

**SOUTH CAROLINA HEALTHY CONNECTIONS
(MEDICAID) PROVIDER MANUAL**

OPTIONAL STATE SUPPLEMENTATION

February 15, 2005
Updated April 1, 2013

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

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OPTIONAL STATE SUPPLEMENTATION PROGRAM ADVISORY

TO: Optional State Supplementation Program Providers

SUBJECT: Provider Manual for the Optional State Supplementation Program

The enclosed revised Optional State Supplementation Provider Manual is effective February 15, 2005 and includes all previous HIPAA changes and policy bulletins.

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

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

The new manual is organized generally as follows, with each section having its own table of contents:

Section 1, **General Information and Administration**, contains an overview of the South Carolina Medicaid program, as well as information about record retention, documentation requirements, utilization review, program integrity, and other general Medicaid policies.

Section 2, **Policies and Procedures**, describes policies and procedures specific to the Optional State Supplementation program.

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

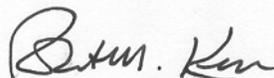
Section 4, **Administrative Services**, contains contact information for DHHS regional and county offices, examples of all forms referenced throughout the manual (as well as some generic forms), and contacts for claim form procurement.

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

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

If you have any questions regarding this provider manual, please contact your Optional State Supplementation Program coordinator at (803) 898-2590. Thank you for your continued support.



Robert M. Kerr
Director

RMK/bwhk

Attachment

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ENROLLMENT PACKAGE

MANAGED CARE SUPPLEMENT

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
04-01-13	1	6	Corrected the URL for MedicaideLearning.com
03-01-13	4	14	Deleted Jasper County PO Box address
02-01-13	1	18	Updated URL address for the National Correct Coding Initiative (NCCI)
01-01-13	4	11 13	<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	13	Updated Electronic Funds Transfer (EFT)
12-01-12	Forms	-	Added Electronic Funds Transfer form
12-01-12	Enrollment Package	-	Deleted
12-01-12	4	3 15	<ul style="list-style-type: none"> • Updated web address for provider information • Updated McCormick county office telephone number
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
10-01-12	Appendix 1	-	Updated edit code information through document

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
08-01-12	1	2, 8, 9, 12, 13, 15, 25, 34	Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012
08-01-12	3	1 13	<ul style="list-style-type: none"> • Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012 • Updated hyperlink
08-01-12	4	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	4	15 16	<ul style="list-style-type: none"> • Updated address for Marion County • Updated phone number for Newberry County
03-01-12	3	2	Added SC Medicaid Web-Based Claims Submission Tool
02-17-12	Enrollment Package	-	Replaced Disclosure of Ownership and Control Interest Statement (Form 1513) with Medicaid Provider Enrollment form (SCDHHS Form 1514)
02-01-12	4	13	Updated the Fairfield county office number
01-01-12	1	2-5, 20, 24	Deleted IVRS Information per “Retirement of Toll Free Eligibility Verification Line” bulletin released 11-18-11
01-01-12	2	7	Deleted IVRS Information per “Retirement of Toll Free Eligibility Verification Line” bulletin released 11-18-11
01-01-12	3	13	<ul style="list-style-type: none"> • Updated hyperlink • Updated EFT information
01-01-12	Managed Care Supplement	9	Deleted IVRS Information per “Retirement of Toll Free Eligibility Verification Line” bulletin released 11-18-11
11-01-11	1	24	Updated TPL contact information
11-01-11	4	5	Updated CLTC Regional Offices addresses
09-01-11	1	19	Deleted information regarding National Correct Coding Initiative
09-01-11	4	17	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

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
07-01-11	4	17	Deleted PO Box address for the Spartanburg County Office
06-01-11	4	9	Corrected Abbeville County PO Box Zip+4 Code
05-01-11	1	8, 11	Added language prohibiting payment to institutions or entities located outside of the United States
04-01-11	4	10	Updated telephone number for Beaufort County
04-01-11	Enrollment Package	-	<ul style="list-style-type: none"> • Updated Electronic Funds Transfer Form • Replaced CRCF Cover letter with updated CRCF Cover Letter • Changed header from “South Carolina Medicaid” to “South Carolina Healthy Connections (Medicaid)”
03-01-11	1	7, 9	Updated to reflect Medicaid Bulletin dated February 9, 2011 – Provider Service Center
03-01-11	3	13	Updated to reflect Medicaid Bulletin dated February 9, 2011 – Provider Service Center
03-01-11	4	4 9	Updated to reflect Medicaid Bulletin dated February 9, 2011 – Provider Service Center Added toll free number for Aiken County
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	9, 13 10	<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
01-01-11	4	17	Added toll-free telephone number for Saluda county
01-01-11	Forms	-	Added Duplicate Remittance Request Form
12-01-10	Cover	-	Replaced “Medicaid Provider Manual” with “South Carolina Healthy Connections (Medicaid)”
12-01-10	Supplements	-	Replaced “South Carolina Medicaid” with “South Carolina Healthy Connections (Medicaid)” in the headers

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	4		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	4	9 12 15 10	<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 • Corrected header
08-01-10	Change Control Record	1	Removed July 1 entries for Appendix 1 and Appendix 2
08-01-10	4	9, 13, 15-17 10	<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

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
07-01-10	4	-	Updated telephone numbers and zip codes for multiple county offices
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	Enrollment Package	-	Created new OSS Enrollment Package section for all applicable forms
05-01-10	Forms	-	Removed all forms included in the OSS Enrollment Package
03-01-10	Cover	-	Replaced the manual cover
03-01-10	Change Control Record	1	Added Time Limit for Submitting Claims Medicaid Bulletin date to section 1 entry dated 12-01-09
02-01-10	Appendix 1	13 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	4	9 14 16	<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
12-01-09	3	9, 10, 13	Updated policy to reflect Medicaid Bulletin dated November 13, 2009 – Electronic Remittance Package
12-01-09	4	12	Updated the Dorchester County office street address

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
10-01-09	1	3-4	<ul style="list-style-type: none"> • Updated the Medicare/Medicaid Eligibility section to include Qualified Medicare Beneficiaries (QMBs)
		4-6	<ul style="list-style-type: none"> • Updated SC Medicaid Healthy Connections language throughout section
		26	<ul style="list-style-type: none"> • Updated South Carolina Medicaid Bulletins and Newsletters • Changed heading to Medicare Cost Sharing
10-01-09	4	14	<ul style="list-style-type: none"> • Updated physical address for Jasper County office
		15	<ul style="list-style-type: none"> • Updated telephone number for Lexington County office
		16	<ul style="list-style-type: none"> • Updated zip codes for Orangeburg County office
10-01-09	Appendix 1	3	<ul style="list-style-type: none"> • Updated edit code 065
		60	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Removed all references to CHCcares to reflect Medicaid Bulletin dated August 3, 2009
		20, 25	<ul style="list-style-type: none"> • 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	4	14	Updated telephone number for York County office
07-01-09	4	10, 16	<ul style="list-style-type: none"> • Updated address for Bamberg and Orangeburg County offices
		12	<ul style="list-style-type: none"> • Updated office zip code for Darlington County
		13	<ul style="list-style-type: none"> • Updated telephone number for Fairfield County office
05-01-09	1	1-6, 11	<ul style="list-style-type: none"> • Updated to reflect managed care policies and procedures effective May 1, 2009
		2	<ul style="list-style-type: none"> • Updated the Eligibility subsection
		3	<ul style="list-style-type: none"> • Added the beneficiary contact telephone number to the South Carolina Healthy Connections Medicaid Card subsection

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		5 28-33	<ul style="list-style-type: none"> Removed the program start date from the SC Healthy Connections Kids SCHIP Dental Coverage subsection Updated the Medicaid Program Integrity subsection
05-01-09	4	17	Updated telephone number for Union County office
05-01-09	Managed Care Supplement	-	Updated supplement to include general policies and procedures effective May 1, 2009
04-01-09	1	2, 3, 8	Updated hyperlinks
04-01-09	3	12	Updated hyperlinks
04-01-09	4	15	Updated telephone number for Lexington County office
03-01-09	4	3 12 9, 15-17	<ul style="list-style-type: none"> Updated hyperlink Corrected Dorchester County's Orangeburg Road 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	-	Fix headers and removed highlighting throughout document
02-01-09	4	9	Updated Allendale County office PO Box zip code
02-01-09	Forms	-	Updated Authorization Agreement for Electronic Funds Transfer (EFT) form
01-01-09	1	8	Updated hyperlink for bulletin.scdhhs.gov
01-01-09	4	15	Updated Lee County office address
11-01-08	1	8	Added e-bulletin information to reflect Medicaid Bulletin dated August 26, 2008

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
11-01-08	3	12	Added EFT information to reflect Medicaid Bulletin dated August 26, 2008
10-01-08	4	13, 17	<ul style="list-style-type: none"> • Updated address for Lake City • Updated phone number for Sumter County office
09-01-08	4	10	Updated phone number for Berkeley County office
09-01-08	4	14	Updated phone number for Kershaw County office
08-01-08	Appendix 1	3	Updated Edit Code 062
08-01-08	4	11	Deleted the PO Box for Chester County
07-01-08	4	15	Deleted the PO Box for Lancaster County
07-01-08	Managed Care Supplement	27	Replaced Web site address for BlueChoice
06-01-08	4	16	Updated telephone number for Orangeburg county office
04-01-08	4	12	Updated address and phone number for Dorchester County office
03-01-08	1	3-5 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
02-01-08	Forms	-	Corrected mailing address for Medicaid Refunds Form 205
01-01-08	4	14	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	4	13, 14 14	<ul style="list-style-type: none"> • Updated telephone numbers for Florence and Kershaw counties • Updated Horry County address to 1601 11th Ave., 1st Floor

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
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	-	-	Added Managed Care Supplement
07-01-07	1	All	Revised policies and procedures throughout section
07-01-07	Forms	-	Updated DHHS Form 205
06-1-07	Forms	-	Updated DHHS forms to add National Provider Identifier field
06-01-07	4	10-12 16 -	<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 4 to create separate Forms section
04-01-07	4	12	Updated phone number for Darlington county office
03-01-07	4	10	Updated Barnwell county office address
11-01-06	4	-	Updated county office addresses
11-01-06	4	-	Replaced enrollment form
10-01-06	4	-	Updated county office addresses
09-01-06	4	-	Updated county office addresses
01-01-06	1	4, 5	Removed SILVERxCARD sample and program description

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
11-01-05	1	6, 7	Removed "HIPAA" from names of S.C. Medicaid Provider Outreach and S.C. Medicaid EDI Support Center
11-01-05	4	9-18	Updated list of DHHS county offices
10-01-05	4	9-18	Updated list of DHHS county offices

SECTION 1

GENERAL INFORMATION AND ADMINISTRATION

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SECTION 1

GENERAL INFORMATION AND ADMINISTRATION

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SECTION 1
GENERAL INFORMATION AND ADMINISTRATION

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SECTION 1 GENERAL INFORMATION AND ADMINISTRATION**SOUTH CAROLINA
MEDICAID
PROGRAM****PROGRAM DESCRIPTION**

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

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

SCDHHS offers two Medicaid Managed Care Programs:

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

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

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

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

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

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

**ELIGIBILITY
DETERMINATION**

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

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

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

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

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

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

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

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

**ENROLLMENT
COUNSELING SERVICES**

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

**MEDICARE / MEDICAID
ELIGIBILITY**

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

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

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

MEDICARE / MEDICAID ELIGIBILITY (CONT'D.)

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

SOUTH CAROLINA HEALTHY CONNECTIONS MEDICAID CARD

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

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



The back of the Healthy Connections Medicaid card includes:

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

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

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

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

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

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

**SC HEALTHY
CONNECTIONS HEALTH
OPPORTUNITY ACCOUNT**

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

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



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

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

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

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

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

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

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

**SOUTH CAROLINA
MEDICAID BULLETINS AND
NEWSLETTERS**

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

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

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

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

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

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

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

PROVIDER PARTICIPATION (CONT'D.)

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

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

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

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

of a third party's potential liability for the service(s). A provider who is not a part of a Managed Care Organization's network may refuse service to a Medicaid MCO member.

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

In furnishing care to beneficiaries who are participating in a Medicaid managed care option, all providers are required to comply with the benefit requirements specified by the applicable managed care program with respect to issues such as the extent of approvals for referrals, etc. Specific questions may be addressed directly 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 (Cont'd.)**

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

APPEALS

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SECTION 2

POLICIES AND PROCEDURES

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SECTION 2 POLICIES AND PROCEDURES

PROGRAM DESCRIPTION

OVERVIEW

The Optional State Supplementation (OSS) program was authorized by federal law through amendments to the Social Security Act. Each state is given the option of providing OSS assistance to help persons with needs not fully covered by Supplemental Security Income (SSI). The OSS is a monetary payment based on need and paid on a monthly basis.

As this is an optional program, each state determines whether it will participate in the OSS program. South Carolina currently provides an OSS payment to all SSI beneficiaries and other low-income individuals who: (1) meet the state's net income limits, (2) reside in a licensed Community Residential Care Facility (CRCF) that is enrolled in the OSS program, and (3) meet all other SSI criteria. All OSS beneficiaries are eligible for Medicaid as well, and are therefore entitled to Medicaid-covered services. The eligibility office in the individual's county of residence uses federal guidelines to determine financial eligibility for the South Carolina OSS program.

OSS beneficiaries keep a portion of their monthly income for personal needs. The Personal Needs Allowance (PNA), Net Income Limit (NIL), and OSS payment level are adjusted through the South Carolina legislative budgetary process and mandated by proviso annually. OSS is funded entirely by the state and is not matched with federal funds (Regulation 126-940).

PROGRAM PROCEDURES

If the applicant meets the financial eligibility requirements to participate in the OSS program (see "Eligibility Criteria" later in this section), the eligibility office notifies the DHHS Regional Office (DRO) that the applicant has been determined financially eligible and is requesting an OSS slot.

A monthly payment is made on behalf of the OSS beneficiary to the facility where the beneficiary resides to cover the difference between the beneficiary's monthly countable income and the OSS net income limit. The OSS payment is considered payment in full, and any differences in the payment amount due to rounding in the system cannot be charged to the resident or the responsible party.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM DESCRIPTION

Waiting List Policy

A projected number of OSS slots are made available for residents throughout the fiscal year based on annual funding allocation by the South Carolina General Assembly. This number may be adjusted according to usage rates and other factors. If the number of individuals receiving and applying for the projected number of OSS slots exceeds program capacity, waiting list procedures are implemented.

The DHHS central office maintains a statewide waiting list, and applicants are placed on the list chronologically by the date the DRO receives the referral (OSS Slot Reservation Form, DHHS Form 3264ME — see the Forms section for an example). Available slots assigned on a first-come, first-served basis provide for a one-for-one replacement of each resident terminated from the OSS program. Priority is given to Adult Protective Service (APS) clients as appropriate. However, APS clients must still be determined eligible and a slot approved prior to admission. OSS payment does not begin until the date the slot is approved.

Resident Admission to a Facility

When an OSS slot becomes available, an applicant receives a Communication Form (DHHS CRCF-02 — see the Forms section) and takes it to a participating CRCF. Once the applicant is admitted, the CRCF completes Section II (the shaded area) of the Communication Form and returns it to the DRO. A delay in returning the DHHS CRCF-02 or the provision of incorrect or incomplete information may result in a delay of the OSS payment to the facility. This slot notification is only valid for a period of 30 days from the date issued and must be returned to the DRO within the 30-day period.

Section III of the original DHHS 3264ME is completed by DRO staff and returned to the county eligibility office that issued the OSS slot request.

The county eligibility office completes the approval process by sending the resident a Medicaid Approval Letter (MEDS ELD018). A copy of the letter is sent to the CRCF where the resident is residing. An example of this letter can be found in the Forms section of this manual.

Notice of Admission

The county eligibility office initiates a Notice of Admission, Authorization & Change of Status For Community Residential Care Facility (DHHS CRCF-01)

SECTION 2 POLICIES AND PROCEDURES

PROGRAM DESCRIPTION

Notice of Admission (Cont'd.)

by completing Section I (Client Information) and Section II B&C (Countable Income and Personal Needs Allowance). This form is signed and dated by the county eligibility worker and sent to the facility. (An example of the form can be found in the Forms section.)

The facility receives the DHHS CRCF-01 and completes the information necessary for payment, Section II A. The facility staff signs and dates the form and a copy is kept for the facility's files. The facility attaches the DHHS CRCF-01 to the monthly Turn Around Document (TAD) and adds this new resident to the last page of the TAD. All DHHS CRCF-01s completed during the month should be attached to the TAD when it is submitted for payment processing. See Section 3 for detailed descriptions of the TAD and the DHHS CRCF-01.

Note: A DHHS CRCF-01 must be included in the month's payment request for every change on that month's TAD. Changes include all admissions, discharges, transfers, and deaths.

A preadmission flowchart can be found in the Forms section.

Personal Needs Allowance

The Social Security Administration mandates the personal needs allowance (PNA). A resident is allowed to keep an allowance for personal needs such as clothing, personal laundry, toiletries, and incidentals, in addition to any income that was disregarded by the county eligibility office during the eligibility process. The amount of the personal needs allowance is determined by the state General Assembly each year. Use of the allowance is at the resident's discretion.

The personal needs allowance must be deducted from other income the resident receives, and must be credited to the resident at the beginning of each month. The personal needs allowance is not deducted from the OSS payment.

Bed Holds – Medical Absence

In the event that a resident is temporarily absent from the facility because of a medical confinement (hospitalization, admission to a nursing facility, admission to a mental health facility, etc.), the OSS benefit payment may continue if all the following conditions are met:

1. The absence from the facility is expected to last less than 30 consecutive calendar days.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM DESCRIPTION

Bed Holds – Medical Absence (Cont'd.)

2. The facility obtains a physician's certification of the need for the medical confinement and the expected length of absence from the facility.
3. The facility or resident obtains a statement from the resident of the need for the continuation of the OSS payment.
4. The facility submits a DHHS CRCF-01 to the OSS program manager with Sections I and III completed accurately and the form signed by the facility representative.

For continued benefit payment, the facility must submit an accurately completed DHHS CRCF-01 within 10 days of the OSS beneficiary's admission to the medical facility.

The form should be sent to the OSS program manager at the address below:

Division of Community and Facility Services
Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202

Supporting documentation specified above (Items 1 – 4) must be included with the request. This information may also be sent by fax to (803) 898-4509. The OSS program manager will issue a written response to the resident with a copy sent to the facility and the county eligibility office.

OSS payments during a temporary absence due to a medical confinement are limited to a maximum of 30 days. If the OSS payment is being continued during a temporary absence due to a medical confinement, no other person is allowed to occupy the resident's space during that time period.

If a resident enters a medical facility and is expected to be absent from the CRCF longer than 30 consecutive calendar days, the facility must notify the DRO and eligibility office within 72 hours via the DHHS CRCF-01. The resident must be terminated from the TAD as a discharge, effective the day of the medical facility admission. Reimbursement cannot be claimed for the date of discharge.

If a resident who receives SSI has a medical absence, the facility must notify SSA of the absence when it occurs.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM DESCRIPTION

Examples

The following scenarios illustrate some possible applications of this policy:

- Case 1** A resident has a severe medical/psychiatric crisis and is admitted to an acute care setting; he or she is not expected to return to the CRCF. The facility completes a DHHS CRCF-01 and discharges the resident effective the date of transfer. The facility immediately sends a copy of the DHHS CRCF-01 to the DRO and another copy to the county eligibility office so that another applicant can be issued that client's slot by the DRO, and so the eligibility office can notify SSA of the client's new location.
- Case 2** A resident enters the hospital on November 5 and is expected to return to the CRCF after a brief hospitalization. The resident returns on November 13. The medical absence policy does not apply because the resident's hospitalization did not extend beyond the 10-day notification requirement. No action is required by the CRCF.
- Case 3** A resident enters the hospital on November 27 and is expected to stay in the hospital for approximately 30 days. The CRCF implements the medical absence policy and submits the required information to the OSS program manager by December 5.
- Case 4** A resident enters the hospital on November 27 and is expected to stay for approximately 30 days (as above). The CRCF has submitted the medical leave information and received approval from the OSS program manager for the medical absence. The resident dies while in the hospital. On December 12, the facility completes the DHHS CRCF-01 and discharges the resident effective December 12. The facility immediately sends a copy of the DHHS CRCF-01 to the DRO and another copy to the county eligibility office. The facility retains a copy to send in with its TAD for payment processing.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM DESCRIPTION

Examples (Cont'd.)

Case 5 A resident enters the hospital and is expected to stay longer than 30 days. The facility completes a DHHS CRCF-01 and discharges the resident effective the date of transfer. The facility immediately sends a copy of the DHHS CRCF-01 to the DRO and another copy to the county eligibility office so that another applicant can be issued that client's slot by the DRO and the eligibility office can notify SSA of the client's new location. The facility retains a copy to send in with its TAD for payment processing.

Bed Holds – Non-Medical Absence

The non-medical absence policy applies only to residents also enrolled in the Integrated Personal Care (IPC) program and occurs when a resident is temporarily absent from the CRCF for a non-medical reason.

Typically, non-medical absences are visits that a resident makes to a family member's home for greater than one calendar day. A calendar day is defined as a full 24-hour period beginning and ending at midnight.

Reimbursement for IPC services is not allowed for any non-medical resident absence from the CRCF; payment reverts to the OSS daily rate for any days the resident is away from the facility.

Examples

The following scenarios illustrate some possible applications of this policy:

Case 1 A resident goes to a family member's home for a temporary stay during the holidays. The resident leaves on December 22 and returns on December 27. The resident was away from the CRCF for four days and cannot receive IPC reimbursement for those four days. The facility completes a DHHS CRCS-01 and sends a copy with the TAD the following month. The facility indicates the absence on the Daily Census Log and faxes or mails a copy of the log to the regional DHHS nurse on or before the 10th day of the following month (January 10).

SECTION 2 POLICIES AND PROCEDURES

PROGRAM DESCRIPTION

Examples (Cont'd.)

Case 2 A resident goes to a family member's home on January 1 and returns to the facility on January 2. The temporary non-medical absence policy does not apply because the resident's absence did not exceed one calendar day. No action is required by the CRCF.

Resident Transfer

The OSS program slot allocation allows a beneficiary to transfer from one CRCF to another at any time during his or her stay as long as the new facility agrees to accept the beneficiary and is enrolled as an OSS program participant. The assigned OSS slot will transfer with the resident to the new facility. The receiving facility should request verification of the OSS beneficiary's eligibility status before accepting him or her as a new resident.

A transfer flowchart can be found in the Forms section of this manual.

Current CRCF Discharges Resident

Within 72 hours of the discharge, the current facility initiates a DHHS CRCF-01 by completing Section I and applicable information in Section II D. Copies of this DHHS CRCF-01 are sent to the county eligibility office and the DRO. The original form is attached to the monthly TAD after making the necessary changes on the TAD. **Reimbursement cannot be claimed for the date of discharge.**

Receiving CRCF Admits Resident

Within 72 hours of the admission, the new/receiving facility initiates a DHHS CRCF-01 by completing Section I and applicable information in Section II A&B and sends the DHHS CRCF-01 to the county eligibility office.

The eligibility office reviews Section I and Section II A&B and completes Section II C. The eligibility caseworker signs, dates, and returns the DHHS CRCF-01 to the facility and sends a copy of the DHHS CRCF-01 to the DRO. The receiving facility attaches the DHHS CRCF-01 to the monthly TAD, and makes the necessary changes, which, in the case of a transfer, would be the addition of a new resident to the TAD. **Reimbursement may be claimed for the date of admission.**

SECTION 2 POLICIES AND PROCEDURES

PROGRAM DESCRIPTION

Resident Discharge

Resident Moves Out of the Facility or Dies

Within 72 hours, the facility initiates the DHHS CRCF-01, completing Section I and the appropriate field in Section II E. Copies are sent to the county eligibility office and to the DRO. The facility attaches the original DHHS CRCF-01 to the monthly TAD and makes necessary changes. Reimbursement cannot be claimed for the date of discharge.

The only exception to this is if the OSS beneficiary enters the facility and dies on the same day. The facility can claim reimbursement for this date.

Resident Loses OSS Eligibility

The eligibility office initiates the DHHS CRCF-01 by completing Section I and Section II E and providing a written explanation in the “Other Reasons for Termination” section, such as “Resident is no longer OSS eligible due to income change.”

The eligibility office forwards the DHHS CRCF-01 to the facility and sends a copy to the DRO. The facility attaches the original DHHS CRCF-01 to the monthly TAD and makes necessary changes. The termination date is the last day of OSS eligibility or the date of discharge, whichever is earlier. The DRO updates the data system when any of these changes are made.

A discharge flowchart can be found in the Forms section of this manual.

Income Changes

A change in an OSS beneficiary’s monthly income may result in a change or termination of the OSS payment. All changes must be reported to the county eligibility office. Changes may be reported by the facility on the DHHS CRCF-01. Any cost of living adjustments to Social Security, SSI, or OSS will be automatically calculated and reported by the county eligibility office.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

PROVIDER QUALIFICATIONS

For a facility to participate in the Optional State Supplementation program (OSS), it must meet all of the following requirements:

- Provide evidence of licensure in good standing as a Community Residential Care Facility (CRCF) by the Department of Health and Environmental Control (DHEC)
- Properly and accurately complete the facility enrollment information on the OSS Enrollment Data Form (DHHS Form 219-RCF)
- Properly and accurately complete the information on the Authorization Agreement for Electronic Funds Transfer and attach a voided check
- Comply with all requirements in the Facility Participation Agreement for the South Carolina Optional State Supplementation (OSS) program found on DHHS 219-RCF

Facility Licensure

The South Carolina Department of Health and Environmental Control (DHEC), Division of Health Licensing, is the licensing authority for the state. Licensing regulations are set by Regulation 61-84 (revised 07/21/01). A facility that wishes to become licensed must contact the Division of Health Licensing at (803) 545-7202.

Facility Enrollment

A facility must enroll in the OSS program with DHHS before receiving reimbursement for OSS residents. A facility may request an enrollment package by calling (803) 788-7622, ext. 41650, or by writing to the OSS Enrollment address given below.

The facility's authorized representative is required to accurately complete, date, and sign all pages of the DHHS 219-RCF and to accurately complete the Authorization Agreement for Electronic Funds Transfer (EFT), including the attachment of a voided check (See Section 3 for more details). These completed forms should be mailed to:

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Facility Enrollment (Cont'd.)

OSS Enrollment
Post Office Box 8809
Columbia, SC 29202-8809

When DHHS receives an accurately completed enrollment form and EFT form, the facility will be issued an official notification of enrollment identifying the participating facility's assigned identification number. This identification number must be used on all communication regarding OSS payments and other documents. An OSS manual will also be sent to the newly enrolled facility, and a provider inservice will be scheduled by the OSS program staff.

Facility Participation Agreement and Sanctioning Process

The Facility Participation Agreement and Sanctioning Process is part of the DHHS 219-RCF. Key elements include:

- Licensure in good standing by DHEC
- Assurance of one composite electronic fund transfer
- Facility documentation of resident funds and personal needs allowance
- Facility underpayment or overpayment adjustments
- Facility notification to DHHS regional offices and the eligibility offices of admissions, discharges, transfers, and deaths within 72 hours
- Monthly processing of the OSS payments
- Approval of payment of new OSS beneficiaries
- Medical absences
- Quality and scope of services
- Annual rate determination
- Freedom of choice
- Cost reports
- Record keeping
- Assurance of compliance with OSS program policies and procedures
- Sanctioning process
- Termination
- Appeals

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Facility Participation Agreement and Sanctioning Process (Cont'd.)

By signing each page of the DHHS 219-RCF, including a signature on each page of the Facility Participation Agreement and Sanctioning Process, the facility representative acknowledges that the execution of the Facility Participation Agreement makes the facility **eligible** to participate in the OSS program. The facility is not guaranteed any specific level of OSS participation.

An example of DHHS Form 219-RCF can be found in the Forms section of this manual.

Cost Reports

Each CRCF participating in the OSS program is required to submit a standardized cost report, developed by DHHS, which reflects all income and operating costs of the facility.

The CRCF must submit a standardized cost report to remain eligible to participate in the OSS program. Facilities failing to submit cost reports by the required due date will not be eligible to participate in the OSS program. Cost reports cover the period of operation from July 1 through June 30 of each year. The due date is specified by the DHHS Division of Long Term Care Reimbursements each year.

Freedom of Choice

An OSS beneficiary has the right to choose any CRCF willing to accept the beneficiary as a resident provided the facility maintains licensure in good standing with DHEC and is enrolled with DHHS as a participating facility.

BENEFICIARY REQUIREMENTS

The county eligibility office is charged with the responsibility of determining the financial eligibility of an individual who wishes to participate in the OSS program.

An individual may be eligible to participate in the OSS program if he or she currently receives SSI. In this case, completion of an application to determine eligibility is not necessary. However, the SSI beneficiary must read and sign a short statement that he or she wishes to enter an enrolled facility. This procedure may be completed at the eligibility office of the county in which the beneficiary resides or may be completed by mail. A copy of this form (The SSI Recipient Request for Optional State Supplementation) is located in the Forms section of this manual.

If an individual is not receiving SSI, an OSS application

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

BENEFICIARY REQUIREMENTS (CONT'D.)

must be completed and eligibility determined by the county eligibility office. An application may be completed at any county eligibility office and most hospitals. At the time an application is made, the following information should be presented for verification:

- Proof of income
- Social Security number
- Bank statements
- Life and health insurance information
- Name and address of CRCF (if the individual is already residing in a facility)

For reference, a list of all county eligibility offices is located in the Forms section of this manual.

Eligibility Criteria

To receive OSS, a person must meet all of the following criteria:

- Be age 65 or older, blind, or disabled
- Have income and financial resources within certain limits
- Be a citizen of the United States of America or meet certain citizenship requirements
- Be a resident in a licensed and enrolled CRCF and have an authorized slot

If the eligibility office finds that an applicant does not meet requirements and denies him or her financial eligibility, an appeal may be filed. The appeal must be filed in writing, within 30 days of the date of notice. The DHHS Division of Appeals will handle these appeals.

SECTION 3

BILLING PROCEDURES

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SECTION 3 BILLING PROCEDURES

GENERAL INFORMATION

BILLING OVERVIEW

The South Carolina Department of Health and Human Services (SCDHHS) strives to make billing as simple for providers as possible. This section is a “how-to” manual on billing procedures with information on how to file a claim, what to do with a rejected claim, etc. Also included is information concerning administrative procedures such as adjustments and refunds. This section will help with these issues, but may not answer all of your questions. You should direct any questions to the Provider Service Center (PSC) at 1-888-289-0709. Providers can also submit an online inquiry at <http://www1.scdhhs.gov/contact-us> and a provider service representative will then respond to you directly.

SCDHHS uses a computer-generated tally sheet referred to as a Turn Around Document (TAD) to process payment to providers of Optional State Supplementation (OSS) services. A monthly TAD for OSS and Integrated Personal Care (IPC) residents is used to enhance efficiency and decrease paperwork burden on providers.

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

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

The OSS payments made on behalf of residents to CRCFs are considered payment in full. Any differences caused by rounding in the payment system cannot be billed to the resident or deducted from the resident’s personal needs allowance.

SECTION 3 BILLING PROCEDURES

GENERAL INFORMATION

SC MEDICAID WEB-BASED CLAIMS SUBMISSION TOOL

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

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

The minimum requirements necessary for using the Web Tool are:

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

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

SECTION 3 BILLING PROCEDURES

CLAIM FILING

TURN AROUND DOCUMENT (TAD)

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

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

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

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

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

A sample TAD can be found in Section 4. Below is an explanation of the various fields on the TAD.

Description of Fields

Field Title and Description

- | | |
|----------|---|
| 1 | CRCF Number
The CRCF's six-digit ID number |
| 2 | Name and Address
The name and mailing address of the CRCF |
| 3 | Line Number
Self-explanatory |
| 4 | County
Beneficiary's county of residence by number |

SECTION 3 BILLING PROCEDURES

CLAIM FILING

Description of Fields (Cont'd.)	5	<p>Recipient's Name</p> <p>Resident's first name, middle initial, and last name</p>
	6	<p>Recipient's Medicaid</p> <p>Resident's 10-digit Medicaid ID number</p>
	7	<p>Recipient's Monthly Income</p> <p>Resident's countable income for the current month</p>
	8	<p>Dates of Service</p> <p>The month and year for which payment is being claimed. On a new admission, this is the Authorization to Begin Payment date or the admission date, whichever is later.</p>
	9	<p>CRCF Days</p> <p>Total number of days the resident resided in the facility during the billing month and did not receive IPC services</p>
	10	<p>IPC Days</p> <p>Total number of IPC Days</p>
	11	<p>Changed CRCF Days</p> <p>If the resident does not stay in the facility the entire month, indicate the number of days the resident was in the CRCF for the month here. Always count days on a calendar; subtracting from the number of days in a month does not work, since the day of admission is covered but the day of discharge is not.</p>
	12	<p>Changed IPC Days</p> <p>Total number of IPC Days for the month</p>
	13	<p>Delete From Next Month's</p> <p>Place an X in this space if the resident should not appear on the next month's TAD (<i>i.e.</i>, death, transfer, termination).</p>

SECTION 3 BILLING PROCEDURES

CLAIM FILING

Description of Fields
(Cont'd.)

14 Signature, Title, Date

The authorized representative of the CRCF must add his or her signature and title here, and record the date of the signature.

Special Notes

- If a resident is discharged and readmitted during the same month, enter all days of residency on one line. Use a separate line for each month if changes occur in two successive months.
- All changes and additions must be supported by an attached CRCF-01.
- All CRCF-01s for transfer and new admissions must be signed and dated by county eligibility staff.
- Add new residents at the end of the TAD.
- A CRCF is not reimbursed for and may not request payment for the day of discharge, unless the resident entered and died on the same day. In this case, the CRCF may request payment for the day of discharge.
- The facility's authorized representative understands that the OSS payment is made from state and federal funds and any falsification or concealment of a material fact may be prosecuted under state and/or federal laws.
- If any of the residents listed will not be in the facility for the next month, enter an "X" in the column titled "Delete from next month's TAD."

CRCF-01

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

SECTION 3 BILLING PROCEDURES

CLAIM FILING

CRCF-01 (CONT'D.)

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

A sample CRCF-01 can be found in Section 4.

Description of Fields

Section I – Identification of Provider and Patient

Completed by the CRCF or eligibility office

Field Title and Action

1 Resident's Name

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

2 Birth Date

Enter two digits each for the month, day, and year.

3 Medicaid ID Number

Enter the 10-digit Medicaid ID number.

4 Resident's Address

Enter the street name and number, the city, and the state in which the resident lives.

5 County of Residence

Enter the county in which the resident resides.

6 Social Security Number

Enter the resident's social security number.

7 CRCF's Name and Address

Enter the name and address of the CRCF.

SECTION 3 BILLING PROCEDURES

CLAIM FILING

Description of Fields
(Cont'd.)

- 8 CRCF's ID Number**
Enter the CRCF's six-digit identification number.
- 9 Date of Request**
Enter the date the form was prepared.

Section II – Admission, Income, Transfer, Termination, Change of Status

Completed by the CRCF or county eligibility office

Item Title and Action

- A Admitted to this CRCF on**
Enter the date the resident was admitted to the CRCF.
- B Authorization to Begin Payment**
County eligibility office enters appropriate date.
- C Resident's Countable Income**
County eligibility office enters effective date and appropriate amount of income and personal needs allowance.
- D Transferred to another CRCF**
Enter the date the resident transferred, and the name and county of the CRCF to which he or she transferred.
- E Termination / Discharge**
Enter the effective date of termination. If the patient died, enter the date of death. Specify the reason for termination or other change of status if not covered by the above. Enter any changes not listed above.

SECTION 3 BILLING PROCEDURES

CLAIM FILING

Description of Fields
(Cont'd.)

Section III – Medical Absences

Completed by the CRCF

Item Title and Action

A Admitted to nursing facility

Enter the date the resident was admitted to the nursing facility and the name of the facility.

B Admitted to a medical institution, mental health facility or nursing facility

Enter the date the resident was admitted to the medical institution or mental health facility and the name of the facility.

C Readmitted from a medical institution, mental health facility or nursing facility

Enter the date the resident was readmitted to the CRCF from the medical institution, mental health facility, or nursing facility, and the name of the facility.

D Temporary Medical Absence

Enter the beginning date of the temporary medical absence and the expected ending date of the medical absence.

E Temporary Non-Medical Absence

Enter the beginning date of the temporary non-medical absence and the expected ending date of the non-medical absence. This must exceed one calendar day.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

REMITTANCE PACKAGE

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

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

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

Providers must access their remittance packages electronically through the SC Medicaid Web-Based Claims Submission Tool (Web Tool). Providers can view, save, and print their remittance advice(s), but not a Remittance Advice belonging to another provider. Electronic remittance packages are available on Friday for claims processed during the previous week. Remittance advices and associated ECFs for the most recent 25 weeks will be accessible.

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

Duplicate Remittance Package

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

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Remittance Advice

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

The numbered data fields on the Remittance Advice are explained below. A sample Remittance Advice can be found in Section 4.

Description of Fields

Field Title and Description

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

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Description of Fields
(Cont'd.)

Field	Title and Description
10	<p>Recipient ID Number Resident's 10-digit Medicaid ID number</p>
11	<p>Date of Service The first date of service during the month of residence under OSS</p>
12	<p>OSS/IPC Days The number of days of residency under OSS and IPC being paid</p>
13	<p>Income OSS resident's income used to calculate the OSS payment</p>
14	<p>OSS/IPC Payment First line is the amount paid for OSS; second line is the amount paid for IPC</p>
15	<p>Status Code An alpha character in this field indicates the present status of the claim.</p> <p style="padding-left: 40px;">P = Payment R = Rejected S = Suspended or in process</p>
16	<p>Edit Code For each rejected claim designated by an "R" in the STATUS CODE field (item 15), an appropriate edit code will appear in this field. This code will indicate the reason the claim was rejected.</p>
17	<p>Claim Control Number A computer-generated number unique to each line/claim on the TAD</p>

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Edit Resolution

If a Remittance Advice shows a rejected claim, the provider should call the OSS program manager for assistance at (803) 898-2590.

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

- 007** Patient's daily recurring income is greater than the nursing facility's daily rate.
- 051** Date of death inconsistent with date of service.
- 509** Date of service over 2 years old.
- 510** Date of service over 1 year old.
- 852** Duplicate of previously paid procedure code for the same date of service.
- 858** Inpatient hospital and nursing facility billing conflict with allowed days for bed reserve.
- 866** Recipient receiving same or similar service from multiple providers for same date of service.
- 900** Provider ID is not on file.
- 902** Pay-to provider not eligible on date of service. Provider was not enrolled when service was rendered.
- 924** OSS recipient must be a pay category 85 or 86.
- 940** Billing provider is not the recipient's IPC physician.
- 950** Patient ID is not on file.
- 951** Recipient not eligible for Medicaid on the date of service.
- 958** IPC days exceeded or not authorized on date of service.
- 959** Silvercard beneficiary, service not pharmacy.

Reimbursement Payment

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

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

Note: Newly enrolled providers will receive a hard copy

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Reimbursement Payment (Cont'd.)

check until the Electronic Funds Transfer (EFT) process is successfully completed.

Electronic Funds Transfer (EFT)

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

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

Medicaid Provider Enrollment
PO Box 8809
Columbia, SC 29202-8809

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

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

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

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

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

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

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

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

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

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

SECTION 4
ADMINISTRATIVE SERVICES

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SECTION 4 ADMINISTRATIVE SERVICES

GENERAL INFORMATION

ADMINISTRATION

The Department of Health and Human Services (DHHS) administers the South Carolina Medicaid Program, as well as the Optional State Supplementation Program. This section outlines the available services for providers, with telephone numbers and addresses for county and regional DHHS offices.

CORRESPONDENCE AND INQUIRIES

Questions concerning beneficiary eligibility or identification numbers should be directed to the DHHS 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 DHHS office for assistance.

Correspondence concerning specific policies and procedures should be directed to the appropriate program or entity from the following list:

Facility Licensure

S.C. Department of Health and Environmental Control
Division of Health Licensing
2600 Bull Street
Columbia, SC 29201
(803) 545-7201

Facility Enrollment

S.C. Department of Health and Human Services
OSS Enrollments
Post Office Box 8809
Columbia, SC 29202-8809
(803) 788-7622 Ext. 41650

Cost Reports

S.C. Department of Health and Human Services
Long Term Care Reimbursements
Post Office Box 8206
Columbia, SC 29202-8206
(803) 898-1014

SECTION 4 ADMINISTRATIVE SERVICES**GENERAL INFORMATION**

Policies and Procedures	S.C. Department of Health and Human Services Community and Facility Services Post Office Box 8206 Columbia, SC 29202-8206 (803) 898-2590 Fax (803) 898-4509
Waiting List	S.C. Department of Health and Human Services Regional Office (see full list in this section)
Eligibility	S.C. Department of Health and Human Services County Eligibility Office (see full list in this section)
Send Completed TADs to:	Claims Receipt – CRCF Claims Section Post Office Box 67 Columbia, SC 29202-0067 (803) 788-7622 Ext. 41613 Fax (803) 699-8637

SECTION 4 ADMINISTRATIVE SERVICES

PROCUREMENT OF FORMS

FAX REQUESTS

A provider may request the following forms via fax number (803) 898-4528:

1. Confidential Medicaid Complaint (Form 126)
2. Medicaid Provider Inquiry (Form 140)
3. Request for Medicaid Forms (142)
4. Medicaid Refund Check Remittance (Form 205)

Copies of these and other forms are also available in the Forms section of this manual.

WEB ADDRESS

Providers should visit the Provider Information page on the SCDHHS Web site at <http://provider.scdhhs.gov> for the most current version of this manual.

To order a paper or CD version of this manual, please contact the SCDHHS Provider Service Center (PSC) at 1-888-289-0709. From the Main Menu, select the Provider Enrollment and Education option. Charges for printed manuals are based on actual costs of printing and mailing.

SECTION 4 ADMINISTRATIVE SERVICES

GENERAL INFORMATION

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SECTION 4 ADMINISTRATIVE SERVICES

CLTC REGIONAL OFFICES

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

SECTION 4 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES REGIONAL OFFICES

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

SECTION 4 ADMINISTRATIVE SERVICES**DEPARTMENT OF HEALTH AND HUMAN SERVICES REGIONAL OFFICES**

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

SECTION 4 ADMINISTRATIVE SERVICES

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SECTION 4 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
1. Abbeville County	(864) 366-5638	Medicaid Eligibility 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
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

SECTION 4 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
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
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

SECTION 4 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
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
13. Chesterfield County	(843) 623-5226	Medicaid Eligibility Chesterfield County DHHS 201 N. Page St. Chesterfield, SC 29709-1201
		Post Office Box 855 Chesterfield, SC 29709-0855
14. Clarendon County	(803) 435-4305	Medicaid Eligibility Clarendon County DSS 3 S. Church St. Manning, SC 29102
		Post Office Box 788 Manning, SC 29102

SECTION 4 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
15. Colleton County	(843) 549-1894	Medicaid Eligibility Colleton County DHHS Bernard Warshaw Building 215 S. Lemacks St. Walterboro, SC 29488
		Post Office Box 110 Walterboro, SC 29488
16. Darlington County	(843) 398-4427	Medicaid Eligibility Darlington County DHHS 300 Russell St., Room 145 Darlington, SC 29532-3340
		Post Office Box 2077 Darlington, SC 29540-2077
		(843) 332-2289 404 S. Fourth St., Suite 300 Hartsville, SC 29550-5718
17. Dillon County	(843) 774-2713	Medicaid Eligibility Dillon County DHHS 1213 Highway 34 W. Dillon, SC 29536-8141
		Post Office Box 351 Dillon, SC 29536-0351
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

SECTION 4 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
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	Medicaid Eligibility Florence County DHHS 2685 S. Irby St., Box I Florence, SC 29505-3440
	(843) 394-8575	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
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

SECTION 4 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
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
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

SECTION 4 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
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
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

SECTION 4 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
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 (803) 714-7549	Medicaid Eligibility Richland County DHHS 3220 Two Notch Rd. Columbia, SC 29204-2826
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

SECTION 4 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
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
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

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FORMS

Number	Name	Revision Date
DHHS 126	Confidential Complaint	06/2007
DHHS 205	Medicaid Refunds	01/2008
DHHS 931	Health Insurance Information Referral Form	01/2008
	EFT Authorization Agreement	03/2011
	Duplicate Remittance Advice Request Form	10/2012
	Sample Remittance Advice	
	Sample Turn Around Document (TAD)	
CRCF-01	Notice of Admission, Authorization & Change of Status for Community Residential Care Facility	01/2003
CRCF-02	Communication Form	
3264-ME	OSS Slot Reservation Form	07/2002
	SSI Recipient Request for Optional State Supplementation	
ELD018	Medicaid Approval Letter	09/2003
	OSS Preadmission Flowchart	
	OSS Discharge/Transfer Flowchart	



**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
Form for Medicaid Refunds**

Purpose: This form is to be used for all refund checks made to Medicaid. This form gives the information needed to properly account for the refund. If the form is incomplete, the provider will be contacted for the additional information.

Items 1, 2 or 3, 4, 5, 6, & 7 must be completed.

Attach appropriate document(s) as listed in item 8.

1. Provider Name: _____

2. Medicaid Legacy Provider #
(Six Characters)

OR

3. NPI#

& Taxonomy

4. Person to Contact: _____

5. Telephone Number: _____

6. Reason for Refund: [check appropriate box]

- Other Insurance Paid (please complete a – f below and attach insurance EOMB)
 - a** Type of Insurance: () Accident/Auto Liability () Health/Hospitalization
 - b** Insurance Company Name _____
 - c** Policy #: _____
 - d** Policyholder: _____
 - e** Group Name/Group: _____
 - f** Amount Insurance Paid: _____

- Medicare
 - () Full payment made by Medicare
 - () Deductible not due
 - () Adjustment made by Medicare

Requested by DHHS (please attach a copy of the request)

Other, describe in detail reason for refund:

7. Patient/Service Identification:

Patient Name	Medicaid I.D.# (10 digits)	Date(s) of Service	Amount of Medicaid Payment	Amount of Refund

8. Attachment(s): [Check appropriate box]

- Medicaid Remittance Advice (required)
- Explanation of Benefits (EOMB) from Insurance Company (if applicable)
- Explanation of Benefits (EOMB) from Medicare (if applicable)
- Refund check

Make all checks payable to: South Carolina Department of Health and Human Services
Mail to: SC Department of Health and Human Services
Cash Receipts
Post Office Box 8355
Columbia, SC 29202-8355



**SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID HEALTH INSURANCE INFORMATION REFERRAL FORM**

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

Contact Person: _____ Phone #: _____ Date: _____

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

Beneficiary Name: _____ Date Referral Completed: _____

Medicaid ID#: _____ Policy Number: _____

Insurance Company Name: _____ Group Number: _____

Insured's Name: _____ Insured SSN: _____

Employer's Name/Address: _____

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

- _____ a. beneficiary has never been covered by the policy – close insurance.
- _____ b. beneficiary coverage ended - terminate coverage (date) _____
- _____ c. subscriber coverage lapsed - terminate coverage (date) _____
- _____ d. subscriber changed plans under employer - new carrier is _____
- new policy number is _____
- _____ e. beneficiary to add to insurance already in MMIS for subscriber or other family member.
(name) _____

ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.

Submit this information to Medicaid Insurance Verification Services (MIVS).

Fax:	or	Mail:
803-252-0870		Post Office Box 101110
		Columbia, SC 29211-9804

**III NEW POLICY NUMBERS FOR INSURANCE IN THE MMIS WITH THE SUBSCRIBER SSN
(SCDHHS is collecting new unique policy numbers and plans to replace existing insurance records through MMIS online modification as computer resources are available.)**

Medicaid Beneficiary ID: _____ SSN: _____

Carrier Name/Code: _____ New Unique Policy Number: _____

Submit this information to South Carolina Department of Health and Human Services (SCDHHS).

Fax:	or	Mail:
803-255-8225		Post Office Box 8206, Attention TPL
		Columbia, SC 29202-8206

South Carolina
Department of Health and Human Services
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

REPORT NH4545R1
DATE 12/16/2002

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
COMMUNITY RESIDENTIAL CARE
FOR MONTH OF FEBRUARY

PAGE 1

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

SC 29687

(3) LINE	(4) COUNTY	(5) RECIPIENT NAME	(6) RECIPIENT ID NO	(7) MONTHLY INCOME	(8) DATE OF SERVICE MO/YR	(9) CRCF DAYS	ENTER CHANGES			
							(10) IPC // DAYS //	(11) CHANGED CRCF DAYS	(12) CHANGED IPC DAYS	(14) DELETE FROM NEXT MONTH'S TA
01	32	MARY SMITH	1234567801		02/03	28				
02	32	SAM PERKINS	9876543201		02/03		28			
03										
04										
05										
06										
07										
08										
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12										
13										
14										
15										
16										
17										

- 1) IF THE ABOVE INFORMATION IS CORRECT AND THERE HAVE BEEN NO ADMISSIONS OR DISCHARGES, SIGN AND DATE AS INDICATED BELOW.
- 2) IF THERE HAS BEEN A NEW OSS APPROVED ADMISSION TO YOUR FACILITY DURING THE MONTH OF DECEMBER, ENTER A NEW LINE FOR THAT RESIDENT WITH THE NAME, ID NUMBER, DATE OF ADMISSION, AND NUMBER OF DAYS IN YOUR FACILITY.
- 3) IF THE FACILITY HAS RECEIVED AUTHORIZATION FROM SCDHHS TO PROVIDE INTEGRATED PERSONAL CARE (IPC) SERVICES TO ANY OSS RESIDENT, REDUCE THE NUMBER OF CRCF DAYS BY THE NUMBER OF DAYS THE RESIDENT WAS AUTHORIZED FOR AND RECEIVED IPC SERVICES AND INSERT THE NUMBER OF DAYS THE RESIDENT RECEIVED AUTHORIZED IPC SERVICES IN THE IPC DAYS COLUMN.
- 4) IF THERE HAS BEEN A DISCHARGE/DEATH FROM YOUR FACILITY DURING THE MONTH OF DECEMBER, INDICATE THE NUMBER OF DAYS, NOT COUNTING THE DATE OF DISCHARGE/DEATH THAT THE RESIDENT WAS IN YOUR FACILITY IN THE COLUMN TITLED "CHANGED CRCF DAYS". IF THE RESIDENT WAS AUTHORIZED FOR AND RECEIVED IPC SERVICES, ENTER THE NUMBER OF DAYS, NOT COUNTING THE DATE OF DISCHARGE/DEATH THAT THE RESIDENT WAS IN YOUR FACILITY AND WAS AUTHORIZED FOR AND RECEIVED IPC SERVICES IN THE "CHANGED IPC DAYS" COLUMN.
- 5) IF ANY OF THE RESIDENTS LISTED WILL NOT BE IN YOUR FACILITY NEXT MONTH, ENTER AN 'X' IN THE COLUMN TITLED 'DELETE FROM NEXT MONTH'S TAD'.

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

SIGNATURE

TITLE

DATE



State of South Carolina
Department of Health and Human Services

Ilim Hodges
Governor

12/11/02

William A. Prino
Director

Dear

RE: 0412723

An Optional State Supplement (OSS) slot is now available for you.

As of the above date, you may select a licensed community residential care facility (CRCF) that participates in the OSS program. Please take this notification to the CRCF you select. This letter is valid for 30 calendar days from the date of the letter. If you are not admitted by 1/10/03, you must reapply for OSS at your DSS County Office. The CRCF must complete the bottom portion of this form on the day you are admitted and return it to the Community Long Term Care office listed below.

Signature and Date of CLTC Staff:

SECTION II

TO BE COMPLETED BY A LICENSED COMMUNITY RESIDENTIAL CARE FACILITY ENROLLED IN THE OSS PROGRAM:

INSTRUCTIONS FOR CRCF: Complete and return this form to the following CLTC area office:

Community Long Term Care
1890 Neely's Creek Road
Rock Hill, SC 29730

Please note that a delay in return of this form, incorrect information or blanks in Section II shall result in a delay of the OSS Payment to your facility.

CRCF name: _____

CRCF provider number: _____

Date resident entered facility: _____

Date completed: _____

Signature and title of CRCF official: _____

South Carolina Department of Health and Human Services
OSS SLOT RESERVATION FORM

Section I—OSS Slot Request
To be completed by the Medicaid Worker and forwarded to the Area CLTC

Applicant's Name: _____ County Number: _____

Address: _____

Telephone: _____ Date of Birth: _____

Social Security No.: _____ Medicare No.: _____ Medicaid No.: _____

Authorized Rep.'s Name: _____ If applicant receives services from another state agency, indicate below:

Address: _____ Name: _____

Telephone: _____ Address: _____

Race: _____ Sex: M F Telephone: _____

Date of OSS Application: _____

Adult Protective Service Priority: Yes No

Date of Entry: (If CRCF resident at time of application) _____ CRCF Name: _____ CRCF No.: _____

Applicant's CRCF Preference: (If not CRCF resident at time of application)

1. _____ 2. _____ 3. _____

Current SSI Recipient

Determined to be financially eligible for OSS but case cannot be approved until OSS slot is authorized and applicant residing in CRCF.

Countable Income: \$ _____

Medicaid Worker's Signature: _____ County: _____ Date: _____

Section II—Receipt of OSS Slot Request
To be completed by the Area CLTC and returned to Medicaid Worker

OSS Slot Request Acknowledged

CLTC Worker's Signature: _____ CLTC Area: _____ Date: _____

Distribution: Return one copy to Medicaid Worker

Section III—Verification of Slot Authorization and CRCF Admission
To be completed by the Area CLTC and returned to Medicaid Worker

Date Applicant Entered CRCF: _____ CRCF Name: _____

Effective Date of OSS Slot: _____ Address: _____

Notified of available slot, applicant did not enter CRCF within _____ days.

CLTC Worker's Signature: _____ CLTC Area: _____ Date: _____

Distribution: Return one copy to Medicaid Worker CLTC retains one copy

SSI Recipient Request for Optional State Supplementation (OSS)

1. I, _____, am currently eligible for supplemental Security Income (SSI).
2. I live or plan to live in a Community Residential Care Facility (CRCF).
3. I need help with paying the cost of living in a CRCF.
4. I request this help through the Optional State Supplementation (OSS) program.

The following statements explain your rights and responsibilities. If there are statements you do not understand, you should discuss those statements with the worker during the interview. You are responsible for giving complete and accurate information.

I understand that I must report any and all changes in my income, living arrangements, or other information that will affect my eligibility for OSS within 10 days of the date of the change(s).

I understand that my case record is confidential and no information will be released from it unless properly authorized by me or as provided for under State/Federal laws.

I understand that any information I have given is subject to being reviewed by staff members of the Department of Social Services and the Department of Health and Human Services. Also, I understand that I must cooperate fully with State and Federal workers if my case is selected for a complete review.

I understand that is request will be considered without regard to race, color, sex, age, handicap, religion, national origin, or political belief.

I understand that I may request a hearing if I am not satisfied with the actions taken on my case or if I feel that I have been discriminated against.

I certify that I have read or had read to me all the statements on this form and the information given is true and complete to the best of my knowledge. I understand that if I have deliberately given any false information or have withheld any information regarding my situation, I am liable for prosecution for fraud and/or perjury. I hereby give the Department(s) permission to verify, without additional consent from me, information discovered by the Department(s) or given by me that is needed to determine my eligibility for OSS.

Signature _____ Date _____

Applicant/Responsible Party

Applicant's SSN _____ Telephone Number _____

Applicant's Address _____
(Name of facility _____
if already residing _____
in CRCF) _____

Worker's Signature _____ Date _____

MEDICAID APPROVAL LETTER

Date:
Worker:
Telephone:
BG #:

Your application has been approved. The person listed below is eligible:

Recipient Name	Recipient ID	Medicaid Card Effective Date
----------------	--------------	------------------------------

The Medicaid card will be mailed to your current address. If you move, you must tell your County Department of Health and Human Services (DHHS) because the Post Office cannot forward your Medicaid cards. You must present this card to the doctor, hospital, drug store each time you go.

You have been approved for a payment to a residential care facility on your behalf effective . All of your monthly income except for your personal needs must be paid to the facility.

You may have a choice about the way that you receive your Medicaid services. For more information, call toll free 1-888-549-0820.

X As a condition of eligibility when you apply for medical assistance, you are assigning to the state your rights to any medical support or other payments for medical care and you are agreeing to cooperate with the state in obtaining third party payments.

X You may ask for a fair hearing before the Department of Health and Human Services if you believe an error was made in processing your application.

To Request A Fair Hearing From the Department of Health and Human Services

- Ask your Medicaid worker in writing within 30 days of the date on this letter. Attach a copy of this letter to your request.

To Get Help With Your Fair Hearing

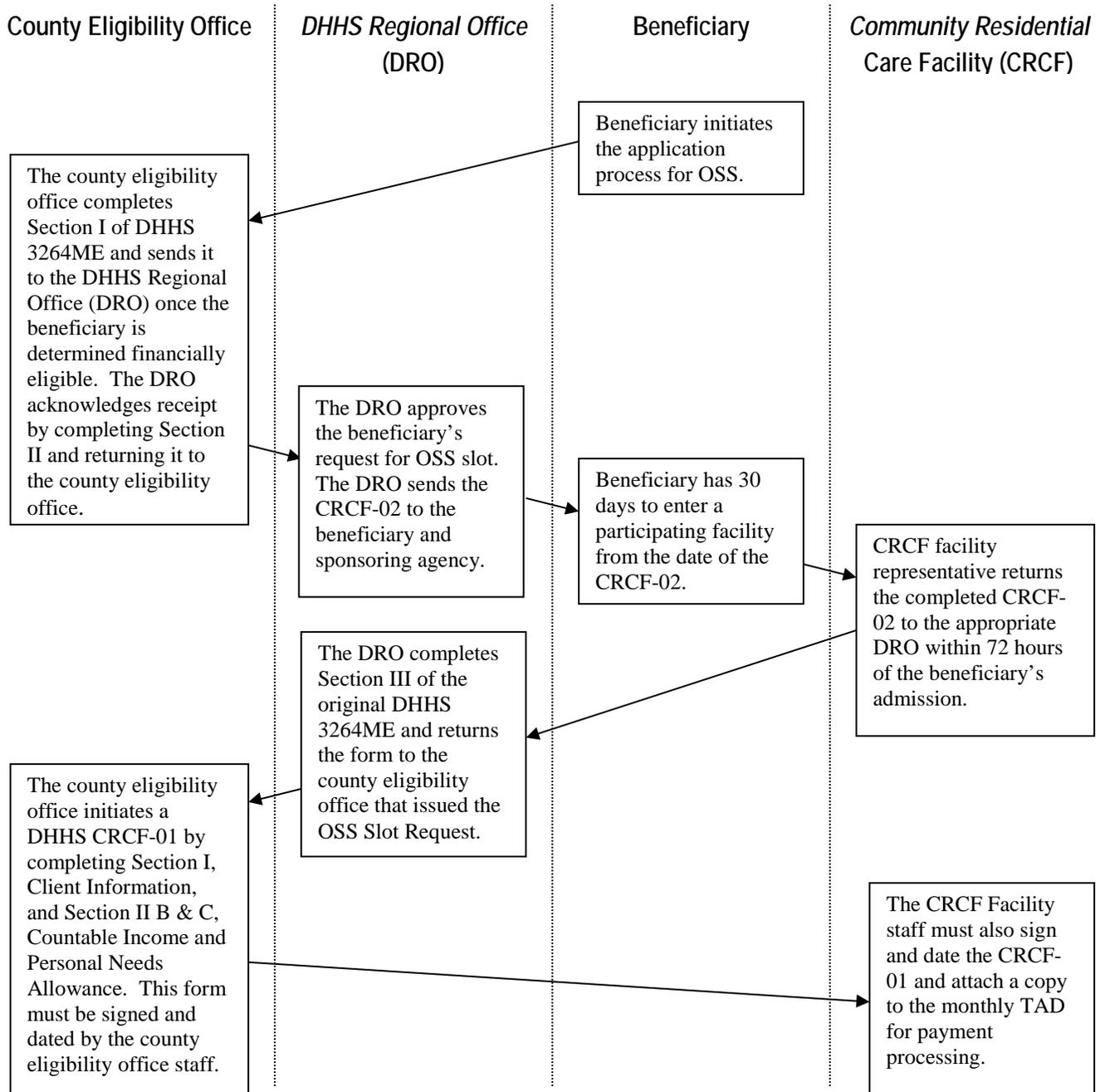
- You can hire an attorney to help you
- You can have someone you know come to the hearing and speak for you
- Contact your Medicaid worker in person or by phone to get help in asking for a hearing.

You must tell your Medicaid worker in ten days if you have a change in:

- Where you live
- Income
- Resources
- Family size (someone moves in or out)
- Any news that would change your case

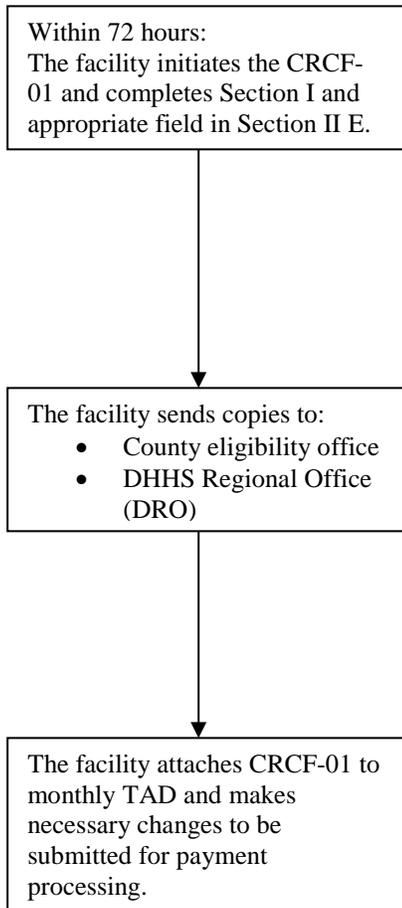
YOU WILL RECEIVE A REVIEW FORM IN THE MAIL EVERY 12 MONTHS (SOMETIMES SOONER). WHEN YOU RECEIVE THE REVIEW FORM, YOU MUST COMPLETE AND RETURN IT OR YOUR MEDICAID WILL STOP.

OSS PREADMISSION FLOW CHART

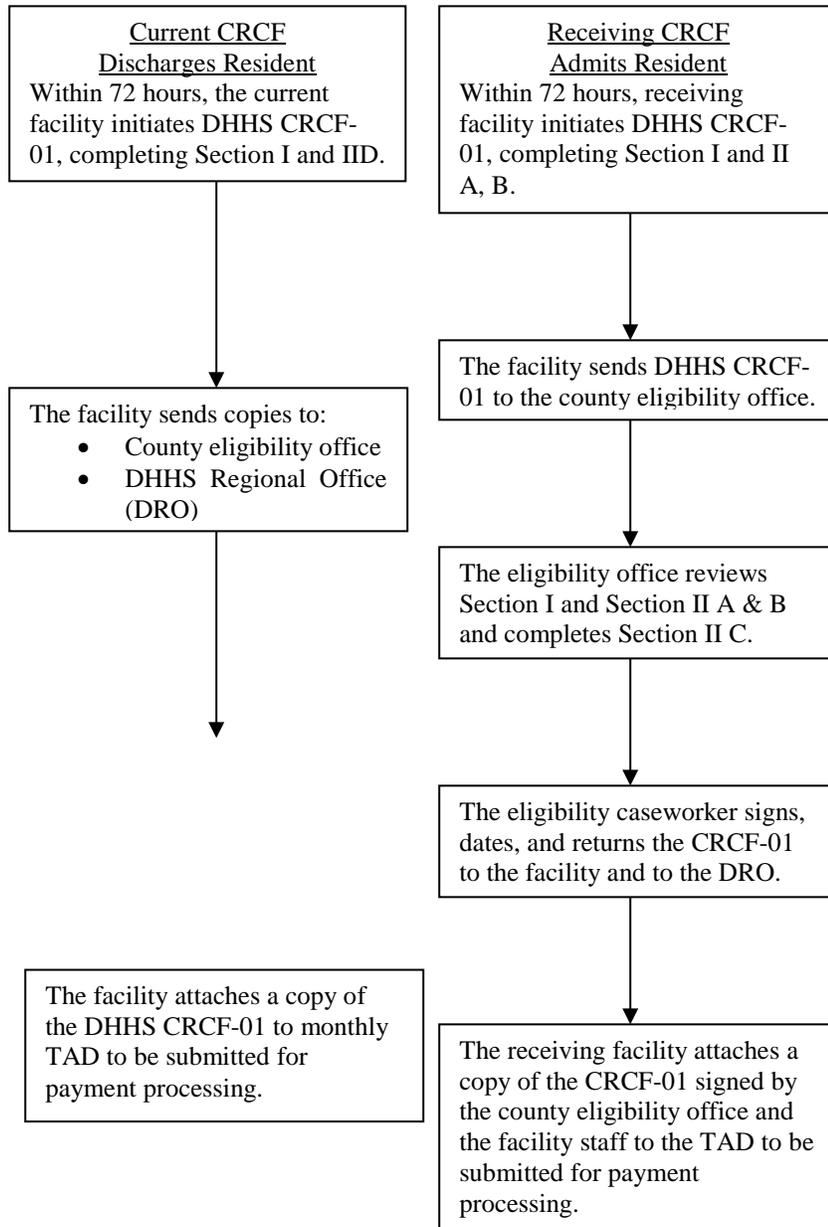


OSS DISCHARGE/TRANSFER FLOW CHART

Beneficiary Discharge



Beneficiary Transfer



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 Web site (www.scdhhs.gov) within the Managed Care section.

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

MANAGED CARE SUPPLEMENT

MANAGED CARE OVERVIEW

(www.scdhhs.gov) for the most current listing of health plans, the counties in which they are authorized to operate, and the number of managed care enrollees within a county.

SC MEDICAID MANAGED CARE CONTACT INFORMATION

For additional information, contact the Bureau of Managed Care at the following address:

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

PROGRAM DESCRIPTIONS

Managed Care Organizations (MCOs)

A Managed Care Organization (MCO) is commonly referred to as an HMO (Health Maintenance Organization) in the private sector. MCOs are required to operate under a contract with SCDHHS to provide healthcare services to beneficiaries through a network of healthcare professionals, both primary and specialty care, as well as hospitals, pharmacies, etc. This network is developed by contracting with the various healthcare professionals.

Primary care providers (PCP) must be accessible within a 30-mile radius, while specialty care providers, to include hospitals, must be accessible within a 50-mile radius. While MCOs will contract with providers within a specific county, enrolled members may seek treatment, or be referred to in-network providers in neighboring counties.

MCOs are responsible for providing core services to Medicaid-eligible individuals as specified in their contract with SCDHHS. The health care providers within the MCO network are not required to accept FFS Medicaid as most claims are filed to and processed by the MCO. Only services rendered on a fee-for-service (FFS) basis require providers be enrolled in SC Medicaid, as those claims are paid by SCDHHS. (Core services are discussed further in the **Core Benefits** section of this supplement.)

Core Benefits

Managed Care Organizations are fully capitated plans that provide a core benefits package similar to the current FFS Medicaid plan. MCO plans are required to provide beneficiaries with “medically necessary” care at current limitations for all contracted services. Unless otherwise specified, service limitations are based on the State fiscal year (July 1 through June 30). While appropriate and necessary care must be provided, MCOs are not bound by the current variety of service settings. For example, a service may only be covered FFS when performed in an inpatient hospital setting, while the MCO may authorize the same service to be performed both in an inpatient and an outpatient hospital setting.

MANAGED CARE SUPPLEMENT

MANAGED CARE OVERVIEW

MCOs may offer SCDHHS-approved additional benefits. These are benefits that go beyond the core package. Additions, deletions, or modifications to additional benefits made during the contract year must be approved by SCDHHS. These benefits may include medical services which are currently non-covered by FFS and/or which are above current Medicaid limitations.

Providers should refer to the **Core Benefits** section of the MCO Policy and Procedures Guide on the SCDHHS website (www.scdhhs.gov) for a detailed explanation of core benefits and service limitations.

Services Outside of the Core Benefits

The South Carolina Healthy Connections (Medicaid) program continues to provide and/or reimburse certain FFS benefits. Providers rendering services that are not included in the MCO's benefits package, but are covered under FFS Medicaid receive payment in accordance with the current Medicaid fee schedule. These services are filed to SC Medicaid for processing and payment. MCOs are responsible for the beneficiaries' continuity of care by ensuring appropriate referrals and linkages to the Medicaid FFS providers. For specifics concerning services outside of the core benefits, please see the MCO Policy and Procedures Guide on www.scdhhs.gov.

MCO Program Identification (ID) Card

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

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

- The MCO name
- The 24-hour telephone number for the beneficiary to use in urgent or emergency situations and to obtain any additional information
- The name of the primary care physician
- The beneficiary's name and Medicaid ID number
- The MCO's plan expiration date (optional)
- The Member Services toll-free telephone number
- The MCO and SC Medicaid logos

Claims Filing

Providers should file claims with the MCO for beneficiaries participating in a managed care program, unless the service rendered is not covered by the MCO and is, instead, paid on a FFS basis by SC Medicaid. Providers should contact the MCO for managed care billing requirements. Non-contracted providers should contact the MCO for billing and prior authorization requirements prior to rendering services to MCO enrolled beneficiaries. An exception is services

MANAGED CARE SUPPLEMENT

MANAGED CARE OVERVIEW

rendered in an emergency room. Even if the physician is not in-network with the MCO, the MCO cannot refuse to reimburse for covered emergency services. Specifics concerning emergency coverage are contained in Section 4, **Emergency Medical Services**, of the MCO contract.

Prior Authorizations and Referrals

Providers, both in and out of network, should contact the beneficiary's MCO for assistance with prior authorization (PA) requirements before administering services. Each MCO may have different prior authorization requirements and services requiring PA may differ according to the terms of a provider's contract with an MCO.

Admission to a hospital through the emergency department **may** require authorization. Hospitals should always check with the beneficiary's MCO plan for their requirements. The physician component for inpatient services **always** requires prior authorization. Specialist referrals for follow-up care after a hospital discharge also require prior authorization.

Medical Homes Networks (MHNs)

Medical Homes Networks (MHNs) are Medicaid's Primary Care Case Management (PCCM) programs that link beneficiaries with a primary care provider (PCP). An MHN is a group of physicians who have agreed to serve as PCCM providers. They work in partnership with the beneficiary to provide and arrange for most of the beneficiary's health care needs, including authorizing services provided by other health care providers. They also partner with a Care Coordination Services Organization (CSO) to accept the responsibility for providing medical homes for beneficiaries and for managing beneficiaries' care. The CSO supports the physicians and enrolled beneficiaries by providing care coordination, disease management, and data management. All providers participating in an MHN must be enrolled SC Medicaid providers, as all services are paid on a fee-for-service (FFS) basis.

The outcomes of the medical home initiative are a healthier, better educated Medicaid beneficiary, and cost savings for South Carolina through a reduction of acute medical care and disease-related conditions. The MHN provides case managers, who assist in developing, implementing, and evaluating the predetermined care management strategies of the network.

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

MHN Program Identification (ID) Card

Medicaid Homes Networks do not issue a separate identification card. Beneficiaries enrolled in an MHN will have only one identification card, the one issued by SC Medicaid. This card does not contain the name or phone number of the assigned PCP. Such information can only be obtained by checking eligibility.

MANAGED CARE SUPPLEMENT

MANAGED CARE OVERVIEW

Core Benefits

Services provided under the MHN program are all paid on a FFS basis. As such, all claims are submitted to and processed by SCDHHS. Benefits offered in the MHN program mirror those offered in FFS with the following exceptions:

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

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

Prior Authorizations and Referrals

The PCP is contractually required to either provide medically necessary services or authorize another provider to treat the beneficiary via a referral. Even if a physician in the same practice, but at a different practice location with a different Medicaid “pay-to or group” provider ID, treats a beneficiary, the services rendered still need a referral from the PCP. If a beneficiary has failed to establish a medical record with the PCP, the CSO, in conjunction with the PCP, shall arrange for the prior authorization (PA) on any existing referral. For a list of services that do not require authorization, refer to the **Exempt Services** section later in this supplement.

In some cases, the PCP may choose to authorize a service retroactively. All authorizations and consultations, including services authorized retroactively, are at the discretion of the PCP. The process for referring a beneficiary to a specialist can be made by telephone or in writing. The referral should include the number of visits being authorized and the extent of the diagnostic evaluation.

A PCP may authorize multiple visits for a specific course of treatment or a particular diagnosis. This prevents a provider to whom the beneficiary was referred from having to obtain a referral number for each visit so long as the course of treatment or diagnosis has not changed. The provider simply files the claims referencing the same referral number. It is the PCP’s responsibility to authorize additional referrals for any further diagnosis, evaluation, or treatment not identified in the scope of the original referral. If a specialist needs to refer the beneficiary to a second specialist for the same diagnosis, the beneficiary’s PCP must be contacted for a referral number.

A referral number is not required for services provided in a hospital emergency department or for an admission to a hospital through the emergency department. However, the physician component for inpatient hospital services does require a referral number. The hospital should contact the PCP for a referral number within 48 hours of the beneficiary’s admission. Specialist referrals for follow-up care after discharge from a hospital also require a referral from the PCP. In addition to the MHN’s authorization, prior approval may be required by SCDHHS to verify medical necessity before rendering some services. Prior authorizations are for medical approval only. Obtaining a prior authorization does not guarantee payment or ensure the beneficiary’s eligibility on the date of service.

MANAGED CARE SUPPLEMENT

MANAGED CARE OVERVIEW

For a list of services requiring a referral number from the PCP, along with noted exceptions, please refer to the MHN Policy and Procedures Guide. Claims submitted for reimbursement must include the PCP's referral number.

Specific services sponsored by state agencies require a referral from that agency's case manager. The state agency's case manager should coordinate with the PCP and the MHN Care Coordinator to ensure the continuity of care. These services include, but are not limited to, the following:

- Audiologist Services
- High/Moderate Management Group Homes Services
- Occupational Therapist Services
- Physical Therapist Services
- Psychologist Services
- Speech Therapist Services
- Therapeutic Foster Care Services

Referrals for a Second Opinion

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

Referral Documentation

All referrals must be documented in the beneficiary's medical record. The CSO and the PCP shall review the monthly referral data to ensure that services rendered to the beneficiary were authorized and recorded accurately in the medical record. It is the PCP's responsibility to review the referral data for validity and accuracy, and to report inappropriate and/or unauthorized referrals to the CSO. The CSO is responsible for investigating these incidents and notifying SCDHHS if Medicaid fraud or abuse is suspected.

Exempt Services

Beneficiaries can obtain the following services from Medicaid providers without obtaining a prior authorization from their PCP:

- Ambulance Services
- Dental Services
- Dialysis/End Stage Renal Disease Services
- Emergency Room Services (billed by the hospital)
- Family Planning Services
- Home- and Community-Based Waiver Services
- Independent Laboratory and X-ray ¹ Services

MANAGED CARE SUPPLEMENT

MANAGED CARE OVERVIEW

- Medical Transportation Services
- Nursing Home Services
- Obstetrician and Gynecologist Services
- Optician Services
- Optometrist Services
- Pharmacy Services
- State Agency 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)

MANAGED CARE SUPPLEMENT**MANAGED CARE OVERVIEW****24-Hour Coverage Requirements**

The MHN requires PCPs to provide access to medical advice and care for enrolled beneficiaries 24 hours per day, 7 days per week. A qualified medical practitioner must provide medical advice, consultation, and/or authorization or referral for services when appropriate within one hour of the beneficiary's presentation or notification. PCPs must have at least one telephone line that is answered by office staff during regular office hours.

Women, Infants, and Children (WIC) Program Referrals

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

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

MANAGED CARE SUPPLEMENT

MANAGED CARE ELIGIBILITY

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

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

- Dually eligible beneficiaries (Medicare and Medicaid)
- Beneficiaries age 65 or older
- Residents of a nursing home
- Participants in limited benefits programs such as Family Planning, Specified Low Income Beneficiaries, Emergency Service Only, etc.
- Home- and Community-Based Waiver participants
- PACE participants
- Medically Complex Children's Waiver Program participants
- Hospice participants
- Beneficiaries covered by an MCO/HMO through third-party coverage
- Beneficiaries enrolled in another Medicaid managed care plan

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

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

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

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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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MANAGED CARE ENROLLMENT

ENROLLMENT PROCESS

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

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

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

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

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

There are three easy ways for beneficiaries to enroll:

- Call SCHCC at (877) 552-4642
- Mail or fax the completed enrollment form contained in the enrollment packet
- Online at www.SCchoices.com

A beneficiary is enrolled in a Managed Care plan for a period of 12 months. The beneficiary shall remain enrolled in the plan unless one of the following occurs:

- The beneficiary becomes ineligible for Medicaid and/or Managed Care enrollment
- The beneficiary forwards a written request to transfer plans for cause
- The beneficiary initiates the transfer process during the annual re-enrollment period
- The beneficiary requests transfer within the first 90 days of enrollment

Enrollment of Newborns

Babies born to Medicaid-eligible mothers are automatically deemed Medicaid eligible. As such, they are subject to being enrolled into a managed care plan. If, at the time of delivery, the mother is enrolled with an MCO, the baby will be automatically enrolled into the same MCO. If, however, the mother is enrolled with an MHN, or is FFS, the baby will revert to FFS Medicaid

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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

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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 style="font-size: small;">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>		

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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	

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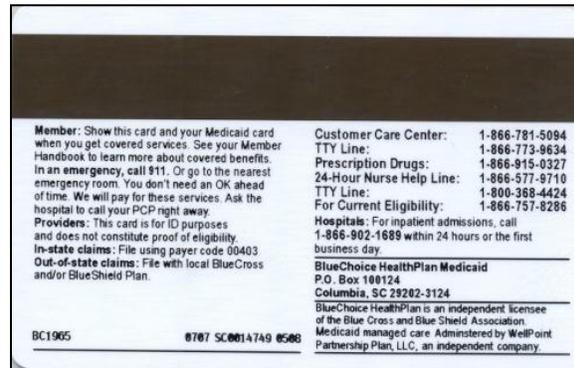
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BlueChoice

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



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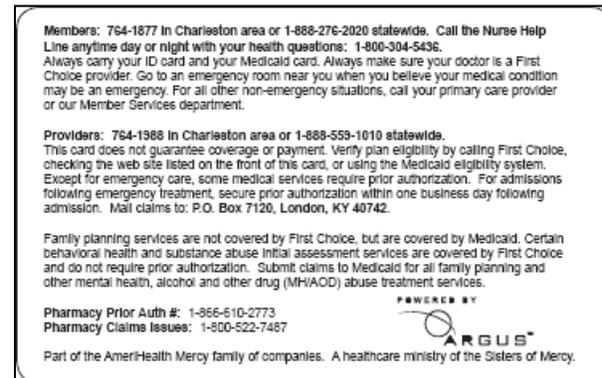
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First Choice by Select Health

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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