new and separate prescription is

SECTION 2 POLICIES AND PROCEDURES

PRESCRIBING/DISPENSING LIMITATIONS

REFILLS (CONT'D.)

necessary (*i.e.*, controlled substance prescription), a new prescription must be issued in accordance with state and federal requirements. **Automatic Refill Programs shall not be utilized for SC Medicaid beneficiaries.** A pharmacy provider shall not automatically generate refills for a SC Medicaid beneficiary.

It is understood that certain circumstances may necessitate an early refill (*e.g.*, change in dosage, stolen or damaged prescriptions, etc.). If the prescription is refilled early (*i.e.*, before 75% of the medication should have been exhausted, according to the prescriber's directions), a ProDUR denial error message ("early refill 866-254-1669") will be returned via the POS system. When there are circumstances that justify an early refill, the pharmacist must request prior authorization by contacting the Magellan Medicaid Administration Technical Call Center at the toll-free number indicated. Requests for "early refill" overrides must meet certain specified criteria; those not meeting the established criteria will be denied.

MEDICAID COVERAGE OF GENERIC PRODUCTS

Medicaid does not cover brand name products for which there are therapeutically equivalent, less costly generics available unless documentation of a treatment failure is furnished.

Furthermore, **the treatment failure must be directly attributed to the patient's use of a generic for the brand name product.**

A South Carolina Medicaid MedWatch form, completed by the prescriber and forwarded to the Magellan Medicaid Administration Clinical Call Center (toll-free fax number: 888-603-7696), serves as the required documentation of a treatment failure with a generic product. (See a copy of the South Carolina Medicaid MedWatch form in this section and a camera-ready copy in the Forms section of this manual.) If the requested brand name product is not approved for Medicaid reimbursement, Magellan Medicaid Administration's Clinical Call Center staff will notify the prescriber. Conversely, if coverage of the product is approved, Medicaid will reimburse the patient's pharmacy, provided all other relevant program requirements are met; such prior authorization approval is in effect for the duration of that specific therapy.

SECTION 2 POLICIES AND PROCEDURES

PRESCRIBING/DISPENSING LIMITATIONS

MEDICAID COVERAGE OF GENERIC PRODUCTS (CONT'D.)

As stated above, Medicaid does not routinely cover brand name products for which there are therapeutically equivalent, less costly generics available EXCEPT for the following brand name products [traditionally categorized as Narrow Therapeutic Index (NTI) drugs]: digoxin, warfarin, theophylline (controlled release), levothyroxine, pancrelipase, phenytoin, and carbamazepine.

Any of these pharmaceuticals, however, may be subject to upper limit of payment policies requiring prescriber certification for the use of the brand name product.

In addition to the South Carolina Medicaid MedWatch form requirement (where indicated), the prescriber's *handwritten* notation on the prescription certifying "brand medically necessary" or "brand necessary" is the required mechanism by which Medicaid will reimburse for the specified brand name drug. Furthermore, in order to avoid recoupment of Medicaid monies, this certification must be present on the prescription *prior* to billing Medicaid for any brand medically necessary product.

For further information, providers should consult the *Upper Limits of Payment for Certain Multiple Source Products* and *Brand Medically Necessary* material found elsewhere in this section.

SUBSTITUTION OF EQUIVALENT DRUG PRODUCTS

With respect to prescriptions reimbursed through the South Carolina Medicaid program, Medicaid beneficiaries for whom the pharmaceuticals are intended are deemed to have consented to substitution of a less costly equivalent generic product that will result in a cost savings to the South Carolina Medicaid program. Therefore, individual patient consent for substitution as stipulated in S.C. Code of Laws 40-43-86 (H) (6) shall not be required.

UPPER LIMITS OF PAYMENT FOR CERTAIN MULTIPLE SOURCE PRODUCTS

Maximum reimbursement rates for certain multiple source drugs (both legend and OTC) are set by the CMS or by DHHS and cannot be exceeded. The entire listing of products having either a federal upper limit (FUL) of payment or a South Carolina Maximum Allowable Cost (SCMAC) may be found at <http://southcarolina.fhsc.com>. The MAC listing at <http://southcarolina.fhsc.com> includes *all products*, either state or federally mandated, *with a maximum allowable cost (MAC)* and *includes unit dose forms* of those products listed. This on-line MAC listing is

SECTION 2 POLICIES AND PROCEDURES

PRESCRIBING/DISPENSING LIMITATIONS

UPPER LIMITS OF PAYMENT FOR CERTAIN MULTIPLE SOURCE PRODUCTS (CONT'D.)

continually monitored and updated to reflect any state or federal changes, additions, or deletions.

Generic equivalents of products having an established FUL or SCMAC are subject to the respective upper limit of payment indicated. Thus, *all* products that contain the same active ingredient(s) and strength(s) are subject to the established pricing restriction.

Furthermore, FULs or SCMACs are applicable for sugar-free or alcohol-free products, provided they contain the same active ingredient(s) and strength(s) as those pharmaceuticals indicated on the MAC listing. Additionally, any product with an upper limit of payment restriction that is packaged in a specialized dosage or convenience pack (e.g., Sterapred®) is subject to the established FUL or SCMAC.

However, it should be further noted that in those instances where the WAC + 0.8% for a given NDC is *lower* than the established FUL or SCMAC, the provider's reimbursement will be based upon that specific product's lower WAC + 0.8%. Furthermore, when the provider agrees to dispense and subsequently bill a prescription to the Medicaid program, Medicaid's reimbursement must be accepted as payment in full. Under no circumstances may the patient be billed the difference between the submitted charge and Medicaid's reimbursement.

Providers are reminded that only *rebated products* (whether brand name or generic) may be considered for Medicaid reimbursement. Certain pharmaceuticals subject to upper limits of payment restrictions may have both legend and OTC packaging. Claims for most OTC pharmaceuticals may be transmitted routinely through Magellan Medicaid Administration's POS system. Providers are reminded that a valid prescription must be on file for all items reimbursed through the Pharmacy Services program.

Unless prior authorization has been approved for the brand name drug, reimbursement for products included on the MAC listing will be based upon the lowest per-unit price (whether SCMAC, FUL, or WAC + 0.8%) in effect on the date of service. (As indicated in the *Medicaid Coverage of Generic Products* section, prior authorization of the brand name product is not necessary for certain specified NTI drugs; however, NTI drugs *are subject to the "brand*

SECTION 2 POLICIES AND PROCEDURES

PRESCRIBING/DISPENSING LIMITATIONS

UPPER LIMITS OF PAYMENT FOR CERTAIN MULTIPLE SOURCE PRODUCTS (CONT'D.)

necessary” or “brand medically necessary” certification requirements described below.)

For those brand name products having an established FUL or SCMAC on the date of service, providers are reminded that in addition to the South Carolina Medicaid MedWatch form requirement (where the prescriber must document the occurrence of a treatment failure that is attributable to the generic product), the prescriber’s *handwritten* notation on the prescription certifying “brand medically necessary” or “brand necessary” is required. This certification must be present on the prescription *prior* to billing Medicaid for any brand medically necessary prescription.

If the “brand medically necessary” certification is absent from the face of the prescription, a dual line prescription form does not satisfy the brand medically necessary certification requirement; the prescriber’s signature on the “Dispense As Written” signature line does not satisfy the brand medically necessary certification requirement; nor does the prescriber’s verbal authorization satisfy the “brand medically necessary” certification requirement. A “blanket” authorization does not satisfy the “brand medically necessary” certification requirement. Therefore, in order to avoid recoupment of Medicaid monies, care should be taken prior to billing to ensure that the appropriate certification is indicated on *each* prescription for those claims transmitted (and reimbursed) as brand medically necessary.

Effective February 17, 2010, the pharmacist must only use the DAW code of ‘1’ to obtain higher Medicaid reimbursement when the prescriber certifies in his/her own handwriting that a specific brand is medically necessary for a particular patient.

If non-POS claims submission methods are utilized (and the provider fails to properly designate the claim as “brand medically necessary” where indicated), requests for manual adjustments of those paid claims will not be honored.

Providers should note the requirement that the NDC submitted to Medicaid for payment **must** be identical to the NDC listed on the package from which the prescription was dispensed. Submission of any other NDC is a violation of Medicaid policy.

SECTION 2 POLICIES AND PROCEDURES**PRESCRIBING/DISPENSING LIMITATIONS****UPPER LIMITS OF
PAYMENT FOR CERTAIN
MULTIPLE SOURCE
PRODUCTS (CONT'D.)**

Regardless of the reason (limitations in computer programming, software, etc.) that any such violations occur, providers should take immediate steps to correct the problem.

Only the specific manufacturer's NDC on the product actually dispensed may be submitted for payment. Similarly, although a provider may be willing to accept reimbursement based upon the SCMAC or FUL, a non-prior authorized brand name NDC should not be submitted *unless it is identical to the NDC indicated on the package from which the prescription was dispensed.*

"Brand medically necessary" claims (including those for NTI drugs) are subject to postpayment review by the DHHS Division of Program Integrity, and all pertinent documentation (*e.g.*, prescriptions or chart orders containing the specified terminology in the prescriber's own handwriting) must be retained in the provider's records. Medicaid payment will be recouped for any claim so designated if the prescriber's certification is not present on the prescription. (See *Brand Medically Necessary* information found elsewhere in this section.)

TELEPHONE ORDERS

Telephone prescriptions are permissible; however, those for "brand medically necessary" pharmaceuticals are required to be signed by the prescriber and must be appropriately certified as "brand medically necessary" prior to being billed to the Medicaid program. To facilitate adherence to this policy, the pharmacist may fax the prescription to the prescriber for signature and "brand medically necessary" certification. Providers are reminded that all state and federal requirements must be adhered to regarding the dispensing of telephone prescriptions.

**ELECTRONICALLY
TRANSMITTED
PRESCRIPTIONS**

Electronically transmitted prescription drug orders are reimbursable by Medicaid; however, such prescriptions must meet state and federal requirements.

**TAMPER-RESISTANT
PRESCRIPTION PADS**

Effective April 1, 2008, Medicaid-covered outpatient prescription and OTC (over-the-counter) drugs are reimbursable only if non-electronic prescriptions are issued on a tamper-resistant pad.

SECTION 2 POLICIES AND PROCEDURES

PRESCRIBING/DISPENSING LIMITATIONS

TAMPER-RESISTANT PRESCRIPTION PADS (CONT'D.)

These new federal requirements result from amendments to section 1903(i) of the Social Security Act, as required by Section 7002(b) of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery and Iraq Accountability Appropriations Act of 2007.

Electronic prescriptions meeting federal and state requirements are excluded from this requirement.

As of April 1, 2008, to be considered tamper-resistant, a prescription pad must contain, at least one of the following three characteristics:

- One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form.
- One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber.
- One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

Effective October 1, 2008, a prescription pad must contain all three characteristics to be considered tamper-resistant and Medicaid reimbursable.

This rule does apply to nursing facilities, intermediate care facilities for the mentally retarded, and other like residential facilities where their prescriptions are separately reimbursed by Medicaid and not included in the facility's rate.

The tamper-resistant pad requirement rule does NOT apply to refills of prescriptions presented at a pharmacy before April 1, 2008. In addition, the requirement does NOT apply to e-prescriptions transmitted to the pharmacy, prescriptions faxed to the pharmacy or prescriptions communicated to the pharmacy by telephone by a prescriber. The requirement does NOT apply to managed care entities when the managed care entity pays for the prescription.

To the extent permissible under state and federal law and regulation, this requirement does not restrict emergency fills of non-controlled or controlled substances for which a prescriber provides the pharmacy with a verbal, faxed, electronic or compliant written prescription(s) within 72

SECTION 2 POLICIES AND PROCEDURES

PRESCRIBING/DISPENSING LIMITATIONS

TAMPER-RESISTANT PRESCRIPTION PADS (CONT'D.)

hours after the date on which the prescription(s) was issued.

Future postpayment audits of pharmacy claims for Medicaid reimbursement, whether conducted by the DHHS Division of Program Integrity or any other agent, will review compliance with the above requirements.

PRESCRIPTION INFORMATION TRANSFER

The one-time transfer of original prescription information for dispensing one refill is permissible between pharmacies in South Carolina, subject to state and federal requirements.

PRESCRIPTION ORIGIN CODE

Effective with dates of service on or after May 5, 2010, the South Carolina Department of Health and Human Services (DHHS) will require that the prescription origin code be submitted on pharmacy claims for new prescriptions. The following values will be accepted in NCPDP field 419-DJ:

- 1 = Written
- 2 = Telephone
- 3 = Electronic
- 4 = Facsimile
- 5 = Pharmacy

Claims with this field left blank or submitted with a "0" (not specified) will reject.

REDISPENSING OF MEDICATIONS

The policy concerning the re-use of drugs returned from patients is contained in state and federal requirements regarding the practice of pharmacy. Re-use of these items would constitute fraud unless the pharmacist documents these drugs by name, date of service, etc., and makes appropriate refund to the Medicaid program.

Due to federal drug rebate program issues, it is preferable to accomplish such "refunds" by claims reversal via the POS system rather than by check.

Once the original paid claim has been reversed (*i.e.*, voided), the provider should immediately resubmit a "corrected" claim, reflecting the amended quantity dispensed and reduced usual and customary charge. If necessary, providers should consult Magellan Medicaid Administration's Technical Call Center staff [866-254-1669] in order to facilitate the claims reversal/resubmission process.

SECTION 2 POLICIES AND PROCEDURES

PAYMENT METHODOLOGY INFORMATION

The pharmacy provider should submit the pharmacy's usual and customary charge when billing Medicaid. The amount reimbursed by Medicaid for a drug dispensed **shall not exceed the lowest of:**

- A. **The federally mandated upper limit of payment (FUL)** for the drug, if any, less 10% plus the current dispensing fee as established by the DHHS in accordance with federal requirements.
- B. **The South Carolina Maximum Allowable Cost (SCMAC)** plus the current dispensing fee as established by the DHHS in accordance with federal requirements.
- C. **The Wholesale Acquisition Cost (WAC)** plus 0.8%, plus the current dispensing fee as established by the DHHS in accordance with federal requirements. (**Note:** The Wholesale Acquisition Cost used in calculating the WAC price is furnished weekly to Magellan Medicaid Administration by a contracted pricing source. The NDC number used in billing Medicaid must be the NDC number contained on the package from which the drug was actually dispensed. Non-compliance with this policy may result in the recoupment of Medicaid monies.)
- D. **The provider's usual and customary charge** to the general public for the prescription as written for the brand actually dispensed. (If the provider's submitted charge for a medication is less than Medicaid's calculated reimbursement, the system will subtract any applicable copayment from the submitted charge and pay the provider the difference).

Note: When a pharmacist submits a "partial fill" prescription to Medicaid, the beneficiary's copayment and the pharmacist's dispensing fee will be prorated based on the fractional percentage of

SECTION 2 POLICIES AND PROCEDURES

PAYMENT METHODOLOGY INFORMATION

PAYMENT METHODOLOGY INFORMATION (CONT'D.)

the quantity dispensed compared to the quantity prescribed. The pharmacy should only do a partial fill if there is a shortage of the drug and the pharmacy does not have enough in stock to fill the prescription.

COPAYMENT

Effective April 1, 2011, the copayment amount on all applicable prescriptions is \$3.40 per prescription. Providers are responsible for collecting applicable copayments and may not refuse service to a beneficiary due to his/her inability to pay copayment at the time the service is rendered. However, an inability to pay at the time of dispensing does not relieve the beneficiary of the responsibility for the copayment amount. The amount of the copayment will be deducted from the Medicaid reimbursement for all claims to which copayment applies. Following is a listing of those beneficiary groups and/or services that are *exempt* from the collection of copayment:

- Beneficiaries from birth to the date of their 19th birthday.
- Beneficiaries residing in long-term care facilities (NFs, ICF-MRs) [exemption does not apply to beneficiaries residing in adult residential care facilities/boarding homes or retirement homes].
- Beneficiaries receiving the Medicaid hospice benefit.
- Beneficiaries enrolled under the Family Planning pay category.
- Beneficiaries who are pregnant (verified by either the patient or prescriber). Pharmacy providers must enter a “2” in the *Prior Authorization Type Code* field in order to identify the prescription as copayment-exempt. [The previous policy exempting copayment only for those prescriptions annotated as “related to pregnancy” or “pregnancy-related” has been replaced with this policy, which exempts pregnant beneficiaries from any copayment requirements.]
- Beneficiaries who are members of the Health Opportunity Account (HOA) Program.

SECTION 2 POLICIES AND PROCEDURES

PAYMENT METHODOLOGY INFORMATION

COPAYMENT (CONT'D.)

- Beneficiaries who are members of a Federally Recognized Indian Tribe.

Since the collection of copayment was established to supplement the dispensing fee, compassionate waiver of copayment shall be limited to a case-by-case basis. Non-compliance by a provider may subject his or her reimbursement to adjustment.

Note: When a pharmacist submits a “partial fill” prescription to Medicaid, the beneficiary’s copayment and the pharmacist’s dispensing fee will be prorated based on the fractional percentage of the quantity dispensed compared to the quantity prescribed.

Regarding coordination of benefits claims, no third party insurer copayments should be collected from beneficiaries if the claim is for a covered Medicaid product. Only the South Carolina Medicaid copayment (if applicable) should be collected from the beneficiary.

Claims for injectable medications covered by the Pharmacy Program that have a route of administration of “intravenous” and require multiple fills of the same drug (same dosage form and strength) will only require one copay per calendar month.

SECTION 2 POLICIES AND PROCEDURES

PAYMENT METHODOLOGY INFORMATION

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SECTION 2 POLICIES AND PROCEDURES

SPECIAL GROUPS/ ISSUES

MEDICARE PART D PRESCRIPTION DRUG COVERAGE

On January 1, 2006, the Centers for Medicare and Medicaid Services (CMS) implemented Medicare prescription drug coverage, known as Medicare Part D. Under Part D, CMS contracts with Prescription Drug Plans (PDPs) to make available a drug coverage benefit for Medicare eligibles (*i.e.*, individuals who have Medicare Parts A or B).

Although individuals eligible for both Medicare and Medicaid (*i.e.*, dual eligibles) no longer receive the complete drug coverage benefit through Medicaid, dual eligibles continue to be eligible for all other Medicaid services that are currently provided. Furthermore, Medicaid continues to cover certain specified PDP-excluded drug categories for dual eligibles only. For additional information, see the section below entitled *Medicaid and Certain PDP-Excluded Drug Categories*.

Resources for Medicare Part D Beneficiaries

Beneficiaries may apply or obtain Medicare Part D and PDP information by:

1. Telephone: 1-800-MEDICARE (1-800-633-4227)
2. Web site: <http://www.medicare.gov/>
3. Online application:
<http://www.socialsecurity.gov/prescriptionhelp/>

Auto-Enrollment of Dual Eligibles

To participate in Part D, Medicare eligibles must have enrolled in a PDP that CMS has approved for South Carolina. To ensure that dual eligibles continue to have prescription drug coverage, CMS automatically enrolls (auto-enrolls) dual eligibles into PDPs if they have not self-enrolled. It should be noted that the PDP into which CMS has auto-enrolled a beneficiary may not be the plan that best accommodates the individual's needs (due to formulary restrictions, pharmacy provider network issues, etc.).

SECTION 2 POLICIES AND PROCEDURES

SPECIAL GROUPS/ISSUES

South Carolina PDPs

There are many different companies that have an assortment of prescription plans available for South Carolina Medicare beneficiaries. Enrollment in a PDP is generally for the calendar year. Medicare beneficiaries may only switch plans during the annual open enrollment period. However, dual eligibles may change plans at any time by calling 1-800-MEDICARE and enrolling in their plan of choice. [Note: Medicare eligibles who are residents of South Carolina must enroll in a PDP that CMS has approved for Part D beneficiaries in South Carolina.]

Medicaid Point-of-Sale (POS) Denial Responses

Pharmacy claims submitted via POS to South Carolina Medicaid for a dual eligible will deny with NCPDP response code 41, "submit bill to other processor or primary payer". Pharmacy providers should do an E1 query through Medicare to determine which Prescription Drug Plan a beneficiary is enrolled in.

Medicare Part B Drugs

Providers should note that Part D is an additional Medicare benefit and does not replace Medicare Part A, B, or C. Medicare Part B coverage remains viable for certain designated drugs under specific conditions (e.g., immunosuppressants following a Medicare-sponsored organ transplant, oral chemotherapy agents, oral antiemetics, etc.). Therefore, for dually eligible beneficiaries, pharmacists will continue to submit such claims (using their respective *supplier* billing numbers) to Medicare Part B for payment consideration. In some circumstances, however, these drugs may be deemed non-covered by Medicare Part B. An example would be an oral chemotherapy drug such as methotrexate when used to treat rheumatoid arthritis. Useful information regarding those drugs that are covered by Part B (rather than Part D) may be found by clicking on Parts B & D Information at <http://www.cms.hhs.gov/pharmacy>. Pharmacy Services providers should refer to the Medicare Parts B and D Coverage Issues Table at this Web site link, to be aware of those circumstances when these drugs may be deemed non-covered by Medicare Part B and, therefore, billable to Part D.

If Medicare Part B denies payment because the drug is considered non-covered for the diagnosis indicated, the claim should then be submitted to the beneficiary's Medicare Part D prescription drug plan (PDP). To

SECTION 2 POLICIES AND PROCEDURES

SPECIAL GROUPS/ISSUES

Medicare Part B Drugs (Cont'd.)

facilitate claims submission, it may be necessary for the pharmacist to contact the prescriber for additional diagnostic or patient-specific information in order to determine which payer (Part B or Part D) should be billed as primary.

Effective April 1, 2010, if Medicare Part B reimburses for any portion of the pharmacy services provider's submitted charge (or if the claim paid amount was applied to the Medicare Part B annual deductible), the pharmacist should bill Medicaid secondarily using the Magellan Medicaid Administration Services Point of Sale (POS) system.

Note: Effective with dates of service January 1, 2007, Medicaid cannot be billed secondarily for Medicare Part B-covered vaccines. In those instances, the beneficiary's Medicare Part D Prescription Drug Plan (PDP) must be billed for any allowable secondary payment.

If the amount paid was applied toward the annual deductible, a copy of the Medicare Part B Explanation of Benefits (EOB) must be faxed to the Magellan Medicaid Administration Services Clinical Call Center at 1-888-603-7696 (toll free). Pharmacists are encouraged to indicate the beneficiary's 10-digit Medicaid identification number on Medicare EOBs furnished to Magellan Medicaid Administration Services. While subsequent fills for that specific drug therapy will continue to require PA, faxing additional copies of the Medicare EOB will not be necessary each time the prescription is refilled.

When billing a prior authorized claim secondarily to Medicaid, the coordination of benefits (COB) data elements are applicable and must be appropriately populated.

Medicaid and PDP-Non-Covered Drugs

Providers are aware that prescription plans have different formularies, preferred drug lists, and prior authorization (PA) programs; the PDPs have these types of processes and programs in effect. It is important for beneficiaries to know that the PDP must notify the individual 60 days before removing one of his or her prescriptions from PDP coverage. Regarding PDP non-covered drugs, providers should be aware that *South Carolina Medicaid will not be a secondary payer for products such as a PDP's non-formulary drug or non-preferred drug or a PDP's PA-required drug.*

SECTION 2 POLICIES AND PROCEDURES

SPECIAL GROUPS/ISSUES

Medicaid and Certain PDP-Excluded Drug Categories

There are several drug categories that PDPs are not required by CMS to cover. *If* the PDP has chosen not to cover such items, South Carolina Medicaid will provide coverage of those products *for dual eligibles only*, subject to Medicaid's existing rules and policies (*i.e.*, product must be rebated; product may require PA under Medicaid rules, etc.). The PDP-excluded drug categories include: barbiturates, benzodiazepines, cough and cold products, vitamins/ minerals, and over-the-counter (OTC) drugs (except for a pharmaceutical such as an OTC proton pump inhibitor or an OTC non-sedating antihistamine since those drugs belong specifically to PDP-covered therapeutic classes).

Only barbiturates, benzodiazepines, vitamins/ minerals, and OTC drugs may be billed to South Carolina Medicaid after the pharmacy provider receives a denial from the *dual eligible's* PDP.

Long-Term Care Facilities

Providers should note that full-benefit dual eligibles residing in long-term care facilities such as nursing homes are not responsible for any cost-sharing (*e.g.*, copayments) under the Part D benefit. These individuals retain their limited personal needs allowances for their personal expenses and do not have to spend the allowance on drug costs. Additionally, providing OTC drugs remains the responsibility of the long-term care facility; therefore, OTC coverage for long-term care residents is not the responsibility of the PDP or the Medicaid outpatient drug program.

Regarding nursing homes and the Part D benefit, PDPs are required to provide convenient access to long-term care pharmacies serving Part D enrollees residing in long-term care facilities. Nursing home staff members are encouraged to use the Web-based Prescription Plan Finder tool at <http://www.medicare.gov/> for individual resident inquiries.

CMS's Contingency Plan for Dual Eligibles

If a situation occurs where a dual eligible needs to have prescriptions filled at the pharmacy and this individual is unaware of the PDP into which he or she is enrolled, the pharmacy provider should contact CMS's True Out-of-Pocket (TrOOP) facilitator contractor (NDC Health is the TrOOP facilitator) to determine the PDP and copayment information. (Information about the TrOOP facilitator may be found at <http://medifacd.ndchealth.com.>)

SECTION 2 POLICIES AND PROCEDURES

SPECIAL GROUPS/ISSUES

CMS's Contingency Plan for Dual Eligibles (Cont'd.)

If the dual eligible is not enrolled in a PDP, then the pharmacy provider should follow through with CMS's POS-facilitated enrollment process **to ensure that the individual obtains his or her needed prescription medication(s) before leaving the pharmacy.** Pharmacy providers should note that this process is applicable to only **dual eligibles**

CMS has contracted with Humana to serve as the enrollment contractor for non-enrolled dual eligibles. Humana will expedite the validation of dual eligibility and process claims at POS to facilitate enrollment in a Medicare Part D Plan with low income premium subsidy for dual eligibles that were not auto enrolled. This enrollment in Contract X0001 will be done through the Limited Income Newly Eligible Transition program, LINET.

Pharmacy providers may execute an E1 query to determine whether a dual eligible is already enrolled in Contract X0001. Beneficiaries may receive services through Contract X0001 for up to two months until CMS enrolls them into another plan. The pharmacy provider should submit an E1 query each new month to determine when the beneficiary has been enrolled into a permanent Part D plan. Pharmacy providers and dual eligible beneficiaries may contact Humana at 1-800-783-1307 for assistance with LINET.

WAIVER PROGRAMS OPERATED BY DIVISION OF COMMUNITY LONG TERM CARE

The Division of Community Long Term Care (CLTC) operates four home- and community-based services waiver programs through its statewide network of area offices. These waivers serve the following individuals: 1) the elderly and disabled (E/D); 2) persons with HIV/AIDS; 3) persons dependent on mechanical ventilation (VENT), and 4) SC Choice participants.. Those adult beneficiaries enrolled in the HIV/AIDS or VENT waiver programs are allowed two additional prescriptions per month above the current monthly limit.

(All previously designated exceptions to the monthly limit remain in effect for waiver program participants.)

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SPECIAL GROUPS/ISSUES

SOUTH CAROLINA DEPT. OF DISABILITIES AND SPECIAL NEEDS WAIVER PROGRAMS

The Department of Disabilities and Special Needs (DDSN) operates two home- and community-based services waiver programs through its statewide network of local boards. These waivers are for: 1) persons with mental retardation or related disabilities (MR/RD) and 2) persons with head and spinal cord injuries (HASCI). Adult beneficiaries enrolled in either of these waivers are allowed additional prescriptions per month above the current monthly limit; adult individuals enrolled in the MR/RD waiver are allowed two additional prescriptions per month, and those enrolled in the HASCI waiver are entitled to three additional prescriptions per month. [Those pharmaceuticals designated as routine exceptions to the monthly limit remain in effect.] Individuals interested in possible HASCI enrollment may contact 866-867-3864 (toll-free) for additional information.

FAMILY PLANNING SERVICES

The Family Planning Program is a statewide program whose primary objective is to ensure that all eligible beneficiaries have access to publicly supported outpatient family planning services. Additionally, one course of treatment for certain sexually transmitted infections (STIs) found during the family planning visit will be covered. Potential beneficiaries are between the ages of 10 and 55 who: 1) are at or below 185% of the Federal Poverty Level, 2) have no health insurance, 3) are legal residents of South Carolina, and 4) have not had a sterilization procedure.

Outpatient contraceptive pharmaceuticals and devices (both legend and over-the-counter), family planning office or clinic examinations, related laboratory services, and counseling services related to family planning and birth control methods are covered under this program.

Additionally, covered services include testing for STIs when performed during the initial or annual physical exam and treatment for certain STIs diagnosed during the initial or annual family planning office or clinic visit. Providers are reminded that Medicaid beneficiaries must present a prescription for *any* pharmaceuticals or devices dispensed to them, including OTC items.

All prescriptions written for STIs, family planning pharmaceuticals, devices, or supplies are exempt from the collection of the \$3.40 Medicaid copayment; also, contraceptive items do not count toward an adult participant's monthly prescription limit.

SECTION 2 POLICIES AND PROCEDURES

SPECIAL GROUPS/ISSUES

FAMILY PLANNING SERVICES (CONT'D.)

Beneficiaries can receive initial antibiotic treatment for the following STIs: syphilis, chlamydia, gonorrhea, herpes, candidiasis, and trichomoniasis but will only be allowed to receive one course of treatment per year under the waiver. **The physician must write the ICD-9 diagnosis code on the prescription for the STI treatment in order for the medication to be considered for reimbursement by Medicaid.**

Participants in the Family Planning Program receive the same permanent plastic South Carolina Healthy Connections Medicaid card as others participating in the Medicaid program; thus, pharmacy services providers who do not utilize the Medicaid POS system for claims submission will be at risk for possible claims rejection.

MEDICAID HOSPICE SERVICES

Medicaid hospice services provide palliative care (relief of pain and uncomfortable symptoms) as opposed to curative care for terminally ill individuals. In addition to meeting the patient's medical needs, hospice care addresses the physical, psychosocial, and spiritual needs of the patient as well as the psychosocial needs of the patient's family and caregiver.

Hospice services are available to Medicaid beneficiaries who choose to elect the benefit and who have been certified by their attending physician and/or the Medical Director of the hospice company to be terminally ill (*i.e.*, a life expectancy of six months or less). Medicaid hospice services are provided to the beneficiary according to a plan of care developed by an interdisciplinary staff of the hospice. Among those services covered by the hospice provider are medical appliances and supplies, including drugs and biologicals, used for the relief of pain and symptom control related to the patient's terminal illness. A beneficiary who elects the hospice benefit must waive all rights to other Medicaid services related to treatment of the terminal condition for the duration of the election of hospice care.

Services (including prescriptions) rendered for illnesses or conditions NOT related to the terminal illness of the patient require prior authorization *from the hospice provider* (rather than from Magellan Medicaid Administration) before delivery. It is necessary for the hospice provider to verify that the services being provided

SECTION 2 POLICIES AND PROCEDURES

SPECIAL GROUPS/ISSUES

MEDICAID HOSPICE SERVICES (CONT'D.)

are for a condition not related to the terminal illness. Furthermore, hospice providers must maintain a documentation log of each prior authorization action and make this documentation available to the staff of DHHS upon request. Documentation must include the service that is prior approved; the service provision date; the Medicaid provider; the approving hospice authority and the date approval was issued. In situations where a dispute regarding whether a prior authorization was obtained, the documentation log will serve as the primary basis in resolving the disagreement.

It should be noted that even though prior authorization may be granted by the hospice provider, all claims billed to Medicaid remain subject to the coverage guidelines outlined in this manual. Furthermore, providers who do not utilize the Medicaid POS system for claims submission will be at risk for possible claims rejection. Specific billing instructions pertaining to hospice patients may be found in the Magellan Medicaid Administration

Pharmacy Provider Manual. Providers should contact the SCDHHS Provider Service Center at 1-888-289-0709 or submit an online inquiry at <http://www.scdhhs.gov/contact-us> if further information is needed.

PALMETTO SENIORCARE (PSC) CAPITATED BILLING PROGRAM

The Palmetto SeniorCare (PSC) is a program that provides an array of services to Medicaid beneficiaries eligible for long term care who reside in Richland and Lexington counties who are age 55 or older. These beneficiaries have voluntarily agreed to receive medical care *only* through PSC. Thus, they waive the right to choose any providers other than those providers who receive prior approval from PSC. Instead, these individuals accept the PSC as sole provider of all direct or indirect medical care.

A capitated payment is made to PSC each month for each enrolled beneficiary. **Once an individual is enrolled in the PSC program, neither Medicaid nor Medicare will pay any other providers for services rendered.** Pharmacy services providers who do not utilize Magellan Medicaid Administration's POS system for claims submission will be at risk for possible claims rejection. Questions regarding the PSC program may be directed to the PSC at 1-888-289-0709 or you may submit an online inquiry at <http://www.scdhhs.gov/contact-us>.

SECTION 2 POLICIES AND PROCEDURES**SPECIAL GROUPS/ISSUES****CLAIMS SUBMISSION FOR
CERTAIN PHYSICIAN-
INJECTABLE PRODUCTS**

Pharmacy providers may bill South Carolina Medicaid for certain physician-injectable products (in lieu of physicians having to “buy and bill”) when the product is administered to a patient in the physician’s office or clinic. This billing option is applicable for services provided to non-dually eligible, Medicaid fee-for-service beneficiaries only, and is not applicable for beneficiaries enrolled in a Medicaid managed care organization (MCO).

Physicians’ offices/clinics may either “buy and bill” omalizumab, leuprolide acetate, palivizumab (Synagis®), or Rh_o(D) immune globulin, Risperdal Consta, Invega-Sustenna and Depo Provera in compliance with existing Medicaid policies, or use the option of pharmacy billing.

Under this option, pharmacists may submit claims for Medicaid fee-for-service beneficiaries for omalizumab, leuprolide acetate, palivizumab, or Rh_o(D) immune globulin, Risperdal Consta, Invega Sustenna, and Depo Provera even though these injectables will be administered in the physician’s office.

As noted previously in this section, physicians must request PA for omalizumab; PA is not required for leuprolide acetate, palivizumab, or Rh_o(D) immune globulin, Risperdal Consta, Invega Sustenna or Depo Provera.

Due to safety and product stability issues, the pharmacy provider must ensure that the pharmaceutical is delivered *directly* to the physician’s office/clinic.

**REIMBURSEMENT
GUIDELINES FOR
INFLUENZA, RABIES, AND
PNEUMOCOCCAL
VACCINES**

Regarding long term care patients, the *Medicare Part B* program covers the administration of influenza and pneumococcal vaccines when furnished in compliance with any applicable State law by a provider of the services having a supplier number. Medicaid will not directly reimburse pharmacy providers for such vaccines where the long term care patient is dually eligible for both Medicare and Medicaid coverage. However, for those long term care patients having *only Medicaid coverage*, DHHS reimburses for the influenza virus and pneumococcal vaccines. Reimbursement is limited to no more than one influenza virus vaccine per beneficiary per flu season (*i.e.*, 270 consecutive days). After the initial pneumococcal vaccine is administered to an adult beneficiary, coverage for any necessary revaccination will be considered on a

SECTION 2 POLICIES AND PROCEDURES

SPECIAL GROUPS/ISSUES

REIMBURSEMENT GUIDELINES FOR INFLUENZA, RABIES, AND PNEUMOCOCCAL VACCINES (CONT'D.)

case-by-case basis. Rabies vaccines are covered for all FFS Medicaid beneficiaries with no restrictions, and are exempt from the monthly prescription limit.

Furthermore, those pharmacists with special certification to administer immunizations may submit claims to the Medicaid Pharmacy Services program for the *in-store administration* of influenza and pneumococcal vaccines. Such claims must be submitted using the NCPDP number or NPI. Reimbursement is limited to beneficiaries 21 years of age and older who have only Medicaid coverage; claims for those patients who are dually eligible for both Medicare and Medicaid must be billed to Medicare Part B.

Note: Effective with dates of service beginning January 1, 2007, Medicaid cannot be billed secondarily for Medicare Part B-covered vaccines. In those instances, the beneficiary's Medicare Part D PDP must be billed for any allowable secondary payment.

Influenza and pneumococcal vaccines administered in either setting are exempt from the monthly prescription limit. In addition to payment for the vaccines themselves, the SCMAC amounts established for these vaccines include a fee for administration of the drug.

Providers who have Medicare Part B reimbursement questions or who wish to obtain an enrollment application in order to request assignment of a Medicare Part B supplier number should contact the Medicare Part B Customer Service Center at 866-238-9654. It should be noted that a DMERC supplier number cannot be used to transmit vaccine claims that are covered under Part B Medicare.

PHARMACY SERVICES AND THIRD PARTY LIABILITY TPL

The Division of Third Party Liability identifies Medicaid beneficiaries having health insurance coverage in order to have that insurance pay for services primary to Medicaid. Providers utilizing the POS system for claims submission should receive immediate confirmation of other third party coverage if a claim rejects for that reason. [Providers who do not use the POS system must contact Magellan Medicaid Administration's Technical Call Center staff to obtain insurance verification and details regarding other third party coverage.] **Since Medicaid is the payer of last resort, the provider MUST request payment from any available third party resource (including Medicare Part**

SECTION 2 POLICIES AND PROCEDURES

SPECIAL GROUPS/ISSUES

PHARMACY SERVICES AND THIRD PARTY LIABILITY TPL (CONT'D.)

B) and may bill Medicaid only after third party payment is made or denied.

*(Note: If Medicare Part B denies payment because the drug is considered non-covered for the diagnosis indicated, the claim should then be submitted to the beneficiary's Medicare Part D prescription drug plan (PDP). Regarding PDP non-covered drugs, providers should be aware that South Carolina Medicaid will **not** be a secondary payer for products such as a PDP's non-formulary or non-preferred drug or a PDP's PA-required drug.)*

If the provider submits a claim to Medicaid prior to billing the responsible third party payer(s), the claim will reject (NCPDP edit 41) and will not be processed further until the provider either indicates the amount paid by the other third party payer(s) or is able to substantiate payment denial by the other third party carrier(s).

If it is determined that the provider is not fully complying with this claims submission policy, recoupment of the Medicaid monies will result.

If the POS system is used to transmit claims to Medicaid and the "submit to primary carrier" error message is returned, additional messaging information regarding the appropriate carrier code (unique five-digit code which identifies the insurance company), the patient's policy number, and the carrier name will be furnished on-line to the provider to facilitate submission of the claim to the designated third party payer(s). [A list of unique five-digit carrier codes may be found at <http://southcarolina.fhsc.com>.

Furthermore, where necessary, providers may contact Magellan Medicaid Administration's Technical Call Center staff to obtain relevant health insurance information.] It should be noted that a beneficiary may have more than one active other insurance policy. Subsequent carrier code/policy information will be displayed via the POS system until all active insurance coverage is exhausted. *No primary insurer copayments or deductible amounts should be collected from beneficiaries if the claim is for a Medicaid-covered product. Only the South Carolina Medicaid copayment (if applicable) should be collected from the beneficiary.* Billing questions regarding appropriate "other coverage" coding, etc., where other third party insurance is involved may be directed to

SECTION 2 POLICIES AND PROCEDURES

SPECIAL GROUPS/ISSUES

PHARMACY SERVICES AND THIRD PARTY LIABILITY TPL (CONT'D.)

Magellan Medicaid Administration's Technical Call Center staff at 1-866-254-1669.

When an insurance coverage has lapsed and the patient or provider has sufficient documentation to validate the termination date, such information (annotated to include the beneficiary's 10-digit

Health Insurance Number) should accompany a completed *Health Insurance Information Referral Form*; the application of a "lapse date" to the beneficiary's insurance record will facilitate timely claims processing and payment. Completed documents may be faxed to Medicaid Insurance Verification Services (MIVS) at 803-252-0870. Additionally, the *Health Insurance Information Referral Form* may be used to furnish information to DHHS staff regarding potential private health insurance coverage not yet reflected in the database. (A sample *Health Insurance Information Referral Form* may be found in Section 5.)

It should be noted that Kaiser Permanente is an HMO that currently has no enrolled pharmacy providers in South Carolina; therefore, Medicaid beneficiaries having insurance coverage through this particular HMO should not be denied pharmaceutical services since there are no Kaiser Permanente-enrolled pharmacies within the state of South Carolina. (See Section 3 and the Third-Party Liability Supplement found elsewhere in this manual for additional TPL-related information. The Magellan Medicaid Administration Pharmacy Provider Manual also contains detailed claims filing instructions regarding coordination of benefits/third party liability.)

ZIDOVUDINE (AZT) SYRUP FOR NEWBORNS

In an effort to ensure timely access to critical AZT therapy for at-risk newborns and to maximize patient compliance, the DHHS will allow the pharmacy provider to bill Medicaid using the mother's Medicaid Health Insurance Number when dispensing the initial six weeks' supply of AZT syrup. Billing this drug to the mother's Medicaid identification number is permissible *only* in those instances where the newborn has not yet been assigned a Medicaid Health Insurance Number at the time of dispensing. This special billing policy pertains **ONLY** to the initial dispensing of AZT syrup; **other medications dispensed to newborns may not be billed to Medicaid in such a manner.**

SECTION 2 POLICIES AND PROCEDURES

SPECIAL GROUPS/ISSUES

RETROACTIVE MEDICAID ELIGIBILITY REIMBURSEMENT ISSUES

When a patient becomes retroactively eligible for Medicaid coverage, pharmacists may subsequently choose to bill Medicaid for reimbursement.

(This is a *voluntary* practice; in such cases, the provider is not obligated to submit claims to the Medicaid program.) Often, however, these patients have already paid for prescriptions dispensed prior to their retroactive eligibility determination. In these instances, if the provider *chooses* to bill Medicaid in order to make appropriate refunds to the patient, Medicaid's reimbursement is payment in full. The provider may only keep any applicable Medicaid copayment. (See Section 1 for additional policy regarding retroactive eligibility.)

MEDICAID COVERAGE OF OTC PHARMACEUTICALS

The South Carolina Department of Health and Human Services reimburses for most *rebated* over-the-counter (OTC) generic pharmaceuticals, including those products formerly designated as "legend."

The majority of nationally marketed over-the-counter products are rebated by their respective manufacturers and may be considered for Medicaid reimbursement within program guidelines (*e.g.*, monthly prescription limit). Most chain pharmacies, however, do not provide federally mandated rebate monies for their "house brand" OTCs; and thus, those specific products are deemed not covered. Additionally, in some instances, prior authorization may be required (*e.g.*, product not on PDL).

For each OTC product dispensed, a valid prescription authorized by a licensed practitioner (*i.e.*, physician, dentist, optometrist, podiatrist, or other health care provider authorized by law to diagnose and prescribe drugs and devices) must be on file. Covered over-the-counter family planning pharmaceuticals and devices are exempt from the monthly prescription limit in effect for adult beneficiaries. Insulin and insulin syringes are reimbursed through the Pharmacy Services program. Diabetic devices and supplies (*e.g.*, glucometers, test strips, and lancets, etc.) are covered under the South Carolina Medicaid Durable Medical Equipment (DME) program; however, certain preferred glucometers, test strips and spacers for metered dose inhalers may be billed by an enrolled DME provider under the Pharmacy POS system.

SECTION 2 POLICIES AND PROCEDURES

SPECIAL GROUPS/ISSUES

COVERAGE POLICY FOR MULTI-INGREDIENT COMPOUNDS

Providers should be aware that multi-ingredient compounds are *non-covered* by South Carolina Medicaid if that specific combination of ingredients is commercially available from a pharmaceutical manufacturer. Therefore, such compounds must not be billed to Medicaid. Additionally, the reconstitution of commercially available products is not considered compounding and as such, may not be billed to Medicaid as a compound. (See Section 3 for instructions regarding claims submission.)

SECTION 2 POLICIES AND PROCEDURES

RECORDS REQUIREMENTS

TYPES OF RECORDS

Records are defined as, but are not limited to the following: prescription drug orders, chart orders, annotations to identify the specific drug dispensed, drug invoices, annotations to reflect refills issued, retained copies of claims filed (if submitting non-POS claims), pharmacy patient record system per individual patient, and any other documentation required by state and federal laws or requirements. Additionally, specific claims payment and/or denial information pertaining to other third party payers should be retained as part of the provider's records. Such coordination of benefits (COB) documentation serves to substantiate that the provider has made every effort possible to collect monies from all other third party payers prior to submitting a claim to Medicaid. All records pertinent to this section must be readily available.

A pharmacy patient record system must be maintained by all pharmacies for patients for whom prescription drug orders are dispensed. The pharmacy patient record system shall provide for the immediate retrieval of information necessary for the dispensing pharmacist to identify previously dispensed drugs at the time a prescription drug order is presented for dispensing.

Pharmacists are advised that a pharmacy patient record system should include the following information:

- Full name of the patient for whom the drug is intended
- Address and telephone number of the patient
- Patient's age or date of birth
- Patient's gender
- List of all prescription drug orders obtained by the patient at the pharmacy during the two years immediately preceding the most recent entry showing the prescription number, name, and strength of the drug, the quantity and date received, the number of refills given, the date of each refill, the identity and quantity of each refill if different from the prescribed quantity, the identity of the dispensing pharmacist and the name of the prescriber

SECTION 2 POLICIES AND PROCEDURES

RECORDS REQUIREMENTS

TYPES OF RECORDS (CONT'D.)

- Pharmacist's comments relevant to the individual's drug therapy, including any other information peculiar to the specific patient or drug and additional comments such as the refusal of the pharmacist's offer to counsel or the patient's refusal to provide information.

The pharmacist shall make a reasonable effort to obtain information from the patient or the patient's agent regarding any known allergies, drug reactions, idiosyncrasies and chronic conditions or disease states of the patient and the identity of any other drugs, including OTC drugs, or devices currently being used by the patient which may relate to prospective drug utilization review. This information shall be recorded in the patient's record.

An automated system that provides the information detailed in the *Records Requirements* portion of this section and meets the requirements outlined in the South Carolina Pharmacy Practice Act may be utilized. Such an automated system shall have the capability of producing sight-readable information on all original and refill prescription drug orders and the pharmacy patient record system.

ACCURACY OF RECORDS

It is crucial that information be recorded in an accurate manner consistent with Medicaid guidelines and pharmacy law. Records function as proof of services rendered and are used for postpayment review purposes.

RECORDS RETENTION

As stated in Section 1, the provider must maintain such records as are necessary to disclose fully the extent of services provided and must make these records available during regular business hours. **The minimum retention period for Medicaid records is five years.**

Additionally, should a change in ownership occur, such records generated by the previous owner should be maintained by the responsible party for three years or longer if an on-going postpayment review is involved. Computer storage of prescription file information is allowed, providing that such storage meets all state and federal requirements.

SECTION 2 POLICIES AND PROCEDURES

RECORDS REQUIREMENTS

LONG-TERM CARE FACILITY RECORDS

Copies of chart orders must be retained for postpayment review purposes either by the nursing facility or by the pharmacy, as described in the information above. A chart order is defined as a lawful order from a practitioner for a drug or device for patients of a hospital or extended care facility. If requested, it is the pharmacy provider's responsibility to obtain these records for auditing purposes.

SECTION 2 POLICIES AND PROCEDURES
RECORDS REQUIREMENTS

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SECTION 2 POLICIES AND PROCEDURES

POSTPAYMENT REVIEWS

Postpayment reviews of documentation, program compliance, and billing procedures are conducted by the Division of Program Integrity. Many of the discrepancies cited could be avoided by adhering to the policies and procedures outlined in the Medicaid Pharmacy Services Provider and Magellan Medicaid Administration Pharmacy Provider Manuals and state and federal requirements regarding the practice of pharmacy. The following topics represent some of the most common discrepancies identified during postpayment reviews:

TAMPER-RESISTANT PRESCRIPTION PADS

Effective October 1, 2007, pharmacies that receive Medicaid reimbursement for written, non-electronic outpatient prescriptions and/or their refills, issued on prescription pads that do not meet the specified criteria for tamper-resistant or those that were not exempt from the criteria, will be required to repay the full Medicaid reimbursement for the prescription(s).

"BRAND MEDICALLY NECESSARY" PRESCRIPTIONS

The use of the "Brand Medically Necessary" claims filing designation (*i.e.*, DAW code of '1') affects reimbursement only for those brand name products with upper limits of payment restrictions (*i.e.*, FUL or SCMAC) established for that date of service. The pharmacist must only use the DAW code of '1' to obtain higher Medicaid reimbursement when the prescriber certifies *in his/her own handwriting* that a specific brand is medically necessary for a particular patient. The handwritten phrase "brand necessary" or "brand medically necessary" must appear on the face of the prescription. A dual line prescription blank (*e.g.*, signing on the "Dispense As Written" line) does not satisfy the brand medically necessary requirement, nor does a blanket statement from the prescriber stating that the patient must have a brand name product satisfy this federal requirement.

The *prescriber's* (NOT his or her staff or agent's) handwritten notation on the prescription certifying "brand necessary" or "brand medically necessary" is the only permissible means for obtaining Medicaid reimbursement for the brand name product.

SECTION 2 POLICIES AND PROCEDURES

POSTPAYMENT REVIEWS

"BRAND MEDICALLY NECESSARY" PRESCRIPTIONS (CONT'D.)

Therefore, in order to avoid recoupment of Medicaid monies, care should be taken PRIOR to billing (*i.e.*, prescriber must complete the South Carolina Medicaid MedWatch form and certify the prescription as "brand necessary" or "brand medically necessary") to ensure that *appropriate claims filing procedures have been followed.*

Note: Those brand name NTI drugs having an established FUL or SCMAC on the date of service do NOT require prior authorization via approval of the South Carolina Medicaid MedWatch form; however, NTI drugs are subject to the "brand necessary" or "brand medically necessary" certification requirements outlined above. Prescriptions for NTI drugs which are not properly annotated are subject to postpayment review and recoupment of Medicaid monies.

SECTION 2 POLICIES AND PROCEDURES

POSTPAYMENT REVIEWS

APPROPRIATE UTILIZATION OF MONTHLY PRESCRIPTION LIMIT OVERRIDE PROCESS

Pharmacists may utilize an override code to exceed the monthly prescription limit for *adult* Medicaid beneficiaries if certain prescription limit override criteria are met. However, it is inappropriate for pharmacy providers to generally promote this particular billing process since not all prescriptions can meet the override criteria. Pharmacists should submit the prescription limit override code on the claim if: 1) *the monthly prescription limit has been met*, 2) the patient has one of the following conditions, and 3) the prescription is for an *essential drug* used in the patient's treatment plan for one of these conditions: *acute sickle cell disease, behavioral health disorder, cancer, cardiac disease (including hyperlipidemia), diabetes, end stage lung disease, end stage renal disease (ESRD), HIV/AIDS, hypertension, life-threatening illness (not otherwise specified), organ transplant, or terminal stage of an illness.*

The override of the monthly prescription limit is reserved for only those prescriptions that meet the prescription override criteria. Pharmacists are expected to make sound clinical decisions regarding use of the prescription limit override on an individual prescription/patient basis. If a pharmacist is uncertain as to the appropriateness of a prescription limit override for a particular medication, the pharmacist should contact the prescriber to obtain additional clinical, patient-specific information so that an informed Medicaid coverage decision may be made. In such instances, the prescription should be annotated to reflect the patient's diagnosis as verified verbally by the prescriber. **Pharmacists must NOT use the override code for a given prescription until after the adult beneficiary's monthly prescription limit has been reached. Since children from birth to age 21 are eligible for an unlimited number of Medicaid-covered prescriptions per month, the override mechanism must NOT be utilized when submitting claims for children.**

Pharmacy providers are advised to carefully review their current practices regarding the override process. Pharmacies will be audited to ensure compliance with prescription limit override policies.

SECTION 2 POLICIES AND PROCEDURES

POSTPAYMENT REVIEWS

QUANTITY OF MEDICATION

The quantity dispensed must not exceed the total quantity ordered by the prescriber. Additionally, the quantity dispensed and the quantity billed must agree.

Generally, to avoid prescription splitting and unnecessary use of the adult beneficiary's limited number of monthly prescriptions, if a prescription is written for an amount sufficient for a 30-day supply, no less than a 30-day supply may be billed to the Medicaid program. However, due to issues regarding drug stability or patient safety, some exceptions to this policy are deemed reasonable (*e.g.*, clozapine therapy, C-II's, etc.). If the provider does not have enough stock on hand to fill a prescription as written, he or she may submit a POS claim indicating the partial quantity dispensed. (Detailed information regarding partial fill functionality may be found in the Magellan Medicaid Administration Pharmacy Provider Manual.) If a non-POS method of claims submission is used, billing Medicaid should be deferred until the entire quantity ordered by the prescriber has been dispensed to the beneficiary.

The Medicaid program reimburses for a maximum one-month supply of medication per prescription or refill or for a days' supply commensurate with the smallest package size available. The DHHS defines a one-month supply as a maximum 31-days' supply per prescription for non-controlled substances. Providers should refer to the South Carolina Controlled Substances Regulations promulgated by the South Carolina Department of Health and Environmental Control (DHEC) for maximum quantity limitations on prescriptions for controlled substances. Additional information regarding this subject may be found earlier in this section.

NO WRITTEN RECORD OF PRESCRIPTION

Providers must maintain original prescription documents in one of the three required appropriate prescription files. These documents must be readily retrievable and retained according to Medicaid policy and State pharmacy law. Providers are reminded that all state and federal requirements must be adhered to regarding prescription documentation and authenticity of records. Prescription records function as proof of services rendered, and it is the pharmacy provider's responsibility to retain these records for auditing purposes.

Additionally, providers are cautioned not to retroactively

SECTION 2 POLICIES AND PROCEDURES

POSTPAYMENT REVIEWS

NO WRITTEN RECORD OF PRESCRIPTION (CONT'D.)

reproduce lost or misplaced original prescription documents. Upon proof of such activity, further administrative actions or sanctions may be taken, including recoupment of Medicaid monies and suspension or termination from the Medicaid program.

USE OF VALID PRESCRIBER IDENTIFICATION NUMBERS

It is imperative that pharmacy providers submit valid prescriber identification numbers when submitting pharmacy claims. The submission of valid prescriber identification information on pharmacy claims is a critical component of provider participation in the Medicaid program. Drug utilization review (DUR), federal drug rebate data, and various Medicaid reporting systems are dependent upon the accuracy of information submitted on pharmacy claims. Therefore, the reporting of inaccurate or invalid prescriber identification numbers adversely impacts the effectiveness and reliability of many programs. If it is determined that the provider is not complying with this policy, recoupment of Medicaid monies will result. Reference detailed information in Section 3 regarding the proper use and submission of the prescriber's designated identification number.

REFILLS

Refills are to be provided only if authorized by the prescriber, allowed by law, and should be in accordance with the best medical and pharmacological practices. Refills must not exceed the number authorized by the prescriber. Refill documentation must be accurate and easily accessible for postpayment-payment purposes. If a refill authorization is received orally, sufficient documentation must be present on the original prescription. At least 75% of the current prescription must be used (according to the prescriber's directions) prior to submitting a refill claim for Medicaid payment. In those instances where a refill requires a new and separate prescription (*i.e.*, controlled substances), a new prescription must be issued in accordance with state and federal requirements.

Automatic Refill Programs shall not be used for SC Medicaid beneficiaries. A pharmacy provider shall not automatically generate refills for SC Medicaid beneficiaries.

SECTION 2 POLICIES AND PROCEDURES

POSTPAYMENT REVIEWS

PACKAGE SIZE/UNIT-DOSE PACKAGING

Providers *must* bill Medicaid using the NDC number that reflects the actual package size from which the medication was dispensed and the original prescription or the patient profile documents such. Manufacturer rebate payments to the State are based on prescription claim payment data by NDC number. To assure that the appropriate manufacturer is billed for the rebate, it is imperative that pharmacists take care to correctly identify the NDC number (and thus the package size) of the pharmaceutical dispensed.

Providers may be required to furnish invoice documentation to substantiate claims information billed to Medicaid. Failure to adhere to this policy will result in the recoupment of Medicaid monies.

The dispensing of unit-dose packaging to the general public is strongly discouraged and should be restricted to those individuals residing in an institutional setting (*e.g.*, nursing facility, ICF-MR, residential care facility, or boarding home). Furthermore, if medication is re-packaged by the provider prior to dispensing or delivery, Medicaid beneficiaries may NOT be charged a repackaging fee.

SECTION 2 POLICIES AND PROCEDURES

POSTPAYMENT REVIEWS

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SECTION 3

BILLING PROCEDURES

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SECTION 3 BILLING PROCEDURES

GENERAL INFORMATION

BILLING MEDIA INFORMATION

The Department of Health and Human Services (DHHS) has contracted with Magellan Medicaid Administration to process pharmacy claims using a computerized point-of-sale (POS) system. Currently, Magellan Medicaid Administration requires that POS claims be submitted using the National Council for Prescription Drug Programs (NCPDP) Telecommunication Standard Format Version 5.1. This on-line system allows participating pharmacies real-time access to beneficiary eligibility, drug coverage, pricing and payment information, and Prospective Drug Utilization Review (ProDUR) across all network pharmacies. Although claims submission via POS is preferred, the following are acceptable media alternatives for claims submission: cartridges (IBM 3480 – NCPDP v1.0), diskettes (3½”, unzipped – batch format version 1.1), and paper (*i.e.*, Universal Claim Form). Payer specifications for NCPDP Version 5.1 or NCPDP Batch Transaction Standard Version 1.1 may be obtained from the NCPDP. South Carolina Medicaid-enrolled pharmacies must have an active enrollment status for any dates of service submitted. Additionally, providers should contact Magellan Medicaid Administration or their software vendor in order to determine if the vendor is certified with Magellan Medicaid Administration.

Detailed billing instructions may be found in the current Magellan Medicaid Administration Pharmacy Provider Manual. Furthermore, Magellan Medicaid Administration provides assistance through its Technical Call Center, which is staffed 24 hours a day, seven days a week. For answers to questions not otherwise addressed in this manual, or if additional information is needed, providers may contact Magellan Medicaid Administration (toll-free) at 1-866-254-1669.

SECTION 3 BILLING PROCEDURES

GENERAL INFORMATION

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SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

SUBMISSION OF CLAIMS

In compliance with federal requirements, all original Medicaid claims must be received by the point-of-sale (POS) contractor within one year from the date of service in order to be considered for payment. This requirement also applies to reversals of POS claims previously submitted if the provider intends to resubmit a corrected claim. (However, claims involving retroactive beneficiary eligibility are exempt from this timeline.) Incorrectly forwarded non-POS claims result in delayed processing time and add unnecessary administrative costs. To facilitate prompt reimbursement, non-POS providers should note each of the following addresses to ensure appropriate claims submission. Hard copy claims (*i.e.*, Universal Claim Forms in D.0 format) may be obtained by going to www.ncpd.org/products.aspx, and the completed form should be forwarded to:

**Magellan Medicaid Administration Services
Corporation
South Carolina Paper Claims Processing Unit
Post Office Box 85042
Richmond, VA 23261-5042**

Diskettes should be mailed to the following address:

**Magellan Medicaid Administration Services
Corporation
Operations Department/South Carolina Medicaid
4300 Cox Road
Glen Allen, VA 23060**

Cartridges should be forwarded to the following address:

**Magellan Medicaid Administration Services
Corporation
Media Control/South Carolina EMC Processing
Unit
4300 Cox Road
Glen Allen, VA 23060**

Compliance with these instructions facilitates claims processing and subsequent reimbursement. Non-POS providers are advised, however, that weekly submissions may not always result in reimbursement on a weekly basis

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

SUBMISSION OF CLAIMS (CONT'D.)

due to various factors, including processing limitations and peak volumes of claims received.

If a non-POS claim submitted for payment has not appeared on a provider's Remittance Advice (RA) within 45 days of the date forwarded, the provider should resubmit the claim.

GENERAL BILLING INSTRUCTIONS

Submission of NDCs

As regards the National Drug Code (NDC) number used in claims filing, providers must take care to **submit the NDC listed on the package or container from which the medication was actually dispensed**. If 100 tablets are dispensed from a bottle of 1000, the NDC from the larger package must be used. Manufacturer rebate payments due to the State are based on prescription claims payment data identified by NDC number. To assure that the appropriate manufacturer is invoiced for the rebate monies due the State, accurate NDC numbers must be submitted on Medicaid claims. Manufacturers use various methods to verify that the claims data that the State furnishes on the rebate invoice accurately reflects their utilization and sales history information, which is specific to the zip code of the pharmacy. The significance of not using the correct NDC number when billing Medicaid becomes apparent when the manufacturer receives a rebate invoice for NDC numbers that are obsolete or for pharmaceuticals which have a limited or non-existent sales history.

Therefore, pharmacists are urged to verify that the NDC billed to Medicaid is identical to the NDC on the package or container from which the medication was dispensed. Additionally, pharmacists must make any necessary software changes to ensure that the correct NDC number is submitted to Medicaid for reimbursement. Failure to comply with this policy may result in the recoupment of Medicaid monies.

As regards the correct billing format, the basic configuration for an NDC number is 5-4-2 (11 digits total). **In order to reduce processing errors, zeroes must be added to many NDC numbers in order to have 11 total digits**. Examples of the different configurations and the proper placement for the added zeroes are shown below:

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Submission of NDCs (Cont'd)

A 4-4-2 code requires a leading zero in the labeler code.

Example: 1234-5678-91 becomes 01234567891

A 5-3-2 code requires a leading zero in the product code.

Example: 12345-678-91 becomes 12345067891

A 5-4-1 code requires a leading zero in the package code.

Example: 12345-6789-1 becomes 12345678901

Metric Decimal Quantities

Providers should note that DHHS *requires* the use of the “metric decimal” quantity on Medicaid pharmacy claims. A “rounded” or “rounded up” number must NOT be submitted as the billed quantity when the dispensed amount is a fractional quantity. **If the dispensed quantity is a fractional amount, then the billed quantity must accurately reflect the specific metric decimal quantity that is dispensed.** For example, the quantity billed per each Lovenox® 120mg/0.8ml prefilled syringe [NDC 00075-2912-01] should be .8ml; in this instance, the quantity submitted should NOT be “per syringe.” The actual metric decimal package size for this specific NDC is .8ml. To further clarify, the *billed quantity* of a product packaged in *fractional quantities only* should be a numerical factor of that product’s metric decimal package size. Billing incorrect quantities negatively affects quarterly rebate invoice data and results in under- or overpayment to providers. Furthermore, mispaid claims due to inaccurate quantities are subject to postpayment review and when appropriate, recoupment of monies. Pharmacy providers must evaluate their software and billing processes in order to ensure that the prescription quantity that is billed to Medicaid accurately reflects the dispensed quantity. [For additional information, see *Quantity Billing Instructions for Certain Pharmaceuticals* located elsewhere in this section.]

Days’ Supply

Medicaid reimburses for a maximum one-month supply of medication per prescription or refill. DHHS defines a one-month supply as a maximum 31-days’ supply per prescription for non-controlled substances. When submitting claims, it is important to accurately record the actual days’ supply of medication dispensed [*e.g.*, a 28-pill pack of oral contraceptives should be billed as a 28-day supply, not a 30-day supply].

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Days' Supply (Cont'd.)

DHHS has noted that pharmacy claims for many products, especially non-tablet or non-capsule product formulations (e.g., ophthalmic solutions, dermatologicals, insulin, etc.), are being submitted with an inaccurate days' supply.

The Drug Utilization Review (DUR) programs (both prospective and retrospective) rely entirely upon billing information from pharmacy providers to determine a beneficiary's over- or underutilization of medications. Submission of erroneous prescription billing information leads to invalid reporting by DHHS and, potentially, Medicaid overpayments. Pharmacy providers are urged to discontinue use of any "routine values" in the days' supply field that are being used to avoid rejection of prescription claims or to circumvent the "refill too soon" edit. *Information submitted on pharmacy claims must be entirely accurate.* The pharmacist-in-charge at each Medicaid-enrolled pharmacy must oversee and ensure compliance with this billing requirement.

Prescriber Identification Number

Effective December 9, 2009, pharmacy providers are **required** to include the prescriber's **NPI number** as the prescriber identification number when submitting Medicaid pharmacy claims; the prescriber's DEA number may NOT be used in lieu of the NPI. The submission of **valid** prescriber identification information on pharmacy claims is a critical component of provider participation in the Medicaid program. Drug utilization review, federal drug rebate data, and various Medicaid reporting systems are dependent upon the information submitted on pharmacy claims. Additionally, valid prescriber identification data enhances the effectiveness of DHHS' Medicaid Fraud and Abuse unit's activities. Thus, submission of inaccurate or invalid prescriber identification numbers adversely impacts the effectiveness and reliability of many programs. Any software programs or claims filing deficiencies that may result in the submission of invalid prescriber identification numbers must be corrected immediately; providers are urged to contact their software vendors or billing agents to ensure that this critical claims submission issue has been adequately addressed. *Pharmacy providers will be audited for inappropriate utilization of identification numbers other than the prescriber's own assigned NPI.*

In the event that a prescriber does not have an individual

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Prescriber Identification Number (Cont'd.)

NPI, the facility NPI (ex.: hospital) may be submitted.

If neither an individual NPI nor facility NPI can be identified, providers may then contact the Magellan Medicaid Administration Technical Call Center at 1-866-254-1669 to request an override. An override will **ONLY** be granted if it is verified that the prescriber does not have an NPI. For the override to work successfully, providers must submit a Prescriber ID Qualifier of 13, and enter the state license number in the Prescriber ID field.

BENEFICIARY ID NUMBER

Enter the patient's Medicaid Health Insurance Number as it appears on the plastic, South Carolina Healthy Connections card. **It must be ten digits.** Each Medicaid beneficiary is assigned a unique identification number.

"BRAND MEDICALLY NECESSARY" DESIGNATION

If the **prescriber** has certified in his or her own handwriting on the prescription that the use of the brand name product is medically necessary, the pharmacy provider may enter a value of "1" in the Dispense as Written (DAW) field. However, with few specified exceptions, the claim will then deny for "PA required." The **prescriber** must contact the Magellan Medicaid Administration Clinical Call Center (1-866-247-1181) to request a prior authorization. *It is the provider's responsibility to ensure that his or her computer software (and/or billing agent) is utilizing a DAW value of "1" in an appropriate manner.*

PROVIDER IDENTIFICATION NUMBER

Effective February 13, 2008, all pharmacy providers will be required to submit only the pharmacy's NPI (NOT the NABP/NCPDP number) in the Service Provider ID field (NCPDP field number 201-B1) on pharmacy claims. When submitting claims using the NPI, Pharmacy Services providers are reminded to use the Service Provider ID qualifier of "01" in NCPDP field number 202-B2. Pharmacy claims with adjudication dates on or after February 13, 2008 will reject if the service provider's NPI is not submitted. No overrides will be allowed for claims that reject due to non-use of the NPI.

PRESCRIPTION NUMBER

Each claim billed to Medicaid **must** have an assigned unique prescription number. [Field may contain up to twelve numeric characters.]

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

SPECIAL BILLING ISSUES/INSTRUCTIONS

340B Providers

Providers designated as 340B providers must be listed on the HRSA Web site (<http://www.hrsa.gov/opa>). Any products obtained at 340B pricing must be billed by entering the pharmacy's drug acquisition cost plus the dispensing fee in the usual and customary field when adjudicating prescription claims.

Monthly Prescription Limit Override Procedures

Prior to claims submission, providers should thoroughly review the policies stated in the *Monthly Prescription Limit Override Criteria for Adult Beneficiaries* portion of Section 2. It should be reiterated that the override of the monthly prescription limit is reserved for only those prescriptions that, in the clinical judgment of the pharmacist, meet the stipulated prescription limit override criteria. If the provider then deems a given prescription for an adult beneficiary meets the designated override criteria, he or she should enter the number "05" in the *Prior Authorization Type Code* field (NCPDP field #461-EU). **The eleven-digit *Prior Authorization Number* field (NCPDP field #462-EV) should be left blank.** Providers who submit paper claims (*i.e.*, UCFs) should indicate the number "05" in the field designated as *PA Type*.

Use of the monthly limit override code is systematically restricted for those therapeutic classes that normally do not meet the override criteria (*e.g.*, vitamins, laxatives, and so forth). However, it should be noted that this override restriction does not imply that use of the override code is appropriate for all prescriptions for medications in the non-restricted therapeutic classes. Pharmacists are expected to review the override criteria and then make sound clinical decisions on an individual prescription/patient basis. If, in the pharmacist's judgment, a prescription for a medication in a restricted therapeutic class meets the necessary criteria, he or she may call the Magellan Medicaid Administration Clinical Call Center at 1-866-247-1181 (toll-free) to request prior authorization. Pharmacies will be audited for appropriate utilization of the prescription limit override code.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Pharmacy Claims for Dually Eligible Medicare Part B-Covered Beneficiaries

In the pharmacy point-of-sale (POS) environment, information regarding potential Medicare Part B drug coverage for dually eligible beneficiaries is communicated to providers when submitting POS pharmacy claims. Such messages are sent because Medicare Part B is the primary payer for certain drugs under specific conditions; therefore, providers are instructed to submit claims for those drugs (using their respective supplier billing numbers) to Medicare Part B for reimbursement.

Pharmacy providers may bill *Medicaid* **secondarily** for those Medicare Part B prescriptions where:

- Medicare **Part B** paid any portion of the Pharmacy Services provider's submitted charge or
- The claim paid amount was applied to the Medicare **Part B** annual deductible and
- The Medicare **Part B** reimbursement to the pharmacy provider *is less than the amount that Medicaid would have paid if Medicaid had served as the primary payer.*

In compliance with Medicare policy, prescriptions for certain designated drugs for dually eligible beneficiaries should be billed first to Medicare Part B. When billing a prior authorized claim secondarily to Medicaid, the coordination of benefits (COB) data elements are applicable and must be appropriately populated. (Note: Effective with dates of service beginning January 1, 2007, Medicaid cannot be billed secondarily for Medicare Part B-covered vaccines. In those instances, the beneficiary's Medicare Part D PDP must be billed for any allowable secondary payment.) Medicaid will reimburse pharmacists up to the Medicaid allowed amount, less payment received from Medicare Part B. This reimbursement is considered payment in full. The carrier code used to designate Medicare Part B is 90798. (Pharmacy providers are reminded that only rebated drugs may be considered for reimbursement by the Medicaid program.) For further instructions pertaining to COB claims filing, pharmacists may contact the First Health Technical Call Center at 866-254-1669 (toll-free).

The calculated *Medicaid* reimbursement should reflect the difference between the **Medicare Part B** paid amount and

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Pharmacy Claims for Dually Eligible Medicare Part B-Covered Beneficiaries (Cont'd.)

the amount that *Medicaid* would have paid if billed as primary.

A prescription billed secondarily to *Medicaid* after **Medicare Part B** reimbursement is exempted from the monthly prescription limit. Therefore, in these instances, the billing procedure in place to override the adult beneficiary's monthly prescription limit is not necessary.

Medicare telephone number (toll-free):

866-238-9652

Medicare mailing address:

National Supplier Clearinghouse
P. O. Box 100142
Columbia, South Carolina 29202-3142

Medicare Web site:

<http://www.palmettogba.com/>

Cost Avoidance Claims Processing

For those beneficiaries having other third party coverage, providers must file claims to the primary health insurance carrier(s) prior to billing Medicaid. If a claim is billed initially to Medicaid when there is applicable insurance coverage on file, the claim will reject for NCPDP edit 41 ("submit bill to other processor or primary payer"). For providers who use the POS system for claims submission, Magellan Medicaid Administration will return a unique 5-digit carrier code identifying the other carrier(s), the patient's policy number(s), and the carrier name(s); this on-line information is displayed in an additional message field. If reimbursement is received from multiple payer sources, Medicaid **requires** the *total amount paid* from ALL payer sources to be entered in the OTHER PAYER AMOUNT field. Pharmacies are audited for compliance that a dollar amount that accurately reflects the total amount paid from all third party payer sources has been entered in this field.

Pharmacy providers are advised that a system change concerning coordination of benefits (COB) for pharmacy claims was implemented on July 1, 2006. This change provides an additional tool for South Carolina Medicaid to verify primary insurance status of beneficiaries. When pharmacy providers submit an Other Coverage Code value of 2, 3, or 4, completion of all COB fields is required for

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Cost Avoidance Claims Processing (Cont'd.)

successful pharmacy claim adjudication. **Other Coverage Code values of 0, 1, 5, 6, 7 and 8 will no longer be allowed.** See table below for applicable OCC values and related required fields.

OCC	Use this value if	Additional Fields to Complete		
		Field Name	Field #	Reason
2	Primary payer makes payment	Other Payer Amount Paid	431-DV	Enter payer's payment amount
		Other Payer Patient Responsibility Amount	352-NQ	Enter patient's liability
3	Primary payer does not cover the drug *OR* Primary payer denied the claim because the beneficiary's coverage was not in effect on the date of service	Other Payer Reject Code	472-6E	Enter payer's reject reason
4	Primary payer's total payment is applied to the beneficiary's deductible or copayment	Other Payer Patient Responsibility Amount	352-NQ	Enter patient's liability

If payment from the primary carrier(s) is denied or is less than Medicaid's allowed amount, providers may then bill Medicaid. Providers should not submit claims to Medicaid until payment or notice of denial has been received from any liable third party payer. However, the one-year timeline for claims submission cannot be extended on the basis of third party liability requirements. It should be noted that, in accordance with federal guidelines, claims for child support court-ordered health coverage continue to be processed and paid using a "pay and chase" methodology and as such are not subject to cost avoidance. To assist pharmacy providers with the claims filing process for those beneficiaries having other third party coverage, insurance carrier code information, specific to S.C. Medicaid pharmacy claims, may be found at <http://southcarolina.fhsc.com>.

Note: If the *Other Coverage Code* value = "2," DHHS

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Cost Avoidance Claims Processing (Cont'd.)

allows providers to override days' supply limitations and/or "drug requires PA" conditions by entering a "05" (exemption from prescription limit) in the *Prior Authorization Type Code* field. This particular override situation applies to TPL/COB processing only and is ONLY allowed when the *Other Coverage Code* value = "2."

However, if the provider indicates he or she is not willing to bill Medicaid secondarily, the patient should be given the opportunity to have his or her prescriptions filled elsewhere. See the Magellan Medicaid Administration Pharmacy Provider Manual or the Third-Party Liability Supplement found elsewhere in this manual for detailed coordination of benefits (COB) information.

Copayment

The current prescription copayment for Medicaid beneficiaries is \$3.40 per prescription or refill.

Copayment-exempt beneficiaries and/or services include:

- Children from birth to the date of their 19th birthday
- Beneficiaries residing in long-term care facilities
- Beneficiaries enrolled in the Family Planning pay category
- Beneficiaries who are pregnant
- Beneficiaries receiving the Medicaid hospice benefit
- Beneficiaries who are members of the Health Opportunity Account (HOA) Program
- Beneficiaries who are members of a Federally Recognized Indian Tribe

Claims Where Medicaid Copayment Exceeds the Calculated Medicaid Reimbursement

Instances may occur where the Medicaid copayment exceeds the calculated Medicaid reimbursement. In these instances, the allowed amount appears in both the "allow amt" field and the "copay" field; this allowed amount constitutes the **total** copay monies owed to the provider. Therefore, where the Medicaid copayment exceeds the calculated reimbursement total, the provider should collect the allowed amount as the copayment for that prescription rather than collecting the entire copayment amount.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Quantity Billing Instructions for Certain Pharmaceuticals

The NDC numbers or product categories outlined below are frequently billed incorrectly as regards the quantities submitted. Where necessary, providers should make appropriate computer software changes to ensure accurate billing for these products. [It should be noted that some of the products listed below require prior authorization; providers should consult the PDL and advise prescribers accordingly.]

- **Fragmin® syringes** should be billed per **ml**, *not* per syringe.
- **Imitrex® 6mg/0.5ml vial** (NDC 00173-0449-02) should be billed per **ml**, *not* per vial.
- **Albuterol 0.83mg/ml solution** should be billed per total **ml**, *not* per each three ml vial.
- **Golytely® powder for reconstitution** (NDC 52268-0100-01) should be billed per **ml after reconstitution** (*i.e.*, 4000 ml), *not* per container. **Golytely® Packets** (NDC 52268-0700-01) should be billed per **packet**, *not* per ml. **Halflytely®** (NDCs 52268-0502-01 and 52268-0520-01) should be billed per **packet**, *not* per ml.
- **Prevpac® Patient Pack** (NDC 00300-3702-01) should be billed in **multiples of 14**. The Prevpac® Patient Pack contains 14 daily dosage cards and the AWP is per dosage card. The quantity billed should reflect the number of **dosage cards** dispensed. The quantity dispensed should *not* be billed per number of individual units of drug or per Patient Pack.
- **Helidac® Therapy** should be billed per number of **individual units of drug** (*not* per package) since the AWP is per unit drug dose. The Helidac® Therapy package contains 14 dosage cards and each card includes four daily dose units. The usual Helidac® prescription is authorized for 56 units (one package consisting of one two-week course of therapy). Therefore, **Medicaid should be billed in multiples of 56 to reflect the individual drug doses**.
- **Inhalers** (*e.g.*, Proventil® HFA and Azmacort®) should be billed per **gram**, *not* per canister or per metered inhalations.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Quantity Billing Instructions for Certain Pharmaceuticals (Cont'd.)

Products may be subject to specific quantity limitations. Listings of those drugs currently subject to the Quantity Limits or Dose Optimization programs may be found at http://southcarolina.fhsc.com/Downloads/provider/SCRx_Quantity_Limits.pdf and http://southcarolina.fhsc.com/Downloads/provider/SCRx_Dose_Optimization_listing.pdf, respectively. Pharmacy claims submitted for quantities exceeding the daily dosing limit will deny for NCPDP error code 76 – Plan Limitations Exceeded. Also, dependent upon the established dosing limitations, additional Dose Optimization program messages may include the following: “1.000 Quantity Per Day Exceeded” or “2.000 Quantity Per Day Exceeded.”

These quantity limitations listings are updated periodically; therefore, providers may find it beneficial to refer to the Magellan Medicaid Administration website for the most current information. Prior authorization is necessary for any quantity exceeding the established limitation. Prescribers should be instructed to contact the Magellan Medicaid Administration Clinical Call Center at 1-866-247-1181 (toll-free) to request prior authorization.

Claims Submission for Medicaid Hospice Patients

For the duration of hospice care, a Medicaid-eligible-only beneficiary who elects the hospice benefit waives all rights to other Medicaid services related to the treatment of the terminal illness. Services (including prescriptions) rendered for illnesses or conditions NOT related to the beneficiary's terminal illness require prior authorization from the hospice provider (rather than from Magellan Medicaid Administration) before delivery. The provider should submit electronic claims with a customer location code of “11” (hospice) and an “8” in the *Prior Authorization Type Code* field (NCPDP field #461-EU). For paper claims submission, the provider must indicate “hospice” in the upper right-hand corner of the UCF. Data entry staff will key the designated customer location and *Prior Authorization Type Code* values in the appropriate fields.

Claims Submission for FPW Beneficiaries

When using Magellan Medicaid Administration's point-of-sale system, pharmacists submitting claims for antibiotics for FPW beneficiaries must enter the value “1” in the *Diagnosis Qualifier* field (field #492-WE) and the actual ICD-9 code as indicated on the prescription in the *Diagnosis*

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Claims Submission for FPW Beneficiaries (Cont'd.)

Code field (Field #424-DO). In addition, the Diagnosis Code Count field (Field #491-VE) should also be populated with the number of ICD-9 values that are being submitted on the claim (for example, this value will be “1” if one ICD-9 code is submitted).

Claims Submission for Certain Physician-Injectable Products

Pharmacists may submit claims for non-dually eligible, Medicaid fee-for-service beneficiaries for Xolair® (omalizumab); Lupron®, Eligard®, and Viadur® (leuprolide acetate); Synagis® and RhoGAM® [Rho(D) immune globulin], Risperdal Consta, Invega Sustenna and Depo Provera even though these injectables will be administered in the physician’s office. It should be noted that physicians must request PA for omalizumab.

Effective January 1, 2012, with the implementation of D.0 changes, pharmacists are no longer required to submit physician-injectable products through the Pharmacy POS system using a PATC of “1” and a Patient Residence of “1”. Upon receipt of a prescription for leuprolide acetate, palivizumab, or Rho(D) immune globulin, Risperdal Consta, Invega Sustenna, Depo Provera or a PA-approved prescription for omalizumab, the pharmacist should:

- Submit a claim to SC Medicaid without the PATC of “1” and the Patient Residence of “1”. Please note that the Patient Location field (NCPDP field #307-C7) was changed to the Patient Residence field (NCPDP field # 384-4X) with the implementation of D.0.
- Dispense the product and ensure the injectable is delivered *directly* to the physician’s office/clinic in compliance with the storage requirements of the product.

Claims Submission for Influenza and Pneumococcal Vaccines

See detailed policy information in Section 2. If the Medicaid eligible-only adult beneficiary resides in a long term care facility, the Patient Residence code submitted should be “03” (*i.e.*, nursing home). If a pharmacist certified to administer immunizations administers these vaccines, the claim should be submitted with a PATC of “1” and a Patient Residence code of “1”. This latter code represents an in-pharmacy administration. Please note that the Customer Location field (NCPDP field #307-C7) is now the Patient Residence field (NCPDP field # 384-4X).

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Partial Fills

Effective January 1, 2012, pharmacies may only do partial fills in cases where there is a drug shortage and the pharmacy does not have the full prescription in stock. Detailed claims submission information may be found in the Magellan Medicaid Administration Pharmacy Provider Manuals as well as the *Medicaid Payer Specifications* document at <http://southcarolina.fhsc.com>.

Multi-ingredient Compound Claims

Providers are reminded to adhere to Medicaid policy when billing for a compounded prescription. For each billed ingredient, include the NDC number and quantity **for that specific NDC** which corresponds to the *actual* (rebated) product used in the compounding of the prescription. When billing for covered multi-ingredient compounds, Pharmacy Services providers must enter “0” in the Product Code/NDC field (NCPDP Field #407-D7) and “2” in the Compound Code field (NCPDP Field #406-D6) to identify the claim as a multi-ingredient compound. The Product Service ID Qualifier should be “00” (NCPDP field # 436-E1).

Please note that the Route of Administration field (NCPDP field #995-E2) is now a required field. See the Magellan Medicaid Administration Pharmacy Provider Manual as well as the *Medicaid Payer Specifications* document at <http://southcarolina.fhsc.com> for further claims submission instructions.

Effective with claims billed on or after July 25, 2011, pharmacy providers submitting claims for compounding pharmacy products may bill for compounding services using the online claims adjudication system.

The compounding fee of \$50 per hour is paid based on the level of effort of the product compounded. The maximum number of minutes to be billed is indicated in the chart below. For dosage forms not included in the chart, pharmacy providers should document actual time spent preparing the compounded product, and bill accordingly. Details regarding the procedure for billing compounding time are available at <http://southcarolina.fhsc.com>.

No more than 60 minutes of compounding time will be allowed for any single preparation. Claims for compounds totaling more than \$170 in total reimbursement will require prior authorization.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Minutes	Type of Product/Dosage Form
15	Oral solutions or suspensions involving the combination of commercially available oral products
	Topical preparations compounded by combining commercially available topical products
	Enemas
30	Suppositories
	Compounded capsules
	Topical preparations containing components that are not commercially available in a topical formulation
45	Oral liquids containing components that are not commercially available in oral formulation
	Ophthalmic preparations
	Chemotherapeutic topical agents
60	Sterile injectable preparations

Other Payer Patient Responsibility Amount field (NCPDP field #352-NQ)

Effective January 1, 2012, the Patient Paid Amount Submitted field (NCPDP field #433-DX) has been changed to the Other Payer Patient Responsibility Amount (NCPDP field #352-NQ). This field should be used in conjunction with Other Coverage Code values of “2” and “4”. This field should contain the dollar amount returned by the primary as the beneficiary's copay.

Date of Service is More Than One Year Old

Only “clean” claims submitted and processed within one year from date of service may be considered for reimbursement. A “clean” claim is one deemed to be error free and able to be adjudicated without obtaining additional documentation from the provider or other entity. This time limit will not be extended on the basis of third party liability requirements.

However, the one-year timeline for claims submission does not apply to those claims involving retroactive Medicaid eligibility. Upon notification of a beneficiary’s Medicaid eligibility, it is the provider’s responsibility to immediately submit all outstanding claims. Providers are advised that such claims must be received by the point-of-sale contractor within six months of the beneficiary’s eligibility determination or one year from date of service, whichever is later. Retain a copy of the beneficiary’s notification of such retroactive eligibility and contact the Department of Pharmacy Services for further billing instructions.

SECTION 3 BILLING PROCEDURES
CLAIM FILING OPTIONS

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SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

REMITTANCE ADVICE

The information on the remittance advice (hard copy example is shown in this section) is drawn from the claims data submitted by the provider. The remittance advice explains the actions taken on all processed claims and adjustments.

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

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

If a provider's claim is rejected, he or she will receive remittance advice information but no payment for that claim. The remittance advice contains NCPDP edit code information, and those codes explain why the claim was not paid. **Care should be taken to retain remittance advice information as part of the provider's records and to ensure that appropriate billing or accounts receivable personnel have access to such claims processing documentation.** Requests for hard copy remittance advices will not be honored.

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

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Web-Based Application

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

- Providers can verify beneficiary eligibility online by entering Medicaid ID, Social Security Number, or a combination of name and date of birth.
- Providers can view, save and print their own remittance advices and associated ECFs.
- Providers can change their own passwords.
- List Management allows users to develop their own list of frequently used information.
- No additional software is required to use this application.
- Data is automatically archived.

The minimum requirements necessary for using the Web Tool are:

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

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

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
PO Box 8809

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

ELECTRONIC FUNDS TRANSFER (EFT) (CONT'D.)

Columbia, SC 29202-8809

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

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

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

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

Upon completion of the pre-certification period, reimbursement payment will be deposited directly into the provider's bank account.

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

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

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

Duplicate Remittance Advice

Effective December 2010, SCDHHS will charge for requests of duplicate Remittance Advice(s). Providers must use the Remittance Advice Request Form located in the Forms Section of this provider manual. The charges associated with the request will be deducted from a future Remittance Advice and will appear as a debit adjustment.

Remittance Advice Explanation of Fields

PROVIDER I.D.

The ten-byte, all-numeric NPI issued to the dispensing pharmacy.

SECTION 3 BILLING PROCEDURES**CLAIM PROCESSING**

Remittance Advice
Explanation of Fields
(Cont'd.)

Note: Providers should obtain one NPI for each active Medicaid Provider Number. However, if a *dually enrolled* Pharmacy Services and Durable Medical Equipment Services (DME) provider decides to use the same NPI for both the Pharmacy Services and DME Provider ID Number, then that NPI should be registered with DHHS using a different taxonomy code for Pharmacy Services and a different taxonomy code for DME.

PAYMENT DATE.

Check date for this remittance.

PAGE NUMBER.

Self-explanatory.

PROVIDER'S OWN REFERENCE NUMBER.

Not applicable.

CLAIM REFERENCE NUMBER.

Unique number assigned by the POS contractor that identifies the claim. Consists of 16 digits and an alpha character which identifies the claim type: "D" = Drug, "U" = Adjustment/Reversed Claim.

BMN.

Reflects the "Dispense as Written" (DAW) Product Selection Code designated on the claim for that prescription number (values 0 through 9).

PAY.

Not applicable.

SERVICE GIVEN.

- a) Date (MMDDYY): The dispensing date for the prescription – hard copy RA data is printed in an ascending chronological date of service sort except for the page entitled *ADJUSTMENTS* and
- b) Code/Quantity: Amount of drug dispensed.

AMOUNT BILLED.

Usual and customary charge billed to Medicaid.

TITLE 19 PAYMENT MEDICAID.

The amount of Medicaid reimbursement for the

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Remittance Advice
Explanation of Fields
(Cont'd.)

claim.

STS (STATUS).

An alpha character appears in this area, indicating the current status of each claim.

Examples:

P = Paid (claim was submitted correctly)

R = Rejected (claim contains one or more errors which must be corrected before payment may be made)

S = In process (not applicable to Pharmacy Services claims)

RECIPIENT I.D. NUMBER.

Self-explanatory.

DRUG CODE.

The National Drug Code (NDC) number submitted on the claim; the NDC number billed must contain 11 digits.

NAME OF DRUG.

Self-explanatory.

EDITS.

For each rejected claim designated by "R" in the status (STS) column, appropriate NCPDP edit code(s) will appear below the affected claim line. These codes indicate the reason(s) the claim was rejected. It is possible for a claim to be rejected for multiple reasons. See Section 4 for a listing of NCPDP error codes used in the South Carolina Medicaid Pharmacy Services program, the error code descriptions, and possible reason(s) for their assignment.

PRESCRIPTION NUMBER.

Self-explanatory.

SCHAP PAGE TOTAL.

Not applicable.

SCHAP TOTAL.

Not applicable.

SECTION 3 BILLING PROCEDURES**CLAIM PROCESSING**

Remittance Advice
Explanation of Fields
(Cont'd.)

MEDICAID PAGE TOTAL.

Total payment for this page of the remittance advice.

MEDICAID TOTAL.

Total amount reimbursed by Medicaid for all paid claims processed on this remittance advice.

CHECK TOTAL.

Usually equal to MEDICAID TOTAL above, unless there is a credit adjustment and/or reversed claims included on this remittance advice (see page entitled ADJUSTMENTS in the RA for additional information).

CHECK NUMBER.

Self-explanatory.

STATUS CODES.

Explanation of the codes listed in status (STS) column.

PROVIDER NAME AND ADDRESS.

Self-explanatory.

ADJUSTMENTS.

Page entitled ADJUSTMENTS (see example in this section) will be included in the RA if the provider is receiving a credit adjustment or if a debit amount is outstanding or being deducted (*e.g.*, reversed or “voided” claims). Descriptions of the data elements contained on this page appear below:

PROVIDER ID. The ten-byte, all-numeric NPI issued to the dispensing pharmacy.

PAYMENT DATE. Check date for this remittance.

PAGE NUMBER. Self-explanatory.

PROVIDER'S OWN REFERENCE NUMBER. Rx number for the reversed/voided claim or a unique reference number assigned by DHHS for a credit (or debit) transaction.

CLAIM REFERENCE NUMBER. For adjustments, a 16-digit number ending with a “U” suffix will be

SECTION 3 BILLING PROCEDURES**CLAIM PROCESSING****Remittance Advice
Explanation of Fields
(Cont'd.)**

indicated. In instances of reversed/voided claims, both the original claim control number of the paid claim (“D” suffix) as well as a claim control number representing an adjustment (“U” suffix) will be indicated.

SERVICE DATE(S) MMDDYY: Date of dispensing for claim being reversed/voided.

PROC/DRUG CODE: Not applicable.

RECIPIENT ID. NUMBER: For reversed/voided claims, the beneficiary’s 10-digit Medicaid identification number will be indicated.

RECIPIENT NAME: For reversed/voided claims, the beneficiary’s last name and first and middle initials will be indicated.

ORIG. CHECK DATE: The original payment date of the reversed/voided claim.

ORIGINAL PAYMENT: Not applicable.

ACTION: Either “credit” or “debit” will be indicated.

DEBIT/CREDIT AMOUNT: The per transaction debit or credit amount.

EXCESS REFUND: Not applicable.

DEBIT BALANCE PRIOR TO THIS REMITTANCE: Self-explanatory.

YOUR CURRENT DEBIT BALANCE: Self-explanatory.

MEDICAID TOTAL: Amount paid on this remittance advice prior to credit/debit transactions.

ADJUSTMENTS: Net amount of credit and/or debit transactions indicated.

CHECK TOTAL: Sum of amounts indicated in MEDICAID TOTAL and ADJUSTMENTS fields.

CERTIFIED AMOUNT, MAXIMUS AMOUNT, FEDERAL RELIEF, and TO BE REFUNDED IN THE FUTURE: Not applicable.

CHECK NUMBER and PROVIDER NAME AND ADDRESS: Self-explanatory.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Remittance Advice Explanation of Fields (Cont'd.)

If the provider is reimbursed by EFT rather than by check, the bank account number as well as other information regarding this payment method appears in the lower left-hand corner of the RA page containing the check total amount.

NCPDP ERROR CODE LISTING

See Section 4 for the NCPDP Error Code Listing.

CLAIMS REVERSALS

Providers are reminded of their obligation to refund appropriate monies to the Medicaid program for those fee-for-service prescriptions that were returned to stock because the beneficiary never picked up the prescription from the pharmacy. This policy pertains both to entire prescriptions as well as to partially filled prescriptions.

Additionally, claims reversals/resubmissions may be necessary due to the provider having submitted an incorrect NDC, the wrong beneficiary identification number, an erroneous usual and customary charge, or incorrect coordination of benefits (COB) data. To be considered for payment, resubmissions must be received by the POS contractor within one year from the date of service; such claims are held to the same timely claims filing standard as initial claims.

Due to federal drug rebate program issues, rather than refunding by check the amount owed, providers are required to promptly reverse inappropriately paid claims (*i.e.*, no later than 30 days following the Medicaid payment date). Such reversed claims result in debit amounts to be recouped.

Appropriate deductions will be made from one or more of the provider's future checks until the amount of the overpayment is reached. (If a provider's participation in the Medicaid program is terminated, any remaining overpayment debit must still be satisfied.)

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

PROVIDER ID.	000000000	+-----+	PAYMENT DATE	PAGE
+-----+	DEPT OF HEALTH AND HUMAN SERVICES		+-----+	+-----+
xxxxxxxxxxxx		ADJUSTMENTS	06/01/2007	10
+-----+	SOUTH CAROLINA MEDICAID PROGRAM	+-----+	+-----+	+-----+

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE DATE(S) MMDDYY	PROC / DRUG CODE	RECIPIENT ID. NUMBER	RECIPIENT NAME F M LAST NAME I I	ORIG. CHECK DATE	ORIGINAL PAYMENT	ACTION	DEBIT / CREDIT AMOUNT	EXCESS REFUND
REFUNDCHK	0414600250030000U	-						CREDIT	24108.42	
6030451	0414703444499900U 0413300820408500D	- 051007-051007		0000000001	SMITH T	052106		DEBIT	-120.43	
6030250	0414707038499900U 0412600902427500D	- 050307-050307		0000000002	JONES W R	051406		DEBIT	-5.72	
6030541	0414707112499900U 0414000958404300D	- 051207-051207		0000000003	WEBSTER C A	052806		DEBIT	-50.14	
6030520	0414707135499900U 0414000574415800D	- 051207-051207		0000000004	MILES Z	052806		DEBIT	-23.36	
6028618	0414707440499900U 0412600554419600D	- 050407-050407		0000000005	LUCAS B	051406		DEBIT	-127.26	
6029876	0414707464499900U 0414000153422800D	- 051207-051207		0000000006	OWENS R	052806		DEBIT	-11.36	
PAGE TOTAL:									23770.15	0.00

	MEDICAID TOTAL	CERTIFIED AMT	FEDERAL RELIEF	TO BE REFUNDED IN THE FUTURE
DEBIT BALANCE PRIOR TO THIS REMITTANCE	+-----+ 15664.30 +-----+	+-----+ 0.00 +-----+	+-----+ 0.00 +-----+	+-----+
+-----+	ADJUSTMENTS	MAXIMUS AMT	PROVIDER NAME AND ADDRESS	
YOUR CURRENT DEBIT BALANCE	+-----+ 23770.15 +-----+	+-----+ 0.00 +-----+	+-----+	
+-----+	CHECK TOTAL	CHECK NUMBER	+-----+	
	+-----+ 39434.45 +-----+	+-----+ 4444444 +-----+	+-----+ PRESCRIPTIONS PLUS, INC JOHN SMITH, RPH 100 MAIN STREET MEDICINE CITY SC 29999 +-----+	

SECTION 4

CODES

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NCPDP ERROR CODE LISTING

1

SECTION 4 CODES

NCPDP ERROR CODE LISTING

For each affected claim, NCPDP error codes appear on the hard copy remittance advice directly below the area entitled “Drug Code.” Outlined below are possible explanations for the assignment of specific NCPDP error codes. If further assistance is needed, contact the Magellan Medicaid Administration Technical Call Center at 1-866-254-1669.

NCPDP Error Code	NCPDP Error Code Description Listing	Possible Reasons For Encountering Error Code
01	M/I Bin	Missing or Invalid Bin Number
02	M/I Version Number	Missing or Invalid Version Number
03	M/I Transaction Code	Missing or Invalid Transaction Code
04	M/I Processor Control Number	Missing or Invalid Processor Control Number
05	M/I Pharmacy Number	Missing or Invalid NABP/NCPDP Provider Number or National Provider Identifier (NPI)
06	M/I Group Number	Missing or Invalid Group Number
		Group Not Covered on Date of Service
07	M/I Cardholder ID Number	Missing or Invalid Beneficiary Number
09	M/I Birth Date	Missing or Invalid Beneficiary Date of Birth
11	M/I Relationship Code	Missing or Invalid Relationship Code
12	M/I Customer Location Code	Missing or Invalid Customer/Patient Location Code
13	M/I Other Coverage Code	Missing or Invalid Other Coverage Code
15	M/I Date of Service	Missing or Invalid Date of Service
16	M/I Rx Number	Missing or Invalid Prescription Number
17	M/I New/Fill Number	Missing or Invalid New/Refill Code
19	M/I Days' Supply	Missing or Invalid Days' Supply
20	M/I Compound Code	Missing or Invalid Compound Code
21	M/I Product/Service ID	Missing or Invalid National Drug Code (NDC)

SECTION 4 CODES

NCPDP Error Code	NCPDP Error Code Description Listing	Possible Reasons For Encountering Error Code
22	M/I Dispense as Written (DAW) Code	Missing or Invalid Dispense As Written Code
23	M/I Ingredient Cost Submitted	Missing or Invalid Ingredient Cost
25	M/I Prescriber ID	Missing or Invalid Prescriber State Medical License Number [must be in specific 10-byte format]
28	M/I Date Prescription Written	Missing or Invalid Date Prescription Written
		Date Written Greater Than Date Of Service
33	M/I Prescription Origin Code	Missing or Invalid Prescription Origin Code
34	M/I Submission Clarification Code	Missing or Invalid Submission Clarification Code
38	M/I Basis of Cost	NDC Has Zero Price For Date of Service
39	M/I Diagnosis Code	Missing or Invalid Diagnosis Code
40	Pharmacy Not With Plan on DOS	Provider Suspended on DOS
		Provider on Prepayment Review
		Provider's Medicaid I.D. Number Terminated on DOS
41	Submit Bill to Other Processor/Primary Payer	Beneficiary Has Third Party Coverage - Submit to Primary Insurer(s)
50	Non-matched Pharmacy Number	Valid NPI Qualifier/Invalid NPI Submitted or Invalid NPI Qualifier/Valid NPI Submitted
		Type of owner not in dispensing fee table
51	Non-matched Group ID	Group ID Not On File
		Benefit Record Not Found
52	Non-matched Cardholder ID	Newborn Age Exceeded - Must Have OWN ID #
		Beneficiary I. D. Number Not on File

SECTION 4 CODES

NCPDP Error Code	NCPDP Error Code Description Listing	Possible Reasons For Encountering Error Code
54	Non-matched Product/ Service ID Number	National Drug Code (NDC) Not on File
56	Non-matched Prescriber ID	Prescriber's State Medical License Not On File
60	Product/Service Not Covered for Patient Age	Drug Not Covered - Age Restriction - 1-866-254-1669
63	Institutionalized Patient Product/Service ID Not Covered	Beneficiary Resides in Institutional Setting - Not All Products Covered
65	Patient Is Not Covered	Fee-for-service claim; beneficiary enrolled in Palmetto SeniorCare program [call 1-803-434-3770 or 1-803-251-2640 for additional information]
		Beneficiary Enrolled in Medicaid MCO Plan
		Family Planning Waiver Beneficiary - Drug Not FP Related
		ISCEDC/COSY Beneficiary - FFS drugs not covered by Medicaid
67	Filled Before Coverage Effective	Date of Service Prior to Beneficiary's Date of Birth
		Date of Service Prior To Enrollment Effective Date
68	Filled After Coverage Expired	Date of Service After Beneficiary's Date of Death
		Beneficiary Not Eligible on Date of Service
69	Filled After Coverage Terminated	Date of Service After Beneficiary's Date of Death
		Beneficiary Not Eligible on Date of Service
70	Product/Service Not Covered	Medical Foster Care Beneficiary - FFS Drugs not covered
		Hospice Beneficiary - PA required; contact hospice provider
		NDC for Compound Use Only/Conflict

SECTION 4 CODES

NCPDP Error Code	NCPDP Error Code Description Listing	Possible Reasons For Encountering Error Code
		Unit Dose Not Allowed For Ambulatory Patients
		DAW=1 Not valid for this claim/No FUL price on DOS
		Provider Not Eligible to Dispense Anti-Hemophilia Factor
		Provider Not Eligible to Dispense Hepatitis-B Vaccine
		Drug Not Covered - Sex Restriction 1-866-254-1669
		Drug Not Covered On DOS
		Refill Too Soon
		DESI/Less Than Effective Drug – Not Covered
		No Rebate Agreement in Effect for DOS
		Medicare Indicated - Bill Medicare as Primary
71	Prescriber Not Covered	Prescribing Physician Not Eligible On DOS
73	Refills Are Not Covered	Refill Not Allowed
74	Other Carrier Payment Meets/Exceeds Payable	Payment from Other Sources > Medicaid Allowed Amount
75	Prior Authorization Required	RPh Override Required - See Manual Criteria
		Orlistat Requires PA - MD Call 1-866-247-1181
		Sildenafil requires PA - MD Call 1-866-247-1181
		Panretin Requires PA - MD Call 1-866-247-1181
		Targretin Requires PA - MD Call 1-866-247-1181
		Override Restriction for Certain Therapeutic Classes – MD Call 1-866-247-1181
		Non-Preferred Drug – MD Call 1-866-247-1181

SECTION 4 CODES

NCPDP Error Code	NCPDP Error Code Description Listing	Possible Reasons For Encountering Error Code
		Growth Hormone Requires PA-MD Call 1-866-247-1181
		PPI Requires PA Call 1-866-247-1181
		COX-2 Requires PA Call 1-866-247-1181
		Drug Requires PA Call 1-866-247-1181
76	Plan Limitations Exceeded	Refill Limit Exceeded for Scheduled Drug III, IV, V
		Quantity Per Day Limit Exceeded
		Maximum Quantity Limitation - MD Call 1-866-247-1181
		DUR Excess Quantity
		Days' Supply Exceeds Maximum Allowed
		Plan Limitations Exceeded Call 1-866-254-1669
		Maximum Number of Billings Has Been Exceeded
		Brand Override Requires PA Call 1-866-247-1181
		Adult beneficiary's monthly limit exceeded - billing error
		Adult beneficiary's monthly limit exceeded - multiple providers
77	Product/Service ID Number	Obsolete NDC - Not Covered
79	Refill Too Soon	Early Refill 1-866-254-1669
80	Drug-Diagnosis Mismatch	Drug – Diagnosis Conflict
81	Claim Too Old	Exceeds Void / Reversal Filing Limit
		Date of Service Not Within Timely Filing Limits
82	Claim is Post-Dated	Claim Control Number Greater Than Current Date

SECTION 4 CODES

NCPDP Error Code	NCPDP Error Code Description Listing	Possible Reasons For Encountering Error Code
		Date of Service Greater Than Current Date
83	Duplicate Paid/Captured Claim	Near Dup Claim-Same NDC/DOS +/- One Day
		Exact Duplicate - Claim Paid
		Duplicate Claim - Different Provider Paid
84	Claim Has Not Been Paid/Captured	Missing / Invalid Claim Control Number
		Provider Type and Claim Type are Inconsistent
		Missing/Invalid Manual Price
85	Claim Not Processed	Rebill Not Found
		Warning: Prescription Not Filled 866-254-1669
87	Reversal Not Processed	Reversal Not Processed
		History Record Already Voided
		Void Not Allowed - Media Mismatch
88	DUR Reject Error	DUR Reject Error 1-866-254-1669
99	Host Processing Error	Host Processing Error 1-866-254-1669
CB	M/I Patient Last Name	Missing or Invalid Beneficiary Last Name
DC	M/I Dispensing Fee Submitted	Missing or Invalid Dispensing Fee
DQ	M/I Usual & Customary Charge	Missing or Invalid Usual & Customary Charge
DT	M/I Unit Dose Indicator	Missing or Invalid Unit Dose Indicator
DV	M/I Other Payer Amount	TPL Indicator/TPL Amount Inconsistent
		Missing or Invalid TPL Amount
E4	M/I Reason for Service Code	Missing or Invalid Reason for Service Code
E5	M/I Professional Service Code	Missing or Invalid Professional Service
E6	M/I Result of Service Code	Missing or Invalid Result of Service Code
E7	M/I Quantity Dispensed	Missing or Invalid Metric Decimal Quantity

SECTION 4 CODES

NCPDP Error Code	NCPDP Error Code Description Listing	Possible Reasons For Encountering Error Code
E8	M/I Other Payer Date	Missing or Invalid Other Payer Date
ER	M/I Procedure Modifier Code	Missing or Invalid Procedure Modifier Code
HD	M/I Dispensing Status	Missing or Invalid Dispensing Status
M2	Recipient Locked In	Not Prescribed By Lock-in Physician
M5	Requires Manual Claim	Submit Paper Claim - Manual Review
PA	PA Exhausted/Not Renewable	Prior Authorization No Longer in Effect
PG	M/I Coupon Segment	Missing or Invalid Coupon Segment

SECTION 4 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 (DHHS) is a cabinet agency of the South Carolina Governor's Office. The DHHS serves as the single state agency designated to administer the South Carolina Medicaid program and is responsible for determining Medicaid eligibility for all coverage groups except Supplemental Security Income (SSI). This section outlines available services for Medicaid providers and beneficiaries, including telephone numbers, addresses, and other appropriate resource information.

CORRESPONDENCE AND INQUIRIES

All correspondence to South Carolina Medicaid should be directed to the SCDHHS Provider Service Center (PSC) at 1-888-289-0709. In addition, provider may submit an online inquiry at <http://www.scdhhs.gov/contact-us>. Inquiries concerning specific claims should also be directed to the PSC, but only after corrections have been made on rejected claims and all claims filing requirements have been met. Medicaid Provider Inquiry (DHHS Form 140) may be used to check the status on outstanding claims. (See the blank form in the Forms section.) Always include the provider's Medicaid number, the resident's Medicaid number, and the date of service when requesting the status of outstanding claims. **Allow 45 days from the submission date before requesting the status of the claim.**

Questions concerning beneficiary eligibility or identification numbers should be directed to the SCDHHS county office in the beneficiary's county of residence. Beneficiaries who have questions regarding specific coverage issues should be referred to the appropriate staff of their county SCDHHS office for assistance. To verify eligibility status, please use the South Carolina Medicaid Web-based Claims Submission Tool (Web Tool). For information on the Web Tool, please contact the PSC at 1-888-289-0709.

SECTION 5 ADMINISTRATIVE SERVICES

GENERAL INFORMATION

PROVIDER ENROLLMENT CHANGES/UPDATES

Non-contracted providers (such as pharmacists) must report any changes in enrollment information, such as mailing and/or payment address, ownership, telephone number, license/permit number, etc., to the address listed below:

Medicaid Provider Enrollment
Post Office Box 8809
Columbia, SC 29202-8809
Telephone: (803) 788-7622 (extension 41650)
Fax: (803) 699-8637

Additionally, once a pharmacy is an enrolled Medicaid provider, the Pharmacy Services program area must be immediately notified (either verbally, in writing, or by fax) if the pharmacy sustains physical damage (*e.g.*, fire, flood, hurricane, etc.) to the extent that it is no longer operational.

When notifying Medicaid of changes in enrollment information, providers must:

1. Be exact regarding the change to be made to their file;
2. Always include their Medicaid provider number (a six character identification number); and
3. Include the name and telephone number of a contact person.

If a provider is paid by electronic funds transfer (EFT) and his/her bank account information sustains a change, Medicaid Provider Enrollment staff should be notified as soon as possible. The provider must complete a new *Authorization Agreement for Electronic Funds Transfer* form, reflecting the account changes. This completed form and a voided check or deposit slip may be faxed to Medicaid Provider Enrollment staff using the fax number listed above. Current EFT-reimbursed providers needing to change their bank account information (or those who wish to begin receiving payment via EFT) may access the *Authorization Agreement for Electronic Funds Transfer* form by following the instructions contained in this specified link:

<http://www.scdhhs.gov/openpublic/hipaa/webfiles/EFT%20Agree%20for%20Provider%20Enrollment.pdf>

A sample form is also included in the Forms section of this manual.

SECTION 5 ADMINISTRATIVE SERVICES

GENERAL INFORMATION

PROVIDER WORKSHOPS

Regional workshops are conducted as needed to familiarize providers with new Medicaid policies and/or claims submission procedures.

REFUNDS

Although claims reversals (*i.e.*, “voided claims”) are preferable (due to rebate invoice issues), if necessary, providers may refund overpayments via check. Refund checks should be made payable to the Department of Health and Human Services and mailed to:

Department of Health and Human Services
Attn: Cash Receipts
Post Office Box 8355
Columbia, SC 29202-8355

In order for DHHS to correctly post the refund, the *Form for Medicaid Refunds* (DHHS Form 205) must accompany all Medicaid refund checks. (This form may be obtained via DHHS’ Web site <http://www.scdhhs.gov/>.)

Select “Inside DHHS,” “Bureaus,” and then “Bureau of Fiscal Affairs.” Click on “Accounts Receivable – Refund Medicaid.”) Contact a Pharmacy Services program representative if a refund is to be made via check rather than by claims reversal. Appropriate documentation (*i.e.*, copy of check and completed form 205, etc.) should be furnished to Pharmacy Services staff for inclusion in the provider’s file.

SECTION 5 ADMINISTRATIVE SERVICES

GENERAL INFORMATION

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SECTION 5 ADMINISTRATIVE SERVICES

MEDICAID FORMS AND PUBLICATIONS

PROGRAM MANUALS AND BULLETINS

Providers are reminded that Medicaid information, publications, manuals, and various forms may be found at <http://provider.scdhhs.gov/>. An additional resource available to pharmacists is the Magellan Medicaid Administration Pharmacy Provider Manual; that publication is located at southcarolina.magellanhealth.com. To request receipt of Medicaid bulletins by email, providers are instructed to go to the following link for instructions:

<http://www2.scdhhs.gov/press-releases>.

The most current version of this manual is available on the DHHS Web site at <http://www.scdhhs.gov>.

To order a paper or CD version of this manual, please contact Medicaid Provider Enrollment and Education at 1-888-289-0709. From the Main Menu, select option 4 for the Provider Enrollment and Education Menu, and then select option 3 to request a provider manual. Charges for printed manuals are based on actual costs of printing and mailing.

FORM 126

Providers may be aware of (or suspect) potential abuse or fraud in the Medicaid program. The *Confidential Medicaid Complaint* form (DHHS Form 126) may be used by providers to report suspected abuse or misuse of Medicaid services; a sample Form 126 is included in the Forms section of this manual. There is also a toll-free Medicaid Fraud and Abuse Hotline available to providers and beneficiaries: 1-888-364-3224.

HEALTH INSURANCE INFORMATION REFERRAL FORM

The *Health Insurance Information Referral Form* should be used to notify DHHS when a beneficiary's insurance coverage has lapsed or when a beneficiary has an insurance policy that is not on file with DHHS. A sample form has been included in the Forms section of this manual; additionally, this form may be accessed via Magellan Medicaid Administration's Web site:

<http://southcarolina.magellanhealth.com>.

SECTION 5 ADMINISTRATIVE SERVICES**MEDICAID FORMS AND PUBLICATIONS****HEALTH INSURANCE
INFORMATION REFERRAL
FORM (CONT'D.)**

Attach any written documentation that supports such information and forward (or fax) those materials to the address indicated on the form.

UNIVERSAL CLAIM FORM

If a claim must be submitted on paper (e.g., billing for dates of service which are more than one year old), the only acceptable paper medium is the Universal Claim Form (UCF) in D.0 format. Providers may contact the National Council for Prescription Drug Products (NCPDP) at www.ncdp.org/products.aspx to obtain the forms.

SECTION 5 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

Questions concerning beneficiary eligibility or correct beneficiary identification numbers should be directed to the DHHS county office in the beneficiary's county of residence. Beneficiaries who have questions regarding specific *drug coverage* issues may be referred to the toll-free Magellan Medicaid Administration Beneficiary Call Center at 1-800-834-2680. All other Medicaid services inquiries should be directed to the DHHS Beneficiary Services' toll-free telephone number: 1-888-549-0820.

To assist providers and beneficiaries, county DHHS office addresses and telephone numbers are listed below:

County	Telephone No.	Address
1. Abbeville County	(864) 366-5638	Medicaid Eligibility Abbeville County DHHS Human Services Building 903 W. Greenwood St. Abbeville, SC 29620-5678
		Post Office Box 130 Abbeville, SC 29620-0130
2. Aiken County	(803) 643-1938	Medicaid Eligibility Aiken County DHHS 1410 Park Ave. S.E. Aiken, SC 29801-4776
	Toll Free: 1-888-866-8852	Post Office Box 2748 Aiken, SC 29802-2748

SECTION 5 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
3. Allendale County	(803) 584-8137	Medicaid Eligibility Allendale County DHHS 521 Barnwell Highway Allendale, SC 29810 Post Office Box 326 Allendale, SC 29810
4. Anderson County	(864) 260-4541	Medicaid Eligibility Anderson County DHHS 224 McGee Rd. Anderson, SC 29625 Post Office Box 160 Anderson, SC 29622-0160
5. Bamberg County	(803) 245-3932	Medicaid Eligibility Bamberg County DHHS 374 Log Branch Rd. Bamberg, SC 29003 Post Office Box 544 Bamberg, SC 29003
6. Barnwell County	(803) 541-3825	Medicaid Eligibility Barnwell County DHHS 10913 Ellenton Street Barnwell, SC 29812 Post Office Box 648 Barnwell, SC 29812
7. Beaufort County	(843) 255-6095	Medicaid Eligibility Beaufort County DHHS 1905 Duke St. Beaufort, SC 29902-4403 Post Office Box 1255 Beaufort, SC 29901-1255

SECTION 5 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
8. Berkeley County	(843) 719-1170	Medicaid Eligibility Berkeley County DSS 2 Belt Dr. Moncks Corner, SC 29461-2801
	Toll Free: 1-800-249-8751	Post Office Box 13748 Charleston, SC 29422-3748
9. Calhoun County	(803) 874-3384	Medicaid Eligibility Calhoun County DHHS 2831 Old Belleville Rd. St. Matthews, SC 29135
		Post Office Box 378 St. Matthews, SC 29135
10. Charleston County	(843) 740-5900	Medicaid Eligibility Charleston County DHHS 326 Calhoun St. Charleston, SC 29401-1124
	Toll Free: 1-800-249-8751	Post Office Box 13748 Charleston, SC 29422-3748
11. Cherokee County	(864) 487-2521	Medicaid Eligibility Cherokee County DHHS 1434 N. Limestone St. Gaffney, SC 29340-4734
		Post Office Box 89 Gaffney, SC 29342
12. Chester County	(803) 377-8135	Medicaid Eligibility Chester County DHHS 115 Reedy St. Chester, SC 29706-1881

SECTION 5 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
13. Chesterfield County	(843) 623-5226	<p>Medicaid Eligibility Chesterfield County DHHS 201 N. Page St. Chesterfield, SC 29709-1201</p> <p>Post Office Box 855 Chesterfield, SC 29709-0855</p>
14. Clarendon County	(803) 435-4305	<p>Medicaid Eligibility Clarendon County DSS 3 S. Church St. Manning, SC 29102</p> <p>Post Office Box 788 Manning, SC 29102</p>
15. Colleton County	(843) 549-1894	<p>Medicaid Eligibility Colleton County DHHS Bernard Warshaw Building 215 S. Lemacks St. Walterboro, SC 29488</p> <p>Post Office Box 110 Walterboro, SC 29488</p>
16. Darlington County	(843) 398-4427	<p>Medicaid Eligibility Darlington County DHHS 300 Russell St., Room 145 Darlington, SC 29532-3340</p> <p>Post Office Box 2077 Darlington, SC 29540-2077</p>
	(843) 332-2289	<p>404 S. Fourth St., Suite 300 Hartsville, SC 29550-5718</p>
17. Dillon County	(843) 774-2713	<p>Medicaid Eligibility Dillon County DHHS 1213 Highway 34 W. Dillon, SC 29536-8141</p> <p>Post Office Box 351 Dillon, SC 29536-0351</p>

SECTION 5 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
18. Dorchester County	(843) 821-0444 Toll Free: 1-800-249-8751	Medicaid Eligibility Dorchester County DSS 216 Orangeburg Rd Summerville, SC 29483-8945 Post Office Box 13748 Charleston, SC 29422-3748
19. Edgefield County	(803) 637-4040	Medicaid Eligibility Edgefield County DHHS 120 W. A. Reel Dr. Edgefield, SC 29824-1607 Post Office Box 386 Edgefield, SC 29824-0386
20. Fairfield County	(803) 589-8035	Medicaid Eligibility Fairfield County DHHS 1136 Kincaid Bridge Rd. Winnsboro, SC 29180-7116 Post Office Box 1139 Winnsboro, SC 29180-5139
21. Florence County	(843) 673-1761 (843) 394-8575	Medicaid Eligibility Florence County DHHS 2685 S. Irby St., Box I Florence, SC 29505-3440 345 S. Ron McNair Blvd Lake City, SC 29560-3434
22. Georgetown County	(843) 546-5134	Medicaid Eligibility Georgetown County DSS 330 Dozier St. Georgetown, SC 29440-3219 Post Office Box 371 Georgetown, SC 29442

SECTION 5 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
23. Greenville County	(864) 467-7800	Medicaid Eligibility Greenville County DSS 301 University Ridge, Suite 6700 Greenville, SC 29601 Post Office Box 100101 Columbia, SC 29202-3101
24. Greenwood County	(864) 229-5258	Medicaid Eligibility Greenwood County DHHS 1118 Phoenix St. Greenwood, SC 29646-3918 Post Office Box 1016 Greenwood, SC 29648-1016
25. Hampton County	(803) 914-0053	Medicaid Eligibility Hampton County DHHS 102 Ginn Altman Ave., Suite B Hampton, SC 29924 Post Office Box 693 Hampton, SC 29924
26. Horry County	(843) 381-8260	Medicaid Eligibility Horry County DHHS 1601 11 th Ave., 1 st Floor Conway, SC 29526 Post Office Box 290 Conway, SC 29528
27. Jasper County	(843) 726-7747	Medicaid Eligibility Jasper County DHHS 10908 N. Jacob Smart Blvd. Ridgeland, SC 29936 Post Office Box 1150 Ridgeland, SC 29936

SECTION 5 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
28. Kershaw County	(803) 432-3164	Medicaid Eligibility Kershaw County DHHS 110 E. DeKalb St. Camden, SC 29020-4432
		Post Office Box 220 Camden, SC 29021-0220
29. Lancaster County	(803) 286-8208	Medicaid Eligibility Lancaster County DHHS 1599 Pageland Highway Lancaster, SC 29720-2409
30. Laurens County	(864) 833-6109	Medicaid Eligibility Laurens County DHHS 93 Human Services Rd. Clinton, SC 29325-7546
		Post Office Box 388 Laurens, SC 29360-0388
31. Lee County	(803) 484-5376	Medicaid Eligibility Lee County DHHS 820 Brown St. Bishopville, SC 29010-4207
		Post Office Box 406 Bishopville, SC 29010-0406
32. Lexington County	(803) 785-2991 (803) 785-5050	Medicaid Eligibility Lexington County DHHS 605 West Main St. Lexington, SC 29072-2550
33. McCormick County	(864) 465-5221	Medicaid Eligibility McCormick County DHHS 215 N. Mine St. McCormick, SC 29835-8363
34. Marion County	(843) 423-5417	Medicaid Eligibility Marion County DHHS 137 Airport Ct., Suite J Mullins, SC 29574

SECTION 5 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
35. Marlboro County	(843) 479-4389	Medicaid Eligibility Marlboro County DHHS County Complex 1 Ag St. Bennettsville, SC 29512-4424
		Post Office Box 1074 Bennettsville, SC 29512-1074
36. Newberry County	(803) 321-2159	Medicaid Eligibility Newberry County DHHS County Human Services Center 2107 Wilson Rd. Newberry, SC 29108-1603
		PO Box 1225 Newberry, SC 29108-1225
37. Oconee County	(864) 638-4420	Medicaid Eligibility Oconee DHHS 223 B Kenneth St. Walhalla, SC 29691
38. Orangeburg County	(803) 515-1793	Medicaid Eligibility Orangeburg County DHHS 2570 Old St. Matthews Rd., N.E. Orangeburg, SC 29118
		Post Office Box 1407 Orangeburg, SC 29116-1407
39. Pickens County	(864) 898-5815	Medicaid Eligibility Pickens County DHHS 212 McDaniel Ave. Pickens, SC 29671
		Post Office Box 160 Pickens, SC 29671-0160
40. Richland County	(803) 714-7562	Medicaid Eligibility Richland County DHHS 3220 Two Notch Rd. Columbia, SC 29204-2826
	(803) 714-7549	

SECTION 5 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
41. Saluda County	(864) 445-2139 Toll Free: 1-800-551-1909	Medicaid Eligibility Saluda County DHHS 613 Newberry Highway Saluda, SC 29138-8903 Post Office Box 245 Saluda, SC 29138-0245
42. Spartanburg County	(864) 596-2714	Medicaid Eligibility Spartanburg County DHHS Pinewood Shopping Center 1000 N. Pine St., Suite 23 Spartanburg, SC 29303
43. Sumter County	(803) 774-3447	Medicaid Eligibility Sumter County DHHS 105 N. Magnolia St., 3rd Floor Sumter, SC 29150-4941 Post Office Box 2547 Sumter, SC 29151-2547
44. Union County	(864) 424-0227	Medicaid Eligibility Union County DHHS 200 S. Mountain St. Union, SC 29379 Post Office Box 1068 Union, SC 29379
45. Williamsburg County	(843) 355-5411	Medicaid Eligibility Williamsburg County DSS 831 Eastland Ave. Kingstree, SC 29556 Post Office Box 767 Kingstree, SC 29556

SECTION 5 ADMINISTRATIVE SERVICES**DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES**

County	Telephone No.	Address
46. York County	(803) 366-1900	Medicaid Eligibility York County DHHS 1890 Neelys Creek Road Rock Hill, SC 29730 Post Office Box 710 Rock Hill, SC 29731-6710

FORMS

Number	Name	Revision Date
DHHS 126	Confidential Complaint	06/2007
DHHS 931	Health Insurance Information Referral Form	01/2008
	Authorization Agreement for Electronic Funds Transfer	03/2011
	Duplicate Remittance Advice Request Form	10/2012
---	South Carolina Medicaid MedWatch	07/2010
---	Prior Authorization Request	07/2010
	Proton Pump Inhibitors Prior Authorization Request	12/2010
	Growth Hormone Prior Authorization Request – Adult Treatment	07/2010
	Growth Hormone Prior Authorization Request – Pediatric Treatment	07/2010
	Prior Authorization Request - Antipsychotics	05/2010
	Prior Authorization Request – Hepatitis B	05/2010
	Prior Authorization Request – Hepatitis C	05/2010



**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
MEDICAID HEALTH INSURANCE INFORMATION REFERRAL FORM**

Provider or Department Name: _____ Provider ID or NPI: _____

Contact Person: _____ Phone #: _____ Date: _____

I ADD INSURANCE FOR A MEDICAID BENEFICIARY WITH NO INSURANCE IN THE MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) – ALLOW 25 DAYS

Beneficiary Name: _____ Date Referral Completed: _____

Medicaid ID#: _____ Policy Number: _____

Insurance Company Name: _____ Group Number: _____

Insured's Name: _____ Insured SSN: _____

Employer's Name/Address: _____

II CHANGES TO AN INSURANCE RECORD THAT IS IN THE MMIS – MIVS SHALL WORK WITHIN 5 DAYS

_____ a. beneficiary has never been covered by the policy – close insurance.

_____ b. beneficiary coverage ended - terminate coverage (date) _____

_____ c. subscriber coverage lapsed - terminate coverage (date) _____

_____ d. subscriber changed plans under employer - new carrier is _____

- new policy number is _____

_____ e. beneficiary to add to insurance already in MMIS for subscriber or other family member.

(name) _____

ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.

Submit this information to Medicaid Insurance Verification Services (MIVS).

Fax: 803-252-0870 **or** **Mail:** Post Office Box 101110
Columbia, SC 29211-9804

**III NEW POLICY NUMBERS FOR INSURANCE IN THE MMIS WITH THE SUBSCRIBER SSN
(SCDHHS is collecting new unique policy numbers and plans to replace existing insurance records through MMIS online modification as computer resources are available.)**

Medicaid Beneficiary ID: _____ SSN: _____

Carrier Name/Code: _____ New Unique Policy Number: _____

Submit this information to South Carolina Department of Health and Human Services (SCDHHS).

Fax: 803-255-8225 **or** **Mail:** Post Office Box 8206, Attention TPL
Columbia, SC 29202-8206

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

PROVIDER INFORMATION

Provider Name _____
Medicaid Provider Number _____
Provider NPI Number _____
Provider Address _____
City _____ State _____ Zip _____

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

Financial Institution Name _____
Financial Institution Address _____
City _____ State _____ Zip _____
Routing Number (nine digit) _____
Account Number _____

Type of Account (check one) Checking Savings

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

I (we) understand that credit entries to the account of the above named payee are done with the understanding that payment will be from federal and/or state funds and that any false claims, statements or documents or concealments of a material fact, may be prosecuted under applicable federal or state laws.

I (we) certify that the information shown is correct. I (we) agree to provide thirty (30) days written notice to the address shown below prior to revoking or revising this authorization.

Contact Name: _____ Phone Number: _____

Signed _____ (Signature)
_____ (Print)

Title _____ Date _____

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

RETURN COMPLETED FORM & BANK VERIFICATION DOCUMENT TO:

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

**South Carolina Department of Health and Human Services
Duplicate Remittance Advice Request Form**

Purpose: This form is to be used for all requests for duplicate remittance advices from South Carolina Medicaid. The form must be completed in its entirety in order to honor the request. If the form is incomplete, the form will be returned requesting the additional information.

Please contact the SCDHHS Provider Service Center (PSC) at 1-888-289-0709 or submit an online inquiry at <http://www.scdhhs.gov/contact-us> for instructions on submission of your request.

1. **Provider Name:** _____

2. **Medicaid Legacy Provider #** _____ **(Six Characters)**

NPI# _____ **& Taxonomy** _____

3. **Person to Contact:** _____ 4. **Telephone Number:** _____

5. **Requesting:**

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

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

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

Street: _____

City: _____

State: _____

Zip Code: _____

8. **Charges for a duplicate remittance advice are as follows:**

Request Processing Fee - \$20.00

Page(s) copied - .20 per page

I understand and acknowledge that a charge is associated with this request and will be deducted from my provider's payment by debit adjustment on a future remittance advice.

Authorizing Signature

Date



SOUTH CAROLINA MEDICAID PROGRAM
PRIOR AUTHORIZATION REQUEST

PRESCRIBER: NAME: _____ (FIRST) (LAST) National Provider ID # _____ PHONE # (____) _____ FAX # (____) _____	BENEFICIARY: NAME: _____ (FIRST) (LAST) MEDICAID #: _____ DATE OF BIRTH: ___/___/___ SEX: <input type="checkbox"/> M <input type="checkbox"/> F REQUEST DATE: ___/___/___
PRESCRIBER'S OFFICE STAFF MEMBER COMPLETING FORM: _____	

PHARMACY: _____ **PHONE:** (____) _____

PRIOR AUTHORIZATION REQUESTED FOR: (Please check appropriate prior authorization type)

<input type="checkbox"/> Orlistat (please include information regarding height, weight, diet plans, nutritional counseling, etc., with all orlistat requests)	<input type="checkbox"/> Quantity Limits <input type="checkbox"/> PDE5 Inhibitor for Pulmonary Arterial Hypertension Other: _____	NOTE: "Brand Medically Necessary" PA requests require a <i>South Carolina MedWatch form</i> . "Growth Hormone" PA requests require a <i>Growth Hormone request form</i> .
--	--	--

DRUG NAME	DOSE	STRENGTH	LENGTH OF THERAPY

DIAGNOSIS: _____

DIAGNOSTIC PROCEDURES AND FINDINGS (please list dates): _____

MEDICAL JUSTIFICATION FOR PRODUCT USE: _____

PRESCRIBER'S SIGNATURE AND SPECIALTY: _____

MAGELLAN MEDICAID ADMINISTRATION USE ONLY:	<input type="checkbox"/> APPROVED	<input type="checkbox"/> DENIED
DATE: ___/___/___	COMMENTS: _____	
MAP RPh/TECH: _____	_____	
NDC: _____	_____	

SUBMIT REQUESTS TO:	MAGELLAN MEDICAID ADMINISTRATION
FAX: (888) 603-7696	
All Fax requests will be processed in one business day To check on the status you may call TELEPHONE: (866) 247-1181	
WEB REQUESTS: PA's may be requested on-line see the following website for details: http://southcarolina.flsc.com/	



SOUTH CAROLINA MEDICAID PROGRAM
PRIOR AUTHORIZATION REQUEST – PROTON PUMP INHIBITORS

PRESCRIBER:	BENEFICIARY:
NAME: _____ (FIRST) (LAST)	NAME: _____ (FIRST) (LAST)
National Provider ID # _____	MEDICAID #: _____
PHONE # (____) _____	DATE OF BIRTH: ____/____/____ SEX: <input type="checkbox"/> M <input type="checkbox"/> F
FAX # (____) _____	REQUEST DATE: ____/____/____
PRESCRIBER'S OFFICE STAFF MEMBER COMPLETING FORM: _____	

PHARMACY: _____ PHONE: (____) _____

Patient's Diagnosis: _____

Have any recent GI procedures been performed? (Check and complete ALL that apply.)

<u>Procedure:</u>	<u>Date of Procedure:</u>	<u>Findings:</u>
<input type="checkbox"/> Upper GI Series	____/____/____	_____ _____
<input type="checkbox"/> Barium Swallow	____/____/____	_____ _____
<input type="checkbox"/> Endoscopy	____/____/____	_____ _____

Has the Patient had a failure (4 week trial) on an acute dose of an H2 Receptor Antagonist in the past 2 years? Yes No
If Yes, Medication Name: _____ Strength: _____ Frequency: _____ Date of trial: ____/____/____

Is the Patient H.Pylori positive? Yes No Date: ____/____/____

Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page. _____

SUBMIT REQUESTS TO:	MAGELLAN MEDICAID ADMINISTRATION
FAX: (888) 603-7696	
All Fax requests will be processed in one business day To check on the status you may call TELEPHONE: (866) 247-1181	
WEB REQUESTS: PA's may be requested on-line see the following website for details: http://southcarolina.flhsc.com/	



SOUTH CAROLINA MEDICAID PROGRAM

GROWTH HORMONE PRIOR AUTHORIZATION REQUEST – ADULT TREATMENT

PRESCRIBER: NAME: _____ (FIRST) (LAST) Prescriber Specialty: _____ PHONE # (____) _____ FAX # (____) _____ PRESCRIBER'S OFFICE STAFF MEMBER COMPLETING FORM: _____	BENEFICIARY: NAME: _____ (FIRST) (LAST) MEDICAID #: _____ DATE OF BIRTH: ___/___/___ SEX: <input type="checkbox"/> M <input type="checkbox"/> F REQUEST DATE: ___/___/___
---	---

PHARMACY: _____ PHONE: (____) _____

DRUG NAME	STRENGTH	DURATION

If request is for a non-preferred agent, please include clinical criteria for this particular agent over one of the following: Genotropin®, Norditropin®, Saizen®

Dosage Schedule: _____

Diagnosis: _____ ICD-9 CODE: _____

Initiation of Therapy: Yes No Continuation of Therapy: Yes No

Provocative Stimulation Test and Findings : _____

Is patient receiving full supplementation of deficient pituitary hormones? Yes No
If yes, please list _____

Does the patient have reduced bone mineral density (BMD) using the WHO criteria? Yes No
If yes, please provide T-Score: _____

Does the patient have a high risk lipid profile? Yes No
If yes, please provide total cholesterol or LDL level: _____

Does the patient have at least 2 pituitary hormone deficiencies other than Growth Hormone? Yes No
If yes, please list: _____

For renewal, is the patient showing improvement? Yes No
* Increase in BMD per DEXA scan: Yes No
* Reduction in lipid panel: Yes No
Document percent reduction: _____

Prescriber's Signature: _____ Date: ___/___/___

SUBMIT REQUESTS TO: FAX: (888) 603-7696 All Fax requests will be processed in one business day To check on the status you may call TELEPHONE: (866) 247-1181 WEB REQUESTS: PA's may be requested on-line see the following website for details: http://southcarolina.fhsc.com/	MAGELLAN MEDICAID ADMINISTRATION
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SOUTH CAROLINA MEDICAID PROGRAM

GROWTH HORMONE PRIOR AUTHORIZATION REQUEST – PEDIATRIC TREATMENT

PRESCRIBER:	BENEFICIARY:
NAME: _____ (FIRST) (LAST)	NAME: _____ (FIRST) (LAST)
Prescriber Specialty: _____ <i>(Note: Requesting prescriber must be a nephrologist or pediatric endocrinologist)</i>	MEDICAID #: _____
PHONE # (____) _____	DATE OF BIRTH: ____/____/____ SEX: <input type="checkbox"/> M <input type="checkbox"/> F
FAX # (____) _____	REQUEST DATE: ____/____/____
PRESCRIBER'S OFFICE STAFF MEMBER COMPLETING FORM: _____	

PHARMACY: _____ PHONE: (____) _____

DRUG NAME	STRENGTH	DURATION

If request is for a non-preferred agent, please include clinical criteria for this particular agent over one of the following: Genotropin®, Norditropin®, Saizen®

Dosage Schedule: _____

Diagnosis: _____ ICD-9 CODE: _____

Birth Weight: _____ Gestational Age at Birth: _____

Last Recorded Height: _____ Date of Measurement: _____

Last Recorded Weight: _____ Date of Measurement: _____

Biological Mother's Height: _____ Biological Father's Height: _____

Therapy: Initiation Continuation

Bone Age Studies Results: _____

Epiphyses: Open Closed

Has Patient been evaluated by Endocrinologist Pediatric Nephrologist

Current Growth Velocity: _____

PLEASE ATTACH COPIES OF GROWTH CHARTS TO THIS REQUEST.

Prescriber's Signature: _____ Date: ____/____/____

SUBMIT REQUESTS TO:	MAGELLAN MEDICAID ADMINISTRATION
FAX: (888) 603-7696	
All Fax requests will be processed in one business day To check on the status you may call TELEPHONE: (866) 247-1181	
WEB REQUESTS: PA's may be requested on-line see the following website for details: http://southcarolina.fhsc.com/	



SOUTH CAROLINA MEDICAID PROGRAM
PRIOR AUTHORIZATION REQUEST – ANTIPSYCHOTICS

PRESCRIBER: NAME: _____ (FIRST) (LAST) National Provider ID # _____ PHONE # (____) _____ FAX # (____) _____	BENEFICIARY: NAME: _____ (FIRST) (LAST) MEDICAID #: _____ DATE OF BIRTH: ___/___/___ SEX: <input type="checkbox"/> M <input type="checkbox"/> F REQUEST DATE: ___/___/___
PRESCRIBER'S OFFICE STAFF MEMBER COMPLETING FORM:	

PHARMACY: _____ **PHONE:** (____) _____

DRUG NAME	DOSE	STRENGTH	LENGTH OF THERAPY

DIAGNOSIS: _____

Is the Prescriber a Psychiatrist? Or, has the Prescriber consulted with a Psychiatrist before requesting this medication?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the patient received a developmentally-appropriate, comprehensive psychiatric assessment with diagnoses, impairments, treatment target and treatment plans clearly identified and documented?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has informed consent for this medication been obtained from the parent or guardian?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has a family assessment been performed (including parental psychopathology and treatment needs) and have family functioning and parent-child relationship been evaluated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Psychosocial treatment has been in place for at least 12 weeks without adequate clinical response and psychosocial treatment with parental involvement will continue for the duration of medication therapy. Select "Yes" if this statement is true.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the requested medication the only antipsychotic medication the patient will be receiving?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If "No" to the question above, is one agent being tapered while titrating another?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is this request for continuation of an established therapy? Or, for continuation of therapy initiated during an in-patient hospitalization?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If "Yes" to the question above, please document the specific medication: _____		
If Tourettes is listed as the diagnosis, please answer the following questions:		
Has the patient failed treatment with previous therapy (such as clonidine or guanfacine)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If "Yes" to the question above, please document the specific medication: _____		

SUBMIT REQUESTS TO:	MAGELLAN MEDICAID ADMINISTRATION
FAX: (888) 603-7696	
All Fax requests will be processed in one business day To check on the status you may call TELEPHONE: (866) 247-1181	
WEB REQUESTS: PA's may be requested on-line see the following website for details: http://southcarolina.fhsc.com/	



SOUTH CAROLINA MEDICAID PROGRAM
PRIOR AUTHORIZATION REQUEST – HEPATITIS B

PRESCRIBER: NAME: _____ (FIRST) (LAST) National Provider ID # _____ PHONE # (____) _____ FAX # (____) _____	BENEFICIARY: NAME: _____ (FIRST) (LAST) MEDICAID #: _____ DATE OF BIRTH: ___/___/___ SEX: <input type="checkbox"/> M <input type="checkbox"/> F REQUEST DATE: ___/___/___ PRESCRIBER'S OFFICE STAFF MEMBER COMPLETING FORM: _____
--	---

PHARMACY: _____ **PHONE:** (____) _____

DRUG NAME	DOSE	STRENGTH	LENGTH OF THERAPY

DIAGNOSIS: _____
HAS THE PATIENT HAD AN HIV SCREEN? Yes No
 If yes, please document results: _____
HAS THE PATIENT HAD A LIVER BIOPSY? Yes No
 If yes, please document results: _____
DOES THE PATIENT HAVE COMPROMISED RENAL FUNCTION? Yes No
 If yes, please provide creatinine clearance rate: _____
 (**Please attach a copy of lab results noted above with this form for our records**)

- | | |
|--|--|
| 1. Does the patient have autoimmune hepatitis? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Is the patient (or patient's partner) pregnant? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Is there a history of kidney, lung or heart transplant? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Does the patient have uncontrolled depression? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Does the patient have severe HTN, heart failure or CAD? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

South Carolina Medicaid has instituted a program to more closely monitor Hepatitis B patients in an attempt to improve medication compliance. To assist in the program, please provide the patient's phone number(s). _____

SUBMIT REQUESTS TO:	MAGELLAN MEDICAID ADMINISTRATION
FAX: (888) 603-7696	
All Fax requests will be processed in one business day To check on the status you may call TELEPHONE: (866) 247-1181	
WEB REQUESTS: PA's may be requested on-line see the following website for details: http://southcarolina.fhsc.com/	



SOUTH CAROLINA MEDICAID PROGRAM
PRIOR AUTHORIZATION REQUEST – HEPATITIS C

PRESCRIBER: NAME: _____ (FIRST) (LAST) National Provider ID # _____ PHONE # (____) _____ FAX # (____) _____ PRESCRIBER'S OFFICE STAFF MEMBER COMPLETING FORM: _____	BENEFICIARY: NAME: _____ (FIRST) (LAST) MEDICAID #: _____ DATE OF BIRTH: ___/___/___ SEX: <input type="checkbox"/> M <input type="checkbox"/> F REQUEST DATE: ___/___/___
--	---

PHARMACY: _____ **PHONE:** (____) _____

DRUG NAME	DOSE	STRENGTH	LENGTH OF THERAPY

DIAGNOSIS: _____
GENOTYPE: _____
INITIAL VIRAL LOAD: _____ **DATE TAKEN:** ___/___/___

HAS THE PATIENT HAD A LIVER BIOPSY? Yes No

If yes, please document results: _____
 (**Please attach a copy of lab results noted above with this form for our records**)

- | | |
|--|--|
| 1. Does the patient have autoimmune hepatitis? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Is the patient (or patient's partner) pregnant? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Does the patient have a hemoglobinopathy?
(e.g., sickle cell, thalassemia) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Is there a history of kidney, lung or heart transplant? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Does the patient have untreated hyperthyroidism? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Does the patient have uncontrolled depression? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Does the patient have severe HTN, heart failure or CAD? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Is the patient going to be taking a Ribavirin? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If not, please explain contraindicaton: _____

South Carolina Medicaid has instituted a program to more closely monitor Hepatitis C patients in an attempt to improve medication compliance. To assist in the program, please provide the patient's phone number(s). _____

SUBMIT REQUESTS TO:	MAGELLAN MEDICAID ADMINISTRATION
FAX: (888) 603-7696	
All Fax requests will be processed in one business day. To check on the status you may call TELEPHONE: (866) 247-1181	
WEB REQUESTS: PA's may be requested on-line see the following website for details: http://southcarolina.fhsc.com/	

**PROVIDER MANUAL SUPPLEMENT
MANAGED CARE**

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MANAGED CARE SUPPLEMENT

MANAGED CARE OVERVIEW

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

- Provide accessible, comprehensive, family-centered coordinated care
- Manage the beneficiary's health care, perform primary and preventive care services, and arrange for any additional needed care
- Provide beneficiaries access to a "live voice" 24 hours a day, 7 days a week, to ensure access to appropriate care
- Provide beneficiary education about preventive and primary health care, utilization of the medical home, and the appropriate use of the emergency room

Enrolling in a managed care plan does not limit benefits. Benefits offered under fee for service (FFS) Medicaid, as well as additional or enhanced benefits are provided by all health plans. These additional benefits vary from plan to plan according to the contracted terms and conditions between SCDHHS and the managed care entity. Beneficiaries and providers should contact the health plan with questions concerning additional benefits.

Examples of additional benefits include:

- 24-hour nurse advice line
- Care coordination
- Health management programs (asthma, diabetes, pregnancy, etc.)
- Unlimited office visits
- Adult dental services

The Bureau of Managed Care administers the program for Medicaid-eligible beneficiaries by contracting with Managed Care Organizations (MCOs) and Care Services Organizations (CSOs) to offer health care services (*CSOs support the Medical Homes Network (MHN) managed care health delivery model*). An MCO must receive a Certificate of Authority from the SC Department of Insurance and must be licensed as a domestic insurer by the State to render Medicaid managed care services. MCO model contracts are approved by the Centers for Medicare and Medicaid Services (CMS) and Medicaid.

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

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

MANAGED CARE SUPPLEMENT

MANAGED CARE OVERVIEW

(www.scdhhs.gov) for the most current listing of health plans, the counties in which they are authorized to operate, and the number of managed care enrollees within a county.

SC MEDICAID MANAGED CARE CONTACT INFORMATION

For additional information, contact the Bureau of Managed Care at the following address:

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

PROGRAM DESCRIPTIONS

Managed Care Organizations (MCOs)

A Managed Care Organization (MCO) is commonly referred to as an HMO (Health Maintenance Organization) in the private sector. MCOs are required to operate under a contract with SCDHHS to provide healthcare services to beneficiaries through a network of healthcare professionals, both primary and specialty care, as well as hospitals, pharmacies, etc. This network is developed by contracting with the various healthcare professionals.

Primary care providers (PCP) must be accessible within a 30-mile radius, while specialty care providers, to include hospitals, must be accessible within a 50-mile radius. While MCOs will contract with providers within a specific county, enrolled members may seek treatment, or be referred to in-network providers in neighboring counties.

MCOs are responsible for providing core services to Medicaid-eligible individuals as specified in their contract with SCDHHS. The health care providers within the MCO network are not required to accept FFS Medicaid as most claims are filed to and processed by the MCO. Only services rendered on a fee-for-service (FFS) basis require providers be enrolled in SC Medicaid, as those claims are paid by SCDHHS. (Core services are discussed further in the **Core Benefits** section of this supplement.)

Core Benefits

Managed Care Organizations are fully capitated plans that provide a core benefits package similar to the current FFS Medicaid plan. MCO plans are required to provide beneficiaries with “medically necessary” care at current limitations for all contracted services. Unless otherwise specified, service limitations are based on the State fiscal year (July 1 through June 30). While appropriate and necessary care must be provided, MCOs are not bound by the current variety of service settings. For example, a service may only be covered FFS when performed in an inpatient hospital setting, while the MCO may authorize the same service to be performed both in an inpatient and an outpatient hospital setting.

MANAGED CARE SUPPLEMENT

MANAGED CARE OVERVIEW

MCOs may offer SCDHHS-approved additional benefits. These are benefits that go beyond the core package. Additions, deletions, or modifications to additional benefits made during the contract year must be approved by SCDHHS. These benefits may include medical services which are currently non-covered by FFS and/or which are above current Medicaid limitations.

Providers should refer to the **Core Benefits** section of the MCO Policy and Procedures Guide on the SCDHHS website (www.scdhhs.gov) for a detailed explanation of core benefits and service limitations.

Services Outside of the Core Benefits

The South Carolina Healthy Connections (Medicaid) program continues to provide and/or reimburse certain FFS benefits. Providers rendering services that are not included in the MCO's benefits package, but are covered under FFS Medicaid receive payment in accordance with the current Medicaid fee schedule. These services are filed to SC Medicaid for processing and payment. MCOs are responsible for the beneficiaries' continuity of care by ensuring appropriate referrals and linkages to the Medicaid FFS providers. For specifics concerning services outside of the core benefits, please see the MCO Policy and Procedures Guide on www.scdhhs.gov.

MCO Program Identification (ID) Card

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

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

- The MCO name
- The 24-hour telephone number for the beneficiary to use in urgent or emergency situations and to obtain any additional information
- The name of the primary care physician
- The beneficiary's name and Medicaid ID number
- The MCO's plan expiration date (optional)
- The Member Services toll-free telephone number
- The MCO and SC Medicaid logos

Claims Filing

Providers should file claims with the MCO for beneficiaries participating in a managed care program, unless the service rendered is not covered by the MCO and is, instead, paid on a FFS basis by SC Medicaid. Providers should contact the MCO for managed care billing requirements. Non-contracted providers should contact the MCO for billing and prior authorization requirements prior to rendering services to MCO enrolled beneficiaries. An exception is services

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rendered in an emergency room. Even if the physician is not in-network with the MCO, the MCO cannot refuse to reimburse for covered emergency services. Specifics concerning emergency coverage are contained in Section 4, **Emergency Medical Services**, of the MCO contract.

Prior Authorizations and Referrals

Providers, both in and out of network, should contact the beneficiary's MCO for assistance with prior authorization (PA) requirements before administering services. Each MCO may have different prior authorization requirements and services requiring PA may differ according to the terms of a provider's contract with an MCO.

Admission to a hospital through the emergency department **may** require authorization. Hospitals should always check with the beneficiary's MCO plan for their requirements. The physician component for inpatient services **always** requires prior authorization. Specialist referrals for follow-up care after a hospital discharge also require prior authorization.

Medical Homes Networks (MHNs)

Medical Homes Networks (MHNs) are Medicaid's Primary Care Case Management (PCCM) programs that link beneficiaries with a primary care provider (PCP). An MHN is a group of physicians who have agreed to serve as PCCM providers. They work in partnership with the beneficiary to provide and arrange for most of the beneficiary's health care needs, including authorizing services provided by other health care providers. They also partner with a Care Coordination Services Organization (CSO) to accept the responsibility for providing medical homes for beneficiaries and for managing beneficiaries' care. The CSO supports the physicians and enrolled beneficiaries by providing care coordination, disease management, and data management. All providers participating in an MHN must be enrolled SC Medicaid providers, as all services are paid on a fee-for-service (FFS) basis.

The outcomes of the medical home initiative are a healthier, better educated Medicaid beneficiary, and cost savings for South Carolina through a reduction of acute medical care and disease-related conditions. The MHN provides case managers, who assist in developing, implementing, and evaluating the predetermined care management strategies of the network.

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

MHN Program Identification (ID) Card

Medicaid Homes Networks do not issue a separate identification card. Beneficiaries enrolled in an MHN will have only one identification card, the one issued by SC Medicaid. This card does not contain the name or phone number of the assigned PCP. Such information can only be obtained by checking eligibility.

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MANAGED CARE OVERVIEW

Core Benefits

Services provided under the MHN program are all paid on a FFS basis. As such, all claims are submitted to and processed by SCDHHS. Benefits offered in the MHN program mirror those offered in FFS with the following exceptions:

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

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

Prior Authorizations and Referrals

The PCP is contractually required to either provide medically necessary services or authorize another provider to treat the beneficiary via a referral. Even if a physician in the same practice, but at a different practice location with a different Medicaid “pay-to or group” provider ID, treats a beneficiary, the services rendered still need a referral from the PCP. If a beneficiary has failed to establish a medical record with the PCP, the CSO, in conjunction with the PCP, shall arrange for the prior authorization (PA) on any existing referral. For a list of services that do not require authorization, refer to the **Exempt Services** section later in this supplement.

In some cases, the PCP may choose to authorize a service retroactively. All authorizations and consultations, including services authorized retroactively, are at the discretion of the PCP. The process for referring a beneficiary to a specialist can be made by telephone or in writing. The referral should include the number of visits being authorized and the extent of the diagnostic evaluation.

A PCP may authorize multiple visits for a specific course of treatment or a particular diagnosis. This prevents a provider to whom the beneficiary was referred from having to obtain a referral number for each visit so long as the course of treatment or diagnosis has not changed. The provider simply files the claims referencing the same referral number. It is the PCP’s responsibility to authorize additional referrals for any further diagnosis, evaluation, or treatment not identified in the scope of the original referral. If a specialist needs to refer the beneficiary to a second specialist for the same diagnosis, the beneficiary’s PCP must be contacted for a referral number.

A referral number is not required for services provided in a hospital emergency department or for an admission to a hospital through the emergency department. However, the physician component for inpatient hospital services does require a referral number. The hospital should contact the PCP for a referral number within 48 hours of the beneficiary’s admission. Specialist referrals for follow-up care after discharge from a hospital also require a referral from the PCP. In addition to the MHN’s authorization, prior approval may be required by SCDHHS to verify medical necessity before rendering some services. Prior authorizations are for medical approval only. Obtaining a prior authorization does not guarantee payment or ensure the beneficiary’s eligibility on the date of service.

MANAGED CARE SUPPLEMENT

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For a list of services requiring a referral number from the PCP, along with noted exceptions, please refer to the MHN Policy and Procedures Guide. Claims submitted for reimbursement must include the PCP's referral number.

Specific services sponsored by state agencies require a referral from that agency's case manager. The state agency's case manager should coordinate with the PCP and the MHN Care Coordinator to ensure the continuity of care. These services include, but are not limited to, the following:

- Audiologist Services
- High/Moderate Management Group Homes Services
- Occupational Therapist Services
- Physical Therapist Services
- Psychologist Services
- Speech Therapist Services
- Therapeutic Foster Care Services

Referrals for a Second Opinion

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

Referral Documentation

All referrals must be documented in the beneficiary's medical record. The CSO and the PCP shall review the monthly referral data to ensure that services rendered to the beneficiary were authorized and recorded accurately in the medical record. It is the PCP's responsibility to review the referral data for validity and accuracy, and to report inappropriate and/or unauthorized referrals to the CSO. The CSO is responsible for investigating these incidents and notifying SCDHHS if Medicaid fraud or abuse is suspected.

Exempt Services

Beneficiaries can obtain the following services from Medicaid providers without obtaining a prior authorization from their PCP:

- Ambulance Services
- Dental Services
- Dialysis/End Stage Renal Disease Services
- Emergency Room Services (billed by the hospital)
- Family Planning Services
- Home- and Community-Based Waiver Services
- Independent Laboratory and X-ray ¹ Services

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- Medical Transportation Services
- Nursing Home Services
- Obstetrician and Gynecologist Services
- Optician Services
- Optometrist Services
- Pharmacy Services
- State Agency Services²

¹ FQHCs/RHCs that provide laboratory and x-ray services under a separate provider number (not the FQHC/RHC number) must enter a prior authorization number on the claim form or the claim will be rejected.

² Agencies exempt from prior authorization are the Department of Mental Health, the Continuum of Care, the Department of Alcohol and Other Drug Abuse, the Department of Disabilities and Special Needs, the Department of Juvenile Justice, and the Department of Social Services.

The above list is not all-inclusive. For a complete list of exempt services, refer to the MHN Policy and Procedures Guide on the SCDHHS website (www.scdhhs.gov). Some services still require a prescription or a physician's order. Physicians should refer to the appropriate Medicaid Provider Manual for more detailed information and/or requirements, or contact the SCDHHS Provider Service Center (PSC) by calling 888-289-0709. Providers can also submit an online inquiry at <http://scdhhs.gov/contact-us> and a provider service representative will respond to you directly.

Primary Care Provider Requirements

The primary care provider is required to either provide services or authorize another provider to treat the beneficiary. The following Medicaid provider types may enroll as a primary care provider:

- Family Medicine
- General Practitioners
- Pediatricians
- Internal Medicine
- Obstetrics and Gynecology
- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)
- Nurse Practitioners (see the MHN Policy and Procedure Guide on the SCDHHS Web site (www.scdhhs.gov) for guidelines)

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24-Hour Coverage Requirements

The MHN requires PCPs to provide access to medical advice and care for enrolled beneficiaries 24 hours per day, 7 days per week. A qualified medical practitioner must provide medical advice, consultation, and/or authorization or referral for services when appropriate within one hour of the beneficiary's presentation or notification. PCPs must have at least one telephone line that is answered by office staff during regular office hours.

Women, Infants, and Children (WIC) Program Referrals

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

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

MANAGED CARE SUPPLEMENT

MANAGED CARE ELIGIBILITY

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

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

- Dually eligible beneficiaries (Medicare and Medicaid)
- Beneficiaries age 65 or older
- Residents of a nursing home
- Participants in limited benefits programs such as Family Planning, Specified Low Income Beneficiaries, Emergency Service Only, etc.
- Home- and Community-Based Waiver participants
- PACE participants
- Medically Complex Children's Waiver Program participants
- Hospice participants
- Beneficiaries covered by an MCO/HMO through third-party coverage
- Beneficiaries enrolled in another Medicaid managed care plan

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

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

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

MANAGED CARE SUPPLEMENT

MANAGED CARE ELIGIBILITY

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MANAGED CARE SUPPLEMENT

MANAGED CARE ENROLLMENT

OVERVIEW

All managed care enrollment and disenrollment activities are handled through one single point of contact, South Carolina Healthy Connections Choices (SCHCC). SCHCC is responsible for processing the enrollment and disenrollment of Medicaid-eligible beneficiaries into a managed care plan. Beneficiaries may enroll online, by telephone, by mail, or by fax. Managed Care eligible Medicaid beneficiaries are encouraged to actively enroll with a managed care plan. Medicaid beneficiaries may currently select among the following Medicaid service delivery options:

- Managed Care Organization
- Medical Homes Network

SCHCC may be reached by calling (877) 552-4642, or via the SCHCC website: www.SCchoices.com. SCHCC should be contacted for assistance with enrollment, as well as transferring to, or disenrolling from, a health plan regardless of how long a beneficiary has been enrolled in their current health plan.

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

An **enrollment packet** is mailed to beneficiaries who are required to make a managed care plan choice. Failure to do so will result in managed care plan assignment by SCHCC.

An **outreach packet** is mailed to beneficiaries who are eligible, but not required, to participate in a managed care plan. Managed care participation is on a voluntary basis for this population. (See **Enrollment Counselor Services** later in this supplement.)

Outreach and assignment is based on the beneficiary's payment category or Recipient Special Program (RSP) indicator, and is effective according to the published cut-off schedule.

If a Medicaid beneficiary enrolled in a managed care plan 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 or the MHN. Beneficiaries must contact SCHCC to enroll in a managed care plan, or to change or discontinue their plan. A member can only change or disenroll without cause within the first 90 days of enrollment. If the beneficiary is approved to enroll in a managed care plan, or changes his or her plan, and is entered into the system before the established cut-off date, the beneficiary appears on the plan's member listing for the next month. If the beneficiary is approved, and entered into the system after the established cut-off date, the beneficiary will appear on the plan's member listing for the following month.

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ENROLLMENT PROCESS

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

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

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

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

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

There are three easy ways for beneficiaries to enroll:

- Call SCHCC at (877) 552-4642
- Mail or fax the completed enrollment form contained in the enrollment packet
- Online at www.SCchoices.com

A beneficiary is enrolled in a Managed Care plan for a period of 12 months. The beneficiary shall remain enrolled in the plan unless one of the following occurs:

- The beneficiary becomes ineligible for Medicaid and/or Managed Care enrollment
- The beneficiary forwards a written request to transfer plans for cause
- The beneficiary initiates the transfer process during the annual re-enrollment period
- The beneficiary requests transfer within the first 90 days of enrollment

Enrollment of Newborns

Babies born to Medicaid-eligible mothers are automatically deemed Medicaid eligible. As such, they are subject to being enrolled into a managed care plan. If, at the time of delivery, the mother is enrolled with an MCO, the baby will be automatically enrolled into the same MCO. If, however, the mother is enrolled with an MHN, or is FFS, the baby will revert to FFS Medicaid

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

Babies automatically enrolled into the mother's MCO have a 90-day choice period following birth during which a change to their health plan may be made. Following the 90-day choice period, the newborn enters into his or her lock-in period and may not change health plans for the first year of life without "just cause." The newborn's effective date of enrollment into a managed care plan is the first day of the month of birth.

Providers should refer to the appropriate Medicaid provider manual for additional limitations when providing services to newborns.

Primary Care Provider Selection and Assignment

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

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

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

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

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MANAGED CARE SUPPLEMENT

MANAGED CARE DISENROLLMENT PROCESS

OVERVIEW

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

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

Transfer requests made during the lock-in period require the completion of a Health Plan Change form, which may only be obtained by contacting SCHCC. The form requires the beneficiary to provide information confirming his or her attempt to resolve any issues necessitating disenrollment. That information includes documenting the date and time of the call to the health plan to discuss his or her issues, as well as the person with whom the beneficiary spoke. Failure to provide all required information results in denial of the disenrollment request as all such requests must be reviewed by the SCDHHS Managed Care staff.

Upon review by Managed Care staff, the managed care plan is notified of the request to disenroll so that a plan representative may follow up with the beneficiary in an effort to address the concerns raised. Managed care plans are required to notify SCDHHS within 10 days of the follow-up results for all complaints or disenrollment requests forwarded to the plan. If just cause is not validated, disenrollment is denied and the beneficiary remains in the managed care plan. A beneficiary’s request to transfer is honored if a decision has not been reached within 60 days of the initial request. The final decision to accept the beneficiary’s request is made by SCDHHS.

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

INVOLUNTARY BENEFICIARY DISENROLLMENT

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

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

MANAGED CARE SUPPLEMENT**MANAGED CARE DISENROLLMENT PROCESS**

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

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

For additional information, please review the involuntary disenrollment guidelines used by SCDHHS and the Managed Care plans in the **Disenrollment Process** section in the MCO or MHN Policy and Procedures Guide.

MANAGED CARE SUPPLEMENT

EXHIBITS

MANAGED CARE PLANS BY COUNTY

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

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

CURRENT MEDICAID MEDICAL HOMES NETWORK (MHNS)

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

Carolina Medical Homes

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

Palmetto Physician Connections

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

South Carolina Solutions

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

MANAGED CARE SUPPLEMENT

CURRENT MEDICAID MANAGED CARE ORGANIZATIONS

South Carolina Healthy Connections (Medicaid) Managed Care Organizations are required to issue a plan identification card to enrolled beneficiaries. Beneficiaries should present both the MCO-issued identification card and the Healthy Connections Medicaid card. MCO cards contain important information on the beneficiary (name, plan number), the MCO (toll-free contact numbers), and the PCP.

SAMPLE MEDICAID MCO CARDS

The following card samples are used by MCOs that are currently authorized to operate in South Carolina. Not all MCOs are authorized to operate in every county of the state. Please consult the SCDHHS website at www.scdhhs.gov for the current list of authorized plans and counties.

Absolute Total Care

Centene Corporation

(866) 433-6041

www.absolutetotalcare.com

	Rx: US Script 1-800-460-8988 BIN:008019	
Name: Bob Q. Sample	Effective Date: X/X/XXXX	
ID#: XXXXXXXXXX	DOB: X/X/XXXX	
PCP Name : Dr. John Doe	PCP Phone #:XXX-XXX-XXXX	
<p>If you have an emergency, call 911 or go to the NEAREST emergency room (ER). You do not have to contact Absolute Total Care for an okay before you get emergency services. If you are not sure whether you need to go to the ER, call your PCP or Absolute Total Care NurseWise toll-free at 1-866-433-6041, option 7, or TDD/TTY 1-866-912-3609. NurseWise is open 24 hours a day.</p>		

(front)

IMPORTANT MEMBER TELEPHONE NUMBERS	
24/7 Member Line: 1-866-433-6041 TDD/TTY: 1-866-912-3609 24/7 NurseWise®: 1-866-433-6041 , option 7 Prescription Drugs: 1-866-433-6041 Vision/Dental Questions: 1-866-433-6041 TDD/TTY: 1-866-912-3609 Prescription Drugs: Pharmacy- see front of card; Members call 1-866-433-6041	
Eligibility: 1-866-912-3604 (IVR) Interactive Voice Response 1-866-433-6041 (Provider Services)	
Medical & Behavioral Health Claims	Absolute Total Care Attn: CLAIMS PO Box 3050 Farmington, MO 63640-3821
Healthy Connections Choices at 1-877-552-4642	

(back)

MANAGED CARE SUPPLEMENT

BlueChoice

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



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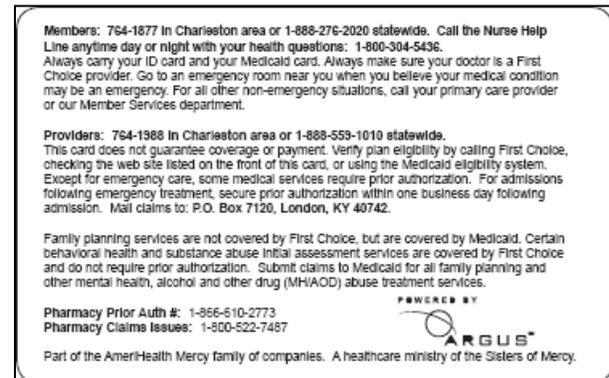
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First Choice by Select Health

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



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UnitedHealthcare Community Plan

UnitedHealthcare Community Plan

(800) 414-9025

www.uhccommunityplan.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

THIRD-PARTY LIABILITY SUPPLEMENT

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.

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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

THIRD-PARTY LIABILITY SUPPLEMENT

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 resubmit the Edit Correction Form (ECF) 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 resubmitting 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.

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2. Confirm that all requested information has been submitted.
 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.

THIRD-PARTY LIABILITY SUPPLEMENT

Attach the form either to a claim filed as a denial or to an ECF. 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.

THIRD-PARTY LIABILITY SUPPLEMENT

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 send the insurance EOB with an ECF.

THIRD-PARTY LIABILITY SUPPLEMENT

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 an ECF for the claim, attach all EOBs and return the ECF 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 may write in the carrier code, policy number, and amount paid in the third occurrences of fields 24, 25, and 26 of the CMS-1500 ECF, and submit the ECF to MCCS. Claims submitted electronically will be processed automatically with up to ten primary payers. You may also submit the ECF and all the EOBs to

THIRD-PARTY LIABILITY SUPPLEMENT

the Division of Third-Party Liability; however, that is no longer required and may slightly delay claim payment.

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

<p>9a Other Insured’s Policy or Group Number Enter the policy number.</p>	<p>11 Insured’s Policy Group or FECA Number Enter the policy number.</p>
<p>9c Employer’s Name or School Name If the insurance has paid, indicate the amount paid in this field. If the insurance has denied payment, enter “0.00” in this field.</p>	<p>11b Employer’s Name or School Name If the insurance has paid, indicate the amount paid in this field. If the insurance has denied payment, enter “0.00” in this field.</p>
<p>9d Insurance Plan Name or Program Name Enter the three-digit carrier code.</p>	<p>11c Insurance Plan Name or Program Name Enter the three-digit carrier code.</p>

<p>10d Reserved for Local Use Enter the appropriate TPL indicator for this claim.</p>
--

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.

<p>29 Amount Paid Enter the total amount paid from all insurance sources. This amount is the sum of 9c and 11b.</p>
--

Complete instructions for filling out CMS-1500 claim forms can be found in Section 3 of provider manuals for professional services. Sample CMS-1500s with TPL information appear at the end of this supplement.

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Institutional Paper Claims

Unlike other claim types, the UB claim form has a section for listing all parties being billed, **including Medicaid**. Medicaid's carrier code, 619, must be entered on all UB claims submitted to Medicaid.

Fields 50, 54, and 60 are the main fields for coding TPL information.

- Identify all other payers, with the primary payer on line A.
- For each payer other than Medicaid, enter the three-digit carrier code in field 50 and the corresponding payment in field 54.
- For denials, enter the carrier code in field 50 and "0.00" in field 54. Then, enter occurrence code 24 and the date of denial in item 31, 32, 33, or 34.
- You are not required to enter a provider number for payers other than Medicaid, though doing so will not affect your claim.
- Enter Medicaid (619) on line B or C. Leave field 54 of the Medicaid line blank; there will never be a prior payment.
- Enter the patient's 10-digit Medicaid ID number on the lettered line (A, B, or C) that corresponds to the Medicaid line in fields 50 – 54. Enter the other policy numbers on the same lettered line as the code and payment for that carrier.

UB-04 TPL Fields

	50 PAYER	51 PROVIDER NO	54 PRIOR PAYMENTS
A	618/620 (Medicare carrier code)		\$33.01
B	401 (BCBS carrier code)		\$255.39
C	619 (Medicaid carrier code)		

60 CERT.-SSN-HIC.-ID NO.
ABQ1111222
123456789-1212
1234567890

If one claim spans multiple claim forms, fields 50, 51, and 54 must be completed in exactly the same way on each page of the claim.

Complete instructions for filling out UB claim forms can be found in the Hospital Services and Psychiatric Hospital Services provider manuals, and a sample UB-04 with TPL information appears at the end of this supplement.

Dental Paper Claims

For samples and complete instructions for filling out the ADA and CMS-1500 claim forms, refer to the DentaQuest Dental Office Reference Manual (ORM) at <http://www.DentaQuest.com>

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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 Edit Correction Form 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 on the ECF, 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.

TPL information appears on the ECF to the right of the Medicaid claims receipt address under the heading “INSURANCE POLICY INFORMATION.” The insurance carrier code, the policy number, and the name of the policyholder are all listed on the ECF, 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 ECF, check to see that all the information you entered is correct. Compare the carrier code and policy number you entered on the claim to what appears on the ECF. Enter the correct information on the ECF.

You can also refile a claim instead of returning an ECF. If you choose to refile a claim that was rejected for any reason, you must re-enter all TPL information.

Other TPL-related edit codes include:

- **165:** TPL balance due/patient responsibility must be present and numeric

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- 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
- 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. Sample corrected ECFs appear at the end of this supplement.

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

THIRD-PARTY LIABILITY SUPPLEMENT

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.

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 ECF to MIVS. If the patient is Part B-only and a UB claim form has received edit 510, the ECF 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.

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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.

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 and ECFs.

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
ECF: Correction to add carrier payment
ECF: Correction to add carrier denial and note about policy lapse

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: AZ999999999999
 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.
- b. beneficiary coverage ended - terminate coverage (date) 12/31/2009
- c. subscriber coverage lapsed - terminate coverage (date) _____
- d. subscriber changed plans under employer - new carrier is _____
 - new policy number is _____
- e. beneficiary to add to insurance already in MMIS for subscriber or other family member.
 (name) _____

ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.

Submit this information to Medicaid Insurance Verification Services (MIVS).

Fax: 803-252-0870 or Mail: Post Office Box 101110
 Columbia, SC 29211-9804

III NEW POLICY NUMBERS FOR INSURANCE IN THE MMIS WITH THE SUBSCRIBER SSN
 (SCDHHS is collecting new unique policy numbers and plans to replace existing insurance records through MMIS online modification as computer resources are available.)

Medicaid Beneficiary ID: _____ SSN: _____
 Carrier Name/Code: _____ New Unique Policy Number: _____

Submit this information to South Carolina Department of Health and Human Services (SCDHHS).

Fax: 803-255-8225 or Mail: Post Office Box 8206, Attention TPL
 Columbia, SC 29202-8206

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 - MIV'S 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 GloboChem

- new policy number is A1111111110

e. beneficiary to add to insurance already in MMIS for subscriber or other family member.
(name) _____

ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.

Submit this information to Medicaid Insurance Verification Services (MIVS).

Fax:	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

THIRD-PARTY LIABILITY SUPPLEMENT



SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES REASONABLE EFFORT DOCUMENTATION

PROVIDER Acme Orthopedic **DOS** 01/01/10
NPI or MEDICAID PROVIDER ID 1234567890
MEDICAID BENEFICIARY NAME Jane Doe
MEDICAID BENEFICIARY ID# 1111111111
INSURANCE COMPANY NAME Jones Health Insurance
POLICYHOLDER Jane Doe
POLICY NUMBER 987654321J
ORIGINAL DATE FILED TO INSURANCE COMPANY 01/15/10
DATE OF FOLLOW UP ACTIVITY 02/16/10

RESULT:

Called insurer to check claim status. Insurer needs bene to fill out subrogation forms

FURTHER ACTION TAKEN:

Called beneficiary on 02/16/10, 02/18/10, and 02/28/10. No answer and no answering machine. No other contact info on file w/ Medicaid or insurer.

DATE OF SECOND FOLLOW UP 03/05/10

RESULT:

Sent certified letter offering to help bene fill out forms. Bene refused letter. Called insurer 8/10/08; they will not act without forms.

I HAVE EXHAUSTED ALL OPTIONS FOR OBTAINING A PAYMENT OR SUFFICIENT RESPONSE FROM THE PRIMARY INSURER.

Mary Orthoped 03/12/10
(SIGNATURE AND DATE)

ATTACH A COPY OF FORM TO THE APPROPRIATE CLAIM OR ECF AND FORWARD TO YOUR MEDICAID CLAIMS PROCESSING POST OFFICE BOX.

Revised 06/2007

THIRD-PARTY LIABILITY SUPPLEMENT



SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES REASONABLE EFFORT DOCUMENTATION

PROVIDER Dr. Betty Smith **DOS** 03/05/10
NPI or MEDICAID PROVIDER ID 1231231230
MEDICAID BENEFICIARY NAME John Jones
MEDICAID BENEFICIARY ID# 9999999999
INSURANCE COMPANY NAME Global Health
POLICYHOLDER John Jones
POLICY NUMBER 8888888888
ORIGINAL DATE FILED TO INSURANCE COMPANY 03/07/10
DATE OF FOLLOW UP ACTIVITY 04/06/10

RESULT:

Called insurer. They received claim and have not suspended it. Sent follow-up letter requesting a response on 04/10/10.

FURTHER ACTION TAKEN:

04/27/10: No response from insurer. Called again; they could not find claim. Resubmitted on 04/29/10.

DATE OF SECOND FOLLOW UP 05/30/10

RESULT:

Called insurer; no action on claim. Notified Dept. of Insurance 05/31/10. Case is still open; Dept. of Ins. advised that we file with Medicaid now, as decision may take some time.

I HAVE EXHAUSTED ALL OPTIONS FOR OBTAINING A PAYMENT OR SUFFICIENT RESPONSE FROM THE PRIMARY INSURER.

Betty Smith 06/03/10

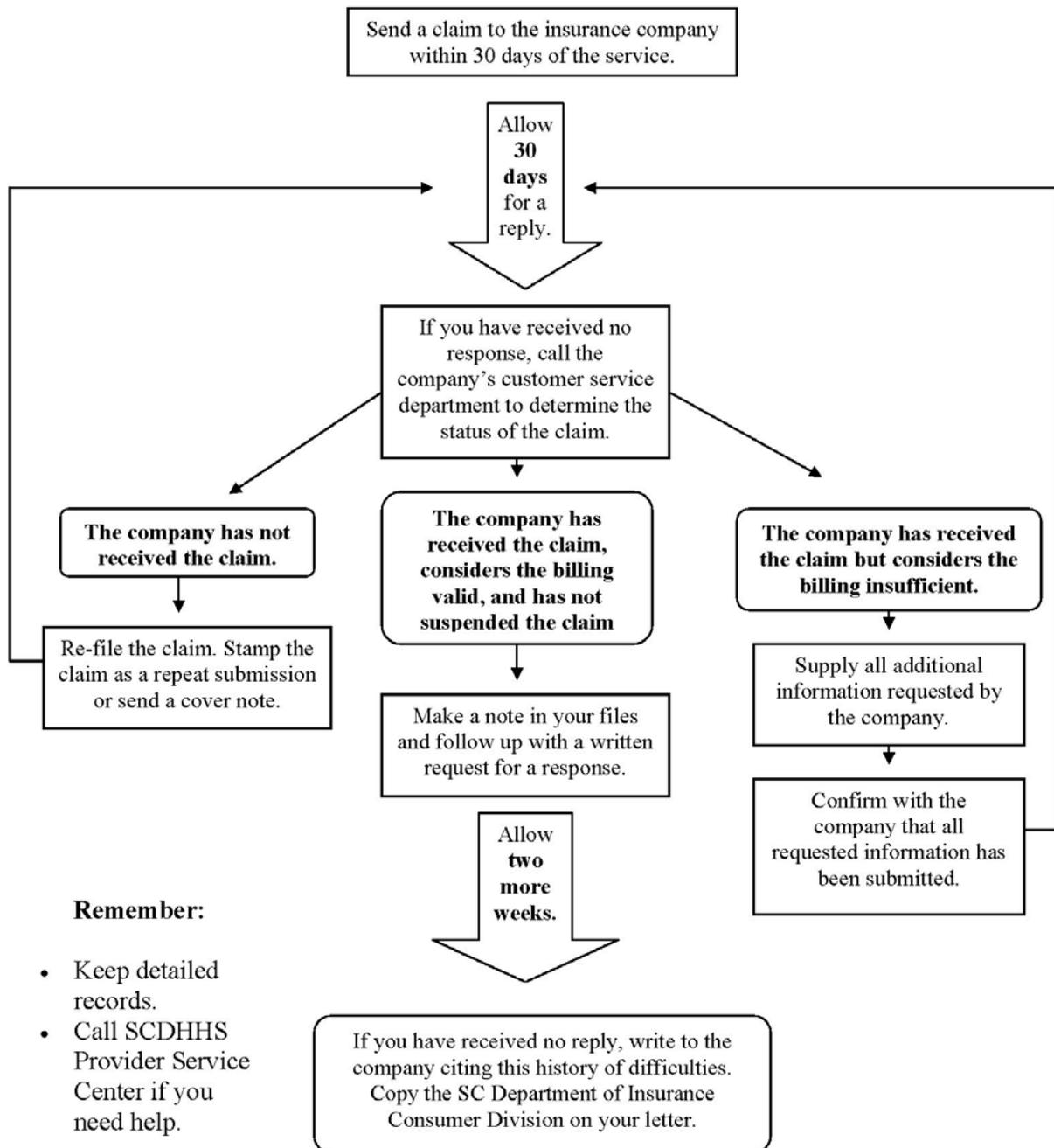
(SIGNATURE AND DATE)

ATTACH A COPY OF FORM TO THE APPROPRIATE CLAIM OR ECF AND FORWARD TO YOUR MEDICAID CLAIMS PROCESSING POST OFFICE BOX.

Revised 06/2007

THIRD-PARTY LIABILITY SUPPLEMENT

**How to Obtain a Response from Insurance Company
A Suggested Third-Party Filing Process**



THIRD-PARTY LIABILITY SUPPLEMENT

South Carolina Department of Health and Human Services - Claim Adjustment Form 130

Provider Name: (Please use black or blue ink when completing form)

Johnson DME Supply

Provider Address :

111 Oak Lane

Provider City , State, Zip:

Anywhere, SC 22222-2222

Total paid amount on the original claim:

\$1244.00

Original CCN:

5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 A

Provider ID:

A B C 1 2 3

NPI:

1 2 3 4 5 6 7 8 9 0

Recipient ID:

2 2 2 2 2 2 2 2 2 2

Adjustment Type:

Void Void/Replace

Originator:

DHHS MCCS Provider MIVS

Reason For Adjustment: (Fill One Only)

- Insurance payment different than original claim
- Keying errors
- Incorrect recipient billed
- Voluntary provider refund due to health insurance
- Voluntary provider refund due to casualty
- Voluntary provider refund due to Medicare
- Medicaid paid twice - void only
- Incorrect provider paid
- Incorrect dates of service paid
- Provider filing error
- Medicare adjusted the claim
- Other

For Agency Use Only

Analyst ID:

[] [] [] [] [] [] [] []

- Hospital/Office Visit included in Surgical Package
- Independent lab should be paid for service
- Assistant surgeon paid as primary surgeon
- Multiple surgery claims submitted for the same DOS
- MMIS claims processing error
- Rate change
- Web Tool error
- Reference File error
- MCCS processing error
- Claim review by Appeals

Comments:

Primary insurer paid after the appeal process.

Signature: Jane Doe

Date: 04/01/10

Phone: (555) 555-5555

THIRD-PARTY LIABILITY SUPPLEMENT

South Carolina Department of Health and Human Services - Claim Adjustment Form 130

Provider Name: (Please use black or blue ink when completing form)

Dr. Joe Jones

Provider Address :

123 Main Street

Provider City , State, Zip:

Somewhere, SC 22222-0000

Total paid amount on the original claim:

\$230

Original CCN:

8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 A

Provider ID:

NPI:

9 8 7 6 5 4 3 2 1 0

Recipient ID:

7 7 7 7 7 7 7 7 7 7

Adjustment Type:

Void Void/Replace

Originator:

DHHS MCCS Provider MIVS

Reason For Adjustment: (Fill One Only)

- Insurance payment different than original claim
- Keying errors
- Incorrect recipient billed
- Voluntary provider refund due to health insurance
- Voluntary provider refund due to casualty
- Voluntary provider refund due to Medicare
- Medicaid paid twice - void only
- Incorrect provider paid
- Incorrect dates of service paid
- Provider filing error
- Medicare adjusted the claim
- Other

For Agency Use Only

Analyst ID:

- Hospital/Office Visit included in Surgical Package
- Independent lab should be paid for service
- Assistant surgeon paid as primary surgeon
- Multiple surgery claims submitted for the same DOS
- MMIS claims processing error
- Rate change
- Web Tool error
- Reference File error
- MCCS processing error
- Claim review by Appeals

Comments:

Primary insurance payment received after Medicaid payment.

Signature: *Mary Smith*

Date: **04/01/10**

Phone: **(803) 555-5555**

THIRD-PARTY LIABILITY SUPPLEMENT

1 ABC MEDICAL CENTER 111 OAK LANE ANYWHERE SC 22222-0000		2		3a FAC. CNTL. # DOE1234		4 TYPE OF BILL 111	
b PATIENT NAME		c PATIENT ADDRESS		5 MED. REC. # 654321-654321		6 STATEMENT COVERS PERIOD FROM 030910	
a JANE DOE		b COLUMBIA		c SC		d 22222-2222	
10 BIRTHDATE 01011960		11 SEX F		12 DATE 030910		13 HR 2	
14 TYPE 7		15 SRC 01		16 DHR 01		17 STAT 80	
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THIRD-PARTY LIABILITY SUPPLEMENT

1500

One Carrier Paid; One Carrier Denied

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

<input type="checkbox"/> PICA <input type="checkbox"/> PICA																																																																																																																																	
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input checked="" type="checkbox"/> FECA BLK/LLING <input type="checkbox"/> OTHER <input type="checkbox"/>					1a. INSURED'S I.D. NUMBER (For Program in Item 1) \$1244.00																																																																																																																												
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Johnson DME Supply					3. PATIENT'S BIRTH DATE MM DD YY SEX Anywhere, SC 22222-2222 M <input checked="" type="checkbox"/> F <input type="checkbox"/>																																																																																																																												
4. INSURED'S NAME (Last Name, First Name, Middle Initial)					5. PATIENT'S ADDRESS (No., Street) 5 5 5 5 5 5 5 5 5 5 5 5 5 5 A																																																																																																																												
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street)																																																																																																																												
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					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 We filed to Medicaid, but then appealed to primary insurer. We won the appeal.																																																																																																																												
a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																																																																																																																												
b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					b. EMPLOYER'S NAME OR SCHOOL NAME																																																																																																																												
c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME Jane Doe																																																																																																																												
10d. RESERVED FOR LOCAL USE 1					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete Item 9 a-d.</i>																																																																																																																												
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 <u>Signature on File</u> 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: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS: GIVE FIRST DATE MM DD YY																																																																																																																												
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM MM DD YY TO MM DD YY																																																																																																																												
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES																																																																																																																												
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 295 32																																																																																																																																	
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER																																																																																																																																	
<table border="1"> <thead> <tr> <th colspan="2">A. DATE(S) OF SERVICE</th> <th>B. PLACE OF SERVICE</th> <th>C. EMG</th> <th colspan="2">D. PROCEDURES, SERVICES, OR SUPPLIES</th> <th>E. DIAGNOSIS POINTER</th> <th>F. \$ CHARGES</th> <th>G. DAYS OR UNITS</th> <th>H. FROD Family No.</th> <th>I. I.D. QUAL</th> <th>J. RENDERING PROVIDER ID.#</th> </tr> <tr> <th>From</th> <th>To</th> <th>YY</th> <th>YY</th> <th>MM</th> <th>DD</th> <th>MM</th> <th>DD</th> <th>YY</th> <th>MM</th> <th>DD</th> <th>YY</th> </tr> </thead> <tbody> <tr> <td>01</td> <td>31</td> <td>10</td> <td>01</td> <td>31</td> <td>10</td> <td>11</td> <td>99999</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>2000</td> <td>1</td> <td></td> <td>ZZ</td> <td>1212121212</td> </tr> <tr> <td></td> <td>NPI</td> <td>1234567890</td> </tr> <tr> <td></td> <td>NPI</td> <td></td> </tr> <tr> <td></td> <td>NPI</td> <td></td> </tr> <tr> <td></td> <td>NPI</td> <td></td> </tr> <tr> <td></td> <td>NPI</td> <td></td> </tr> <tr> <td></td> <td>NPI</td> <td></td> </tr> </tbody> </table>										A. DATE(S) OF SERVICE		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. FROD Family No.	I. I.D. QUAL	J. RENDERING PROVIDER ID.#	From	To	YY	YY	MM	DD	MM	DD	YY	MM	DD	YY	01	31	10	01	31	10	11	99999												2000	1		ZZ	1212121212											NPI	1234567890											NPI												NPI												NPI												NPI												NPI	
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25. FEDERAL TAX I.D. NUMBER 555555555			26. PATIENT'S ACCOUNT NO. DOE1234		27. ACCEPT ASSIGNMENT? (For gross payments, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 2000		29. AMOUNT PAID \$ 1000		30. BALANCE DUE \$ 1000																																																																																																																						
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.)			32. SERVICE FACILITY LOCATION INFORMATION			33. BILLING PROVIDER INFO & PH # (555) 5555555 ABC Clinic 111 Main Street Anytown, SC 22222-2222																																																																																																																											
SIGNED _____ DATE _____			a. NPI			b. 1234567890			c. ZZ1212121212																																																																																																																								

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

CARRIER PATIENT AND INSURED INFORMATION PHYSICIAN OR SUPPLIER INFORMATION

Sample Only

THIRD-PARTY LIABILITY SUPPLEMENT

1500

Medicare Paid; Private Carrier Paid

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

<input type="checkbox"/> PICA		<input type="checkbox"/> PICA	
1. MEDICARE <input checked="" type="checkbox"/> (Medicare #)		MEDICAID <input type="checkbox"/> (Medicaid #)	
TRICARE <input type="checkbox"/> (Sponsor's SSN)		CHAMPVA <input type="checkbox"/> (Member ID#)	
GROUP HEALTH PLAN <input checked="" type="checkbox"/> (SSN or ID)		FECA BLK LING <input type="checkbox"/> (SSN)	
OTHER <input type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) \$1244.00	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Johnson DME Supply		3. PATIENT'S BIRTH DATE MM DD YY Anywhere, SC 2222-2222 M	
5. PATIENT'S ADDRESS (No., Street) 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 A		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY A B C 1 2 3		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	
STATE 1 2 3 4 5		9. PATIENT STATUS Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>	
ZIP CODE 2 2 2 2 2 2 2 2 2 2 2		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
TELEPHONE (Include Area Code) ()		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
a. OTHER INSURED'S POLICY OR GROUP NUMBER <small>(Insuree derived claim - decided equipment when medically necessary)</small>		11. INSURED'S POLICY GROUP OR FECA NUMBER We filed to Medicaid, but then appealed to primary insurer. We won the appeal.	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M F		a. INSURED'S DATE OF BIRTH MM DD YY M F	
c. EMPLOYER'S NAME OR SCHOOL NAME (555) 555-5555		b. EMPLOYER'S NAME OR SCHOOL NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME 134		c. INSURANCE PLAN NAME OR PROGRAM NAME Jane Doe	
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 other than 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 (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES. FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 295 32		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		23. PRIOR AUTHORIZATION NUMBER	
B. PLACE OF SERVICE		F. \$ CHARGES	
C. EMG		G. DAYS OR UNITS	
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		H. ICD-9-CM	
E. DIAGNOSIS POINTER		I. ID. QUAL	
J. RENDERING PROVIDER ID.#		K.	
1 01 31 10 01 31 10 11 99999 2000 1 NPI 1212121212 1234567890		2 NPI	
3 NPI		3 NPI	
4 NPI		4 NPI	
5 NPI		5 NPI	
6 NPI		6 NPI	
25. FEDERAL TAX I.D. NUMBER SSN EIN 55555555		26. PATIENT'S ACCOUNT NO. DOE1234	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 20 00	
29. AMOUNT PAID \$ 10 00		30. BALANCE DUE \$ 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.)		32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.	
SIGNED DATE		33. BILLING PROVIDER INFO & PH# (555) 5555555 ABC Clinic 111 Main Street Anytown, SC 2222-2222	
SIGNED DATE		a. 1234567890 b. ZZ1212121212	

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APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

CARRIER ↑ PATIENT AND INSURED INFORMATION ↓ PHYSICIAN OR SUPPLIER INFORMATION ↑

THIRD-PARTY LIABILITY SUPPLEMENT

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RUN DATE 06/01/2010 000001204          SC DEPARTMENT OF HEALTH AND HUMAN SERVICES          CLAIM CONTROL #999999999999999999A
REPORT NUMBER CLM3500                    EDIT CORRECTION FORM          PAGE 1136 ECF 1136 PAGE 1 OF 1
ANALYST ID                                HIC - 60  PRAC SPEC - 12      EMC Y
SIGNON ID                                  DOC IND  N
TAXONOMY:                                  SFL ZIP:          PRV ZIP:
1      2      3      4      5      6      7      8      9
PROVIDER  RECIPIENT  P AUTH  TPL  INJURY  EMERG  PC COORD  ---- DIAGNOSIS ----
ID        ID        NUMBER  CODE  CODE
ABC123    1111111111
NPI: 1234567890

10 RECIPIENT NAME - DOE, JANE          11 DATE OF BIRTH 01/25/1992  12 SEX  F
*****
13      14      15      16      17      18      19      20      21  22  **  AGENCY USE ONLY  **
RES  ALLOWED  LN  DATE OF  PLACE  PROC  MOD          INDIVIDUAL CHARGE  PAY  UNITS  **  APPROVED EDITS  **
NO      SERVICE  CODE
23
NDC
.00      1      05/07/10  11  85025  000          ABC123    29.50      1.000
NPI: 1234567890  TAXONOMY: 1212121212
2      / /
NPI:          TAXONOMY:
3      / /
NPI:          TAXONOMY:
4      / /
NPI:          TAXONOMY:
5      / /
NPI:          TAXONOMY:
6      / /
NPI:          TAXONOMY:
*****
24      25      26
INS CARR  POLICY  INS CARR
NUMBER    NUMBER  PAID
01      401      1231231230  5.00
02
03
27 TOTAL CHARGE  29.50
28 AMT REC'D INS  .00  5.00
29 BALANCE DUE  29.50  24.50
30 OWN REF #  DOE12345

RESOLUTION DECISION _R_
ADDITIONAL DIAG CODES:

```

RETURN TO:
 MEDICAID CLAIMS RECEIPT
 P. O. BOX 1412
 COLUMBIA, S.C. 29202-1412
 PROVIDER:
 ABC HEALTH PROVIDER
 PO BOX 00000
 ANYWHERE, SC 00000-0000

INSURANCE POLICY INFORMATION
 401 1231231230
 DOE JOHN

THIRD-PARTY LIABILITY SUPPLEMENT

```

RUN DATE 06/01/2010 000001204          SC DEPARTMENT OF HEALTH AND HUMAN SERVICES          CLAIM CONTROL #999999999999999999A
REPORT NUMBER CLM3500                    EDIT CORRECTION FORM                      PAGE 1136 ECF 1136 PAGE 1 OF 1
ANALYST ID                                HIC - 60 PRAC SPEC - 12                    EMC Y
SIGNON ID                                  DOC IND N
TAXONOMY:                                  SFL ZIP:          PRV ZIP:
1      2      3      4      5      6      7      8      9
PROVIDER  RECIPIENT  P AUTH  TPL  INJURY  EMERG  PC  COORD  ----- DIAGNOSIS -----
ID        ID        NUMBER  CODE  CODE
ABC123    111111111    1
NPI: 1234567890

10 RECIPIENT NAME - DOE, JANE          11 DATE OF BIRTH 01/25/1992  12 SEX  F
*****
13      14      15      16      17      18      19      20      21  22      **      **
RES  ALLOWED  LN  DATE OF  PLACE  PROC  MOD  INDIVIDUAL CHARGE  PAY  UNITS  **      AGENCY USE ONLY      **
NO    SERVICE  CODE
23
NDC
*****
      .00  1  05/07/10  11  85025  000  ABC123  29.50  1.000
NPI: 1234567890  TAXONOMY: 1212121212
      2  / /
NPI:  TAXONOMY:
      3  / /
NPI:  TAXONOMY:
      4  / /
NPI:  TAXONOMY:
      5  / /
NPI:  TAXONOMY:
      6  / /
NPI:  TAXONOMY:
*****
24      25      26
INS CARR  POLICY  INS CARR
NUMBER    NUMBER  PAID
01      401      9999999999  0.00
02
03
27 TOTAL CHARGE 29.50
28 AMT REC'D INS .00
29 BALANCE DUE 29.50
30 OWN REF # DOE12345
RESOLUTION DECISION _R_
ADDITIONAL DIAG CODES:

```

RETURN TO:
 MEDICAID CLAIMS RECEIPT
 P. O. BOX 1412
 COLUMBIA, S.C. 29202-1412
 PROVIDER:
 ABC HEALTH PROVIDER
 PO BOX 00000
 ANYWHERE, SC 00000-0000

INSURANCE POLICY INFORMATION
 401 9999999999
 DOE JOHN

(No longer covered by this insurance.)

THIRD-PARTY LIABILITY SUPPLEMENT

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