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SECTION 2 POLICIES AND PROCEDURES

PROGRAM OVERVIEW

GENERAL INFORMATION

The South Carolina Medicaid program recognizes all medical services that are medically necessary, unless limitations are noted within the policy restrictions of this manual. The South Carolina Medicaid program is restricted to services for eligible beneficiaries that are provided services by enrolled or contracted providers and rendered within the South Carolina service area.

Note: Medicaid beneficiaries enrolled in special programs may have limits and restrictions for Medicaid reimbursable services. For Managed Care program participants, providers should review the Managed Care supplement provided with this manual for health care services. Please confirm eligibility and coverage by checking Medifax or the South Carolina Medicaid Web-based Claims Submission Tool (if provider is a member).

The South Carolina Medicaid program recognizes the services outlined in this manual and will reimburse providers as defined under the heading "Provider Qualifications" below. All other services are considered non-covered services within the South Carolina Medicaid program. The South Carolina service area is usually defined as within twenty-five miles of the state line. Services rendered outside the service area are subject to the outlined prior approval guidelines. All services are subject to the guidelines and limitations established in this manual.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM OVERVIEW

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SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

PROVIDER QUALIFICATIONS

Physician

For Medicaid billing purposes, the term "physician" includes doctors of medicine and osteopathy who are currently licensed in the state in which they are rendering services by that state's Board of Medical Examiners.

Physician Services

Physician services rendered either in the patient's home, a hospital, a skilled nursing facility, physician's office, clinic, or elsewhere are defined as those services provided by, or under the personal supervision of, an individual licensed under state law to practice medicine or osteopathy in the state in which he or she is rendering services. When billing for services, the provider of service must be the same as the provider of service noted in the patient's medical record, unless working in an exceptional situation such as supervision, locum tenens, etc. Additionally, Medicaid providers should bill actual charges for their services rather than the anticipated reimbursement. Refer to Section 3 of this manual, "Billing Procedures," for more detailed Medicaid billing instructions.

Hospital-Based Physician

A hospital-based physician is defined as a physician licensed to practice medicine or osteopathy who is employed by a hospital, and whose payment for services is claimed by the hospital as an allowable cost under the Medicaid program and billed by the contracted hospital.

Physician's Assistant

A physician's assistant is defined as a health professional that performs tasks which are approved by the State Board of Medical Examiners in the state in which he or she is rendering services in a dependent relationship with his or her supervising physician and under personal supervision as defined in the "Direct Physician Supervision" section of this manual. Medicaid reimbursement will be made to the supervising physician, clinic, or hospital where the professional is employed and where the service is rendered under the criteria set forth in this manual.

On July 1, 2004, SCDHHS began enrolling physician assistants as medical professionals under the Physician Services program for dually eligible Medicare and Medicaid beneficiaries only. Medicaid reimbursement was made to the physician assistant for those dually eligible beneficiaries and the rate was 80 percent of the physician's rate.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Physician's Assistant (Cont'd.)

Effective November 1, 2009, SCDHHS will only reimburse physician assistants directly for services rendered to Qualified Medicare Beneficiaries (QMBs). All other services must be performed under the direct supervision of a physician and billed under the supervising physicians NPI number. The reimbursement rate will be consistent with the South Carolina State Plan, which currently reflects 75% of the Medicare physician assistant's fee schedule. The fee schedule that will be utilized will be the current Medicare fee schedule that SC Medicaid is operating under.

Please note that not all dually eligible beneficiaries are QMBs. To establish if a beneficiary is a QMB, providers can access the Medicaid Web-Based Claims Submission Tool (the Web Tool) to retrieve the beneficiary eligibility information. In the Web Tool, the Eligibility or Beneficiary Information section will indicate "Yes" if the beneficiary is a Qualified Medicare Beneficiary.

Certified Nurse Midwife

A certified nurse midwife (CNM) must be licensed to practice as a registered nurse and as a certified nurse midwife in the state in which he or she is rendering services. Services are provided under the supervision of a physician preceptor according to a mutually agreed-upon protocol. Reimbursement is 100% of the physician rate.

Licensed Midwife

A licensed midwife is defined as a person who is not a medical or nursing professional licensed by the South Carolina Department of Health and Environmental Control (SCDHEC), for the purpose of providing specifically defined prenatal, delivery, and postpartum services to low-risk women. Reimbursement is 65% of the physician rate.

Certified Registered Nurse Anesthetist (CRNA)

A CRNA must be licensed to practice as a registered nurse in the state in which he or she is rendering services **and** currently certified by the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists. A recent graduate is a new graduate of an advanced formal education program for nurse anesthetist accredited by the national accrediting organization who must achieve certification within one year of graduation. Upon obtaining certification, recent graduates must notify Provider Enrollment to continue practicing as a Medicaid provider. CRNAs may work under the medical direction of a surgeon or under the supervision of an anesthesiologist. CRNAs working under the medical direction of a surgeon will be reimbursed at ninety percent of the anesthesiologist reimbursement rate.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Anesthesiologist Assistant (AA)

An Anesthesiologist Assistant (AA) must be licensed to practice as an AA in the state he or she is rendering services. AAs may only work under the supervision of an anesthesiologist.

Paramedical Professionals

The following medical professionals may render services to Medicaid patients under the direct supervision of a licensed physician:

- Audiologists
- Speech pathologists
- Physical therapists
- Occupational therapists
- Licensed master social workers
- Psychiatric nurse practitioners
- X-ray or lab technicians
- Licensed respiratory therapists
- Nurse midwives
- Nurse practitioners (NPs)

Reimbursement will be made to the supervising physician or hospital where the professional is employed, and where the service is rendered, under the restrictions set forth in this manual. If any of these medical professional services are included in a hospital cost report, they cannot also be billed separately as professional services.

Certified Nurse Practitioner (CNP) and Clinical Nurse Specialist (CNS)

The CNP/CNS may enroll with South Carolina Medicaid and be assigned a Medicaid ID number if he or she meets all of the following criteria:

- Licensed to practice as a registered nurse
- Licensed as a CNS/CNP in the state in which he or she is rendering services
- Practicing under a physician preceptor according to a mutually agreed-upon protocol

CNP/CNSs may bill for services under their physician preceptor's NPI number or under their individual NPI number (NP + 4 digits).

The services they render are limited to those that are allowed under state law and are documented in the approved written protocol.

Delegated acts and protocols that outline the scope of practice guidelines for NPs, CNMs, CNs, or PAs should be current and available in the

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Certified Nurse Practitioner (CNP) and Clinical Nurse Specialist (CNS) (Cont'd.)

personnel file of the supervised practitioner. Upon submission of a claim, the rendering physician is attesting that the services have been accurately and fully documented in the medical record and that he or she assumes responsibility for the NP, CNM, CNS, or PA. The claim also confirms that the provider has certified the medical necessity and reasonableness for the service(s) submitted to Medicaid for payment. This policy does not supersede state law, as it relates to requirements, for off-site practice protocols that outline co-signature guidelines for PAs. These requirements can be found in Article 7, Section 40-47-955, of the South Carolina Physician Assistants Practice Act.

Services rendered and billed under the NP individual NPI number are reimbursed at 80% of the physician's fee schedule for evaluation and management codes and all professional codes, and 100% for supplies and pathology services.

Any CNP/CNS employed by a hospital will be ineligible to submit claims for his or her services, as these services are included in the hospital cost report.

To request a CNP/CNS enrollment form, contact provider enrollment at 1-888-289-0709.

Direct Physician Supervision

For Medicaid billing purposes, direct supervision means that the supervising physician is accessible when the services being billed are provided; and, the supervising physician is responsible for <u>all</u> services rendered, fees charged and reimbursements received.

Co-signatures

Effective with dates of service on or after January 1, 2010, SCDHHS will discontinue the requirement of the physician's co-signature in a medical record when services are performed by the following professionals:

- Nurse Practitioner (NP)
- Certified Nurse-Midwife (CNM)
- Certified Nurse Specialist (CNS)
- Physician Assistant (PA)

Delegated acts and protocols that outline the scope of practice guidelines for NP, CNM, CNS, or PA should be current and available in the personnel file of the supervised practitioner. Upon submission of a claim, the rendering physician is attesting that the services were accurately and fully documented in the medical record and that he or she assumes responsibility for the NP, CNM, CNS, or PA. The claim also confirms the provider has certified the medical necessity and reasonableness for the service(s) submitted to Medicaid for payment.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Co-signatures (Cont'd.)

This policy update does not supersede state law as it relates to requirements for off-site practice protocols that outlines when co-signatures are required for PAs. These requirements can be found in Article 7 of the South Carolina Physician Assistants Practice Act section 40-47-955.

Clinics and Ancillary Services

Under the Omnibus Budget Reconciliation Act of 1989 (OBRA '89), several specific types of health professionals and facilities are eligible for enrollment in the South Carolina Medicaid program. Their services are compensable only for beneficiaries with special needs, age 21 and under, and are related to an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) exam.

These providers include physical therapists, occupational therapists, speech therapists, and audiologists. Facilities and private therapists providing rehabilitative services have to meet certain qualifications. Guidelines for these services are outlined in the "Rehabilitative Services Policies and Procedures" manual available online at www.scdhhs.gov.

Federally Qualified Health Centers and Rural Health Clinics are eligible for participation under South Carolina Medicaid. For information and policy guidelines on these clinics call the SCDHHS Provider Service Center (PSC) at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us.

BILLING REQUIREMENTS/ REIMBURSEMENT

Services Outside of the Country

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.

Pre- and Post-Payment Review

All Medicaid claims, including claims for surgery, are paid through an automated claims processing system. These claims are subject to pre-payment edits and may require documentation. Additionally, post-payment reviews are conducted regarding utilization, appropriateness, medical necessity, and other factors.

All claims and reimbursements are subject to post-payment monitoring and recoupment if review indicates a claim was paid inappropriately or incorrectly. Providers are required to maintain and disclose their records consistent with Section 1 of this manual.

SCDHHS reserves the right to request medical records at any time for purposes of medical justification and/or review of billing practices.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Physician's Office Within an Institution

When a physician establishes an office within a nursing home, hospital, or other institution, coverage of services and supplies furnished in the office must be determined in accordance with the "incident to a physician's professional services" criteria as determined by federal regulations. A physician's office within an institution must be confined to a separately identified part of the facility that is used solely as the physician's office and cannot be construed to extend throughout the entire institution. Thus, services performed outside the "office" area will be subject to coverage rules applicable to services furnished outside the office setting (*i.e.,* a technical component that is included in the institutional reimbursement).

Consideration must be given to the physical proximity of the institution and the physician's office. When his or her office is located within a facility, a physician may not be reimbursed for services, supplies, or use of equipment that falls outside the scope of services "commonly furnished" in physician's offices. Additionally, a distinction must be made between the physician's office practice and the institution, especially when the physician is the administrator or owner of the facility. Thus, for their services to be covered the auxiliary medical personnel must be members of the office staff rather than of the institution's staff, and the cost of supplies must represent an expense of the physician's office practice. Finally, the physician must directly supervise services performed by the employees of the physician outside the "office" area; his or her presence in the facility as a whole is not sufficient.

Teaching Physician Policy: Requirements for Billing

Services provided by residents under the direct supervision of a teaching physician are billable to Medicaid. For Medicaid billing purposes, direct supervision means that the teaching physician is accessible, as defined in Subsection I, when the resident provides the services being billed. The teaching physician is responsible for all services rendered, fees charged, and reimbursements received. The services must be documented, as defined in Subsection II, in the patient's medical record. The supervising physician must sign the patient's medical record, indicating that he or she accepts responsibility for the services rendered.

For the purpose of the policy, the following definitions apply:

- **Resident** – A resident is an individual who participates in an approved graduate medical education (GME) program, or a physician who is not in an approved GME program but who is authorized to practice only in a hospital setting. The term includes interns and fellows in GME programs recognized as approved for purposes of direct GME payments made by the fiscal intermediary.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Teaching Physician Policy: Requirements for Billing (Cont'd.)

- **Medical Student** – A medical student is an individual who is enrolled in a program culminating in a degree in medicine. Any contribution of a medical student to the performance of a billable service or procedure must be performed in the physical presence of a teaching physician or jointly with a resident in the course of providing a service meeting the requirements set forth for teaching physician billing.
- **Teaching Physician** – A teaching physician is an individual who, while functioning under the authority and responsibility of a resident program director, involves resident and/or medical students in the care of his or her patients or supervises residents in the care of patients.

Subsection I: Accessibility of the Teaching Physician

Accessibility of the teaching physician while the resident is providing a service is defined as follows for particular service types.

Ambulatory Services

Accessibility of the teaching physician for supervision of ambulatory services requires the teaching physician to be present in the clinic or office setting while the resident is treating patients. The physician is thus immediately available to review the patient's history, personally examine the patient if necessary, review the records of the encounter and laboratory tests, confirm or revise the diagnoses, and determine the course of treatment.

Inpatient Services

Accessibility of the teaching physician for supervision of non-procedural inpatient services requires that the teaching physician evaluate the patient within 24 hours of admission and on each day thereafter for which services are billed. The teaching physician must review the patient's history, personally examine the patient as needed; review the records of the encounter and laboratory tests, confirm or revise the diagnoses; and determine the course of treatment.

Procedures

Minor Procedures – For supervision of procedures that take only a few minutes to complete or involve relatively little decision-making once the need for the procedure is determined, accessibility requires that the teaching physician be on the premises and immediately available to provide services during the entire procedure.

All Other Procedures – For supervision of all other procedures, accessibility requires that the teaching physician be physically present during all critical and key portions of the procedure and be immediately available to provide services during the entire procedure.

Subsection II: Documentation of the Teaching Physician

Documentation for services must include a description of the presence and participation of the teaching physician. The resident may document the encounter, to include a note that describes the involvement of the teaching physician. The teaching physician's signature is then adequate to confirm agreement.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Subsection II: Documentation of the Teaching Physician (Cont'd.)

Documentation of an encounter by the teaching physician may reference portions of a medical student's notes. The combined entries of the medical student, resident, and teaching physician must be adequate to substantiate the level of service required and billed. Documentation must include the teaching physician's signature for each encounter.

Reciprocal Billing and Locum Tenens Arrangements

Reciprocal Billing

A physician may submit claims and receive payment for covered visit services (including emergency visits and related services) that the physician arranges to be provided by a substitute physician on an occasional reciprocal basis.

Locum Tenens Arrangements

It is a longstanding and widespread practice for physicians to retain substitute physicians to take over their professional practices when the regular physician is absent for reasons such as illness, pregnancy, vacation, or continuing medical education. The regular physician usually bills using his or her Medicaid provider number and receives payment for the substitute physician's services as though the regular physician performed them personally. The regular physician generally pays the substitute physician a fixed amount per diem, with the substitute physician having the status of an independent contractor rather than an employee. These substitute physicians are generally called "locum tenens" physicians.

A physician may submit claims and receive payment for covered visit services (including emergency visits and related services) of a locum tenens physician who is not an employee of the regular physician, and whose services for the regular physician's patients are not restricted to the regular physician's office.

The following requirements must be met for both reciprocal billing and locum tenens arrangements:

- The regular physician must be unavailable to provide the visit services.
- The Medicaid beneficiary must have arranged or be seeking to schedule the visit services from the regular physician.
- The substitute physician must meet the same licensing requirements as required by Medicaid. However, Medicaid enrollment is not required.
- The substitute physician cannot provide the visit services to Medicaid beneficiaries over a continuous period of longer than 60 days.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Locum Tenens Arrangements (Cont'd.)

- Claims should be filed using the regular physician's Medicaid Provider ID or NPI number.

The regular physician's office must keep on file a record of each service provided by the substitute physician and make this record available to Medicaid upon request. "Covered visit services" include those services ordinarily characterized as a covered physician visit, as well as any other covered items and services furnished by the substitute physician or by others as incident to the physician services.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

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SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

EVALUATION AND MANAGEMENT SERVICES

Refer to the Current Procedural Terminology (CPT) when multiple evaluation and management services are provided on the same date of service.

Primary Care Services

Guidelines in this section include South Carolina Medicaid policies for general medical care, such as office exams and hospital or nursing home visits.

These services are predominantly billed to Medicaid by Primary Care Physicians such as family physicians, internists, general practitioners, obstetrician/gynecologists, and pediatricians. However, the guidelines are written for all physicians rendering services to South Carolina citizens who are Medicaid beneficiaries.

SCDHHS will implement 42 CFR Part 438, 441, and 447 for services provided January 1, 2013 through December 31, 2014. This action implements the Affordable Care Act (ACA) requirement that increases payments to physicians with a specialty designation of family medicine, general internal medicine, pediatric medicine, and related subspecialists for specified primary care services and charges for vaccine administration under the Vaccines for Children Program.

To qualify for the enhanced rates, a physician must self-attest to one of the following criteria:

- Board certification in one of the specialty designations by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS) or the American Osteopathic Association (AOA)
- Sixty (60) percent of all Medicaid services billed, or provided in a managed care environment in Calendar Year 2012 (January 1, 2012 to December 31, 2012) were for E& M codes 99201-99499 and vaccine administration codes 90460, 90461, 90471, 90472, 90473 and 90474. (Newly enrolled, non-board certified physicians in one of the designated specialties are eligible if they attest to meeting the 60 percent threshold in the prior month).

Enrolled providers must complete the Primary Care Physician Attestation Form at www.scdhhs.gov/physicianattestation. Contact the PSC at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us for more information.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Records and Documentation Requirements

The appropriate medical documentation must appear in the patient's medical record to justify medical necessity for the level of service reimbursed, including the illness, history, physical findings, diagnosis, and prescribed treatment. The record must reflect the level of service billed and must be legible.

Procedural and Diagnostic Coding

Medicaid recognizes the medical terminology as defined in the *Current Procedural Terminology (CPT), Fourth Edition*, published by the American Medical Association; and the diagnosis codes as defined in the *International Classification of Diseases, Ninth Edition (ICD-9)*, provided by the U.S. National Center for Health Statistics.

In 1996, the Centers for Medicare and Medicaid Services (CMS) implemented the National Correct Coding Initiative (CCI) to control improper coding that leads to inappropriate increased payment for health care services. The South Carolina Medicaid program utilizes Medicare reimbursement principles. Therefore, the agency will use CCI edits to evaluate billing of CPT codes and Healthcare Common Procedure Coding System (HCPCS) codes by Medicaid providers in post-payment review of providers' records. For assistance in billing, providers may access the CCI Edit information online at the CMS Web site, http://www.cms.hhs.gov/NationalCorrectCodInitEd/.

Office/Outpatient Exams

Definitions

Some phrases commonly used to describe a patient's relationship to a physician or practice group are defined as follows:

- **New Patient** – Medicaid defines a new patient as one visiting the office for the first time. A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years. An exception can be justified if all records are lost or destroyed.
- **Established Patient** – An established patient is one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years.

The designation of new or established patient does not preclude the use of a specific level of services. Medicaid will reimburse no more than one visit per day unless medically justified. If a second visit is medically necessary, the second visit must be clearly documented in the patient's chart.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Definitions (Cont'd.)

In the instance where a physician is on call for or covering for another physician, the patient's encounter is classified as it would have been by the physician who is not available. For example, if the patient is an established patient of the physician who is not available, then the covering physician would also report his or her services as an established patient visit.

After Hour Services

Effective April 1, 2013 CPT codes 99050 and 99051 are covered for Primary Care Providers (Pediatrician's, Family Practice, General Practice, Internal Medicine and OB/GYN). Providers will be able to bill the evaluation and management code that best describes the level of service being rendered.

99050: Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (i.e., holidays, Saturday or Sunday), in addition to basic service.

99051: Service provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service.

The purpose of this coverage is to encourage expanded office hours. SCDHHS defines CPT code 99050 to mean all patients scheduled outside published business hours; this would not include a visit that was scheduled at 4:00 p.m. and the patient was not seen by the physician until 6:30 p.m. For CPT code 99051, SCDHHS defines evening hours to be any time after 6:00 p.m. and before 8:00 a.m. Weekends are defined as Saturday 8:00 a.m. to Monday 8:00 a.m. Providers may only bill for the following holidays, the day of New Year's, Independence, Labor, Thanksgiving and Christmas. Holidays are defined as 8:00 a.m. the morning of the holiday until 8:00 a.m. the following morning. After hours procedure codes are not covered when the service is provided in a hospital emergency department, an inpatient setting, outpatient setting, or an urgent care facility (place of service codes 20, 21, 22, and 23). The reimbursement for each of these CPT codes will be $12.00. All CPT codes, claims submission and policy will be subject to review by the Department of Program Integrity.

Levels of Service

Medicaid recognizes the terminology in the CPT for the levels of services as established criteria for billing office visits.

Ambulatory Care Visit Guidelines

Medicaid patients ages 21 and older are allowed 12 ambulatory care visits (ACVs) per year, commencing on July 1st of each year. Beneficiaries under age 21 are exempt from this limitation.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Ambulatory Care Visit Guidelines (Cont'd.)

Ambulatory care has been defined as all outpatient examinations, to include paid claims for the following types of examinations:

- Encounter Codes T1015
- Psychiatric Diagnostic Exam 90801
- Physician Examinations 99201-99205, 99212-99215
- Consultations 99241-99245
- Healthy Adult Physical 99385-99387

The following services **do not** count toward the ACV limit:

- Maternal care codes, including antepartum and postpartum care codes
- Established visit codes 99212 and 99213 billed with a primary or secondary pregnancy diagnosis code
- Family Planning visits when billed with the FP modifier or the family planning codes. Refer to the "Obstetrics and Gynecology" heading in this section for the codes.
- EPSDT screenings
- Minimal exams performed without a physician's direct involvement for ongoing therapies, blood pressure checks, injections, etc., if billed using CPT code 99211
- Emergency department services
- Ambulatory visits for beneficiaries who are currently being treated for HIV/AIDS. These recipients will be exempt from the ACV limit even if the services being provided are not related to the actual cancer treatment.

  Note: In order to bill for these services, providers must attach the "P4" modifier to the appropriate Evaluation and Management (E&M) code. All claims will be subject to post-payment review by Program Integrity.

- Ambulatory visits for beneficiaries who are currently being treated for cancer. These recipients will be exempt from the ACV limit even if the services being provided are not related to the actual cancer treatment.

  Note: In order to bill for these services, providers must attach the "P4" modifier to the appropriate Evaluation and Management (E&M) code. All claims will be subject to post-payment review by Program Integrity.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Ambulatory Care Visit Guidelines (Cont'd.)

- Ambulatory visits medically necessary for patients identified by their physician as having a medical need to exceed the 12 ambulatory visit limits. (Refer to the "Medical Necessity Guidelines" section below for more detail.)

Medical Necessity Guidelines

SCDHHS has modified its policy concerning the potential approval of additional ambulatory care visits. To be reimbursed for additional visits over the 12-visit limit, providers must submit a letter directly to Physicians Services requesting additional visits. The letter must be on office letterhead and include the provider's National Provider Identifier (NPI) number, the patient's name and Medicaid ID number, and the physician's signature. Providers must also provide the medical reasons for the request. SCDHHS Division of Physician Services will reply, in writing, with approval or denial and the number of additional visits granted if approved. Prescription or 'fill-in-the-blank' form documents will not be accepted. This process is closely monitored for medical necessity and abuse. Please send all requests to:

SCDHHS Division of Physician Services
Attn: Ambulatory Care Visit Review
Post Office Box 8206
Columbia, SC 29202-8206

The department's copayment policy will continue with each of the authorized additional visits.

In order to possibly avoid receiving a 977 edit for exceeding the12 allowable ambulatory visits when filing the claim, providers must attach the letter of approval from the SCDHHS Medical Director to the claim. This letter must accompany each claim in order for it to suspend to the program area for review. Additionally, the letter of approval should be maintained in the patient's medical records in the event of a post payment review. Claims must be submitted within the timely filing guidelines.

All covered ancillary services, including other diagnostic lab and x-ray services, are compensable. Surgical procedures, hospital care, and other medically necessary services will be reimbursed by South Carolina Medicaid, regardless of the number of ambulatory visits used by the patient.

Verifying the beneficiary's coverage will reflect the estimated visits remaining at the time of service. The estimated visits only reflect the number of exams paid by Medicaid through the claims processing system (MMIS), and should not be considered a guarantee of payment.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Ambulatory Care Visit Guidelines (Cont'd.)

When any services are rendered, providers should always request the beneficiary's Medicaid card and verify coverage. However, possession of the card does not guarantee Medicaid eligibility. Beneficiaries may become ineligible for Medicaid for a given month, only to regain eligibility at a later date. It is possible a beneficiary will present a card during a period of ineligibility. It is very important to verify Medicaid eligibility, coverage, and type prior to providing services.

Medicaid eligibility can be verified through the South Carolina Medicaid Web-Based Claims Submission Tool (Web Tool). Please contact the SCDHHS Medicaid Provider Service Center at 1-888-289-0709 for further information.

All examinations rendered after the patient has exhausted his or her ambulatory care visits will be rejected. **Edit 977 will appear on the rejection notice. The provider is responsible for the exam charge.**

Exceptions to the 977 Edit

Exceptions may be made to this edit under the following criteria:

- SCDHHS has modified the policy regarding Ambulatory Care Visits (ACV) for beneficiaries residing in a nursing home or long-term care facility. Claims with the place of service 31 (Skilled Nursing Facility [SNF]), 32 (Nursing Facility), 33 (Custodial Care Facility), and 54 (Intermediate Care Facility/ Intellectually Disabled) will be exempt from the ACV limit of 12 visits.
- An ECF must be returned within six months of the rejection with a copy of verification of coverage attached indicating ambulatory visits were available for the date of service being billed. The availability of ambulatory visits must have been verified on the actual date of service being billed or the day before.
- If the visit code was a line item rejection and other services paid on the claim, the provider must file a new claim within six months of the rejection with a copy of verification of coverage indicating ambulatory visits were available for the date of service being billed. The availability of ambulatory visits must have been verified on the actual date of service being billed or the day before.
- All timely filing requirements must be met.

A provider has the option to bill the patient for the non-covered office visit only. Medicaid will reimburse lab work, injections, x-rays, etc. done in addition to the office visit.

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PROGRAM REQUIREMENTS

Exceptions to the 977 Edit (Cont'd.)

Another available option is to change the office visit code in field 17 to the minimal established office E/M code, 99211, and accept the lower reimbursement. This code does not count toward the ambulatory visit limit.

Additional Ambulatory Services

Services commonly rendered in addition to an office exam are compensable if medically necessary. Diagnostic procedures such as lab and x-ray are compensable as separate charges.

Laboratory Services

Diagnostic lab services are compensable as separate charges when the provider actually renders the service and CMS's Clinical Laboratory Improvement Amendments (CLIA) certification standards are met. The appropriate lab service must be coded with a CPT code in the 80000 range.

If the provider only extracts the specimen to send to an outside independent laboratory or hospital laboratory, then the physician cannot charge for the lab test. When the specimen is sent to the independent lab or hospital lab, report the patient's Medicaid number and the lab will bill for their service. The physician should send the specimen(s) to Medicaid-enrolled labs or the beneficiary will be responsible for the lab charges and should be informed prior to having the specimen taken.

A handling service is compensable to the physician if the specimen is collected by venipuncture or catheterization. In addition, collection of pap smears may be charged. See Initial OB Exam guidelines for handling service codes for pap smears. Medicaid will not reimburse for special handling of specimens using either procedure code 99000 or 99001.

X-ray and EKG Services

Medicaid will reimburse only one provider for the interpretation of diagnostic x-rays and EKGs. Reinterpretations, after a physician has interpreted and reported the test, are not allowed. See Radiology guidelines for further details.

If an outside source performed the technical part of an x-ray or EKG, then the physician should bill only the professional component.

Special Services/Visits

Postoperative Follow-up Visit – Procedure code 99024 is non-compensable. See surgical package guidelines under "General Surgery Guidelines" in this section.

Emergency Office Services – Procedure code 99058 may be billed in addition to the appropriate level office E/M code when office services are provided on an emergency basis (after posted office hours).

Procedure codes 99051 through 99056 are non-compensable.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Supplies

Supplies are reimbursable when provided in the physician's office using the following list of procedure codes **only.** All other supplies are reimbursable through DME providers only.

Supplies (Cont'd.)

Major Surgical Tray – Reimbursement may be allowed for a surgical tray when minor surgery is performed in a physician's office that necessitates local anesthesia and other supplies (*i.e.*, gauze, sterile equipment, suturing material, etc.). If the procedure code description includes anesthesia, only the minor surgical tray can be billed. When a major surgical tray is used, local anesthesia cannot be billed separately. Reimbursement will not be provided when a hospital outpatient department or Skilled Nursing Facility supplies the tray.

To report, use supplemental procedure code A4550 for a major surgical tray. A major surgical tray may not be charged for a suture removal tray.

Minor Surgical Tray – A minor surgical tray includes those trays necessary for suture removal, minor debridement, superficial foreign body removal, or incision and drainage of superficial abscess. To report use the supplemental code 99070.

Small Supplies and Materials – Procedure code 99070 is used to bill for supplies provided by the physician (except spectacles), which are over and above those usually included with the office visit or other services rendered. Procedure code 99070 can be used when a starter dose of a one-to-three-day supply purchased by the physician is given to assist in the diagnostic or treatment process. Surgical dressings are compensable if the supplies are medically necessary. Documentation should indicate what supply was used or provided. Charges billed should indicate the actual cost to the physician.

Splints and Casts —- These items are reimbursable only under certain circumstances. For details, refer to the musculoskeletal system under the heading "Surgical Guidelines for Specific Systems" in this section.

The following additional supply codes are listed with a description**:**

A4263 – Lacrimal Puncture Plugs

A4340 – Indwelling Catheter

A4357 – Urinary Drainage Bag

A4358 – Urinary Leg Bag

A4550 – Major Surgical Tray (including anesth. inject)

A4570 – Splint

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PROGRAM REQUIREMENTS

Supplies (Cont'd.)

A4580 – Cast Supplies (*e.g.*, plaster)

A4590 – Special Casting Material (*e.g.*, fiberglass)

A4627 – Spacer, bag, or reservoir with/without mask

A9500 – Sestamibi

A9502 – Supply of Radiopharmaceutical (Technetium)

A9503 – Technetium Medronate (up to 30 mCi)

A9505 – Thallous Chloride

A9600 – Strontium

E0112 – Crutches, wooden, pair

J7300 – Paraguard Intrauterine Device (IUD),cost

L0120 – Cervical Collar, flexible, foam

L0150 – Philadelphia Cervical Collar, semi-rigid

L1610 – Pavlik Harness

L1830 – Knee Immobilizer, canvas longitudinal

L3650 – Shoulder Immobilizer

L3660 – Figure 8 Mobilizer

L3670 – Acromioclavicular Brace

A4267 – Family Planning Condoms

A4269 – Contraceptive Supply, Spermicide (*e.g.* vaginal foam/cream, suppositories, contraceptive gel/sponge)

99070 – Minor Surgical Tray

A4614 – Peak Flow Meter

V5264 – Ear Mold, not disposable, any type (use LT or RT modifier)

V5265 – Ear Mold, disposable, any type (use LT or RT modifier)

Q0144 – Zithromax, oral, 1 gram, single dose

V2500 – Contact Lens, spherical, per lens

V2501 – Contact Lens, toric/prism ballast, per lens

V2510 – Contacts, gas permeable, spherical, per lens

V2511 – Contacts, gas permeable, toric/prism, per lens

V2520 – Contacts, hydrophilic, spherical, per lens

V2521 – Contacts, hydrophilic, toric/ballast, per lens

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Supplies (Cont'd.)

V2630 – Anterior Chamber Intraocular Lens

V2632 – Posterior Chamber Intraocular Lens

29105 – Application of Long Arm Splint

29125 – Application of Short Arm Splint, static

29126 – Application of Short Arm Splint, dynamic

29130 – Application of Finger Splint, static

29131 – Application of Finger Splint, dynamic

29445 – Application of Rigid Total Contact Cast

29505 – Application of Long Leg Splint

29515 – Application of Short Leg Splint

99070 – Supplies and Materials

99071 – Educational Supplies

This supply list is not all-inclusive. Some supply codes specific to certain specialties may be listed in those sections.

Telemedicine

Telemedicine is the use of medical information about a patient that is exchanged from one site to another via electronic communications to provide medical care to a patient in circumstances in which face-to-face contact is not necessary. In this instance, a physician or other qualified medical professional has determined that medical care can be provided via electronic communication with no loss in the quality or efficacy of the care. Electronic communication means the use of interactive telecommunication equipment that typically includes audio and video equipment permitting two-way, real-time interactive communication between the patient and the physician or practitioner at the referring site.

Telemedicine includes consultation, diagnostic, and treatment services. Telemedicine as a service delivery option, in some cases, can provide beneficiaries with increased access to specialists, better continuity of care, and eliminate the hardship of traveling extended distances.

Telemedicine services are not an expansion of Medicaid-covered services but an option for the delivery of certain covered services. However, if there are technological difficulties in performing an objective through medical assessment or problems in beneficiaries' understanding of telemedicine, hands-on or direct face-to-face care must be provided to the beneficiary instead. Quality of health care must be maintained regardless of the mode of delivery.

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PROGRAM REQUIREMENTS

Consultant Sites

A consultant site means the site at which the specialty physician or practitioner providing the medical care is located at the time the service is provided via telemedicine. The health professional providing the medical care must be currently and appropriately licensed in South Carolina and located within the South Carolina Medical Service Area (SCMSA), which is defined as the state of South Carolina and areas in North Carolina and Georgia within 25 miles of the South Carolina state border.

Referring Sites

A referring site is the location of an eligible Medicaid beneficiary at the time the service being furnished via a telecommunication system occurs. Medicaid beneficiaries are eligible for telemedicine services only if they are presented from a referring site located in the SCMSA. Referring site presenters may be required to facilitate the delivery of this service. Referring site presenters should be a provider knowledgeable in how the equipment works and can provide the clinical support if needed during a session.

Covered referring sites are:

- The office of a physician or practitioner
- Hospital (Inpatient and Outpatient)
- Rural Health Clinics
- Federally Qualified Health Centers
- Community Mental Health Centers

Telemedicine Providers

Providers who meet the Medicaid credentialing requirements and are currently enrolled with the South Carolina Medicaid program are eligible to bill for telemedicine and telepsychiatry when the service is within the scope of their practice.

The referring provider is the provider who has evaluated the beneficiary, determined the need for a consultation, and has arranged the services of the consulting provider for the purpose of consultation, diagnosis, and/or treatment.

The consulting provider is the provider who evaluates the beneficiary via telemedicine mode of delivery upon the recommendation of the referring provider. Practitioners at the distant site who may furnish and receive payment of covered telemedicine services are:

- Physicians
- Nurse practitioners
-

SECTION 2 POLICIES AND PROCEDURES

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Covered Services

Services that are eligible for reimbursement include consultation, office visits, individual psychotherapy, pharmacologic management, and psychiatric diagnostic interview examinations and testing, delivered via a telecommunication system. A licensed physician and/or nurse practitioner are the only providers of telepsychiatry services. As a condition of reimbursement, an audio and video telecommunication system that is HIPAA compliant must be used that permits interactive communication between the physician or practitioner at the consultant site and the beneficiary at the referring site.

Covered Services (Cont'd.)

Office and outpatient visits that are conducted via telemedicine are counted towards the applicable benefit limits for these services.

Medicaid covers telemedicine when the service is medically necessary and under the following circumstance:

- The medical care is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's need; and
- The medical care can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide.

The list of Medicaid telemedicine services includes:

- Office or other outpatient visits (CPT codes 99201 – 99215)
- Inpatient consultation (CPT codes 99251-99255)
- Individual psychotherapy (CPT codes 90804 – 90809)
- Pharmacologic management (CPT code 90862)
- Psychiatric diagnostic interview examination (CPT code 90801);
- Neurobehavioral status examination (CPT code 96116);
- Electrocardiogram interpretation and report only (CPT code 93010)
- Echocardiography (CPT code 93307, 93308, 93320, 93321, and 93325)

Non-Covered Services

The following interactions do not constitute reimbursable telemedicine or telepsychiatry services and will not be reimbursed:

- Telephone conversations
- E-mail messages
- Video cell phone interactions

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- Facsimile transmissions
- Services provided by allied health professionals

Coverage Guidelines

The following conditions apply to all services rendered via telemedicine.

1. The beneficiary must be present and participating in the telemedicine visit.
2. The referring provider must provide pertinent medical information and/or records to the consulting provider via a secure transmission.

Coverage Guidelines (Cont'd.)

3. Interactive audio and video telecommunication must be used; permitting encrypted communication between the distant site physician or practitioner and the Medicaid beneficiary. The telecommunication service must be secure and adequate to protect the confidentiality and integrity of the Telemedicine information transmitted.
4. The telemedicine equipment and transmission speed and image resolution must be technically sufficient to support the service billed. Staff involved in the telemedicine visit must be trained in the use of the telemedicine equipment and competent in its operation.
5. An appropriate certified or licensed health care professional at the referring site is required to present (patient site presenter) the beneficiary to the physician or practitioner at the consulting site and remain available as clinically appropriate.
6. If the beneficiary is a minor child, a parent and/or guardian must present the minor child for telemedicine service unless otherwise exempted by State or Federal law. The parent and/or guardian need not attend the telemedicine session unless attendance is therapeutically appropriate.
7. The beneficiary retains the right to withdraw at any time.
8. All telemedicine activities must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996: Standards for Privacy of individually identifiable Health Information and all other applicable state and federal laws and regulations.
9. The beneficiary has access to all transmitted medical information, with the exception of live interactive video, as there is often no stored data in such encounters.

SECTION 2 POLICIES AND PROCEDURES

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Coverage Guidelines (Cont'd.)

10. There will be no dissemination of any beneficiary's images or information to other entities without written consent from the beneficiary.
11. The provider at the distant site must obtain prior approval for service when services require prior approval, based on service type or diagnosis.

Reimbursement for Professional Services

Reimbursement to the health professional delivering the medical service is the same as the current fee schedule amount for the service provided. Consulting site physicians and practitioners submit claims for telemedicine or telepsychiatry services using the appropriate CPT code for the professional service along with the telemedicine modifier GT, "via interactive audio and video telecommunications system" (*e.g.*, 99243 GT). By coding and billing the "GT" modifier with a covered telemedicine procedure code, the consulting site physician and/or practitioner certifies that the beneficiary was present at originating site when the telemedicine service was furnished. Telemedicine services are subject to copayment requirements.

Reimbursement for the Originating Site Facility Fee

The **referring site** is only eligible to receive a facility fee for telemedicine services. Claims must be submitted with HCPCS code Q3014 (Telemedicine originating site facility fee).The reimbursement is $14.96 per encounter. If a provider from the referring site performs a separately identifiable service for the beneficiary on the same day as telemedicine, documentation for both services must be clearly and separately identified in the beneficiary's medical record, and both services are eligible for full reimbursement.

Reimbursement for FQHC's and RHC's

Referring Site

RHCs and FQHCs are eligible to receive reimbursement for a facility fee for the telemedicine services when operating as the referring site. Claims must be submitted with HCPCS code Q3014 (Telemedicine originating site facility fee). The reimbursement is $14.96 per encounter. When serving as the referring site, the RHCs and FQHCs cannot bill the encounter T1015 code if these are the only services being rendered.

Consulting Site

The RHCs and FQHCs would bill a T1015 encounter code when operating as the consulting site. Only one encounter code can be billed for a date of service. Both provider types will use the appropriate encounter code for the service along with the "GT" modifier (via interactive audio and video telecommunications system) indicating interactive communication was used.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Hospital Providers

Hospital providers are eligible to receive reimbursement for a facility fee for telemedicine when operating as the referring site. Claims must be submitted with revenue code 780 (Telemedicine). There is no separate reimbursement for telemedicine services when performed during an inpatient stay, outpatient clinic or emergency room visit, or outpatient surgery, as these are all-inclusive payments.

Documentation

Documentation in the medical records must be maintained at the referring and consulting locations to substantiate the service provided. A request for a telemedicine service from a referring provider and the medical necessity for the telemedicine service must be documented in the beneficiary's medical record. Documentation must indicate the services were rendered via telemedicine. All other Medicaid documentation guidelines apply to the services rendered via telemedicine. Examples include but are not limited to:

- The diagnosis and treatment plan resulting from the telemedicine service and progress note by the health care provider
- The location of the referring site and consulting site
- Documentation supporting the medical necessity of the telemedicine service
- Start and stop times

Unusual Travel

Procedure code 99082 is compensable only when a patient must be transported to a medical facility and is accompanied by a physician because there is no other recourse available based on the necessary medical skills and expertise required for the patient's condition. Documentation must be submitted with the claim. Coverage and reimbursement will be determined on a claim-by-claim basis.

Unlisted Services or Procedures

A service or procedure may be provided that is not listed in the CPT. When reporting such a service; the appropriate "unlisted" procedure code may be used to indicate the service, identifying it by special report.

Appropriate records to justify the use of the unlisted code, the complexity of the service, and the charge must accompany the unlisted procedures. The reimbursement will be directly related to the support documentation submitted with the claim. To ensure proper interpretation and payment, a complete description of the performed service is required.

Procedures that are considered an integral part of an examination should not be charged separately (*i.e.*, simple vision test, blood pressure check, ophthalmoscopy, otoscopy). Charges for these services in addition to an E/M visit will be denied.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Non-Covered Services

CPT procedure codes 99075, 99078, 99080, and 99090 indicating medical testimony, special reports for insurance, educational services for groups, and data analysis are non-compensable by Medicaid.

Preventive/Rehabilitative Services for Primary Care Enhancement (P/RSPCE)

Preventive/Rehabilitative Services for Primary Care Enhancement (P/RSPCE) are provided to support primary medical care in patients who exhibit risk factors that directly impact their medical status. These services are designed to help the physician maximize the patient's treatment benefits and outcomes by supplementing routine medical care.

These services can be provided by public health nurses, social workers, dieticians, health educators, home economists, and public health assistants who have special training and experience in working in the home or other community setting to assist the client in meeting mutually developed health care objectives.

Following are examples of P/RSPCE:

- Comprehensive assessments/evaluations of a client's medical, nutritional, or psychosocial needs by health professionals
- Home or community follow-up as requested by a Primary Care Physician (PCP) to monitor the medical plan of care, reinforce the treatment regime, counsel, provide anticipatory guidance, and support the client's medical needs. Nurses can apply the nursing process with the overall aim of optimizing the health outcomes of the client.
- Social work assessment, counseling, or anticipatory guidance relative to the medical plan of care
- Medical nutrition therapy for clients with chronic disease, growth problems, medically diagnosed anemias, elevated blood lead, or other nutritional disorders
- Coordination of medical services for clients with multiple providers and/or complex needs

Counseling interventions address the client's attitude, knowledge base, beliefs, behaviors, and values relative to the medical condition. Individual and group interventions are tailored to meet the patient's needs and include specific targeted actions that are more than simple didactic presentations of information. These actions are intended to be collaborations between the P/RSPCE, the PCP, and the patient.

Contact the PSC for more details on P/RSPCE services.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Missed Appointments

Medicaid beneficiaries cannot be charged for missed appointments. A missed appointment is not a distinct reimbursable Medicaid service, but a part of provider's overall costs of doing business. The Medicaid rate covers the cost of doing business, and providers may not impose separate charges on beneficiaries.

Home Services

Medical services rendered by a physician, or by a paraprofessional under physician supervision, are covered when the patient is non-ambulatory. All guidelines are the same as for office examinations. To report, use codes 99341-99350.

Home Health Services – Physician Requirements

Home health services are provided only by home health agencies that are certified by SCDHEC and have contracted with SCDHHS. Coverage is dependent upon a physician's orders and payable only to a contracted home health agency.

Plan of Care – Covered home health services must be ordered by the beneficiary's attending physician as part of a written plan of care, consistent with the functions the practitioner is legally authorized to perform. The plan of care should specify the treatment, services, items, or personnel needed by the patient and the expected outcome. The care must be appropriate to the home setting and to the patient's needs. For additional information, providers should contact the PSC at 1-888-289-0709 or submit an online inquiry http://www.scdhhs.gov/contact-us.

Community Long-Term Care Program

The Community Long-Term Care (CLTC) Program is designed to serve Medicaid-eligible aged and disabled adults who require long-term care. Careful assessment, service planning, and counseling allow each client to receive care in his or her own home, thus avoiding premature and costly nursing home admission.

For additional information, providers should contact the PSC or submit an online inquiry.

Nursing Home / Rest Home Facility Services

Services provided by a physician for a patient residing in a nursing home or long-term care facility must be medically necessary, requested by the patient or responsible party, or performed to meet the requirements of continued long-term care.

Services such as physical therapy, occupational therapy, recreational therapy, dietary consultation, social services, and nursing care are reimbursable only through the nursing home facility charges, according to the per diem rate.

If nursing home placement is not available, refer to *Administrative Days* under the heading "Inpatient and Outpatient Hospital Services" in this section.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Nursing Home/Rest Home Facility Services (Cont'd.)

The attending physician must submit signed and dated certification by the 60th day of the patient's stay at the skilled nursing facility (SNF) in order for the patient to remain certified.

Documentation Requirements

Progress notes are required in the patient's record for all visits, including those performed to meet the requirements of continued long-term care. The medical record must justify and reflect the level of service billed. Nursing home visits are subject to post-payment review under the same Medicaid guidelines as any other medical services.

Injections

Coverage Guidelines (General)

Injectable drugs are covered if the following criteria are met:

- They are of the type that cannot be self-administered. The usual method of administration and the form of the drug given to the patient are two factors in determining whether a drug should be considered self-administered. If a form of the drug given to the patient is usually self-injected (*e.g.*, insulin), the drug is excluded from coverage unless administered to the patient in an emergency situation (*e.g.*, diabetic coma).
- The medical record must substantiate medical necessity. When acceptable oral and parenteral preparations exist for necessary treatment, the oral preparation should be the route of administration. If parenteral administration is necessary, the record should document the reason for choosing this route.
- Use of a drug or biological must be safe and effective, and otherwise reasonable and necessary. Drugs or biologicals approved for marketing by the FDA are considered safe and effective for purposes of this requirement when used for indications specified on the labeling. Occasionally, FDA-approved drugs are used for indications other than those specified on the labeling. Provided the FDA has not specified such use as non-approved, coverage is determined considering the generally accepted medical practice in the community.
- Drugs and biologicals that have not received final marketing approval by the FDA are not covered unless CMS advises otherwise.
- The injection must be furnished and administered by a physician, or by auxiliary personnel employed by the physician and under his or her personal supervision.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Coverage Guidelines (General) (Cont'd.)

- When billing for a drug administered in the office, the physician must bill an injection code. A prescription cannot be filled by a pharmacist and then returned to a physician's office for administration.

Orphan Drugs

An orphan drug is a drug or biological product used for the treatment or prevention of a rare disease or condition. Prior approval is required for orphan drugs that are not listed on the injection code list (*i.e.,* Ceredase).

Unlisted Injections

Unlisted Injections (Cont'd.)

If an injection is not listed, procedure code J3490 and/or J9999 should be used. A description of the drug, the NDC number, and the dosage, along with the office record, flow record (if possible), and an invoice indicating the cost of the drug, must all be attached to the claim or Edit Correction Form (ECF) to be considered for payment. Claims/ECFs containing this code without the required documentation will be rejected. Additional documentation may be required if the unlisted injection is being submitted for reimbursement for the first time. When billing multiple unlisted injection codes on the same claim, the documentation needs to clearly identify the specific unlisted code that is to be considered for reimbursement. Procedure code 96372 is billed per injection for administration.

Botox® (JO585, Injection, Onabotulinumtoxina, 1 Unit), Dysport ™ (J0586, 5 Units), Myobloc ® (J0587, Injection Rimabotulinumtoxinb, 100 Units), and Xeomin (J0587, Injection, Incobotulinumtoxina, 1 Unit)

Botox® - JO585, Injection, Onabotulinumtoxina, 1 Unit

Botox® is FDA-approved for strabismus, blepharospasm, severe primary axillary hyperhidrosis, upper limb spasticity in adults, cervical dystonia in adults, and for the prophylaxis of headaches in adult patients with chronic headache and chronic migraine prophylaxis ($\geq$15 days per month with headache lasting 4 hours a day or longer). In addition, Botox® is (FDA)-approved to treat urinary incontinence due to detrusor overactivity associated with a neurologic condition [*e.g.,* spinal cord injury (SCI), multiple sclerosis (MS)] in adults who have an inadequate response to or are intolerant of an anticholinergic medication.

Dysport ™ - J0586, 5 Units

Dysport™ is FDA-approved for cervical dystonia in adults.

Myobloc ® - J0587, Injection, Rimabotulinumtoxinb, 100 Units

Myobloc® is FDA-approved for cervical dystonia in adults.

Xeomin - J0587, Injection, Incobotulinumtoxina, 1 Unit

Xeomin® is FDA-approved for cervical Systonia in adults and for blepharospasm in adults previously treated with onabotulinumtoxinA (Botox®).

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PROGRAM REQUIREMENTS

Botox® (JO585, Injection, Onabotulinumtoxina, 1 Unit), Dysport ™ (J0586, 5 Units), Myobloc ® (J0587, Injection Rimabotulinumtoxinb, 100 Units), and Xeomin (J0587, Injection, Incobotulinumtoxina, 1 Unit) (Cont'd.)

The botulinum toxin products listed on the left share certain properties and some FDA approvals. However, these agents are not identical. They have differing therapeutic and adverse even profiles. They also have differing units and not equivalent dosing. Botulinum toxin products are not directly interchangeable with one another. Failure to recognize the unique unitage and characteristics of each formulation of botulinum toxin can lead to undesired patient outcomes.

Effective with dates of service prior to July 31, 2012, SCDHHS requires support documentation to be submitted with claims filed for Botox®, Dysport™, Xeomin®, or Myobloc®. Medicaid will pay claims for Botox®, Dysport™, Xeomin® or Myobloc® only when administered for FDA-approved indications. Therefore, medical records submitted with the claim must:

1) Include the beneficiary's age
2) Clearly delineate the symptom or particular circumstance that necessitates the administration of Botox®, Dysport™, Xeomin®, or Myobloc®.

Claims will reject if information is omitted or if it cannot be determined that the product was given for an FDA-approved indication.

Effective with dates of service on or after August 1, 2012, all Botulinum Toxin must be preauthorized by KePRO except for those being performed on patients that are dually eligible for Medicare and Medicaid. (See the heading "Utilization Review Services" in this section for more information.) KePRO will pre-authorize all Botulinum Toxin – Type A for Botox® and Type B (Myobloc) when administered for FDA-approved indications.

Xolair® (Omalizumab)

Xolair® is FDA-approved for patients 12 years of age or older under some circumstances (see below for more detail). Physician CMS-1500 claims should be billed using code J2357 and must include the prior authorization number. Claims submitted without prior authorization number will be rejected. All prior authorizations should be faxed to (803) 255-8342, Attn. Prior Review Authorization with documentation to support the medical necessity. Responses to requests will be faxed back to the provider with an approval or denial and instructions for claims processing.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Xolair® (Omalizumab) (Cont'd.)

For recipients receiving a prescription to be filled in a pharmacy effective with date of service August 1, 2004, SCDHHS requires prior approval for Xolair® (Omalizumab), 150 mg powder/vial. Prior authorization requests should be telephoned or faxed, toll-free, to the Magellan Medicaid Administration Clinical Call Center by the prescriber or the prescriber's designated office personnel at the following contact numbers:

Magellan Medicaid Administration Clinical Call Center
Telephone: 866-247-1181
Fax: 888-603-7696

Authorizations will be based on the following criteria:

I. FDA-Labeled Indications:

Approved for treatment of patients 12 years of age or older with moderate persistent or severe persistent asthma for at least one year, who have had positive skin test or in vitro reactivity to a perennial aeroallergen and whose symptoms are inadequately controlled with inhaled corticosteroids.

II. Symptoms Not Adequately Controlled with the Following Three Treatments:

Patient must have tried or have a contraindication to inhaled corticosteroids.

Patient should have tried or have a contraindication to long acting Beta 2 agonists (Ref. NHLBI guidelines).

Patient should have tried or have a contraindication to a leukotriene receptor antagonist.

III. Length of Prior Authorization

6 months

Provider must verify clinical improvement at each subsequent renewal if approved.

IV. The Physician Requesting the Prior Approval Must Be One of the Following:

Allergist/Immunologist

Pulmonologist

V. Required Labs

History of positive skin test or RAST test to a perennial aeroallergen

Pretreatment serum lgE level should be 30 to 700 IU/ml

Weight and height

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

National Drug Code (NDC) Billing Requirements for Drug-Related HCPCS Codes

To comply with Centers for Medicare and Medicaid Services (CMS) requirements related to the Deficit Reduction Act (DRA) of 2005, Medicaid requires providers billing for physician-administered drugs in an office, a clinic, or other outpatient setting to report the National Drug Code (NDC) when using a drug-related Healthcare Common Procedure Coding System (HCPCS) code. The HCPCS code must include the correct NDC 5-4-2 format (11 digits total) to receive reimbursement from Medicaid. The NDC must be used on all claims submission (electronic, Web Tool, and CMS-1500).

Additionally, providers must implement a process to record and maintain the NDC(s) of the drug(s) administered to the beneficiary as well as the quantity of the drug(s) given.

Billing Unlisted/Not Otherwise Specified HCPCS Codes (J3490, J9999)

In addition to documentation detailing the drug that was administered and the medical necessity, providers must also include the product's 11-digit NDC. The claim will suspend for review. Please note that the drug-related procedure code is not payable if the 11-digit NDC is omitted.

NDC Not Found On The NDC To HCPCS Crosswalk

For a drug-related HCPCS code to be reimbursable by SCDHHS, the manufacturer of the drug must participate in the Federal Drug Rebate program. To determine whether the pharmaceutical manufacturer participates in the rebate program, please visit the following website for the NDC/HCPCS crosswalk at https://www.dmepdac.com/crosswalk/index.html. The first five digits of the NDC identify the manufacturer of the product. Prescribers should use the crosswalk and the criteria below to determine if the drug is reimbursable by SCDHHS:

- If the first five digits of the 11-digit NDC are listed on the crosswalk, the manufacturer participates in the rebate program and the claim should be submitted to Medicaid. The claim will suspend for review.
- If the first five digits of the 11-digit NDC are not on the crosswalk, the manufacturer does not participate in the rebate program. South Carolina Medicaid does not provide coverage of non-rebated drugs.

Refer to Section 3 of this manual for information and instructions for claims submission.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Physician-Administered Injectable Drug Reimbursement Methodology

Effective with dates of service on or after October 1, 2010, the South Carolina Department of Health and Human Services (SCDHHS) will change the reimbursement methodology for injectable drugs administered in an office, clinic, or outpatient hospital setting.

The new reimbursement schedule has a four-tier structure. The reimbursement for drugs within each tier is set as follows:

- Tier 1 contains certain generic and injectable drugs in classes with therapeutic alternatives and is priced at Maximum Allowable Cost (MAC)/Least Cost Alternative (LCA).
- Tier 2 contains newer agents and higher cost drugs and is priced at Average Sales Price (ASP) plus 6%.
- Tier 3 contains moderately priced agents and older drugs where there are often significant Average Wholesale Price (AWP)/ASP differences and is priced at ASP plus 10%.
- Tier 4 contains drugs where ASP pricing is not available and is priced at AWP minus 18%.

The SCDHHS will adjust the provider-administered injectable drug fee schedule quarterly so that reimbursement levels reflect changes in market prices for acquiring and administering drugs.

Billing Notes

A list of injection codes is provided in Section 4 of this manual. Injection codes include the cost of the drug only, not the administration.

The unit of measure for reimbursement for injectable drugs corresponds to the unit of measure noted in the code description. Indicate the same unit of measure in the days/units field (24G) on the claim form. For example, if the injection code lists one unit as 50 mg, be sure to indicate 50 mg as one unit. If 100 mg was administered, two units would be indicated on the claim.

Office E/M visits and additional office services are allowed as separate reimbursement from injection codes. If the administration of the drug is the only reason for the visit, then only a minimal established office E/M visit is allowed in addition to the administration code and the drug code. Code 96372 includes the syringe and administration of the drug. Minimal office visits include the observation time, if indicated.

On rare occasions, parenteral medications are provided by someone other than the physician (pharmaceutical company research, patient, etc.). In these cases, the physician may bill South Carolina Medicaid for a minimal office visit if this is the only reason for the visit and providing the service is normally covered.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Billing Notes (Cont'd.)

Note: Beneficiaries are not allowed to use their Medicaid card to obtain non-self-injectable drugs. The reason this practice is not allowed is to prevent a possible duplicate payment from being made by Medicaid (*i.e.*, payment for drug to both the pharmacy provider and to the physician).

Codes for intravenous solutions are also listed. Code 99070 should be used for reimbursement of the IV setup, needle, and/or intra-catheter. Code 99070 is compensable in addition to the office visit and the appropriate intravenous solution code.

Guidelines on allergen immunotherapy can be found under the heading "Allergen and Clinical Immunology;" and those for chemotherapy under the heading "Oncology and Hemotology" in this section. Immunization guidelines can be located under the heading "Preventive Care Services."

Synagis® (Palivizumab)
90378

Beginning with dates of service on or after October 1, 2005, if a 50 mg vial of Synagis® is administered to an infant up to 2 years old, revenue code 636 should be billed using procedure code 90378.

Due to the Health and Insurance Portability and Accountability Act of 1996 (HIPAA) requirements, SCDHHS was required to delete procedure code S9853 (100 mg vial of Synagis®) from the Medicaid Management Information System.

SCDHHS has established a 50 mg rate and a 100 mg rate. For multiples of 50 mg dosages (150 mg) or 3 units, SCDHHS will pay the 100 mg price plus the 50 mg price not to exceed 4 units. Procedure code 96372 (Therapeutic, Prophylactic, or Diagnostic Injections) may also be billed for the administration of the drug. Providers must use the dosage that is appropriate for each child according to his or her weight.

In order to ensure consistency, reimbursement for Synagis® is limited to physicians, hospitals, and infusion centers. To avoid possible duplicate reimbursement, SCDHHS will not reimburse pharmacy providers for Synagis®. Effective November 1, 2004, payment for Synagis® administration will be limited to six doses per Respiratory Synctial Virus (RSV) season given on or after October 1 and no later than March 31.

Prior approval is not required for up to six doses as long as they are given at least 30 days apart and meet the guidelines of the American Academy of Pediatrics (AAP) for Synagis® administration. Any dose over the limit of six or administered after the RSV season (October — March) will require prior approval. If prior approval is needed, please submit requests to:

South Carolina Department of Health and Human Services
Division of Hospital Services
Attn: Medical Review/Synagis® Program

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Synagis® (Palivizumab)
90378 (Cont'd.

Post Office Box 8206
Columbia, SC 29202-8206

SCDHHS will continue to utilize the American Academy of Pediatrics (AAP) 2012 guidelines for the administration of Synagis®. The AAP guidelines are available at http:// www.aap.org. Prior approval by the SCDHHS Medical Director will still be required for any request to administer Synagis® outside of the AAP guidelines.

However, providers should use discretion in the administration of Synagis® to those infants born between 32 and 35 weeks of gestation who do not have chronic lung disease (CLD). SCDHHS will not reimburse providers for Synagis® administration to children in this age group that do not have two or more risk factors listed in the AAP guidelines.

SCDHHS will conduct ongoing post-payment reviews of medical records relating to the administration of Synagis® and recover funds for doses given outside the AAP guidelines.

Medicaid's policy is to provide medically necessary treatment to Medicaid beneficiaries while maintaining consistent reimbursement to providers. Therefore, the drug should be drawn up with caution and used only in accordance with the AAP's guidelines, which are outlined below:

1. Palivizumab, or Respiratory Syncytial Virus Immune Globulin Intravenous (Human) (RSV-IGIV), prophylaxis should be considered for infants and children younger than 2 years of age with chronic lung disease (CLD) who have required medical therapy for their CLD within six months before the anticipated RSV season.

   Patients with more severe CLD may benefit from prophylaxis for two RSV seasons, especially those who require medical therapy. Decisions regarding individual patients may need additional consultation from neonatologists, intensivists, or pulmonologists.

   There are limited data on the efficacy of palivizumab during the second year of age; risk of severe RSV disease exists for children with CLD who require medical therapy. Although those with less severe underlying disease may receive some benefit for the second season, immuno-prophylaxis may not be necessary.

2. Infants born at 32 weeks of gestation or earlier without CLD, or who do not meet the criteria in recommendation 1, also may benefit from RSV prophylaxis. In these infants, major risk factors to consider are gestational age and chronological age at the start of the RSV season:

   - Infants born at 28 weeks of gestation or earlier may benefit from prophylaxis up to 12 months of age.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Synagis® (Palivizumab)
90378 (Cont'd.)

- Infants born at 29 to 32 weeks of gestation may benefit most from prophylaxis up to 6 months of age.

Decisions regarding duration of prophylaxis should be individualized according to the duration of the RSV season. Practitioners may wish to use RSV re-hospitalization data from their own region to assist in the decision-making process.

3. Given the large number of patients born between 32 to 35 weeks and the cost of the drug, the use of palivizumab in this population should be reserved for those infants with additional risk factors until more data are available.
4. Palivizumab and RSV-IGIV are not licensed by the FDA for patients with Congenital Heart Disease (CHD). Available data indicate that RSV-IGIV is contraindicated in patients with cyanotic CHD. However, patients with CLD, who are premature, or both, who meet the criteria in recommendations 1 and 2, and who have asymptomatic acyanotic CHD (*e.g.*, patent ductus arteriosus or ventricular septal defect) may benefit from prophylaxis.
5. Palivizumab or RSV-IGIV prophylaxis has not been evaluated in randomized trials in immunocompromised children. Although specific recommendations for immunocompromised patients cannot be made, children with severe immunodeficiencies (*e.g.*, severe combined immunodeficiency or severe acquired immunodeficiency syndrome) may benefit from prophylaxis.

   If these infants and children are receiving standard IGIV monthly, physicians may consider substituting RSV-IGIV during the RSV season.
6. RSV prophylaxis should be initiated at the onset of the RSV season and terminated at the end of the RSV season. In most areas of the United States, the usual time for the beginning of RSV outbreaks is October to December, and termination is March to May, but regional differences occur. The onset of RSV infections occurs earlier in southern states than in northern states. Practitioners should contact their health departments and/or diagnostic virology laboratories in their geographic areas to determine the optimal time to begin administration.
7. RSV is known to be transmitted in the hospital setting and to cause serious disease in high-risk infants. In high-risk hospitalized infants, the major means to prevent RSV disease is strict observance of infection control practices, including the use of rapid means to identify and cohort RSV-infected infants. If an RSV outbreak is documented in a high-risk unit (*e.g.*, pediatric

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Synagis® (Palivizumab) 90378 (Cont'd.)

intensive care unit), primary emphasis should be placed on proper infection control practices. The need for and efficacy of prophylaxis in these situations has not been evaluated.

8. The guidelines for modification of immunizations after RSV-IGIV have not changed. Palivizumab does not interfere with the response to vaccines.

Preventive Care Services

Preventive measures are defined as any routine service exam for adults or children when the procedures are performed in the absence of an illness or complaint(s). Generally, the South Carolina Medicaid program requires that a complaint or illness be recorded before a service is compensable. The exceptions to this policy are listed below.

Cancer Screening Services

The cancer screening services in the following table are covered. Refer to the current edition of the ICD-9 for the most appropriate diagnosis code. If a more appropriate code is not available, use diagnosis code V70.9.

Service	Procedure Code	Frequency Limitations	Comments
Mammography	77057	Baseline (ages 35-39*). 1 per year (ages 50 and over).	Must be referred by a physician.
Hemocult Test	One of the following: 82270, 82271 or 82272	1 per year age 50 and up for low-risk clients Age 40 and up for high-risk clients***	The hemocult code includes both the collection of the stool and interpretation of the test.
Sigmoidoscopy	G0104	1 per 5 years age 50 and up for low-risk clients. Age 40 and up for high-risk clients.	
Screening Colonoscopy	G0121 G0105	1 per 10 years age 50 and up for low-risk clients. Age 40 and up for high-risk clients.	

* The age limits on the cancer screening services are the recommended ages to begin screening services. If medically indicated, screening services are reimbursable to younger beneficiaries provided the medical documentation supports the screening service.

** Low-risk clients — no risk factors known.

*** High-risk clients — personal history of polyps, ulcerative colitis, or colorectal cancer; family history of breast or gynecological cancer.

South Carolina will sponsor reimbursement for mammography (77057) for dually eligible Medicare/Medicaid beneficiaries according to the frequency limitations listed. Claims rejected by Medicare for having exceeded their frequency limitations should be filed with Medicaid on a

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Cancer Screening Services (Cont'd.)

CMS-1500 claim form with no Medicare information provided.

All services must be physician-generated, and the physician must be currently enrolled in the Medicaid program.

Adult Physical Exams

Adult physical exams are covered under the following guidelines:

- The exams are allowed once every **two** years per patient.
- The patient must be 21 years of age or older.
- Procedure code 99385 – 99387 and 99395 – 99397 for the appropriate age and diagnosis code V70.9 should be used when billing.
  - 99385 – Preventive visit, new, age 18-39
  - 99386 – Preventive visit, new, age 40-64
  - 99387 – Preventive visit, new, age 65+
  - 99395 – Preventive visit, established, 18-39
  - 99396 – Preventive visit, established, 40-64
  - 99397 – Preventive visit, established, 65+

This exam may also be offered to patients with Medicare and Medicaid. The physical exam is expected to include the following:

- A past history for a new patient or an interval history on an established patient.
- A generalized physical overview of the following organ systems:
  - EENT
  - Lungs
  - Abdomen
  - Skin
  - Breasts (Female)
  - External Genitalia
  - Heart
  - Back
  - Pelvic (Female)*
  - Prostate (Male)
  - Rectal

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Adult Physical Exams (Cont'd.)

- Brief Neurological
- Brief Muscular
- Brief Skeletal
- Peripheral Vascular

- Family planning counseling must be offered if the patient is female within childbearing years or men. (An additional family planning code may be billed for this service when provided. Refer to the OB/GYN heading in this section for the description of codes.)
- The following lab procedures are included in the reimbursement for the physical:
  - Hemocult
  - Urinalysis
  - Blood Sugar
  - Hemoglobin

Any other lab procedures, x-rays, etc., may be billed separately. Portions of the physical may be omitted if not medically applicable to the patient's condition or if the patient is not cooperative and resists specific system examinations (despite encouragement by the physician and office staff). A note should be written in the record explaining why that part of the exam was omitted.

Immunizations

Children may receive immunizations through the EPSDT program during the health screening process.

The Vaccine for Children (VFC) program is a federally funded program created by the Omnibus Budget Reconciliation Act of 1993 that provides vaccines at no cost to children who might not otherwise be vaccinated because of inability to pay. Children who are eligible for VFC are entitled to receive pediatric vaccines that are recommended by the Advisory Committee on Immunization Practices. In South Carolina, the VFC program is managed by the South Carolina Department of Health and Environmental Control (SCDHEC). Please refer to your "Dear VFC Provider" letter from the SCDHEC, Immunization Division, for any questions concerning availability or program specifics, or contact SCDHEC by telephone at (800) 277-4687.

SCDHHS will reimburse providers for the administration of the vaccine products that are available free of charge for South Carolina Medicaid covered children under 19 years of age through the VFC program.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Immunization (Cont'd.)

Effective with dates of service on or after June 1, 2010, the SCDHHS will implement the following changes to the billing policy for the reimbursement of VFC vaccine administration. For accuracy and program compliance, providers will now be required to include information on all VFC supplied vaccine products administered. The appropriate vaccination product(s) **Current Procedural Terminology code (CPT), must be included on the claim when filing for reimbursement for the administration of these vaccines.**

For immunizations covered under the VFC program, Medicaid will reimburse for the administration using the codes listed below:

- **90460 –** Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component (one unit per date of service)
- **90461 –** Each additional vaccine component (two units per date of service)

PLEASE NOTE: CPT advises to bill the above codes based on the number of components. At this time, SCDHHS will continue to use these codes per administration of each vaccine/toxoid and not per component for the VFC program.

The administration of VFC vaccines is limited to a maximum of three units per date of service regardless of the number of additional vaccines administered.

The following table is a list of CPT codes that correspond to the different vaccines that are available under the VFC program. The administration code and the vaccine code for the administered vaccine must be listed on the claim to receive reimbursement for the vaccine administration. For this code combination, only the administration code will be reimbursable.

VFC VACCINE CPT CODES

90633	90655	90670	90702	90716	90744
90634	90656	90680	90707	90718	90748
90645	90657	90681	90710	90723	90740
90647	90658	90696	90713	90732	90743
90648	90660	90698	90714	90733	90747
90649	90650	90669	90700	90715	90734
Q2035	Q2036	Q2037	Q2038	Q2039	

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Immunization (Cont'd.)

When billing for vaccines that are not covered under the VFC program or for beneficiaries over the age of 19, the provider may bill for the vaccine and the administration code 96372.

Pneumonia Vaccine

The pneumonia vaccine (code 90732) for patients (two years of age and older) diagnosed in one of the following high-risk categories is allowed:

- Cardiovascular disease
- Pulmonary dysfunction
- Immune deficiencies
- Sickle cell anemia
- End stage renal disease
- Neonates
- Patients over age of 65
- Diabetes mellitus

Influenza Vaccine

The influenza vaccine is covered for Medicaid-eligible beneficiaries. Medicaid providers enrolled in the South Carolina Vaccine for Children (VFC) Immunization Partnership may obtain free vaccine for children who meet the guidelines of the VFC program. Under the VFC program, SCDHHS will reimburse codes 90460 and 90461 for the administration of the vaccine via any route of administration. The influenza vaccine, FluMIST®, will only be available through the VFC program for beneficiaries two years old through 18 years of age.

Adult Influenza Vaccine – Vaccines purchased by the provider for beneficiaries over 19 years of age 90656, 90658, Q2035, Q2036, Q2037, Q2038 or Q2039.is billed. The Administration code of 96372 may also be billed. SCDHHS will not reimburse for the FluMIST® vaccine product or the administration fee outside of the VFC program.

Monovalent Vaccine

Reimbursement for a second and separate immunization for monovalent vaccine for A-Taiwan virus is based on the cost of Fluogen (J3490) with an administrative fee.

Hepatitis Vaccine

The hepatitis vaccine is reimbursed when exposure and risk for a specific patient is documented and justified. For institutionalized patients, the vaccine is ordinarily included in the service provided by the institution and not billable as a separate service. End Stage Renal Disease (ESRD) patients under the supervision of a physician and undergoing in-center hemodialysis treatments or those on home dialysis are considered approved for hepatitis vaccine injections. The vaccine is not an exception

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Hepatitis Vaccine (Cont'd.)

for the dually eligible Medicare/Medicaid client; patients eligible for Medicare must use Medicare coverage before billing Medicaid for the coinsurance.

Meningococcal Vaccine

Medicaid covers the meningococcal vaccine and vaccine injection administration for beneficiaries over 19 years of age.

- **90733** – Meningococcal polysaccharide vaccine (any groups(s)), for subcutaneous use.
- **90734** – Meningococcal conjugates vaccine, serogroups A, C, Y, and W-135 (tetravalent), for intramuscular use.

When billing for the adult meningococcal vaccine the provider may also bill the vaccine administration code, 96372.

Rabies Vaccine and Immune Globulin

Effective with dates of service on or after September 1, 2009, SCDHEC will discontinue providing rabies vaccine and immune globulin to medical practices in South Carolina. To accommodate medical practices needing rabies vaccine for Medicaid-eligible beneficiaries, SCDHHS will begin coverage of the rabies vaccine **for post exposure prophylaxis**. The coverage will be provided either as a medical or a pharmacy benefit.

As a medical benefit, physicians would purchase the vaccine and immune globulin then bill Medicaid for the vaccine, the immune globulin and related office services, using appropriate codes. Established billing codes for the rabies vaccine CPT codes 90675 and 90676 and rabies immune globulin are 90375 and 90376.

Should a medical practice prefer to obtain the vaccine and immune globulin for a specific Medicaid beneficiary from a pharmacy, the prescriber would transmit a prescription to the pharmacy. The pharmacy would fill the prescription, bill Medicaid for the vaccine and immune globulin using the appropriate national drug code (NDC), then provide the vaccine and immune globulin to the patient or the medical practice for administration. The physician would administer the vaccine and bill only for the administration and related services, not for the vaccine and immune globulin itself.

Respiratory Syncytial Virus Immune Globulin (Synagis®)

Medicaid recognizes the CPT code 90378 for the billing of Synagis® administration. This code reflects a 50 mg dose. Providers may bill up to four units of this code depending upon the amount of Synagis® administered. Prior approval is not required when Synagis® is administered within the recommendation published by the American Academy of Pediatrics (AAP). Providers should use discretion in the administration of Synagis® to those infants born between 32 and 35 weeks of gestation who do not have chronic lung disease (CLD), but do

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Respiratory Syncytial Virus Immune Globulin (Synagis®) (Cont'd.)

have other risk factors. SCDHHS will conduct reviews of medical records relating to the administration of Synagis® and will edit for children greater than two years of age and any child being given more than seven injections in the RSV season.

The AAP guidelines are available at http://www.aap.org. Prior approval by the SCDHHS Medical Director will still be required for any request to administer Synagis® outside of the AAP guidelines.

If you have any questions concerning the administration of Synagis®, please contact the PSC at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact -us.

Diabetes Patient Education

Diabetes Management services are medically necessary, comprehensive self-management and counseling services provided by programs enrolled by SCDHHS. Enrolled programs must adhere to the National Standards for Diabetes Self-Management Education and be recognized by the American Diabetes Association, American Association of Diabetes Educators, Indian Health Services, or be managed by a Certified Diabetes Educator. An eligible beneficiary must have a diabetes diagnosis and be referred by their primary care physician.

For details on this service, refer to the Diabetes Management Services Provider Manual. Contact the PSC for a list of recognized programs in your area or information on how to become a provider of diabetes education.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

PEDIATRICS AND NEONATOLOGY

Pediatrics

All procedures, with the following exceptions, must be submitted under the child's own Medicaid number regardless of the child's age.

Routine Newborn Circumcision

Routine newborn circumcisions are non-covered services.

Routine Newborn Care Exam

Procedure code 99460 should be used to report routine newborn care. This procedure is an all-inclusive code for any visits made during the first day of the newborn's birth.

Routine Newborn Follow-up Care

Follow-up nursery visits made to a healthy newborn on subsequent days are reimbursable by billing procedure code 99462. Only one follow-up nursery visit is reimbursed per day regardless of the number of visits made to the nursery.

Newborn Discharged Early

Code 99463 should be used only to report the history and examination of a normal newborn who is assessed and discharged from the hospital on the day of delivery.

Physicians following a newborn who is discharged before a routine follow-up exam (procedure code 99462) can be performed may bill procedure code 99461 for the office follow-up exam. This procedure code has a frequency limit of one every 10 months.

Healthy Mothers/Healthy Futures Newborn Health Initiatives

If a physician performs the services listed below in addition to the newborn care exam, Medicaid will provide enhanced reimbursement using code 97802.

- Mother and infant referral to the WIC program at the county health department (for supplemental food and nutritional counseling)
- Referral to the county health department to set up an infant home visit
- Referral to the county DSS for infant eligibility and an appointment for the first EPSDT well-baby examination

Newborn Care Billing Notes

The following procedures may also be billed under the newborn’s mother’s Medicaid number:

99460 – Routine newborn care exam in hospital or birthing center

99461 – Normal newborn care not in hospital or birthing room setting

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PROGRAM REQUIREMENTS

Newborn Care Billing Notes (Cont'd.)

99462 – Follow-up care in nursery for a healthy newborn

99463 – History and examination

99465 – Newborn resuscitation

97802 – Mother/newborn WIC referral

99360 – Standby for newborn care, limited to two units (*e.g.*, C-section/high risk delivery)

Note: Any other pediatric charges not noted in the above exceptions must be billed under the Child's Medicaid number.

Newborn Care for the Sick Newborn

A sick child is defined as a newborn not considered a well-baby, but not sick enough to be considered a neonate or critically ill. Procedure code 99460 should be used to report the newborn care exam for a sick newborn. If the newborn becomes critically ill, refer to the "Neonatology" heading in this manual section for coding instructions.

Follow-up Care for the Sick Newborn

Follow-up visits made to a sick newborn may be billed using the appropriate level subsequent hospital care code (99231-99233) or critical care code (99291-99292) depending on the severity of illness.

Sick Newborn Care Billing Notes

Sick child care **may not** be billed under the newborn's mother's Medicaid number. Sick child care must be billed under the newborn's Medicaid number.

High Risk Channeling Project (HRCP) Neonatal Risk Screening

Refer to *Best Practice Guidelines for Perinatal Care (Replaces High Risk Channeling Project)* under the heading "Obstetrics and Gynecology" in this manual section.

Postpartum Infant Home Visit

The postpartum infant home visit is designed to assess the environmental, social, and medical needs of the infant and mother. All Medicaid-sponsored postpartum mothers and newborns are eligible for this visit, within six weeks of delivery. Providers must be enrolled as a Postpartum Infant Home visit provider to perform this service. The Division of Care Management should be contacted for enrollment at (803) 898-4614. For further details on this service refer to the Enhanced Services Provider Manual.

Sudden Infant Death Syndrome (SIDS)

Sudden Infant Death Syndrome is defined as the unexpected and sudden death of an apparently normal and healthy infant that occurs during sleep and with no physical or autopsy evidence of disease. Procedure codes 99251-99255 should be used to bill for infants being tested for SIDS. They are allowed once and are all-inclusive.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Sick Child Care

Physicians are reimbursed for all services provided to Medicaid-eligible children as long as the services are medically necessary and a diagnostic reason for the service is documented in the physician's records. Children (age birth through the end of the month of 21st birthday) are eligible for unlimited office visits as long as the previously mentioned criteria are met.

Well-child Care and Immunizations

Well-child care (other than routine newborn care in the hospital) and immunizations are only covered through EPSDT. For more information, refer to the “EPSDT” heading below.

Initial Comprehensive Assessments

An Initial Comprehensive Assessment is reimbursed by procedure code 99420. This assessment is required for children entering foster care. The DSS foster care worker arranges for this overall assessment of health and emotional status within five working days of the child’s entry into foster care. The medical provider rendering the service completes DSS Form 3057, Comprehensive Medical Assessment, or a comparable form. The DSS worker obtains this form for the child’s case record.

This assessment is also reimbursable to providers performing medical evaluations of suspected victims of child sexual abuse. This evaluation is done to reassure child victims, parents, or guardians; to prevent or detect medical conditions for treatment; and to collect and provide verbal and physical evidence for protection of the child and prosecution of the abuse.

This evaluation must include, but is not limited to, a medical and family history and a complete physical examination.

Neonatology

Hospital Care for Sick Newborns

Hospital care for newborns who do not meet the criteria for Neonatal Intensive Care (NIC) codes should be billed using hospital care codes or critical care codes, if appropriate.

When the neonate no longer requires the intensity or level of care described in the NIC codes and remains under the care of the same group or physician, subsequent hospital care or critical care codes, if appropriate, may be used. When a neonate is transferred from one hospital to another hospital and remains under the same group or same physician's care, the appropriate level critical care or subsequent hospital care codes may be billed. NIC codes may not be billed if the neonate does not meet the severity of illness or intensity of treatment as defined in the CPT manual.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Newborns Stabilized for Transport

If a physician treats a critically ill newborn in a hospital and stabilizes the newborn for transport to a higher-level hospital, critical care codes 99291 and 99292 would be appropriate for those services. Code 36600 (arterial puncture, withdrawal of blood for diagnosis) may not be billed in addition to the critical care. However, codes 36620 (arterial catheterization or cannulation for sampling, monitoring or transfusion; percutaneous) and 36660 (catheterization, umbilical artery, newborn, for diagnosis or therapy) are allowed in addition to critical care.

Neonatal Intensive Care Codes

Neonatology codes 99468, 99469, 99471, and 99472 are used to report services provided by a physician directing the inpatient care of a critically ill neonate/infant. Use of these codes **must** reflect the severity of the neonate's illness, the intensity of treatment, and the level of care as defined in the CPT.

Critical care codes may be used in place of NIC codes when direct physician care is given for an extended period of time exclusively to one neonate. Time must be clearly documented for critical care services.

Additionally, 99360 (physician standby service) and 99465 (newborn resuscitation) are to be used when the physician is standing by for the Caesarean section and newborn resuscitation is required.

Once the neonate is no longer considered to be critically ill, the codes for subsequent hospital care (99469) and, when appropriate, subsequent normal newborn hospital care should be used. Initial and subsequent neonatal care includes monitoring and treatment of the patient including nutritional, metabolic, and hematologic maintenance; parent counseling; and personal direct supervision of the health care team in the performance of cognitive and procedural activities.

99471 (Initial Pediatric Critical Care, Per-Day) – This code reflects initial evaluation and management of a critically ill infant or young child, 29 days up through 24 months of age. This code is allowed only once per day and includes 24 hours of care provided by the attending physician.

If a physician treats a critically ill infant/young child in a hospital and stabilizes the infant/young child for transport to a higher-level hospital, critical care codes 99291 and 99292 would be appropriate for those services. Code 36600 (arterial puncture, withdrawal of blood for diagnosis) may not be billed in addition to the critical care. However, codes 36620 (arterial catheterization or cannulation for sampling, monitoring or transfusion; percutaneous), and 36660 (catheterization, umbilical artery, newborn, for diagnosis or therapy) are allowed in addition to critical care.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Neonatal Intensive Care Codes (Cont'd.)

The initial NIC code is also allowed for an infant/young child who has been treated for more than one day in one facility and is then transported to another facility for specialized treatment under another group or physician's care. The admitting physician at each facility may report the admission using this code. If the infant/young child is transferred back to the original facility, the appropriate subsequent level of care must be billed since this is considered a continuation of the same hospitalization.

If the neonate is released home and subsequently readmitted to the hospital, NIC codes cannot be billed. You must bill hospital care codes (99221-99239) or critical care codes (99291-99292).

99472 (Subsequent Pediatric Critical Care, Per Day) – This code reflects subsequent evaluation and management of a critically ill infant or young child, 29 days up through 24 months of age. This code is allowed only once per day and includes 24 hours of care provided by the attending physician.

99468 (Initial NIC Care, Once Per Physician or Group) – This code reflects the admission of a critically ill neonate when the intensity of care meets the definition set forth in the CPT. This code is allowed only one time and includes 24 hours of care provided by the attending physician.

99469 (Subsequent NIC Care, Per Day) – This code reflects subsequent evaluation and management of a critically ill neonate, 28 days of age or less. This code is allowed only once per day and includes 24 hours of care provided by the attending physician.

99478 (Subsequent NIC Care, Per Day) – This code reflects subsequent evaluation and management of the recovering very low birth weight infant (present body weight less than 1500 grams). This code is allowed only once per day and includes 24 hours of care provided by the attending physician.

99479 (Subsequent NIC Care, Per Day) – This code reflects subsequent evaluation and management of the recovering low birth weight infant (present body weight 1500-2500 grams). This code is allowed only once per day and includes 24 hours of care provided by the attending physician.

Additional Services

The following services may be billed in addition to the NIC codes. Documentation that the billing physician rendered the services or directly supervised the rendering of the services must be recorded in the medical record. The following list is not a complete list of additional services allowed, but the most frequently billed services only:

31720 – Tracheal Lavage*

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Additional Services (Cont'd.)

99251 – 99255 – SIDS Evaluation

33960 – Prolonged Extracorporeal Circulation for Cardiopulmonary Insufficiency (ECMO)

33961 – ECMO, each additional 24 hours

36400 – Venipuncture, under age 3 years, femoral, jugular, or sagittal sinus*

36405 – Scalp Vein*

36406 – Other Vein*

36440 – Push Transfusion, blood, 2 years or under*

36450 – Exchange Transfusion, blood; newborn

36625 – Cutdown Arterial Catheterization*

36640 – Arterial catheterization for prolonged infusion therapy,(chemotherapy), cutdown

36660 – Catheterization, umbilical artery, newborn, for diagnosis or therapy*

36822 – Insertion of cannula(s) for ECMO

51000 – Aspiration of bladder by needle*

99360 – Physician Standby Service, requiring prolonged physician attendance, each 30 minutes (limited to two units)**

99465 – Newborn Resuscitation

** These codes are included in the description of the NIC codes in the CPT, however, Medicaid policy has made an exception and these codes may be billed in addition to the NIC codes.*

*** This code is used only for prolonged physician attendance prior to delivery.*

Primary or assistant surgeon charges may be billed in addition to the neonatal or critical care codes.

Extracorporeal Membrane Oxygenation Support (ECMO)

ECMO services are reimbursed by the following CPT codes:

36822 – Insertion of cannula(s) for prolonged extracorporeal circulation for cardiopulmonary insufficiency

33960 – Prolonged extracorporeal circulation for cardiopulmonary insufficiency initial 24 hours

33961 – Prolonged extracorporeal circulation for cardiopulmonary insufficiency, each additional 24 hours

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Extracorporeal Membrane Oxygenation Support (ECMO) (Cont'd.)

Procedure code 33960 will be paid for the initial 24 hours and 33961 will be paid for each additional 24 hours up to four days. However, starting with day five, progress notes should be sent attached to the claim for appropriate reimbursement.

The initial and subsequent NIC care codes (99468, 99469, 99471, 99472, 99478, and 99479) may be billed in addition to the ECMO codes.

All other specific CPT surgical procedures that are not included in the 24 hour neonatal codes should be billed separately.

Step Down Neonatal Services

When a neonate is transferred from a Level III hospital to a Level II hospital and remains under the same group or same physician's care, the appropriate level of subsequent, critical care or hospital care codes should be billed depending on the service(s) provided. This coding is also applicable for neonates transferred from the NIC in a hospital to a lower level nursery or unit in the same hospital while remaining under the care of the same group or physician.

Back Transfer of Neonatal Intensive Care Infants

Care must be transferred to another group or another physician's care in order to establish a permanent medical home for these high-risk infants. This coding is also applicable for neonates transferred from the NIC in a level III hospital to a lower level nursery or unit in the same hospital when their care is transferred to another group or physician.

T1028 – NICU discharge home visit

The following six codes can be billed as appropriate, depending on level of care:

99471 – Initial pediatric critical care, per day

99472 – Subsequent pediatric critical care, per day

99468 – Initial NIC care, once per physician or group

99469 – Subsequent NIC care, per day

99478 – Subsequent NIC care, per day, recovering very low birth weight (body weight less than 1500 grams)

99479 – Subsequent NIC care, per day, recovering low birth weight (body weight 1500-2500 grams)

Pre-Discharge Home Visit

The pre-discharge home visit is designed to assess the condition of the home of an infant who is, or has been a patient, in a neonatal intensive care unit (NICU), or who has had a significant medical problem. The goal is to ensure a safe environment, conducive to maintaining the health status of the infant, after discharge from the hospital.

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PROGRAM REQUIREMENTS

Pre-Discharge Home Visit (Cont'd.)

The visit must be made in response to a referral by a physician directly involved in the care of the infant while hospitalized (unless the infant is a member of an MCO). This also applies to infants who have been transported from the Level III hospital back to their county of residence.

Forensic Medical Evaluations

Effective February 1, 2009 SCDHHS will reimburse Forensic Medical Evaluation services for beneficiaries up to age 21. The purpose of the forensic evaluation is to:

- Determine if a child has been abused, and to identify possible perpetrators
- Gather forensically sound facts necessary to assist law enforcement officials and protect the child
- Allow the child to disclose information in a non-threatening environment and assess the extent and nature of the alleged abuse
- Evaluate the child's social and behavioral functioning in order to make treatment recommendations, and to establish a foundation for effective treatment if needed

This service will be covered when billed in association with a South Carolina Office of Victims Assistance (SOVA) service that meets the threshold of state law Section 16-3-1350 that governs criminal sexual conduct or child sexual abuse. Coverage will also include those events that meet the reporting requirements of the South Carolina Department of Social Services (DSS) Child Protective Services state law Section 63-7-310 identifying and reporting child abuse and neglect. An event is defined as each original occurrence that meets the forensic evaluations requirements of SOVA and DSS.

All forensic evaluations must be medically necessary. Use the following Healthcare Common Procedure Coding System (HCPCS) codes to bill for these services:

New Code	SCDHHS Definition
G9008	Prolonged evaluation and management service before and/or after direct (face-to-face) patient care *(e.g.*, review of extensive records and test, communication with other professionals and/or the patient/family); first 30 minutes (list additional minutes separately) for other physician service(s) and/or inpatient or outpatient evaluation and management service. **Note**: **Code G9008 is used to report the <u>accumulated</u> duration of the time spent by a health care professional providing prolonged care, even if the time spent spans over more than one date of service. (The last date of service should be billed.)**

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New Code	SCDHHS Definition
G9009	Each additional 15 minutes (list separately); must be used in conjunction with G9008
G9007	Medical team conference with interdisciplinary team of healthcare professionals, face-to-face *with* patient and/or family; 15 minutes or more participation by non-physician qualified healthcare professional. **Note: A non-physician qualified health care professional includes, but is not limited to, nurse practitioners and physician assistants.**
G9010	Medical team conference with interdisciplinary team of healthcare professionals, *without* patient and/or family; 15 minutes or more participation by physician
G9011	Participation by non-physician qualified healthcare professional; 15 minutes or more

Forensic Medical Evaluations (Cont'd.)

All forensic evaluations must be medically necessary. The appropriate modifiers must be attached to each procedure code billed. All professionals must meet one of the following credential qualifications in order to render forensic services:

Provider	Modifier
Physician	AF
Nurse Practitioner	TD
Physician Assistant	AF
Registered Nurse or P-Sane (Pediatric Sexual Assault Nurse Examiner)	AF

Only Physicians and Nurse Practitioners may bill SCDHHS directly, using their NPI, for services rendered. Registered Nurses (P-SANE) and Physician Assistants must bill using the supervising Physicians NPI number in order to be reimbursed by SCDHHS. Modifiers will indicate which medical professional rendered services. All provider information must be maintained in the patient's records.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The South Carolina Medicaid Program, in accordance with federal requirements, must develop and maintain a program of Early and Periodic Diagnosis, Screening, and Treatment (EPSDT) for Medicaid-eligible children. EPSDT is the preventive, well-child screening program in South Carolina. EPSDT provides comprehensive and preventive health services to Medicaid-eligible children from birth to age 21 through periodic medical screenings. The screening package includes the following:

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PROGRAM REQUIREMENTS

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) (Cont'd.)

- A comprehensive health and developmental history, including assessment of both physical and mental health development
- A comprehensive unclothed physical examination
- Identify the appropriate immunizations according to age and health history (does not include the administration)
- Health education, including anticipatory guidance
- Vision and hearing screening
- Dental screening

Immunization administration, topical fluoride varnish, laboratory tests, blood level assessments, age limited screenings, and elective tests are covered separately utilizing the appropriate CPT code and billed according to the periodicity schedule under "Reimbursement Policies" in this section. Each of these will also be outlined in this section.

Transportation

SCDHHS county offices will continue to be available to schedule transportation services and assist in referrals to other professionals.

EPSDT Standards

- To provide **Early** health assessments of the child who is Medicaid eligible so that potential diseases can be prevented
- To **Periodically** assess the child's health for normal growth and development
- To **Screen** the child through simple tests and procedures for conditions needing closer medical attention
- To **Diagnose** the nature and cause of conditions requiring attention, by synthesizing findings of the health history and physical examination
- To **Treat** abnormalities detected in their preliminary stages or make the appropriate referral whenever necessary

Enrollment Prerequisites

Professional practitioners and other providers must be licensed and/or certified by the appropriate standard setting agency to provide services covered by South Carolina Medicaid.

Registered nurses working in county health department offices must meet the standards for performing EPSDT screenings established by SCDHEC.

Registered nurses who perform screenings in schools must have successfully completed the SCDHHS-approved Child Health Maintenance course. A physician should be available for consultation, if necessary.

Registered nurses in physicians' offices or clinics who assist in the performance of EPSDT screenings should do so under the direct supervision of

SECTION 2 POLICIES AND PROCEDURES

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Enrollment Prerequisites (Cont'd.)

a physician/nurse practitioner who assumes responsibility for quality of care. They are encouraged to successfully complete the SCDHEC course.

In accordance with federal regulations (42 CFR 493.1809), SCDHHS requires that in order to perform laboratory tests, all laboratory testing sites must meet the Clinical Laboratory Improvement Amendments (CLIA) certification standards administered by CMS.

Required Services

Infants, children, and youth will receive, at a minimum, the following services, which constitute evaluations of their physical and mental health; their growth and development; and their nutritional and immunization status. The administration of appropriate immunizations at the time of screening is also required.

These evaluations are provided through the following generally accepted practices or standards:

Comprehensive Health and Developmental History – A comprehensive history includes the birth history, the family history, and medical history. A complete history is initiated during the first screening. An updated or interval history is obtained at each subsequent screening.

In addition to the history, the child's height and weight are obtained to assess growth and development. Head circumference is obtained until age two or three. All three measurements are plotted on a graphic recording sheet to compare them with the norm for the child's age group.

Assessment of nutritional status is obtained at each screening to include eating habits and general diet history.

Assessment of immunization status is obtained to determine the need for immunization at the time of screening.

Developmental Assessment – For children under six years of age, a complete developmental assessment should be performed and documented in the patient record at the following screening intervals:

5	through	7 months
12	through	14 months
21	through	24 months
3, 4	and	5 years of age

A standardized developmental test is recommended for children under six years of age. However, if a standardized test is not used, documentation should include the recording of observations for specific age-appropriate skills/tasks in

Required Services

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PROGRAM REQUIREMENTS

(Cont'd.)

each functional area (fine motor, gross motor, communication, self-help, social/emotional, and cognitive). For example, a 5-month-old infant should readily demonstrate the social/emotional skill of a social smile. The 24-month-old toddler should demonstrate the gross motor skill to throw a ball overhand, etc.

The developmental assessment of children six through 21 years of age should include a review of the emotional, psychosocial, and educational development/progress.

The assessment of the adolescent should be designed to identify problems or needs unique to this age group. The history for this age group should include inquiries as to high-risk behaviors.

Note: It is important in evaluating a child's overall development and well-being that every consideration be given to helping that child achieve his or her maximum potential. Therefore, all health related problems that are identified should include referral – when indicated – to the proper entity for evaluation and treatment. Referrals may include such services as evaluations to determine the need for assistive technology (defined as devices or services which are used to increase, maintain, or improve the functional capacities of individuals with disabilities) if it is determined that these services are medically necessary and that the child may benefit from them. These services must be medical in nature and not for educational purposes.

Comprehensive Unclothed Physical Examination – A complete evaluation is required of all body systems.

Identify Appropriate Immunizations According to Age and Health History – An assessment of the child's immunization status should be made at each screening and immunizations administered as appropriate.

Dental Assessment – A general assessment of the dental condition (teeth and/or gums) is obtained on all children.

Vision Screening – Vision should be assessed at each screening. In infants, the history and subjective findings of the ability to regard and reach for objects, the ability to demonstrate an appropriate social smile, and to have age appropriate interaction with the examiner is sufficient. At ages four and above, objective measurement using the age-appropriate Snellen Chart, Goodlite Test, or Titmus Test should be done and recorded. If needed, a referral should be made to an ophthalmologist or optometrist.

Visual Evoked Potential (VEP) testing is not reimbursable as a routine screening tool to meet the requirements of a vision screening during an EPSDT exam. If during an EPSDT exam, the physician documents a medical need for additional vision services (*i.e.*, an abnormality is suspected), the physician is expected to make the appropriate referral for a more formal vision assessment.

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(Cont'd.)

VEP is considered medically necessary for any of the following indications:

- To diagnose and monitor multiple sclerosis (acute or chronic phases)
- To localize the cause of a visual field defect not explained by lesions seen on Computerized Tomography (CT) or Magnetic Resonance Imaging (MRI), metabolic disorders, or infectious diseases
- To evaluate signs and symptoms of visual loss in persons who are unable to communicate (*e.g.,* unresponsive person).

Note: VEP should not be used in lieu of recognized methods to conduct routine screening of infants and young children for vision and related disorders.

Hearing Screening – A hearing test is required appropriate to the child's age and educational level. For the child under age four, hearing is determined by whatever method is normally used by the provider, including, but not limited to, a hearing kit. For the child over age four, an audiometer, if available, is recommended. If needed, an appropriate referral should be made to a specialist. It is recommended that high-risk neonates be evaluated with objective measures, such as brain stem evoked response testing, prior to discharge from the hospital nursery.

Developmental Screening – EPSDT providers are allowed to bill for an objective developmental screening in addition to an EPSDT screening at the 9 month, 18 month, 24 month and 48 month well-child visit. EPSDT providers also have the option of providing the developmental screening anytime that surveillance (medical history of developmental risk factors, parental/caregiver concern) identifies a need. Providers are encouraged to use standardized screening tools that have a moderate to high sensitivity, specificity and validity level and is culturally sensitive. The following code, which is limited to five (5) units per date of service (five different screening tools used), may be used to bill for this screening:

96110 – Developmental testing; limited (*e.g.,* Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report. In order to bill this code, providers must use a standardized screening tool. Examples of screening tools allowed for this code include, but are not limited to:

- Ages and Stages Questionnaire (ASQ)
- Ages and Stages Questionnaire/Social Emotional (ASQ-SE)
- Denver DST/Denver II
- Battelle Developmental Screener
- Bayley Infant Neurodevelopmental Screener (BINS)
- Parents Evaluation of Development (PEDS)
- Early Language Accomplishment Profile (ELAP)

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(Cont'd.)

- Brigance Screens II
- Modified Checklist for Autism in Toddlers (M-CHAT)
- Vanderbilt Rating Scales
- Behavior Assessment Scale for Children-Second Edition (BASC-II)

Anemia Screening – A hemocrit or hemoglobin test should be performed between six and nine months of age and at least once during adolescence for menstruating females.

Blood Pressure – Blood pressure should be measured on children ages three and over at each screening.

Health Education – Providers are required to provide age-appropriate health education (including anticipatory guidance) at each screening.

Lead Screening – Screening for lead poisoning is a required component of an EPSDT screen. Current CMS policy requires a screening blood lead test for all Medicaid- eligible children at 9- and 24-months of age. In addition, children over the age of 24-months, up to six years of age, should receive a screening blood lead test if there is no record of a previous test. Any additional diagnostic and treatment services determined to be medically necessary must also be provided to a child diagnosed with an elevated blood lead level. An assessment of the individual and family history of lead exposure/symptoms, environment, and personal risk factors should be obtained and documented.

- History of the child with prior report of elevated blood lead, low iron, or use of home remedies that contain lead
- Report of family member with elevated blood level
- Living in or frequently visiting housing built prior to 1950, proximity to lead related (lead smelters, battery recycling, auto salvage) manufacturing facilities, storage areas, or disposal sites
- A parent or adult in the household with work or a hobby that involves exposure to lead
- Use of pottery/ceramics for food preparation, storage, or consumption
- Prolonged visiting or living outside the continental United States
- Eating paint chips, soil, or dirt
- Painted mini-blinds from countries other than the United States of America and older mini-blinds with unknown place of origin. When purchasing new mini-blinds, make sure the box states "No Lead or lead acetate used in the making of this product."

In order to reduce children's exposure to lead, anticipatory guidance at each well-child visit should be targeted towards cautioning parents/caregivers about

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(Cont'd.)

the hazards of lead-based paint, improper renovation of older homes, and other local lead sources, such as battery factories, junk yards, etc.

EPSDT requirements for blood lead testing:

- The screening blood lead sample should be obtained via heel stick for those children who are less than one year old or by finger stick for children who are at least one year old. The initial blood sample should not be drawn by venipuncture.
- The screening blood test is required as part of the EPSDT service. The finger or heel stick collection of the blood lead sample is covered by the EPSDT rate; therefore, no additional reimbursement is available. However, the lab analysis is covered as a separate service.
- A lab result of $\geq$ 10 μg/dL on a sample obtained by finger or heel stick must be confirmed with a venous sample. The venipuncture can be billed using CPT code 36415. **An elevated blood lead result can occur due to a contaminated sample. In order to prevent unnecessary venipuncture, it is vitally important to thoroughly clean the collection site.** For information on blood collection for blood lead, visit the South Carolina Department of Health and Environmental Control's Web site at http://www.scdhec.gov/health/lab/. This URL will take you directly to the Bureau of Laboratories main page. Click on "Services Guide." Guidelines for Blood Collection for Blood Lead Testing are located on page 11 of Section II, "Ordering Supplies and Specimen Collection."
- In most cases, a laboratory will have to analyze the blood sample. It cannot be done in a physician's office without special equipment. Private labs or SCDHEC's Bureau of Laboratories (State Lab) can perform the analysis.

  Private labs generally provide courier service. The State Lab, located in Columbia, SC, will pick up samples from County Health Department offices, so samples can be taken to the Health Department in order for a courier to transport them to Columbia. Please contact your County Health Department to make arrangements for utilizing their courier service.
- Reimbursement for the lab analysis is not part of the EPSDT service rate. If your office sends the blood lead samples to an outside laboratory for analysis, the laboratory should bill Medicaid directly for the blood lead analysis using CPT code 83655. If your office is using the ESA LeadCare Blood Lead Testing System to analyze the blood lead samples internally, then your office should bill Medicaid directly using CPT code 83655.

Required Services

- The EPSDT service requires that a child be tested twice – at 12 months

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(Cont'd.)

and again at 24 months of age. However, the provider administering the EPSDT service does not have to perform a screening blood test, if **ALL** of the following conditions have been met:

- A blood test has already been performed by the WIC program.
- The test was administered within three months of the EPSDT-defined parameters of 12 and 24 months (*i.e.*, between 9 and 15 months or between 21 and 27 months).
- The actual/exact results of the WIC blood test are known and documented in the child's medical record.

The child must still receive two screening tests, venipuncture to confirm elevated results and any necessary follow-up services based on the confirmed blood lead level. Please note that children under the age of six (72 months) who have not been tested must also receive a screening blood lead test.

Note: The WIC program is not federally mandated to provide screening blood lead testing. Beginning in July 2003, SCDHEC began phasing out the blood lead testing that was being performed by WIC clinic staff. As of January 2004, blood lead testing is no longer being performed at any of the WIC clinics in the state.

If a blood lead result of >10 μg/dL has been confirmed by venipuncture, you may contact the lead nurse at the County Health Department and he or she can explain the additional steps to take if you wish to continue following the child.

The Health Department can also assume the follow-up role at this point if you prefer.

Note: The South Carolina Code of Laws, Section 44-53-1380 mandates that any physician, hospital, public health nurse, or other diagnosing person or agency must report known or suspected cases of lead poisoning to the SCDHEC within seven days. If you would like more information about the South Carolina Childhood Lead Poisoning Prevention Program, please call (866) 466-5323.

Urinalysis – A urinalysis should be performed on all children at least once between ages 4 and 6. A urinalysis should be performed for leukocytes for sexually active male and female adolescents.

Elective Tests/Procedures:

- Sickle Cell Test - A screening test is administered when indicated by family or medical history or in the presence of anemia, usually to the child under age 10.

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(Cont'd.)

- Tuberculin Skin Test – Mantoux test (with five tuberculin units [TU] of purified protein derivative [PPD] administered intradermally) should be considered for all children at increased risk of exposure to individuals with tuberculosis. Providers may want to check with local, state, or regional tuberculosis control officials (public health department) for more specific information relating to the epidemiology of tuberculosis in their area.
- Parasites Test – A test for parasites is administered when indicated by medical history, physical assessment, or a positive result of previous test.
- Effective August 1, 2007, SCDHHS will cover the application of topical fluoride varnish for children up to three years old in a primary care physician's office during EPSDT well-child visits. The best practices of the American Academy of Pediatrics recommend that children up to three years old who are at high risk for dental caries should receive fluoride varnish application in their primary care physician's office during their EPSDT well-child visit two times per year (once every six months) and in their dental home two times per year (once every six months).

  In coordination with application of fluoride varnish, primary care physician offices must provide anticipatory guidance on oral health to parents or caregivers to promote oral health to children and families.

  Anticipatory guidance topics include oral development, tooth eruption, gum and tooth cleaning, the appropriate use of fluoride, bottle use, and feeding and eating practices.

  The American Dental Association has established a new Current Dental Terminology (CDT) procedure code, D1206, for the application of topical fluoride varnish. The primary care physician can bill this procedure on the CMS-1500 claim form.

  Prior to billing Medicaid for these services, staff members in the primary care physician's office that will be using the CAT and applying fluoride varnish must complete a training module, available online, outlining the use of the CAT and illustrating the correct process of applying fluoride varnish. Each staff member must complete a post test to be retained in the office files for documentation purposes.

  Training modules are available at the two Web sites listed below:

  - The National Maternal and Child Oral Health Resource Center: http://www.mchoralhealth.org/OpenWide
  - American Academy of Pediatrics: http://www.aap.org/commpeds/dochs/oralhealth/screening.

Required Services (Cont'd.)

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Note: Documentation in the patient's medical record must reflect both required and elective services.

Screening Frequency

Periodic Screenings – EPSDT beneficiaries are eligible to receive 29 screenings in 21 years of life. Screening ranges are determined according to the age of the child and, in some circumstances, when last screened. The total number of periodic screenings allowed is determined by the child's age at the time Medicaid eligibility begins. The following is a general guide for the ranges in which screenings should occur (refer also to the Screening Age Guidelines chart at the end of the "Pediatrics and Neonatology" Heading):

- Neonatal exam (identified from hospital claim and not billable as an EPSDT screening)
- Birth to 1 month
- 1 month through 2 months
- 3 months through 4 months
- 5 months through 7 months
- 8 months through 11 months
- 12 months through 14 months
- 15 months through 17 months
- 18 months through 20 months
- 21 months through 24 months (when the child passes age 2, another screening is not due until age 3)
- 3 years of age through month of 21st birthday (19 screenings are allowed one year apart)

Screening Frequency (Cont'd.)

Interperiodic Screenings – A child may receive an "interperiodic" screening outside the normal screening schedule if a suspected problem or condition exists. The provider must indicate the diagnosis code of the problem to justify the medical necessity for performing an interperiodic screening. The interperiodic screening must include all the required screening components appropriate to the child's age. Individual screening components or follow-up treatment cannot be billed as an interperiodic screening. Reimbursement for an interperiodic screening is the same as a periodic screening.

Note: Sports physicals are non-covered.

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Immunizations

The administration of immunizations is a required component of EPSDT screening services. An assessment of the child's immunization status should be made at each screening and immunizations administered as appropriate. If the child is due for an immunization, it should be administered at the time of the screening. However, if illness precludes immunization, the reason for delay should be documented in the child's record. An appointment should be given to return for administration of the immunization at a later date.

If a provider does not routinely administer immunizations as part of his or her practice, then the child should be referred to the county health department for that service. The provider should still maintain a record of the child's immunization status.

Medicaid providers may obtain free vaccines from the SCDHEC through the Vaccine for Children (VFC) program for children under the age of 19. Vaccines are delivered free of charge to the provider. SCDHEC will not distribute vaccines to providers not enrolled in. Funding will determine the availability of vaccines through the program. To make application for the program, contact:

Division of Immunization and Prevention
SC Department of Health and Environmental Control
Mills/Jarrett Complex
Post Office Box 101106
Columbia, SC 29211
(803) 898-0460 or
(800) 27-SHOTS (outside of the Columbia area)

Billing

Filing Claims on the CMS-1500 Claim Form – Providers can bill EPSDT services and immunizations on the CMS-1500 using the CPT codes. Providers who are set up for electronic billing may bill using the electronic billing system when using these CPT codes. Providers using the CMS-1500 will bill under the Medicaid provider numbers they currently use for billing on the CMS-1500 (*i.e.*, physicians will bill under their group or individual provider numbers, clinics will use their clinic numbers, rural health centers (RHCs) and federally qualified health centers (FQHCs) will use their RHC/FQHC provider numbers, etc.).

Providers using the CMS-1500 will be responsible for handling their own EPSDT scheduling for patients in their practice.

Reimbursement Policies

EPSDT screening will be reimbursed at a uniform rate. Although screening services vary according to age and schedule, the reimbursement is intended to be an equitable average fee. Any other test or treatment service performed should be billed separately. The following guidelines should be used when billing:

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* Screening components cannot be fragmented and billed separately. The screening provider cannot bill an office visit on the same day a screening is billed.
* South Carolina Medicaid policy does not allow providers to bill an EPSDT well-child screening on the same day as a sick visit.
* Use diagnosis code V20.2 when no medical problems are identified.
* If individual components of a screening are not performed, the reason must be appropriately documented. Reimbursement for the screening fee may be subject to recoupment if each age-appropriate component is not performed and documented.
* Medicaid providers enrolled with SCDHEC in the VAFAC program may bill an immunization administration fee.

The codes to be used when billing for screenings and immunizations are as follows:

99381 – Preventive visit, new, infant

99382 – Preventive visit, new, age 1 – 4

99383 – Preventive visit, new, age 5 – 11

99384 – Preventive visit, new, age 12 – 17

99385 – Preventive visit, new, age 18 – 39*

99391 – Preventive visit, established, infant

99392 – Preventive visit, established, age 1 – 4

99393 – Preventive visit, established, age 5 – 11

Reimbursement Policies (Cont'd.)

99394 – Preventive visit, established, age 12 – 17

99395 – Preventive visit, established, age 18 – 39*

** Only ages 18 – 21 are covered for this code under the EPSDT program.*

The administration CPT codes 90460-90461 are covered for the administration of vaccines provided through the VFC program for beneficiaries under the age of 19. For the administration of vaccines by injection, the following CPT codes must be used:

90460 – Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular, and jet injections); one vaccine (single or combination vaccine/toxoid). **This code will only cover the first vaccine administered.**

90461 – Each additional vaccine (single or combination vaccine/toxoid.) (List separately in addition to code for primary procedure.)

Note: Use code 90461 in conjunction with code 90460. This code can only be

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billed twice per visit, regardless of how many additional vaccines are administered at the time of the visit. Both CPT codes 90460 and 90461 are reimbursed at a flat rate of $12.61 each. The maximum reimbursement is $37.83 per day.

For the administration of the FluMIST® or PRV, by intranasal or oral, the following CPT codes must be used:

90460 – Immunization administrations by intranasal or oral, one vaccine. This code will only cover the first vaccine administered per visit. The administration fee for this CPT code is $12.61.

90461 – Each additional intranasal or oral vaccine (single or combination vaccine/toxoid), The administration fee for this CPT code is $12.61.

The following indicators must be used in field 24H of the CMS-1500 when billing a screening:

Indicator 1 – Well-child care with treatment of an identified problem treated by the physician

Indicator 2 – Well-child care with a referral made for an identified problem to another provider

Indicator N – No problems found during visit

Resources

To obtain a copy of the AAP Guidelines for Health Supervision please contact:

American Academy of Pediatrics
141 North West Point Boulevard
Post Office Box 927
Elk Grove Village, IL 60009-0927
(800) 433-9016

To order the Denver II test forms, screening manual, test kit, and training videotape, contact:

Denver Developmental Materials, Inc.
Post Office Box 371075
Denver, CO 80237-5075
(303) 355-4729

To obtain a hearing kit, contact:

BAM Work Market, Inc.
Post Office Box 10701

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University Park Station
Denver, CO 80210

To obtain a new or reconditioned audiometer, contact:

Health and Hygiene/ELB
605 Eastowne Drive
Chapel Hill, NC 27514

To order growth charts, contact:

Ross Laboratories
Division of Abbott Labs
Columbia, OH 43216
(614) 624-7677

or

Mead Johnson and Company
Nutritional Division
Evansville, IN 47721
(812) 429-5000
(800) 227-5767

To order a well-child record system, contact:

Milcom
A Division of Hollister, Inc.
2000 Hollister Drive
Libertyville, IL 60048
(800) 243-5546

Resources (Cont'd.)

To order Anticipatory Guidance/TIPP educational materials, contact:

Materials Library/Educational Resources
Department of Health and Environmental Control
Columbia, SC 29201
(803) 898-3804

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Recommended Immunization Schedule for Persons Aged 0 Through 6 Years—United States • 2010

For those who fall behind or start late, see the catch-up schedule

Vaccine ▼ Age ▶	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19–23 months	2–3 years	4–6 years
Hepatitis B[1]	HepB	HepB			HepB						
Rotavirus[2]			RV	RV	RV[2]						
Diphtheria, Tetanus, Pertussis[3]			DTaP	DTaP	DTaP	see footnote[3]	DTaP				DTaP
Haemophilus influenzae type b[4]			Hib	Hib	Hib[4]	Hib					
Pneumococcal[5]			PCV	PCV	PCV	PCV				PPSV	
Inactivated Poliovirus[6]			IPV	IPV	IPV						IPV
Influenza[7]					Influenza (Yearly)						
Measles, Mumps, Rubella[8]						MMR	see footnote[8]				MMR
Varicella[9]						Varicella	see footnote[9]				Varicella
Hepatitis A[10]						HepA (2 doses)				HepA Series	
Meningococcal[11]										MCV	

Range of recommended ages for all children except certain high-risk groups

Range of recommended ages for certain high-risk groups

This schedule includes recommendations in effect as of December 15, 2009. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Considerations should include provider assessment, patient preference, and the potential for adverse events. Providers should consult the relevant Advisory Committee on Immunization Practices statement for detailed recommendations: **http://www.cdc.gov/vaccines/pubs/acip-list.htm**. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS) at **http://www.vaers.hhs.gov** or by telephone, **800-822-7967.**

1. **Hepatitis B vaccine (HepB).** (Minimum age: birth)
   At birth:
   - Administer monovalent HepB to all newborns before hospital discharge.
   - If mother is hepatitis B surface antigen (HBsAg)-positive, administer HepB and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth.
   - If mother's HBsAg status is unknown, administer HepB within 12 hours of birth. Determine mother's HBsAg status as soon as possible and, if HBsAg-positive, administer HBIG (no later than age 1 week).

   After the birth dose:
   - The HepB series should be completed with either monovalent HepB or a combination vaccine containing HepB. The second dose should be administered at age 1 or 2 months. Monovalent HepB vaccine should be used for doses administered before age 6 weeks. The final dose should be administered no earlier than age 24 weeks.
   - Infants born to HBsAg-positive mothers should be tested for HBsAg and antibody to HBsAg 1 to 2 months after completion of at least 3 doses of the HepB series, at age 9 through 18 months (generally at the next well-child visit).
   - Administration of 4 doses of HepB to infants is permissible when a combination vaccine containing HepB is administered after the birth dose. The fourth dose should be administered no earlier than age 24 weeks.
2. **Rotavirus vaccine (RV).** (Minimum age: 6 weeks)
   - Administer the first dose at age 6 through 14 weeks (maximum age: 14 weeks 6 days). Vaccination should not be initiated for infants aged 15 weeks 0 days or older.
   - The maximum age for the final dose in the series is 8 months 0 days
   - If Rotarix is administered at ages 2 and 4 months, a dose at 6 months is not indicated.
3. **Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP).** (Minimum age: 6 weeks)
   - The fourth dose may be administered as early as age 12 months, provided at least 6 months have elapsed since the third dose.
   - Administer the final dose in the series at age 4 through 6 years.
4. ***Haemophilus influenzae* type b conjugate vaccine (Hib).** (Minimum age: 6 weeks)
   - If PRP-OMP (PedvaxHIB or Comvax [HepB-Hib]) is administered at ages 2 and 4 months, a dose at age 6 months is not indicated.
   - TriHiBit (DTaP/Hib) and Hiberix (PRP-T) should not be used for doses at ages 2, 4, or 6 months for the primary series but can be used as the final dose in children aged 12 months through 4 years.
5. **Pneumococcal vaccine.** (Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPSV])
   - PCV is recommended for all children aged younger than 5 years. Administer 1 dose of PCV to all healthy children aged 24 through 59 months who are not completely vaccinated for their age.
   - Administer PPSV 2 or more months after last dose of PCV to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant. See *MMWR* 1997;46(No. RR-8).
6. **Inactivated poliovirus vaccine (IPV)** (Minimum age: 6 weeks)
   - The final dose in the series should be administered on or after the fourth birthday and at least 6 months following the previous dose.
   - If 4 doses are administered prior to age 4 years a fifth dose should be administered at age 4 through 6 years. See *MMWR* 2009;58(30):829–30.
7. **Influenza vaccine (seasonal).** (Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 2 years for live, attenuated influenza vaccine [LAIV])
   - Administer annually to children aged 6 months through 18 years.
   - For healthy children aged 2 through 6 years (i.e., those who do not have underlying medical conditions that predispose them to influenza complications), either LAIV or TIV may be used, except LAIV should not be given to children aged 2 through 4 years who have had wheezing in the past 12 months.
   - Children receiving TIV should receive 0.25 mL if aged 6 through 35 months or 0.5 mL if aged 3 years or older.
   - Administer 2 doses (separated by at least 4 weeks) to children aged younger than 9 years who are receiving influenza vaccine for the first time or who were vaccinated for the first time during the previous influenza season but only received 1 dose.
   - For recommendations for use of influenza A (H1N1) 2009 monovalent vaccine see *MMWR* 2009;58(No. RR-10).
8. **Measles, mumps, and rubella vaccine (MMR).** (Minimum age: 12 months)
   - Administer the second dose routinely at age 4 through 6 years. However, the second dose may be administered before age 4, provided at least 28 days have elapsed since the first dose.
9. **Varicella vaccine.** (Minimum age: 12 months)
   - Administer the second dose routinely at age 4 through 6 years. However, the second dose may be administered before age 4, provided at least 3 months have elapsed since the first dose.
   - For children aged 12 months through 12 years the minimum interval between doses is 3 months. However, if the second dose was administered at least 28 days after the first dose, it can be accepted as valid.
10. **Hepatitis A vaccine (HepA).** (Minimum age: 12 months)
    - Administer to all children aged 1 year (i.e., aged 12 through 23 months). Administer 2 doses at least 6 months apart.
    - Children not fully vaccinated by age 2 years can be vaccinated at subsequent visits
    - HepA also is recommended for older children who live in areas where vaccination programs target older children, who are at increased risk for infection, or for whom immunity against hepatitis A is desired.
11. **Meningococcal vaccine.** (Minimum age: 2 years for meningococcal conjugate vaccine [MCV4] and for meningococcal polysaccharide vaccine [MPSV4])
    - Administer MCV4 to children aged 2 through 10 years with persistent complement component deficiency, anatomic or functional asplenia, and certain other conditions placing tham at high risk.
    - Administer MCV4 to children previously vaccinated with MCV4 or MPSV4 after 3 years if first dose administered at age 2 through 6 years. See *MMWR* 2009;58:1042–3.

The Recommended Immunization Schedules for Persons Aged 0 through 18 Years are approved by the Advisory Committee on Immunization Practices (**http://www.cdc.gov/vaccines/recs/acip**), the American Academy of Pediatrics (**http://www.aap.org**), and the American Academy of Family Physicians (**http://www.aafp.org**).

Department of Health and Human Services • Centers for Disease Control and Prevention

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Recommended Immunization Schedule for Persons Aged 7 Through 18 Years—United States • 2010

For those who fall behind or start late, see the schedule below and the catch-up schedule

Vaccine ▼ Age ►	7–10 years	11–12 years	13–18 years
Tetanus, Diphtheria, Pertussis[1]		Tdap	Tdap
Human Papillomavirus[2]	*see footnote 2*	HPV (3 doses)	HPV series
Meningococcal[3]	MCV	MCV	MCV
Influenza[4]	Influenza (Yearly)		
Pneumococcal[5]	PPSV		
Hepatitis A[6]	HepA Series		
Hepatitis B[7]	Hep B Series		
Inactivated Poliovirus[8]	IPV Series		
Measles, Mumps, Rubella[9]	MMR Series		
Varicella[10]	Varicella Series		

Range of recommended ages for all children except certain high-risk groups

Range of recommended ages for catch-up immunization

Range of recommended ages for certain high-risk groups

This schedule includes recommendations in effect as of December 15, 2009. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Considerations should include provider assessment, patient preference, and the potential for adverse events. Providers should consult the relevant Advisory Committee on Immunization Practices statement for detailed recommendations: **http://www.cdc.gov/vaccines/pubs/acip-list.htm**. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS) at **http://www.vaers.hhs.gov** or by telephone, **800-822-7967.**

1. **Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap).** (Minimum age: 10 years for Boostrix and 11 years for Adacel)
   - Administer at age 11 or 12 years for those who have completed the recommended childhood DTP/DTaP vaccination series and have not received a tetanus and diphtheria toxoid (Td) booster dose.
   - Persons aged 13 through 18 years who have not received Tdap should receive a dose.
   - A 5-year interval from the last Td dose is encouraged when Tdap is used as a booster dose; however, a shorter interval may be used if pertussis immunity is needed.
2. **Human papillomavirus vaccine (HPV).** (Minimum age: 9 years)
   - Two HPV vaccines are licensed: a quadrivalent vaccine (HPV4) for the prevention of cervical, vaginal and vulvar cancers (in females) and genital warts (in females and males), and a bivalent vaccine (HPV2) for the prevention of cervical cancers in females.
   - HPV vaccines are most effective for both males and females when given before exposure to HPV through sexual contact.
   - HPV4 or HPV2 is recommended for the prevention of cervical precancers and cancers in females.
   - HPV4 is recommended for the prevention of cervical, vaginal and vulvar precancers and cancers and genital warts in females.
   - Administer the first dose to females at age 11 or 12 years.
   - Administer the second dose 1 to 2 months after the first dose and the third dose 6 months after the first dose (at least 24 weeks after the first dose).
   - Administer the series to females at age 13 through 18 years if not previously vaccinated.
   - HPV4 may be administered in a 3-dose series to males aged 9 through 18 years to reduce their likelihood of acquiring genital warts.
3. **Meningococcal conjugate vaccine (MCV4).**
   - Administer at age 11 or 12 years, or at age 13 through 18 years if not previously vaccinated.
   - Administer to previously unvaccinated college freshmen living in a dormitory.
   - Administer MCV4 to children aged 2 through 10 years with persistent complement component deficiency, anatomic or functional asplenia, or certain other conditions placing them at high risk.
   - Administer to children previously vaccinated with MCV4 or MPSV4 who remain at increased risk after 3 years (if first dose administered at age 2 through 6 years) or after 5 years (if first dose administered at age 7 years or older). Persons whose only risk factor is living in on-campus housing are not recommended to receive an additional dose. See *MMWR* 2009;58:1042–3.
4. **Influenza vaccine (seasonal).**
   - Administer annually to children aged 6 months through 18 years.
   - For healthy nonpregnant persons aged 7 through 18 years (i.e., those who do not have underlying medical conditions that predispose them to influenza complications), either LAIV or TIV may be used.
   - Administer 2 doses (separated by at least 4 weeks) to children aged younger than 9 years who are receiving influenza vaccine for the first time or who were vaccinated for the first time during the previous influenza season but only received 1 dose.
   - For recommendations for use of influenza A (H1N1) 2009 monovalent vaccine. See *MMWR* 2009;58(No. RR-10).
5. **Pneumococcal polysaccharide vaccine (PPSV).**
   - Administer to children with certain underlying medical conditions, including a cochlear implant. A single revaccination should be administered after 5 years to children with functional or anatomic asplenia or an immunocompromising condition. See *MMWR* 1997;46(No. RR-8).
6. **Hepatitis A vaccine (HepA).**
   - Administer 2 doses at least 6 months apart.
   - HepA is recommended for children aged older than 23 months who live in areas where vaccination programs target older children, who are at increased risk for infection, or for whom immunity against hepatitis A is desired.
7. **Hepatitis B vaccine (HepB).**
   - Administer the 3-dose series to those not previously vaccinated.
   - A 2-dose series (separated by at least 4 months) of adult formulation Recombivax HB is licensed for children aged 11 through 15 years.
8. **Inactivated poliovirus vaccine (IPV).**
   - The final dose in the series should be administered on or after the fourth birthday and at least 6 months following the previous dose.
   - If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.
9. **Measles, mumps, and rubella vaccine (MMR).**
   - If not previously vaccinated, administer 2 doses or the second dose for those who have received only 1 dose, with at least 28 days between doses.
10. **Varicella vaccine.**
    - For persons aged 7 through 18 years without evidence of immunity (see *MMWR* 2007;56[No. RR-4]), administer 2 doses if not previously vaccinated or the second dose if only 1 dose has been administered.
    - For persons aged 7 through 12 years, the minimum interval between doses is 3 months. However, if the second dose was administered at least 28 days after the first dose, it can be accepted as valid.
    - For persons aged 13 years and older, the minimum interval between doses is 28 days.

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The Recommended Immunization Schedules for Persons Aged 0 through 18 Years are approved by the Advisory Committee on Immunization Practices (**http://www.cdc.gov/vaccines/recs/acip**), the American Academy of Pediatrics (**http://www.aap.org**), and the American Academy of Family Physicians (**http://www.aafp.org**).

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Catch-up Immunization Schedule for Persons Aged 4 Months Through 18 Years Who Start Late or Who Are More Than 1 Month Behind—United States • 2010

The table below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age.

Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
PERSONS AGED 4 MONTHS THROUGH 6 YEARS					
Hepatitis B[1]	Birth	**4 weeks**	**8 weeks** (and at least 16 weeks after first dose)		
Rotavirus[2]	6 wks	**4 weeks**	**4 weeks**[2]		
Diphtheria, Tetanus, Pertussis[3]	6 wks	**4 weeks**	**4 weeks**	**6 months**	**6 months**[3]
Haemophilus influenzae type b[4]	6 wks	**4 weeks** if first dose administered at younger than age 12 months; **8 weeks (as final dose)** if first dose administered at age 12–14 months; **No further doses needed** if first dose administered at age 15 months or older	**4 weeks**[4] if current age is younger than 12 months; **8 weeks (as final dose)**[4] if current age is 12 months or older and first dose administered at younger than age 12 months and second dose administered at younger than 15 months; **No further doses needed** if previous dose administered at age 15 months or older	**8 weeks (as final dose)** This dose only necessary for children aged 12 months through 59 months who received 3 doses before age 12 months	
Pneumococcal[5]	6 wks	**4 weeks** if first dose administered at younger than age 12 months; **8 weeks (as final dose for healthy children)** if first dose administered at age 12 months or older or current age 24 through 59 months; **No further doses needed** for healthy children if first dose administered at age 24 months or older	**4 weeks** if current age is younger than 12 months; **8 weeks (as final dose for healthy children)** if current age is 12 months or older; **No further doses needed** for healthy children if previous dose administered at age 24 months or older	**8 weeks (as final dose)** This dose only necessary for children aged 12 months through 59 months who received 3 doses before age 12 months or for high-risk children who received 3 doses at any age	
Inactivated Poliovirus[6]	6 wks	**4 weeks**	**4 weeks**	**6 months**	
Measles, Mumps, Rubella[7]	12 mos	**4 weeks**			
Varicella[8]	12 mos	**3 months**			
Hepatitis A[9]	12 mos	**6 months**			
PERSONS AGED 7 THROUGH 18 YEARS					
Tetanus, Diphtheria/ Tetanus, Diphtheria, Pertussis[10]	7 yrs[10]	**4 weeks**	**4 weeks** if first dose administered at younger than age 12 months; **6 months** if first dose administered at 12 months or older	**6 months** if first dose administered at younger than age 12 months	
Human Papillomavirus[11]	9 yrs	**Routine dosing intervals are recommended**[11]			
Hepatitis A[9]	12 mos	**6 months**			
Hepatitis B[1]	Birth	**4 weeks**	**8 weeks** (and at least 16 weeks after first dose)		
Inactivated Poliovirus[6]	6 wks	**4 weeks**	**4 weeks**	**6 months**	
Measles, Mumps, Rubella[7]	12 mos	**4 weeks**			
Varicella[8]	12 mos	**3 months** if person is younger than age 13 years; **4 weeks** if person is aged 13 years or older			

1. **Hepatitis B vaccine (HepB).**
   - Administer the 3-dose series to those not previously vaccinated.
   - A 2-dose series (separated by at least 4 months) of adult formulation Recombivax HB is licensed for children aged 11 through 15 years.
2. **Rotavirus vaccine (RV).**
   - The maximum age for the first dose is 14 weeks 6 days. Vaccination should not be initiated for infants aged 15 weeks 0 days or older.
   - The maximum age for the final dose in the series is 8 months 0 days.
   - If Rotarix was administered for the first and second doses, a third dose is not indicated.
3. **Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP).**
   - The fifth dose is not necessary if the fourth dose was administered at age 4 years or older.
4. ***Haemophilus influenzae* type b conjugate vaccine (Hib).**
   - Hib vaccine is not generally recommended for persons aged 5 years or older. No efficacy data are available on which to base a recommendation concerning use of Hib vaccine for older children and adults. However, studies suggest good immunogenicity in persons who have sickle cell disease, leukemia, or HIV infection, or who have had a splenectomy; administering 1 dose of Hib vaccine to these persons who have not previously received Hib vaccine is not contraindicated.
   - If the first 2 doses were PRP-OMP (PedvaxHIB or Comvax), and administered at age 11 months or younger, the third (and final) dose should be administered at age 12 through 15 months and at least 8 weeks after the second dose.
   - If the first dose was administered at age 7 through 11 months, administer the second dose at least 4 weeks later and a final dose at age 12 through 15 months.
5. **Pneumococcal vaccine.**
   - Administer 1 dose of pneumococcal conjugate vaccine (PCV) to all healthy children aged 24 through 59 months who have not received at least 1 dose of PCV on or after age 12 months.
   - For children aged 24 through 59 months with underlying medical conditions, administer 1 dose of PCV if 3 doses were received previously or administer 2 doses of PCV at least 8 weeks apart if fewer than 3 doses were received previously.
   - Administer pneumococcal polysaccharide vaccine (PPSV) to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant, at least 8 weeks after the last dose of PCV. See *MMWR* 1997;46(No. RR-8).
6. **Inactivated poliovirus vaccine (IPV).**
   - The final dose in the series should be administered on or after the fourth birthday and at least 6 months following the previous dose.
   - A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months following the previous dose.
   - In the first 6 months of life, minimum age and minimum intervals are only recommended if the person is at risk for imminent exposure to circulating poliovirus (i.e., travel to a polio-endemic region or during an outbreak).
7. **Measles, mumps, and rubella vaccine (MMR).**
   - Administer the second dose routinely at age 4 through 6 years. However, the second dose may be administered before age 4, provided at least 28 days have elapsed since the first dose.
   - If not previously vaccinated, administer 2 doses with at least 28 days between doses.
8. **Varicella vaccine.**
   - Administer the second dose routinely at age 4 through 6 years. However, the second dose may be administered before age 4, provided at least 3 months have elapsed since the first dose.
   - For persons aged 12 months through 12 years, the minimum interval between doses is 3 months. However, if the second dose was administered at least 28 days after the first dose, it can be accepted as valid.
   - For persons aged 13 years and older, the minimum interval between doses is 28 days.
9. **Hepatitis A vaccine (HepA).**
   - HepA is recommended for children aged older than 23 months who live in areas where vaccination programs target older children, who are at increased risk for infection, or for whom immunity against hepatitis A is desired.
10. **Tetanus and diphtheria toxoids vaccine (Td) and tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap).**
    - Doses of DTaP are counted as part of the Td/Tdap series
    - Tdap should be substituted for a single dose of Td in the catch-up series or as a booster for children aged 10 through 18 years; use Td for other doses.
11. **Human papillomavirus vaccine (HPV).**
    - Administer the series to females at age 13 through 18 years if not previously vaccinated.
    - Use recommended routine dosing intervals for series catch-up (i.e., the second and third doses should be administered at 1 to 2 and 6 months after the first dose). The minimum interval between the first and second doses is 4 weeks. The minimum interval between the second and third doses is 12 weeks, and the third dose should be administered at least 24 weeks after the first dose.

Information about reporting reactions after immunization is available online at **http://www.vaers.hhs.gov** or by telephone, **800-822-7967**. Suspected cases of vaccine-preventable diseases should be reported to the state or local health department. Additional information, including precautions and contraindications for immunization, is available from the National Center for Immunization and Respiratory Diseases at **http://www.cdc.gov/vaccines** or telephone, **800-CDC-INFO** (800-232-4636).

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PROGRAM REQUIREMENTS

Age	Newborn	1M	2M	4M	6M	9M	12M	15M	18M	24M	3Y	4Y	5Y	6Y	7Y	8Y	9Y	10Y	11Y	12Y	13Y	14Y	15Y	16Y	17Y	18Y	19Y	20Y	21Y
EPSDT Visit	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
History	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Measurements																													
Length/Height and Weight	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Head Circumference	X	X	X	X	X	X	X	X	X	X																			
Weight for Length	X	X	X	X	X	X	X	X	X	X																			
Body Mass Index										X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Blood Pressure	X*	X*	X*	X*	X*	X*	X*	X*	X*	X*		X	X	X		X		X		X		X		X		X		X	
Sensory Screening																													
Vision	X*	X*	X*	X*	X*	X*	X*	X*	X*	X*	X	X	X	X	X*	X	X*	X	X*	X*	X*	X*	X*	X*	X*	X*	X*	X*	X*
Hearing	X	X*	X*	X*	X*	X*	X*	X*	X*	X*	X*	X	X	X	X*	X	X*	X	X*	X*	X*	X*	X*	X*	X*	X*	X*	X*	X*
Developmental/Behavioral Assessment																													
Developmental Screening						X			X																				
Autism Screening									X	X																			
Developmental Surveillance	X	X	X	X	X		X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Psychosocial/Behavioral Assessment	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Alcohol and Drug Use Assessment																			X*	X*	X*	X*	X*	X*	X*	X*	X*	X*	X*
Physical Examination	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Procedures																													
Newborn Metabolic/Hemoglobin Screening	X	X	X																										
Immunization	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Hematocrit or Hemoglobin				X*			X		X*	X*	X*	X*	X*	X*	X*	X*	X*	X*	X*	X*	X*	X*	X*	X*	X*	X*	X*	X*	X*
Lead Screening					X*	X*	X		X*	X	X*	X*	X*	X*															
Tuberculin Test		X*			X*		X*		X*	X*	X*	X*	X*	X*	X*	X*	X*	X*	X*	X*	X*	X*	X*	X*	X*	X*	X*	X*	X*
Dyslipidemia Screening										X*		X*		X*		X*		X*	X*	X*	X*	X*	X*	X*	X*	X*	X*	X*	X*
STI Screening																			X*	X*	X*	X*	X*	X*	X*	X*	X*	X*	X*
Cervical Dysplasia Screening																			X*	X*	X*	X*	X*	X*	X*	X*	X*	X*	X*
Oral Health		X			X*	X*	X*		X*	X*	X			X															
Anticipatory Guidance	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

* Risk Assessment

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

PHARMACY SERVICES

This section is for information only. Physicians are not reimbursed for self-injectable medications. The following information is provided only as a guideline for physicians and nurse practitioners writing prescriptions.

The Omnibus Budget Reconciliation Act (OBRA) of 1990 requires that pharmaceutical manufacturers have a rebate agreement in effect with the Centers for Medicare and Medicaid Services in order for their pharmaceuticals to be reimbursed by Medicaid. The pharmaceuticals of those manufacturers who have NOT entered into such an agreement are non-covered. However, devices or supplies such as insulin syringes and over-the-counter (OTC) family planning products remain covered items since this limitation applies only to medications (OTC as well as legend) dispensed to Medicaid beneficiaries.

Prescriptions

Medicaid-eligible beneficiaries from birth to the date of their 21st birthday are allowed unlimited prescriptions per month. For patients over the age of 21, unless otherwise specifically allowed, the traditional fee-for-service Medicaid program sponsors reimbursement for a maximum of four prescriptions per patient per month. Current routine exceptions to this monthly prescription limit are:

- Insulin syringes used in the administration of home parenteral therapies
- Home-administered parenteral therapies (However, insulin and those injectable products used to treat erectile dysfunction count toward the monthly prescription limit, but claims for insulin that are rejected for exceeding the monthly limit may be overridden if certain criteria are met.)
- Aerosolized pentamidine
- Clozapine therapy
- Family planning pharmaceuticals and devices

Whether the drug dispensed is legend or OTC, the patient must have a valid prescription from a licensed practitioner. Medicaid reimburses for a maximum one-month supply of medication per prescription or refill. SCDHHS defines a one-month supply as a maximum 31-days' supply per prescription for non-controlled substances. Providers should refer to the South Carolina Controlled Substances Regulations promulgated by the SCDHEC for maximum quantity limitations on prescriptions for controlled substances. The number of refills is left to the discretion of the prescriber, subject to state and federal requirements.

The copayment for all applicable prescriptions is listed in the appendices section under "Schedule of Copayments". All prescriptions written for

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PROGRAM REQUIREMENTS

Prescriptions (Cont'd.)

family planning pharmaceuticals, devices, or supplies are also exempt from copayment.

In the event that an injectable medication is administered or dispensed weekly or biweekly, the beneficiary may not be charged a copayment more than once in a calendar month for the same medication. If a 30-day supply of the medication was dispensed or administered and the beneficiary refills the medication a second time in the same month, they are responsible for paying any applicable copayments.

The following beneficiary groups are exempt from the collection of prescription copayments:

- Beneficiaries from birth to the date of their 19th birthday
- Long-term care facility residents
- Beneficiaries receiving hospice services
- Beneficiaries who are pregnant
- Beneficiaries enrolled in the South Carolina Department of Disabilities and Special Needs' ID/RD or HASCI waiver programs
- Beneficiaries enrolled in SCDHHS' Mechanical Ventilator Dependent (VENT), South Carolina Choice, HIV/AIDS, or Elderly and Disabled (E/D) waiver programs

Tamper-Resistant Prescription Pads

Medicaid covered outpatient prescription and OTC (over-the-counter) drugs will be reimbursable only if non-electronic prescriptions are issued on a tamper-resistant pad. These new federal requirements result from amendments to section 1903(i) of the Social Security Act, as required by Section 7002(b) of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery and Iraq Accountability Appropriations Act of 2007. Electronic prescriptions meeting Federal and State requirements are excluded from this requirement.

To be considered tamper-resistant, a prescription pad must contain the following three characteristics:

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

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PROGRAM REQUIREMENTS

Tamper-Resistant Prescription Pads (Cont'd.)

The requirement does NOT apply to e-prescriptions transmitted to the pharmacy, prescriptions faxed to the pharmacy or prescriptions communicated to the pharmacy by telephone by a prescriber.

Coverage Guidelines

The South Carolina Medicaid Pharmacy Services Program reimburses for most rebated generic legend or OTC products with the following exclusions:

- Weight control products (except for lipase inhibitors)
- Investigational pharmaceuticals or products
- Immunizing agents
- Those pharmaceuticals determined by the Food and Drug Administration (FDA) to be less than effective and identical, related, or similar drugs (frequently referred to as "DESI" drugs)
- Injectable pharmaceuticals administered by the practitioner in the office, in an outpatient clinic or infusion center, or in a mental health center

  Note: Medicaid reimbursement for palivizumab (Synagis® and RespiGam®); Xolair®; and Cerezyme® is limited solely to physician providers, hospital providers, and infusion centers through their respective Medicaid program area (*e.g.*, Physician's Services, Hospital Services, etc.). If a physician administers an injectable in the office due to medical necessity, the physician should purchase such drugs through appropriate channels and bill directly using injection codes found in this manual.
- Fertility products
- Products used as flushes to maintain patency of indwelling peripheral or central venipuncture devices
- Pharmaceuticals which are not rebated
- Nutritional supplements (enteral nutrition therapy administered through a feeding tube and Total Parenteral Nutritional [TPN] therapy may be covered through SCDHHS' Department of Durable Medical Equipment; however, neither program reimburses for oral nutritional supplements.)
- Oral hydration therapies for adults
- Pharmaceuticals used for cosmetic purposes or hair growth
- Devices and supplies (*e.g.*, glucometers, diabetic supplies such as test strips and lancets, infusion supplies, etc.)

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PROGRAM REQUIREMENTS

Non-Covered Drugs

If a prescription is written for a drug not compensable through the Pharmacy Services Program, the pharmacist should advise the beneficiary. The beneficiary may then request that the physician be called and a change requested.

If the beneficiary does not want the physician called, or the physician chooses not to change the prescription, the beneficiary is responsible for payment. If an authorized change is made, the pharmacist will make a notation on the prescription.

Prior Authorization

The South Carolina Medicaid Pharmacy Services' PA program, administered by Magellan Medicaid Administration, is comprised of a clinical PA process as well as a non-clinical PA process. Regarding **clinical** PA requests, the prescriber must contact Magellan Medicaid Administration Clinical Call Center at (866) 247-1181 toll free in order to furnish necessary patient-specific medical information. Although faxed requests from prescribers are permissible, **telephoned PA requests may be processed more expeditiously** since all needed information can be supplied at the time of the telephone call. Magellan Medicaid Administration employs a clinical staff of pharmacists and pharmacy technicians whose primary responsibilities include responding to prescribers' prior authorization requests. Based on established criteria, Magellan Medicaid Administration makes the determination regarding coverage of the product prescribed for the beneficiary.

It should be noted that for certain categories of drugs, the need for prior authorization is based on the age and/or gender of the beneficiary or on the quantity to be dispensed.

Maximum quantity limitations have been established for certain drugs; these established maximum quantities are based upon a 31-days' supply of medication. A listing of drugs subject to quantity limitations may be found at: http://southcarolina.fhsc.com. Furthermore, only *rebated* pharmaceuticals may be considered for possible reimbursement though the PA process.

Magellan Medicaid Administration requires that PA be requested (and subsequent approval entered into the system) prior to the dispensing of the medication; thus, retroactive PAs may be considered only in cases of retroactive Medicaid eligibility determination. Clinical prior authorization timelines may vary, depending upon the category of drug requested and patient-specific diagnostic information.

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

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PROGRAM REQUIREMENTS

Prior Authorization (Cont'd.)

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

With few specified exceptions, Medicaid does not routinely cover brand name products for which there are "A" rated, therapeutically-equivalent generic products available. The following drugs (or categories of drugs) require clinical prior authorization:

- **Products not included on the South Carolina Medicaid Preferred Drug List (PDL)** for the respective therapeutic classes indicated; refer to the PDL posting at http://southcarolina.fhsc.com.
- Growth hormone products such as **Serostim®**, **Nutropin®**, **Norditropin®**, **Humatrope®**, and **Genotropin®** (The prescriber should contact Magellan Medicaid Administration's Clinical Call Center at 866-247-1181.)

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

  In order for an injectable product to be considered for reimbursement by Pharmacy Services, the drug must be rebated and administered in the patient's home (to include long-term care facility settings, boarding homes, etc). Pharmacy providers may bill for only those injectable products for which the pharmacist has verified that the injectable will be self- or home-administered.
- **Lipase inhibitors (*e.g.*, Xenical®) when prescribed for morbid obesity or hyper- cholesterolemia**

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

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

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Prior Authorization (Cont'd.)

- **Targretin® (bexarotene)**

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

- **Certain anti-ulcer products (*i.e.*, proton pump inhibitors (PPIs) and histamine-2 receptor antagonists (H2RAs)**

  The anti-ulcer prior authorization program includes the following:

  - Proton pump inhibitors

  Note: Prior authorization is not required for PPI prescriptions/refills for patients under the age of 21 unless the product to be dispensed is a non-preferred agent.

  - **Brand name** histamine-2 receptor antagonists following treatment failures of two (different entity) generic H2RAs

  The presciber must contact Magellan Medicaid Administration's Clinical Call Center at (866) 247-1181 to communicate patient-specific clinical information. If coverage of the requested product is approved, subsequent PA requests will be necessary at certain intervals for that specified therapy and dosage.

- **Certain anti-arthritis products (*i.e.*, cyclooxy- genase 2 (COX-2) inhibitors and brand name, non-steroidal, anti-inflammatory drugs (NSAIDs)**

  The anti-arthritis prior authorization program includes the following:

  - COX-2 inhibitors, all strengths and dosages **[Prior authorization is not required for COX-2 inhibitor prescriptions/refills for patients 60 years of age and greater.]**
  - Brand name NSAIDs following treatment failures of two, different entity, generic NSAIDs **and** the brand name NSAID is used for an FDA-approved diagnosis **(PA is not required for generic NSAIDs.)**

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

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PROGRAM REQUIREMENTS

Prior Authorization (Cont'd.)

- **OxyContin®**

  Prior authorization of OxyContin® is required for those prescriptions that exceed the following quantity limitations:

  - Maximum of six OxyContin® tablets per day (regardless of strength or combination of strengths)
  - Maximum of 180 OxyContin® tablets per 30-day period (regardless of strength or combination of strengths)

  The prescriber must contact Magellan Medicaid Administration's Clinical Call Center at (866) 247-1181 to request prior authorization of OxyContin® therapy that exceeds these quantity limitations.

Medicaid Coverage of Brand-Name Products/Federal and State Maximum Allowable Cost (MAC) Drug List

Medicaid does not cover brand name products for which there are "A" rated, therapeutically equivalent, less costly generics available unless documentation of a treatment failure is furnished. Furthermore, **the treatment failure must be directly attributed to the patient's use of a generic of the brand name product.**

A South Carolina Medicaid MedWatch form, completed by the prescriber and forwarded to the Magellan Medicaid Administration Clinical Call Center (toll free fax number: 1-888-603-7696), serves as the required documentation of a treatment failure with a generic product. If the requested brand name product is not approved for Medicaid reimbursement, Magellan Medicaid Administration's Clinical Call Center staff will notify the prescriber.

As stated above, Medicaid does not routinely cover brand name products for which there are "A" rated, therapeutically equivalent, less costly generics available EXCEPT for the following brand name products [traditionally categorized as Narrow Therapeutic Index (NTI) drugs]:

- Digoxin
- Warfarin
- Theophylline (controlled release)
- Levothyroxine
- Pancrelipase
- Phenytoin
- Carbamazepine

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

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PROGRAM REQUIREMENTS

Medicaid Coverage of Brand-Name Products/Federal and State Maximum Allowable Cost (MAC) Drug List (Cont'd.)

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

Maximum reimbursement rates for certain multiple source drugs (both legend and OTC) are set by CMS or by SCDHHS and cannot be exceeded except for those brand name products that have been pre-authorized and properly annotated as "brand medically necessary" in the prescriber's own handwriting. The entire listing of products having either a federal upper limit (FUL) of payment or a South Carolina maximum allowable cost (SCMAC) may be found at http://southcarolina.fhsc.com. The MAC listing at http://southcarolina.fhsc.com includes *all products*, either state or federally mandated, *with a maximum allowable cost (MAC)* and *includes unit dose forms* of those products listed. This on-line MAC listing is continually monitored and updated to reflect any state or federal changes, additions, or deletions.

DURABLE MEDICAL EQUIPMENT / SUPPLY

Durable Medical Equipment is equipment that provides therapeutic benefits or enables a beneficiary to perform certain tasks that he or she would be unable to undertake otherwise due to certain medical conditions and/or illness. This equipment can withstand repeated use and is primarily and customarily used for medical reasons. It is appropriate and suitable for use in the home. This includes medical products; surgical supplies; equipment such as wheelchairs, traction equipment, walkers, canes, crutches, ventilators, prosthetic and orthotic devices, oxygen; hearing aid services (provided by contractor only), hospital beds, and ostomy supplies; and other medically needed items when ordered by a physician as medically necessary in the treatment of a specific medical condition. The attending physician must prescribe the items and has the responsibility of determining the type or model of equipment needed and length of time the equipment is needed through a written necessity statement. Luxury and deluxe models are restricted if standard models would be appropriate. Repairs to medical equipment are covered if reasonable.

Providers who are enrolled in the Medicaid program as DME providers are reimbursed for providing equipment and/or supplies to eligible Medicaid beneficiaries in compliance with the Department of Durable Medical Equipment's (DME) policy.

For DME policy guidelines, contact the PSC at 1-888-289-0709, submit an online inquiry http://www.scdhhs.gov/contact-us *or* write to:

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PROGRAM REQUIREMENTS

DURABLE MEDICAL EQUIPMENT / SUPPLY (CONT'D.)

SCDHHS Department of Durable Medical Equipment
Post Office Box 8206
Columbia, SC 29202-8206

There are a select few DME items that are reimbursable through Physician Services. These items are listed as supplies under the heading "Additional Ambulatory Services" in this section.

SERVICES FOR AIDS PATIENTS

In an effort to find a medical home for AIDS patients covered under the Medicaid program and to properly reimburse physicians for the complications involved with treating these patients, supplemental codes (see table below) have been developed for physicians treating Medicaid beneficiaries diagnosed with AIDS or AIDS Related Complex (ARC). In order to bill for these services, you must use the P4 modifier in correlation to the appropriate E/M code.

FREQUENCY DESCRIPTION	CODES*	LIMITS
OFFICE VISITS		
NEW PATIENT OFFICE VISIT	**99201-99205, 99211-**	**1/3 YEARS****
ESTABLISHED PATIENT OFFICE VISIT	**99215, 99251-99255**	**1/DAY**
HOSPITAL VISITS		
INITIAL HOSPITAL VISIT	**99221-99223**	**1/HOSPITAL ADMISSION**
SUBSEQUENT HOSPITAL VISIT		**1/DAY**
HOME VISITS		
NEW PATIENT HOME VISIT	**S6920**	**1/3 YEARS****
ESTABLISHED PATIENT HOME VISIT	**99341-99345, 99347-99350**	**1/DAY**
EMERGENCY VISIT		
ER VISIT	**99281-99285**	**1/DAY**
CONSULTANTS		
INITIAL CONSULTATION	**99241-99245**	**1/REFERRAL**
FOLLOW-UP CONSULTATION	**99211-99215**	**1/DAY (AS REQUESTED)**

* In order to use these codes, a documented diagnosis of AIDS or ARC must be on each patient's chart.
** New patient is defined as a patient not seen by any member of the group, regardless of specialty.

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PROGRAM REQUIREMENTS

Additional CLTC Services (Cont'd.)

Aside from traditional Medicaid services (physician, hospital, drugs, etc.), SCDHHS offers home- and community-based waiver services through the Division of Community Long Term Care (CLTC). In addition to being HIV positive, the individual must meet an established medical level of care prior to receiving these services. Services available are listed below:

- Case management services
- Private duty nursing services
- Personal care aide services
- Modified and therapeutic-diet home-delivered meals
- Counseling services
- Foster care services
- Limited incontinence supplies
- Limited nutritional supplements
- Environmental modifications
- Attendant care
- Home management
- Two additional prescription drugs per month

CLTC Offices

There are 11 area and three satellite CLTC offices statewide. Each office is staffed by service managers who are professional social workers and registered nurses. These service managers work with the person and/or the family to plan and coordinate the services the beneficiary may need.

If you have clients who you feel may benefit from any of these services, or if you have questions about the CLTC program, please call your area CLTC office as listed in the table on the following page.

For additional information, please contact the PSC at 1-888-289-0709, submit an online inquiry http://www.scdhhs.gov/contact-us, or write to:

SCDHHS
Community Long-Term Care Department
Post Office Box 8206
Columbia, SC 29202

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

AREAS	COUNTIES SERVED	PHONE NUMBERS
Area 1 – Greenville	Greenville, Pickens	(864) 242-2211 (888) 535-8523
Area 2 – Spartanburg	Cherokee, Spartanburg, Union	(864) 587-4707 (888) 551-3864
Area 3 – Greenwood, IMS	Abbeville, Edgefield, Greenwood, Laurens, McCormick, Saluda	(864) 223-8622 (800) 628-3838
Area 4 – Rock Hill	Chester, Lancaster, York	(803) 327-9061 (888) 286-2078
Area 5 – Columbia	Fairfield, Lexington, Newberry, Richland	(803) 741-0826 (888) 847-0908
Area 6 – Orangeburg	Allendale, Bamberg, Calhoun, Orangeburg	(803) 536-0122 (888) 218-4915
Area 6A – Aiken Satellite Office	Aiken, Barnwell	(803) 641-7680 (888) 364-3310
Area 7 – Sumter	Clarendon, Kershaw, Lee, Sumter	(803) 905-1980 (888) 761-5991
Area 8 – Florence	Chesterfield, Darlington, Dillon, Florence, Marlboro	(843) 667-8718 (888) 798-8995
Area 9 – Conway	Georgetown, Horry, Marion, Williamsburg	(843) 248-7249 (888) 539-8796
Area 10 – Charleston	Berkeley, Charleston, Dorchester	(843) 529-0142 (888) 805-4397
Area 10A – Point South Satellite	Beaufort, Colleton, Hampton, Jasper Beaufort Line:	(843) 726-5353 (800) 262-3329 (843) 521-9191
Area 11 – Anderson, IMS	Anderson, Oconee	(864) 224-9452 (800) 713-8003

Outpatient Pediatric Aids Clinics

Outpatient Pediatric AIDS Clinics (OPACs) are designed to provide specialty care, consultation, and counseling services for HIV infected and exposed, Medicaid-eligible children and their families. Clinics presently contracted are located at the Medical University of South Carolina, Department of Pediatrics; the USC School of Medicine, Department of Pediatrics; and Greenville Hospital. The mission of OPAC is to follow

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Outpatient Pediatric Aids Clinics (Cont'd)

children who have been exposed to HIV perinatally as children born to women infected with HIV.

ALCOHOL AND DRUG ABUSE REHABILITATION SERVICES

The medical benefits package for Medicaid beneficiaries includes outpatient alcohol and drug (A&D) rehabilitative services. Crisis Management is also available for patients who are experiencing emotional, physical, and/or psychological trauma.

The effectiveness of this program relies on the referrals by physicians. There are several alternatives a physician can use to refer a Medicaid beneficiary for A&D services. Likewise, there are several ways to bill for referral services.

Initial Medical Assessment and Referral

Procedure Code 90801 – This is a face-to-face contact between physician and client to assess the patient status, provide diagnostic evaluation screening, and provide physician's referral for alcohol and drug rehabilitative services. This includes the completion of the Alcohol and Drug Medical Assessment signed and dated by the physician. A sample copy of the form can be found in the Forms section of this manual. Additional forms are available upon request from your county alcohol and drug abuse program. This form will be placed in the client's file at the local alcohol and drug abuse authority site. A copy should be retained in the patient's file. The assessment form completion is included in the reimbursement fee.

Local Alcohol and Drug Authorities Currently Enrolled in Medicaid

The chart beginning on the following page includes an address and telephone number for all of the local alcohol and drug authorities currently enrolled in Medicaid:

County	Program Name and Address	Telephone Number
	South Carolina Department of Alcohol and Drug Abuse (DAODAS) 101 Executive Center Drive, Suite 215 Columbia, South Carolina 29210	(803) 896-5555
Abbeville	Cornerstone 112 Whitehall Street Abbeville, South Carolina 29620	(864) 366-9661
Aiken	Aiken Center 1105 Gregg Highway Aiken, South Carolina 29801	(803) 649-1900

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PROGRAM REQUIREMENTS

County	Program Name and Address	Telephone Number
Allendale	New Life Center 570 Memorial Avenue Allendale, South Carolina 29810	(803) 584-4238
Anderson	Anderson/Oconee Behavioral Health Services 226 McGee Road Anderson, South Carolina 29625	(864) 260-4168
Bamberg	Dawn Center (Tri-County Commission of Alcohol and Drug Abuse) 608 North Main Street Bamberg, South Carolina 29003	(803) 245-4360
Barnwell	Axis I Center of Barnwell 644 Jackson Street Barnwell, South Carolina 29812	(803) 541-1245
Beaufort	Beaufort County Department of Alcohol and Other Drug Services 1905 Duke Street Beaufort, South Carolina 29901	(843) 470-4545
Berkeley	Ernest E Kennedy Center 306 Airport Drive Monks Corner, South Carolina 29461	(843) 761-8272
Calhoun	Dawn Center (Tri-County Commission of Alcohol and Drug Abuse) Herlong Extension Industrial Park St. Matthews, South Carolina 29135	(803) 655-7963
Charleston	Charleston Center 5 Charleston Center Drive Charleston, South Carolina 29401	(843) 958-3300
Cherokee	Cherokee County Commission of Alcohol and Other Drug Services 201 West Montgomery Street Gaffney, South Carolina 29341	(864) 487-2721
Chester	Hazel Pittman Center 130 Hudson Street Chester, South Carolina 29706	(803) 377-8111

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PROGRAM REQUIREMENTS

County	Program Name and Address	Telephone Number
Chesterfield	Alpha Center 1218 East Boulevard Chesterfield, South Carolina 29709	(843) 623-7062
Clarendon	Clarendon County Commission on ADA 14 North Church Street Manning, South Carolina 29102	(803) 435-2121
Colleton	Colleton County Commission on ADA 1439 Thunderbolt Drive Walterboro, South Carolina 29488	(843) 538-4343
Darlington	Rubicon Inc. 510 East Carolina Avenue Hartsville, south Carolina 29550	(843) 332-4156
Dillon	Trinity Behavioral Care 204 Martin Luther King Jr. Blvd. Dillon, South Carolina	(843) 774-6591
Dorchester	Dorchester Alcohol & Drug Commission 500 North Main Street, Suite 4 Summerville, South Carolina 29483	(843) 871-4790
Edgefield	Cornerstone 400 Church Street, Room 112 Edgefield, South Carolina 29824	(803) 637-4050
Fairfield	Fairfield County Substance Abuse Commission 200 Calhoun Street Winnsboro, South Carolina	(803) 635-2335
Florence	Circle Park Behavioral Health Services 601 Gregg Avenue Florence, South Carolina 29501	(843) 665-9349
Georgetown	Georgetown County ADA Commission 1423 Winyah Street Georgetown, South Carolina 29440	(843) 546-6081
Greenville	The Phoenix Center 1400 Cleveland Street Greenville, South Carolina 29607	(864) 467-3739

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

County	Program Name and Address	Telephone Number
Greenwood	Cornerstone 1510 Spring Street Greenwood, South Carolina 29646	(864) 227-1001
Hampton	New Life Center 102 Ginn Altman Avenue, Suite C Hampton, South Carolina 29924	(803) 943-2800
Horry	Shoreline BHS 2404 Wise Road Conway, South Carolina 29526	(843) 365-8884
Jasper	New Life Center 113 East Wilson Street Ridgeland, South Carolina 29936	(843) 726-5996
Kershaw	Alpha Center 709 Mill Street Camden, South Carolina 29020	(803) 432-6902
Lancaster	Counseling Services of Lancaster 114 South Main Street Lancaster, South Carolina 29720	(803) 285-6911
Laurens	Gateway Counseling Center 219 Human Services Road Clinton, South Carolina 29325	(864) 833-6500
Lee	The Lee Center Family Counseling and Addiction Services 108 East Church Street Bishopville, South Carolina 29010	(803) 484-6025
Lexington	Lexington/Richland Alcohol and Drug Abuse Council (LRADAC) 130 North Hospital Drive West Columbia, South Carolina 29169	(803) 733-1390
Marion	Trinity Behavioral Care 103 Court Street Marion, South Carolina 29571	(843) 423-8292

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

County	Program Name and Address	Telephone Number
Marlboro	Trinity Behavioral Care 211 North Marlboro Street, 2nd Floor Bennettsville, South Carolina 29512	(843) 479-5683
McCormick	Cornerstone 504 North Mine Street McCormick, South Carolina 29835	(864) 465-2631
Newberry	Westview Behavioral Health Services 800 Main Street or 909 College Street Newberry, South Carolina 29108	(803) 276-5690
Oconee	Anderson/Oconee Behavioral Health Services 691 South Oak Street Seneca, South Carolina 29678	(864) 882-7563
Orangeburg	Dawn Center (Tri-County Commission of Alcohol and Drug Abuse) 910 Cook Road Orangeburg, South Carolina 29118	(803) 536-4900
Pickens	Behavioral Health Services of Pickens County 309 East Main Street Pickens, South Carolina 29671	(864) 898-5800
Richland	Lexington/Richland Alcohol and Drug Abuse Council (LRADAC) 2711 Colonial Drive Columbia, South Carolina 29203	(803) 726-9300
Saluda	Saluda Behavioral Health System 204 Ramage Street Saluda, South Carolina 29138	(864) 445-2968
Spartanburg	Spartanburg County Alcohol and Drug Abuse Commission 187 West Broad Street, Suite 200 Spartanburg, South Carolina 29306	(864) 582-7588
Sumter	Sumter County Commission on ADA 115 North Harvin Street, 3rd Floor Sumter, South Carolina 29150	(803) 775-6815

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

County	Program Name and Address	Telephone Number
Union	Union county Commission on ADA 201 South Herdon Street Union, South Carolina 29379	(864) 429-1656
Williamsburg	Williamsburg Commission on ADA 115 Short Street Kingstree, South Carolina 29556	(843) 354-9113
York	Keystone Substance Abuse Services 199 South Herlong Avenue Rock Hill, South Carolina 29732	(803) 324-1800

ALCOHOL AND DRUG TESTING POLICY

Effective December 1, 2011, South Carolina Department of Health and Human Services (SCDHHS) will be implementing limitations on alcohol and drug screenings. Medicaid will cover no more than 25 drug screens utilizing CPT code G0431 per fiscal year. If the beneficiary exceeds 25 drug screens G0431 per fiscal year, the claim will be denied for the number of units exceeded. This means that the alcohol and drug screening maximum units allowed for this fiscal year has been exhausted and no additional drug screens will be considered. South Carolina Medicaid fiscal year begins July 1st and ends June 30th. For children under the age of 21 who have exceeded the 25 drug screen limitation, providers must submit documentation to support medical necessity with the Edit Correction form for review.

SCDHHS policy has been and continues to be that alcohol and drug screenings, as with all lab tests, must be ordered by a qualified practitioner operating within their scope of practice and as allowed by state law. Qualified practitioners may authorize certain laboratory tests to be performed at defined intervals over a period of 60 days with one “standing order” only when used in connection with an extended course of treatment for substance abuse disorders. The ordering practitioner must document in the beneficiary’s clinical record the medical necessity for the testing and the results of each test. Qualified practitioners ordering unnecessary tests for which Medicaid is billed may be subject to civil penalties.

A qualified practitioner is defined as a physician, nurse practitioner, or a physician assistant. The qualified practitioner may write an individualized standing order for the beneficiary, but must be updated every 60 days.

Laboratory standing orders must be in a written form, patient specific, and include a duration that cannot exceed 60 days. In all instances, standing orders are rendered invalid after 60 days from the date the initial

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

ALCOHOL AND DRUG TESTING POLICY (CONT'D.)

test was ordered. Existing standing orders must be reviewed regularly to ensure their continuing validity.

Standing orders must include the following information:

- The treating physician, nurse practitioner, or physician assistant name, address, telephone number, license number, and NPI number
- The name, date of birth, sex, Medicaid ID number, diagnosis and statement of clinical symptoms that justify medical necessity of the beneficiary for whom the tests are ordered
- The date the test was ordered
- The name of all tests performed, listed individually
- Specific intervals, at which each individual test should be performed, based on the individual treatment needs
- Signature, title and date of qualified practitioner that evaluated the beneficiary and confirmed the medical necessity

Alcohol and drug screens for employment purposes or for a court ordered alcohol and drug screen are not covered under the Medicaid program.

G0431 is a bundled code, which covers all classifications of drugs. The following procedure codes are not covered 80100, 80101, 80102, 80103, and 80104.

TOBACCO CESSATION

SCDHHS recognizes tobacco use is the single most preventable cause of disease and premature death in the state. Medicaid provides coverage for tobacco cessation through counseling and treatment programs. SCDHHS has partnered with the SCDHEC to communicate information regarding tobacco treatment services in South Carolina. The following programs are available to assist Medicaid beneficiaries with the tobacco cessation process.

South Carolina Tobacco Quitline

The South Carolina Tobacco Quitline program is a free comprehensive tobacco treatment service that emphasizes a one-on-one counseling approach (using telephone and/or web-based counseling) and is available to all South Carolinians. Participants in the Quitline program are assigned a personal Quit Coach® who establishes a goal of working with the participant throughout the tobacco cessation process. This is an evidence-based program that has been clinically proven to help participants discontinue tobacco use for both the short and long term. Prescribers and pharmacists may contact the Quitline at 1-800-QUIT-NOW (1-800-784-

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

South Carolina Tobacco Quitline (Cont'd.)

8669) or visit the SCDHEC website at *http://www.scdhec.gov /quitforkeeps* for more information.

The nationally recognized leader in delivering validated tobacco treatment, Free & Clear®, operates the South Carolina Tobacco Quitline program. SCDHEC has developed an informational webpage that describes the Quitline and provides information about ordering patient education and referral materials. Prescribers and pharmacists can downloaded these resources from the SCDHEC website at *http://www.scdhec.gov/health/chcdp/tobacco/quit-for-keeps/healthcare- professionals.htm*

SCDHHS strongly encourages prescribers and pharmacists to make this information available to patients who are interested in discontinuing tobacco use. Telephone services at the Quitline are available seven days a week between the hours of 8:00 a.m. and 12:00 p.m.

Rebated Tobacco Cessation and Nicotine Replacement Therapy (NRT) Products

SCDHHS provides reimbursement for rebated tobacco cessation and nicotine replacement therapy (NRT) products through the Pharmacy program. A prescription written for a product listed in the chart below is covered within program limitations (*e.g.*, monthly prescription limit) for all Medicaid fee-for-service beneficiaries, except for dual eligibles (individuals eligible for both Medicaid and Medicare). For dual eligibles, Medicaid provides coverage of rebated, over-the-counter (OTC) products for tobacco cessation. However, as with any Medicaid-covered OTC drug, a prescription for the specific OTC product must be authorized by the prescriber. A dual eligible's Medicare Part D prescription drug plan should provide coverage for legend (non-OTC) tobacco cessation products.

Prior authorization (PA) is not required (except where indicated in the chart) for reimbursement of the tobacco cessation products. However, there are quantity limitations for these pharmaceuticals as well as a coverage period limit. Medicaid coverage of tobacco cessation pharmaceuticals includes prescriptions authorized for any one of the following rebated products per beneficiary per calendar year:

No Prior Authorization Required	Prior Authorization Required*
Bupropion extended release products (only the generic for Zyban®	Nicorette® lozenge
Chantix (Varenicline)	Zyban (bupropion SR tablet)
NRT patches, gum, lozenges (legend or OTC)	Nicotrol® NS Spray and Inhaler/cartridge
*To request prior authorization, prescribers should contact Magellan Health Call Center at 1-866-247-1181 (toll free).	

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PROGRAM REQUIREMENTS

TOBACCO CESSATION FOR PREGNANT WOMEN

Effective with dates of service on or after February 1, 2012, the South Carolina Department of Health and Human Services (SCDHHS) will cover Tobacco Cessation treatment for all pregnant women in accordance with Section 4107 of the Affordable Care Act, which amended Section 1905 (bb)(2) of the Social Security Act. For the complete policy and billing instructions, please review the Physician, Laboratories and Other Medical Professionals manual located on the SCDHHS website at www.scdhhs.gov.

The tobacco cessation policy for pregnant women will cover two (2) quit attempts per fiscal year, counseling, and pharmacotherapy. Providers may bill the Current Procedure Terminology (CPT) codes 99406 and 99407 for the counseling services. SCDHHS will cover four (4) counseling sessions per quit attempt. SCDHHS currently reimburses for the following pharmaceuticals used to facilitate the discontinuation of tobacco products:

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

Beneficiaries may also access the South Carolina Department of Health and Environmental Control (SCDHEC) quit line. The quit line may be utilized by having the beneficiary call 1-800-QUIT-NOW (1-800-784-8669), (this is a toll free call); or they may go to the quit line web page at www.scdhec.gov/quitforkeeps.

SCDHHS policy requires that all tobacco cessation treatment must be ordered by a qualified practitioner defined as a physician, nurse practitioner, certified nurse midwife, or physician assistant. Medical documentation such as time spent counseling the patient, treatment plan, and pharmacotherapy records must be maintained in the patient's chart.

HOSPICE

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

Hospice services will be available to Medicaid beneficiaries who choose to elect the benefit and who have been certified to be terminally ill with a life expectancy of six months or less by their attending physician and/or medical director of the hospice.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

HOSPICE (CONT'D.)

Hospice services are provided to the beneficiary according to a plan of care developed by an interdisciplinary staff of the hospice. The services below are covered under the South Carolina Medicaid Hospice Program:

- Nursing care provided by or under the supervision of a registered nurse
- Medical social services provided by a social worker under the direction of a physician
- Physician's services provided by the hospice medical director or physician member of the interdisciplinary group (General supervisory services; participation in the establishment of plans of care; supervision of care and services; and establishment of governing policies are included in the hospices reimbursement rate and may not be billed as a physician's service.)
- Counseling services, including dietary and bereavement counseling, provided to the beneficiary and family
- Short-term inpatient care provided in a hospital or inpatient hospice unit
- Medical appliances and supplies, including drugs used for the relief of pain and symptom control related to the terminal illness and biologicals
- Home health aide services and homemaker services
- Physical therapy, occupational therapy, and speech language pathology services

A beneficiary who elects the hospice benefit must waive all rights to other Medicaid benefits for services related to treatment of the terminal condition for the duration of the election of hospice care. Specific services which must be waived include the following:

- Hospice care provided by a hospice other than the hospice designated by the individual (unless provided under arrangements made by the designated hospice)
- Any Medicaid services that are related to the treatment of the terminal condition for which hospice care was elected; or a related condition; or services that are equivalent to hospice care **except for the following:**
    - Services provided (either directly or under arrangement) by the designated hospice
    - Services provided by the individual's attending physician if that physician is not an employee of the designated hospice or

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

HOSPICE (CONT'D.)

receiving compensation from the hospice for those services

SCDHHS will provide reimbursement for hospice services for children under 21 years of age in conjunction with curative treatment of the child's terminal illness. Section 2302 of the Affordable Care Act, entitled "Concurrent Care for Children" removes the prohibition of receiving curative treatment upon the election of the hospice benefit by or on behalf of children enrolled in Medicaid or Children's Health Insurance Program (CHIP). This provision does not change the criteria for hospice. A physician must certify that the child is terminally ill with a life expectancy of six months or less. However, this provision allows parents with children under the age of 21 receiving hospice services to no longer forgo any other services to which the child is entitled under Medicaid treatment of the terminal condition. Services rendered by a provider other than the hospice must be discussed and coordinated with the hospice provider.

Effective with dates of service on or after October 1, 2012, SCDHHS will require prior authorization for hospice services to Medicaid–only beneficiaries. Hospice providers must submit requests for prior authorization along with medical documentation to KePRO. All hospice services except general inpatient (GIP) care must be pre-authorized for up to six months. If a beneficiary is in need of hospice services beyond the initial six months, the hospice provider must submit a new request to KePRO.

For further information, call the PSC at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us.

INPATIENT AND OUTPATIENT HOSPITAL SERVICES

General Policy Guidelines

Services performed by the physician in a hospital are compensable if medically necessary. Special procedures are compensable if deemed a separate and reimbursable service. Services or supplies administered by the hospital or hospital employee are considered a part of the overall hospital service and are reimbursable **only** under the hospital allowable costs.

A physician who is either salaried or contracted by the hospital (a hospital-based physician), and who performs services under said contract or employment, may not bill for those services separately under his or her individual Medicaid provider number. The contracting hospital may claim these services under the professional fees allowable for the hospital under its hospital-based physician Medicaid number.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Levels of Service

The terminology for levels of service as defined in the American Medical Association (AMA) Current Procedural Terminology (CPT) guidelines will be recognized. The medical record must reflect the level of service billed.

Records and Documentation Requirements

Both the physician and hospital are expected to comply with South Carolina Medicaid policy in providing the agency with medical records if requested.

Hospital Visits

Initial Hospital Care

Refer to the current CPT when multiple evaluation and management services are prescribed on the same date as initial hospital care.

Only one physician for each hospital admission is reimbursed. If two physicians of different specialties perform a comprehensive exam on admission day, one may use a consultation code (with the exception of a transfer), as long as the service meets the criteria of a consultation.

A comprehensive level of service is not allowed for readmission for the same illness or problem. A reduced level of service must be used if the patient is discharged and readmitted.

If a patient is transferred from one hospital to another, the receiving physician may bill for a comprehensive level of service (even if the transfer occurs on the day of admission).

Initial hospital care codes are exempt from the surgical package. For instructions on surgical package billing, refer to the “General Surgery” heading in this section.

Subsequent Hospital Care

Subsequent hospital care is generally allowable one visit per day per physician.

Postoperative visits by the surgeon are not allowed as a separate reimbursement since the visits are included in the surgical package unless the surgical procedure is not part of a surgical package.

Codes 99231 – 99233 will "multiply" and should be reported as one line item, with the number of visits indicated in the “units” column.

Hospital Discharge

Hospital discharge is a covered service. This charge is acceptable only if **billed in lieu of a hospital visit code**. It may not be charged if a surgical procedure was performed and the surgery is considered a surgical package. Reimbursement is made for only one physician for each hospital discharge.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Concurrent Care Guidelines

When two or more physicians render subsequent hospital care, consultations (office or inpatient), critical care, emergency room, nursing home, rest home, or office medical care to the same patient at the same time, this is referred to as "medical concurrent care."

Concurrent Care Criteria

If physicians of the same specialty or similar specialty render care for the same condition at the same time, benefits are provided only for the attending physician.

When two physicians render care for unrelated conditions at the same time, benefits are provided to each physician if both of the following apply:

- The physicians are not of the same or similar specialty.
- Each physician is treating the patient for a condition unique to his specialty.

Medical/Surgical

Benefits are provided for in-hospital medical services performed by a physician other than the admitting surgeon in addition to benefits for in-hospital surgical services under the following circumstances:

- The medical care rendered was not related to the condition causing surgery and was not part of routine pre- and postoperative care.
- The medical care required supplemental skills not possessed by the attending surgeon.
- A physician other than a surgeon admits a patient for medical treatment, and the need for surgery arises later during the hospitalization.
- A cardiovascular surgeon performs cardiac surgery and a cardiologist follows the patient during hospitalization even though the diagnosis is the same

Critical Care Services

Using the critical care guidelines as defined in the current CPT, codes 99291 – 99292 should be used to report critical care services. Follow current CPT guidelines indicating services are considered a part of critical care and not reimbursed separately. Up to four hours of critical care per day are allowed. Critical care must be billed per **date of service.** Critical care services are not included in the surgical package and may be billed separately.

EKG interpretations would not be covered separately when performed as part of, or in conjunction with, critical care.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Critical Care Services (Cont'd.)

Code 99291 (Critical Care, first hour) is used to report the services of a physician providing constant attention to an unstable, critically ill patient for a total of 30 minutes to 74 minutes on a given day. Reimbursement is limited to one per day. If the total duration of critical care on a given day is less than 30 minutes, the appropriate E/M code should be used. In the hospital setting, the higher level code 99233 would most often apply. Time must be clearly documented in the medical record.

Code 99292 (Critical Care, each additional 30 minutes) is used to report the services of a physician providing constant attention to an unstable, critically ill patient for up to 30 minutes beyond the first 74 minutes of care on a given day.

Reimbursement is limited to six per day for a total of three hours per day. Time must be clearly documented in the medical record.

Prolonged Services

Medicaid will reimburse for Prolonged Physician Services with Direct (face-to-face) Patient Contact – CPT codes 99354 and 99356.

Documentation for CPT codes 99354 and 99356 must clearly indicate that the service provided was direct (face-to-face) contact between the physician and the patient for more than one hour beyond the usual service for the level of E/M code billed. These codes are billed in addition to the appropriate E/M code. Please refer to the CPT guidelines for coding these services. CPT codes 99355 and 99357 (Prolonged Services each additional 30 minutes) are non-covered.

CPT codes 99358 and 99359 for Prolonged Physician Services without Direct (face-to-face) Patient Contact will remain non-covered.

Emergency Room (ER) Services

Outside Attending Physician

A private physician called to the hospital in an emergency situation may bill for emergency room services in the following instances:

- When a hospital-based ER physician is not available
- The physician is called in by the ER physician
- If a life-threatening situation develops

Hospital-Salaried or Hospital-Based ER Physicians

Medicaid has established policies and procedures for outpatient hospital services to distinguish between outpatient (OP) clinic services and emergency room services. Since some hospitals do not have separate and distinct OP clinics, the ER physician must designate in the patient's records if the patient's visit to the emergency room was actually an emergency situation.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Hospital-Salaried or Hospital-Based ER Physicians (Cont'd.)

Professional services rendered in an outpatient hospital environment must be charged on a CMS-1500 form. If a hospital-based or salaried physician renders a professional service in an emergency room, all services must be charged separately by submitting a CMS-1500 or by using a PAID or billing through the PAID Spin Off Program.

The physician's service must be charged using a CPT code in the 99281 – 99288 range. Procedures identifiable as a unique and separate service may be reported separately.

Levels of Service

Each level of service in the 99281-99285 **series** includes examinations, evaluations, and treatments that are medically necessary, and that are presented as an emergency in a hospital emergency room setting. These levels of service exclude the interpretation of diagnostic tests. Medicaid will only reimburse for one emergency room visit per day for the same or related diagnosis.

Emergency Life Support

Procedure code 99288 indicating physician direction of an emergency medical system (EMS) or ambulance transport service for advanced life support is covered when medically indicated. The service is compensable in addition to other medically necessary services performed by a physician. Emergency services performed by other hospital professionals are considered part of a technical charge by the hospital and may not be billed or charged as a separate professional service.

Observation Unit

Medicaid will sponsor the professional reimbursement for evaluation and management services provided to patients requiring observation in a hospital. Refer to the current CPT for coding guidelines. Observation codes should be billed with place of service 22.

Administrative Days

Medicaid sponsors Administrative Days in any South Carolina- enrolled acute care hospital and acute care hospitals enrolled within the South Carolina service area for Medicaid-eligible patients who no longer require acute hospital care but are in need of nursing home placement that is not available at the time.

Physicians who are treating these patients can bill for their services rendered to these patients using the same procedure codes that they use for their patients in nursing homes and rest home facilities. Those procedure codes are in the range 99304-99337 and are listed in your CPT manual. The specific code you use would depend on whether it is a new or established patient and on the level of care given. Use place of service **21** when billing.

One limited examination per 30 days is required for all Administrative

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Administrative Days (Cont'd.)

Day patients. Additional visits may be allowed if medical justification is submitted.

OBSTETRICS AND GYNECOLOGY

General

Pregnancy Determination

An examination to determine if a patient is pregnant should be coded as an office E/M visit. The exception would be if a positive pregnancy test was determined and the provider performed an initial OB exam in the same visit.

Healthy Mothers/Healthy Futures (HM/HF) Obstetrical Program

Obstetrical care provided under the Healthy Mothers/Healthy Futures program (HM/HF) must be billed as separate charges (fragmented), not as global OB care. The program includes increased reimbursement for health education, referral to the WIC program at the local county health department, and follow-up on missed appointments.

Standard obstetrical care, without the previously listed enhanced services, is also compensable. All services must be documented in the patient's chart.

Healthy Mothers/Healthy Futures Checklist – One way of documenting the additional services is the HM/HF checklist. A sample copy of the checklist can be found in the Forms section of this manual. The checklist is only an option for documenting services, and is by no means a requirement. The only requirement is that services be documented. If a practice chooses to use the HM/HF checklist, the physicians should sign and date the back of the checklist at the time of the initial visit so that it is not forgotten at a later date.

It is not necessary to cover all of the educational components on the checklist with each patient, but only the ones that pertain to each individual patient's health. If one component is discussed with the patient on more than one occasion, it may be checked and dated for each time. It is very important that at least one educational component on the checklist be checked and dated for each HM/HF enhanced visit that is billed to Medicaid.

Best Practice Guidelines for Perinatal Care (Replaces High Risk Channeling Project – HRCP) Best Practice

The High Risk Channeling Project (HRCP), a Freedom of Choice Waiver program that encouraged risk-appropriate care for Medicaid sponsored pregnant women and infants, expired on August 11, 2001. Because the waiver expired, SCDHHS transitioned to recommended best practice guidelines for perinatal care.

South Carolina Medicaid remains committed to the concept(s) of risk-appropriate care and enhancing maternal and child health outcomes.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Best Practice Guidelines for Perinatal Care (Replaces High Risk Channeling Project – HRCP) Best Practice (Cont'd.)

Therefore, the following Medicaid Best Practice guidelines are recommended:

- Early and continuous risk screening should be provided for all pregnant women.
- Early entry into prenatal care should be encouraged.
- Care for all prenatal women should be delivered by the provider level and specialty best suited to the risk of the patient. (*Guidelines for Perinatal Care*, Fourth Edition, American Academy of Pediatrics and American College of Obstetricians and Gynecologists, 1997.)
- All infants should receive risk-appropriate care in a setting that is best suited to the level of risk presented at delivery. (*Guidelines for Perinatal Care*, Fourth Edition, American Academy of Pediatrics and American College of Obstetricians and Gynecologists, 1997.)
- Risk assessment of the infant should be performed prior to discharge from the hospital.
- Every Medicaid-eligible mother and infant should receive a Postpartum/Infant Home Visit (PP/IHV).
- Effective communication/coordination regarding the perinatal plan of care between each provider is essential (*i.e.*, the specialist physician should communicate pertinent information back to the community level physician).
- A medical home should be established for the mother-infant unit after delivery to handle the long-term health care needs.
- Preventive/Rehabilitative Services for Primary Care Enhancement (P/RSPCE) referrals should be made when medically indicated.

For additional recommendations and guidelines for risk-appropriate ambulatory prenatal care for pregnant women, the "*Guidelines for Perinatal Care*," which are endorsed by the American Academy of Pediatrics (AAP) and the American College of Obstetrics and Gynecology (ACOG) may be referenced.

Initial OB Exam

A higher-level E/M code may be billed for OB visits other than those outlined in the manual; however, the visit must meet CPT guidelines for level of complexity and be documented in the patient's chart.

Only one initial OB exam (procedure code 99202 or 99203) may be billed per pregnancy.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Initial OB Exam (Cont'd.)

Initial OB Exam (99203) HM/HF OB Program – An initial OB exam may be billed one time during a term of pregnancy. Requirements for the use of this HM/HF code are:

- Comprehensive medical exam
- Establishment of the patient's medical history
- Provision of health education materials
- WIC referral to the local county health department

The WIC referral can be made at a later date since the provider may not be aware that a patient has Medicaid benefits until later in her pregnancy. The WIC referral must be documented in the patient's chart.

Initial OB Exam (99202) without Enhanced Services – Use of this code has the same requirement as the HM/HF code (99203), except that a WIC referral is not required.

Screening Brief Intervention and Referral to Treatment Initiative

The South Carolina Department of Health and Human Services (SCDHHS) began the Screening, Brief Intervention and Referral to Treatment (SBIRT) initiative in August 2011. In the Department's effort to improve birth outcomes and overall health of the Mother and Baby, we have partnered with other stakeholders throughout the state to help identify and treat pregnant beneficiaries who may experience alcohol or other substance dependencies, depression, smoking, or domestic violence.

SBIRT services (screening and, when applicable, a brief intervention) are reimbursable in addition to an office visit to pregnant women, or those who are within their 12-month postpartum period. Providers may bill for a screening once per fiscal year and a brief intervention twice per fiscal year using the following codes:

- Screening: H0002 with a U1 modifier reimburses at $24.00
- Brief Intervention: H0004 with a U1 modifier reimburses at $48.00

The Institute for Health and Recovery's Integrated Screening Tool, which is a validated and objective resource, must be used to receive reimbursement for screening and intervention. A copy of this screening tool is located in the "Forms" section of this manual.

Antepartum Visits

South Carolina Medicaid provides pregnant women with unlimited antepartum ambulatory care visits, and recognizes evaluation and management procedure codes as antepartum visits when billed in conjunction with a pregnancy diagnosis code. **To ensure that the E/M codes billed for antepartum care do not count towards the patient's**

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Antepartum Visits (Cont'd.)

limit of 12 ambulatory care visits per year, a pregnancy diagnosis code must be used on the claim. The pregnancy diagnosis codes are V22, V23, V28, 640 – 648, 650 – 658, 671, 673,675, and 676.

Antepartum Visits (99213) with Additional Services – Antepartum care includes continuing physical exams and recording of weight, blood pressure, and fetal tones. The additional services necessary for use of this enhanced antepartum code include:

- Follow-up on referrals
- Follow-up on missed appointments
- Continued health education

The enhanced services may be documented by a notation in the woman's chart on each visit, or by dating the HM/HF checklist for the topic covered each visit. Use of the HM/HF checklist is optional. A sample copy of the checklist can be found in the Forms section of this manual.

Antepartum Visits (99212) without Additional Services – Use of procedure code 99212 for an antepartum visit must include continuing physical exams, recording of weight, blood pressure, and fetal tones.

Antepartum Visits with "Higher than Usual" Level of Care – If appropriate due to the level of care, a higher-level E/M code (99214 or 99215) may be billed for the antepartum visit. Documentation must justify the level of care.

Ultrasounds

SCDHHS policy allows three obstetrical ultrasounds per pregnancy for OB/GYN providers. Ultrasounds in the first trimester are performed to establish viability, gestational age, or to detect malformations. Two additional ultrasounds, performed during the second or third trimester, establishes more detailed anatomy and/or interval growth. Additional ultrasounds may be approved if supporting documentation is attached to the claim clearly indicating that the service provided is medically necessary. Examples of appropriate documentation include ultrasound reports and patient clinical records and history. If the documentation is insufficient or illegible, reimbursement for additional ultrasounds will be rejected. Claims for obstetrical ultrasounds that exceed the defined limits will be reviewed by KePRO for medical necessity.

For Maternal Fetal Medicine (MFM) specialist, there is no limit on the number of ultrasounds that can be submitted for reimbursement. However, all ultrasounds provided by MFM specialists must have documentation to support medical necessity in the patient's medical record.

All ultrasound services that appear to fall outside of best practice guidelines are subject to post-payment review by the Division of Program

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Ultrasounds

Integrity. Multiple gestations billed with CPT add-on codes will be counted as one ultrasound if billed on the same claim with primary CPT codes.

Ultrasounds requested by the patient to determine the sex of the fetus or for other reasons are the responsibility of the patient.

When ultrasounds are performed at the hospital, a 26 modifier is required if the physician provides the interpretation. When the ultrasounds are performed in the office, no modifier is required if the physician owns the equipment. The physician's interpretation of the ultrasound must be documented in the patient's record.

No prior authorization is necessary for ultrasounds when performed within the guidelines as stated in the Current Procedural Terminology (CPT) book. Repeat ultrasounds are allowed when medically necessary. The medical record must substantiate the reason for the follow-up ultrasounds.

Additional Services

Fetal Biophysical Profile (76818) – Fetal biophysical profiles must also be medically justified. The medical record must reflect medical necessity.

Amniocentesis (59000) – Amniocentesis is a covered service when medically necessary. Justification must be documented in the medical record. Refer to Genetic Studies for coverage criteria. Reimbursement is the same in the office or hospital (do not use 26 modifier for place of service 21 or 22).

Ultrasound for Amniocentesis Guidance (76946) – When performed in the hospital, do not use the 26 modifier since the code is for supervision and interpretation only.

Non-Stress Test (59025) – Non-stress tests (NST) are reimbursed when medically necessary. Reimbursement is not allowed when performed in the hospital by hospital personnel. If the physician provides the interpretation in place of service 21 or 22, he or she should bill with the 26 modifier. The physician's interpretation of the NST must be clearly documented in the patient's record.

Tocolytic – Tocolysis is non-compensable as a separate reimbursement under the Physician Services program. If a patient is admitted for tocolysis, the physician may bill for the appropriate hospital visits, prolonged services (99356), or critical care services when applicable. The medical record must reflect the level of service billed. Tocolysis agents and monitoring are considered an integral part of the hospital allowable charged.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Additional Services (Cont'd.)

Lab Procedures – If the physician sends a specimen to an independent lab, the lab will bill for their services.

- The collection of a urine specimen is included in the office visit.
- Finger/heel/ear stick for collection of specimen(s) will be included in office visit reimbursement or lab test reimbursement and may not be billed under code 36415. Lab tests performed in the office may be billed as a separate charge by billing the appropriate 80000 range CPT code allowed by the laboratory's CLIA certification category. Medicaid does not reimburse the maternal care provider for tests performed at an independent lab.

Venipuncture – When performing a venipuncture, bill the service using procedure code 36415. No documentation is required to be sent with the claim. If more than one venipuncture is performed on the same date of service, the claim must be billed hard copy with documentation of the number of venipunctures attached.

Non-Self-Injectable Drugs – The physician must provide any drugs that are not self-injectable and bill Medicaid the appropriate procedure code for the cost of the drug in addition to procedure code 96372 for the administration of the drug. A physician may not write the patient a prescription for the medication to be filled at a pharmacy with the expectation that the beneficiary return to the physician's office for administration. The pharmacy will not be reimbursed for the prescription.

Enhanced Services for Pregnant Women Offered by SCDHEC – In addition to traditional medical care, pregnant women often have nutritional, environmental, psychosocial, and educational needs that may influence pregnancy outcomes.

In an effort to address these needs, all Medicaid pregnant women are eligible for the following Family Support Services through SCDHEC:

- **Psychosocial Intervention** – Patients may be referred to SCDHEC for services by an appropriately credentialed social worker for an assessment followed by services based on an individualized plan of care.
- **Nutritional Services** – Patients may be referred to SCDHEC for services by an appropriately credentialed nutritionist or dietitian for an assessment followed by treatment that responds to individual patient needs and problems.
- **Health Education** – Information and process-oriented activities may be provided on an individual or group basis to predispose, enable, or reinforce patient adaptation or behavior conducive to health at the local health department.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Additional Services (Cont'd.)

For information on referrals to authorized providers of these services, call the PSC at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us.

17 Alpha Hydroxyprogesterone Caproate (17P)

SCDHHS currently covers the use of 17 alpha hydroxyprogesterone caproate (17-P) intramuscular injections to support the prevention of preterm births. The therapy is considered effective in reducing negative outcomes and improving the quality of care in pregnant women. 17-P will be covered on a weekly basis beginning at 16 weeks gestation through 36 weeks gestation when the patient presents with a history of spontaneous preterm delivery in a single pregnancy, before 37 weeks gestation. All other risk factors for preterm delivery and administering 17-P are considered investigational and not medically necessary.

Providers must bill with Healthcare Common Procedure Coding System (HCPCS) code **J3490** (unclassified drug) and the **TH** modifier in order to be reimbursed by SCDHHS. The maximum reimbursement rate is $20.00 per unit (1 unit per 250mg injection). Providers can also be reimbursed for an administration code. The Current Procedural Terminology (CPT) code **96372** can be billed for administration of the drug, which must be given in the physician's office or clinic. When billing Medicaid, providers must include the National Drug Code in field 24A of the CMS-1500 claim form and the number of units in field 24G.

17 Alpha Hydroxyprogesterone Caproate (Makena™)

The brand name form of 17 Alpha Hydroxyprogesterone Caproate, Makena™, is a covered service. Makena™ is a prescription hormone medicine (progestin) used to lower the risk of preterm birth in women who are pregnant. Prior Authorization is required. Physicians must bill using code HCPCS code J1725 and include the prior authorization number on the claim. CPT code 96372 is billed per injection for the administration.
Requests for prior approval should be faxed to (803) 255-8342, Attn: Prior Review Authorization, with documentation to support the medical necessity. Responses to requests will be faxed back to the provider with an approval or denial and instructions for claims processing.

Perinatal Care

Emergency Room Visit – When the physician meets the maternal patient in the emergency room or labor and delivery unit for immediate medical attention, the appropriate level emergency department code should be billed (99281 – 99285).

Observation Admission – When the physician meets the maternal patient at the emergency room or labor and delivery unit and admits the patient to the hospital for observation (less than 24 hours), the physician may bill the appropriate level hospital observation code (99217 – 99220) with place of service 22.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Perinatal Care (Cont'd.)

External Version (59412) – External version is reimbursable as a separate procedure. The physician may bill this procedure in addition to the delivery charge. If applicable, prolonged services may also be billed. The medical record must document the service billed. This procedure is compensable at 100% of the established rate when performed on the same day of delivery.

Note: No assistant is allowed for this procedure.

Uncomplicated (Routine) Deliveries

Both vaginal (59409 and 59612) and Caesarean section (59514 and 59620) deliveries are considered surgical packages. The following are inclusive in the surgical packages:

- Pitocin induction
- Surgical or mechanical induction
- Fetal monitoring (internal or external)
- Amnio infusion
- Episiotomy
- Laceration repair
- Suture removal
- Standby for delivery
- Subsequent routine hospital care
- Hospital discharge
- Any related evaluation/management visits within 30 days following the delivery
- Routine follow-up care (However, one postpartum visit may be billed separately using procedure code 59430. Refer to *Postpartum Care* under the "Obstetrics and Gynecology" heading in this section.)
- Procedure code 59200, Insertion of Cervical Dilator (*e.g.*, laminaria, prostaglandin) is considered included in the surgical package and may not be billed in addition to the CPT code for the delivery. This applies whether being placed the day of delivery, or several days prior to delivery if placed by the delivering physician or physician within the same practicing group.

Effective with dates of service on or after August 1, 2012, providers are required to append the following modifiers, and in some cases complete the ACOG Patient Safety Checklist or a comparable patient safety justification form, when scheduling an induction of labor or a planned cesarean section for deliveries less than 39 weeks gestation. The provider

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Uncomplicated (Routine) Deliveries (Cont'd.)

is responsible for maintaining a copy of this documentation in their files and in the hospital record, which are subject to SCDHHS Program Integrity review. Copies of ACOG and BOI-approved delivery guidelines, which justify elective inductions and deliveries prior to 39 weeks gestation, and the ACOG Patient Safety Checklist are located online at www.scdhhs.gov in the appendix section of this manual.

Providers should append the following modifiers to all CPT codes when billing for vaginal deliveries and cesarean sections:

GB - 39 weeks gestation and or more

For all deliveries at 39 weeks gestation or more regardless of method (induction, cesarean section, or spontaneous labor)

CG - Less than 39 weeks gestation

- For deliveries resulting from patients presenting in labor, or at risk of labor, and subsequently delivering before 39 weeks, or
- For inductions or cesarean sections that meet the ACOG or BOI-approved medically necessary guidelines, the appropriate ACOG Patient Safety Checklist must be completed and maintained for documentation in the patient's file, or
- For inductions or cesarean sections that do not meet the ACOG or approved BOI guidelines, the appropriate ACOG Patient Safety Checklist must be completed. In addition, the provider must obtain approval from the regional perinatal center's Maternal Fetal Medicine physician and maintain this documentation in the patient's file.

No Modifier - Elective non-medically necessary deliveries less than 39 weeks gestation

For deliveries less than 39 weeks gestation that do not meet ACOG or approved BOI guidelines or are not approved by the designated regional perinatal center's Maternal Fetal Medicine physician

Delivery in Cases of Prolonged Labor

Effective with dates of service on or after January 1, 2012, SCDHHS modified the delivery policy in cases of prolonged labor when a vaginal delivery with failure to progress converts to a cesarean section. For beneficiaries that have been admitted to the hospital and have been in active labor for at least six hours, the procedure code 59514 and modifier UA should be used when billing for the cesarean delivery. The patient records must indicate the time the beneficiary was admitted to the hospital with active labor and the start time of the cesarean section. All claims and reimbursements are subject to an audit by the Division of Program Integrity.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Hospital Admission for Delivery

The hospital admission codes 99221 – 99223 are not allowed if the delivering physician or group has provided prenatal care to the beneficiary. The appropriate level admission code may be billed with drop-in vaginal and Caesarean section deliveries only.

Emergency Deliveries

If the patient gives birth outside the hospital setting and the patient's private physician did not perform the delivery, but later meets the maternal patient at the hospital for post-delivery services, the following procedures apply:

- The private physician should bill procedure code 59414 for delivery of the placenta, if applicable.
- The private physician may also bill for subsequent hospital care and the hospital discharge, if applicable.

If a hospital-based physician actually performs the delivery and the private physician arrives in time to assist the hospital-based physician or arrives shortly after the delivery, the following apply:

- The hospital-based physician would bill for the delivery.
- The private physician would bill for the post-delivery services using procedure code 59414 if the private physician performed the services.
- The private physician may also bill for subsequent hospital care and the hospital discharge, if applicable.

If the private physician is not involved in the delivery or post-delivery services, then the following applies:

- The physician may bill for the admission (if appropriate), subsequent hospital care, and the discharge, if applicable, during the hospitalization for the delivery.

If a physician or certified nurse midwife is preparing to deliver a baby and it is decided that the baby must be delivered by an emergency C-section and an obstetrician must be called in, then the following applies:

- The physician or certified midwife may receive payment from Medicaid for his or her involvement in the case by billing the C-section code with an 80 modifier. Technically, the physician or certified nurse midwife would be billing as an assistant surgeon on the C-section. Reimbursement for this procedure is 20% of the C-section rate.

Multiple Births

If the patient delivers multiple babies, all either vaginally or by C-section, the first birth should be billed with no modifier, and each consecutive birth should be billed using modifier 51.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Multiple Births (Cont'd.)

Example: Delivery of triplets, all vaginally

59409 (00) Vaginal Delivery

59409 (51) Vaginal Delivery

59409 (51) Vaginal Delivery

Billing Note: For multiple births of more than two, the claim should be sent hardcopy with operative notes attached.

If the patient delivers multiple babies, the first vaginally and one (or more) via C-section, the first birth should be billed with no modifier, and the following birth, via C-section, should be billed using modifier 79.

Example: Delivery of triplets, 1st birth vaginally, 2nd and 3rd via C-Section

59409 (00) Vaginal Delivery

59514 (79) C-section Delivery

59514 (51) C-section Delivery

If you should have further questions regarding multiple births, please contact PSC at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us.

Pre-Term Deliveries

Refer to the "Abortion Guidelines" below for the policy on coding for a vaginal delivery or non-elective abortion.

Postpartum Care

Routine Postpartum Visit (59430) – The postpartum visit includes an uncomplicated routine GYN examination of the mother following a vaginal or C-section delivery. Only one postpartum exam per delivery is allowed. Reimbursement for all other routine postpartum visits is included in payment for the delivery.

Effective July 1, 2005, Family Planning counseling or instruction (99401 and 99402) may not be billed in addition to the postpartum code when Family Planning services are rendered and documented.

See "Family Planning" in this section for the code description and more details.

Complication/Other Medical Attention During 30 Days Post Delivery – If E/M services unrelated to routine postpartum care are necessary during the 30 days post-delivery, bill these services using modifier 24. Documentation in the patient's chart should substantiate that the visit was unrelated to the delivery.

Note: Wound infection is not considered routine postpartum care.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Abortion Guidelines

Non-Elective Abortions

All non-elective abortions, including spontaneous, missed, incomplete, septic, hydatidiform mole, etc., require only that the medical record verify such a diagnosis. Medical procedures necessary to care for a patient with an ectopic pregnancy are not modified by this section and are compensable services.

Therapeutic Abortions

In compliance with federal regulations (42 CFR 441.203 and 441.206), SCDHHS requires documentation for all charges associated with instances of therapeutic abortion. This includes the attending physician, the anesthesiologist, and the hospital.

Therapeutic abortions are sponsored only in cases that a physician has found, and certified in writing to the Medicaid agency, that on the basis of his or her professional judgment, the pregnancy is the result of an act of rape or incest; or the woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed.

The abortion statement must contain the name and address of the patient, the reason for the abortion, and the physician's signature and date. The patient's certification statement is only required in cases of rape or incest. The medical record must document that continued pregnancy would endanger the life of the mother or that the pregnancy is the result of an act of rape or incest. This may be reflected in the office admission history notes and physical, discharge summary, consultation reports, operative records, and/or pathology reports. Both the abortion statement and the appropriate medical records must be submitted with the claim. A sample copy of the abortion statement form can be found in the Forms section of this manual. If documentation is insufficient or the abortion statement is improperly completed, the claim will be rejected.

Questions should be directed to the PSC at 1-888-289-0709 or providers should submit an online inquiry at http://www.scdhhs.gov/contact-us.

Billing Notes

When billing for any type of abortion, the procedures must be billed using the abortion procedure codes. The range 59812 – 59830 and 59870 should be used for spontaneous, missed, and septic abortions, and hydatidiform mole; and 59840 – 59857 should be used for therapeutic abortion. The vaginal delivery code should not be used to report an abortion procedure.

The only exception to this rule is if the physician actually performs the delivery of the fetus and only when the gestation is questionable and there is a probability of survival. The medical record must contain documented

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Billing Notes (Cont'd.)

evidence that the fetus was delivered by the physician. If the physician did not perform the delivery, but problems necessitated his or her presence, then the appropriate E/M codes should be used to report these services.

Diagnosis codes in the 635 range should be used only to report therapeutic abortions. Spontaneous, inevitable, and missed abortions should be reported with the appropriate other diagnosis codes (*e.g.*, 630, 631, 634, 636, and 637). Abortions which are reported with diagnosis and procedure codes for therapeutic abortion must be accompanied by complete medical records which substantiate life endangerment to the mother or that the pregnancy is a result of rape or incest, and the signed abortion statement.

The following diagnosis codes do not require documentation: 630, 631, 632, 656.5 (0, 1, 3), or 658.2 (0, 1, 3).

Licensed Midwives

Medicaid sponsors the enrollment of licensed midwives. The scope of practice is limited to that defined in the South Carolina State Register, Volume 17, Issue 7, Chapter 61.

As Medicaid providers, licensed and certified midwives are required to maintain and disclose their records consistent with Section 1 of this manual, "General Information and Administration." As allied health professionals, licensed midwives are required by state law (SC Code Section 20-7-510) to report any signs of abuse or neglect to children that they may encounter in the office or home setting.
Additional enrollment and documentation requirements are specified below. For more information on Medicaid-sponsored midwifery services, please contact the PSC at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us.

Requirements for Physician Backup

The same physician or group must agree to provide the following services:

- Two assessment visits as required by regulations
- Appropriate prescriptions for any medications that the midwife may administer at the time of the delivery according to the regulations (*e.g.*, Pitocin, RhoGam, eye prophylaxis, etc.)
- Medical evaluation and treatment in the event of a complication during pregnancy
- Delivery services in the event of an emergency

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Licensed Midwife Documentation Requirements

The following documentation must be maintained for all services provided by a licensed midwife:

- The midwife's initial claim for prenatal services for each beneficiary must be accompanied by signed documentation from a physician credentialed in obstetrics who agrees to provide medical backup in the event of a complication or emergency.
- Documentation of the physician's hospital privileges must be provided to SCDHHS.
- Any changes in the physician backup must be reported in writing to the Division of Physician Services.
- The physician who agrees to provide backup must be enrolled as a Medicaid provider.

Additional Documentation That Must Be in the Patient's Record

The following additional documentation regarding the Licensed Midwife must be kept in the patient's medical record:

- A signed consent form that documents the beneficiary's awareness that her choice of provider can be made or changed at any point in the pregnancy
- A certification statement provided to the physician by the midwife that the particular home is an acceptable environment for a birth
- A copy of the plan for accessing emergency care with a confirmed source of transportation to the hospital provided to the beneficiary
- Documentation that the beneficiary has been advised of Family Support Services available through the SCDHEC

Billing Procedures

Required Modifier for Licensed Midwives – When filing claims for services rendered by licensed midwives, all procedure codes must be filed with an SB modifier.

Initial OB Exam by the Licensed Midwife – The initial obstetrical exam by the licensed midwife must be billed using the appropriate level of evaluation and management CPT procedure code for the complexity of the exam. An initial OB exam may be billed one time only during the term of pregnancy. An exam billed using this procedure code must meet the following requirements:

- Must be a comprehensive medical exam
- Must establish the patient's medical history
- Must provide health education materials
- Must include a WIC referral to the local county health department

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Billing Procedures (Cont'd.)

(This referral can be made at a later date since the provider may not be aware that a patient has Medicaid benefits until later in her pregnancy. The WIC referral must be documented in the patient's chart.)

Physician Backup Coding – Each of the two obstetrical examinations by the backup physician must be billed using the appropriate level of complexity evaluation and management CPT procedure code.

Delivery Supply Code (S8415) – An additional code has been developed to reimburse for supplies used for delivery in the home setting. Procedure code S8415 may be billed by the licensed midwife in addition to the vaginal delivery code.

Newborn Care (99461) – The newborn examination should be billed with CPT code 99461 using the SB modifier.

Newborn Metabolic Screening (S3620) – In compliance with DHEC Newborn Screening regulations, if there is no attending physician, then the licensed midwife is responsible for the collection of specimens. Procedure code S3620 may be billed by the licensed midwife when an invoice has been sent to them from DHEC for the service. The invoice must be maintained in the medical records.

Birthing Centers

Medicaid will contract with birthing centers for obstetrical and newborn services. The birthing center must be licensed by SCDHEC prior to enrolling in the Medicaid program. For enrollment information, please contact our enrollment department at 1-888-289-0709.

OB/Newborn Care (59409) with TC modifier – Medicaid will reimburse for an all-inclusive facility fee. The facility fee will include all technical services provided by the birthing center including, but not limited to, administration, nursing, drugs, surgical dressings, supplies, and materials for anesthesia.

Observation for Maternity/Labor– Procedure code 99218 is billable for observation of maternity/labor. This code is billable only if the patient is at the birthing center laboring but the labor does not progress and the patient is sent home to return at a later time or discharged to the hospital.

Newborn Exam – Procedure code 99463 should be billed for newborn Exams.

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PROGRAM REQUIREMENTS

Levonorgestrel-Releasing Intrauterine Contraceptive System (Mirena) Coverage

Medicaid will sponsor reimbursement for the Levonorgestrel-Releasing Intrauterine Contraceptive (Mirena®). To bill for Mirena®, the provider may use HCPCS code J7302. Please include the FP modifier on the claim form. Providers should continue to use the appropriate Family Planning diagnosis codes and CPT codes for the insertion and removal of the device. Please follow the National Drug Code (NDC) requirements as outlined in the September 11, 2006 bulletin.

Etonogestrel Implant (Implanon™) Coverage

Medicaid will sponsor reimbursement for the Etonogestrel Implant (Implanon™), a single-rod implantable contraceptive that is effective for up to three years. To bill for Implanon™, the provider may use HC`PCS code J7307. Please include the FP modifier on the claim form. Providers should continue to use the appropriate Family Planning diagnosis codes and CPT codes for the insertion and removal of the device. Please follow the National Drug Code (NDC) requirements as outlined in the September 11, 2006 bulletin.

Zithromax (Oral Suspension)

Medicaid will sponsor reimbursement for Zithromax (Azithromycin) for oral suspension in one gram dose packets by prescription or when provided in the physician's office. Procedure code Q0144 may be used when this oral drug is provided in the physician's office.

Leupron Depot (Leuprolide Acetate)

Medicaid will sponsor reimbursement for Leupron Depot injections. The provider must supply the drug. No prior authorization is required. Use J1950 (3.75 mg) to bill.

Pessary

Medicaid will sponsor reimbursement for pessaries. The physician must provide the pessary. To bill, use procedure code A4561.

Salpingectomy and/or Oophorectomy (58700 and 58720)

The operative report must be submitted with the claim. The medical record must reflect medical necessity for the procedure performed. Reimbursement using these codes is not allowed if performed as a sterilization procedure, unless a copy of the Sterilization Consent Form is attached. A sample copy of the form can be found in the Forms section of this manual.

Depo-Provera for Other than Contraceptive Purposes

Procedure code J1051 is used to report Depo-Provera for other than contraceptive purposes. Dosage is 50 mg. Frequency is limited to 500 mg and should be billed in units of 50 mg.

Hysterectomies

Prior Approval – All hysterectomies must be preauthorized by KePRO except for those being performed on patients that are dually eligible for Medicare and Medicaid. (See the heading "Utilization Review Services" in this section for more information.) All prior approval requests for

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Hysterectomies (Cont'd.)

hysterectomies must be in writing. The South Carolina Medicaid Surgical Justification Form and the Consent for Sterilization (DHHS 1723) must be completed and submitted to KePRO. The forms are available in the Forms section of the manual. Both forms must be submitted at least 30 days prior to the scheduled surgery to KePRO via facsimile at 1-855-300-0082.

InterQual criteria will be used to for screening prior authorization request. In addition to meeting InterQual criteria a hysterectomy must be medically necessary and meet the following requirements:

- The individual or her representative, if any, must be informed orally and in writing that the hysterectomy will render the individual permanently incapable of reproducing.
- The individual or her representative, if any, must sign and date the acknowledgement of receipt of hysterectomy information (DHHS Form 1729) prior to the hysterectomy.

The Consent for Sterilization form is not required if the individual was already sterile before the surgery, or if the individual required a hysterectomy because of a life-threatening emergency situation in which the physician determined that prior acknowledgement was not possible. In these circumstances, a physician statement is required. The statement must indicate the cause of the sterility or the diagnosis and description of the nature of the emergency.

Reimbursement for a hysterectomy is not allowed if the hysterectomy is performed solely for the purpose of rendering an individual permanently incapable of reproducing. A hysterectomy may not be covered if there was more than one purpose for performing the hysterectomy, but the primary purpose was to render the individual permanently incapable of reproducing.

A hysterectomy can be reimbursed by Medicaid in cases of retroactive eligibility only if the physician certifies in writing **ONE** of the following:

- The individual was already sterile before the hysterectomy and the physician who performs the hysterectomy certified in writing that the individual was sterile at the time of the hysterectomy. The certification must state the cause of the sterility.
- The individual requires a hysterectomy because of a life-threatening emergency situation, and the physician who performs the hysterectomy certified in writing that the hysterectomy was performed under a life-threatening situation in which the physician determined prior acknowledgement was not possible. The certification must include a diagnosis and description of the

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Hysterectomies (Cont'd.)

nature of the emergency. If timing permits, prior approval may be requested, but appropriate and timely medical care should not be delayed to obtain this approval.

Infertility Procedures

Any medications, tests, services, or procedures performed for the diagnosis or treatment of infertility are non-covered.

Ectopic Pregnancy

For surgical treatment of an ectopic pregnancy, bill the appropriate code for the 59120 – 59151 series. No documentation is required with the claim when using these codes.

Pelvic Exam

A pelvic exam under anesthesia should only be billed if performed separately and if medically indicated. Pelvic exams at the time of surgery involving the vagina or through a vaginal incision are included in the surgical procedure and should not be billed in addition to the surgical procedure (*e.g.*, vaginal hysterectomy, laparoscopic elective sterilization, conization of the cervix, etc.).

Family Planning

Family Planning (FP) services are pregnancy prevention services for males (vasectomies) or females of reproductive age (usually between the ages of 10 and 55 years). Family Planning services do not require a referral or prior authorization for beneficiaries in Medicaid's managed care programs. All services rendered to dually eligible (Medicare and Medicaid) patients should be filed to Medicare first. Family Planning services that are non-covered services by Medicare are reimbursed by Medicaid. Providers should contact PSC at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us for billing procedures.

Covered Services

Family Planning services may be prescribed and rendered by physicians, hospitals, clinics, pharmacies, or other Medicaid providers recognized by state and federal laws and enrolled as a Medicaid provider. Services include family planning examinations, counseling services related to pregnancy prevention, contraceptives, laboratory services related to Family Planning, etc., and sterilizations (including vasectomies) accompanied by a completed sterilization consent form (DHHS Form 1723). (This form is located in the Forms section of this manual).

All Family Planning services should be billed using the appropriate CPT or HCPCS code with an FP modifier and/or an appropriate diagnosis code.

Note: Pregnancy testing (when the test result is negative) is a reimbursable family-planning-related service in two situations:

1. The test is provided at the time family planning services are initiated for an individual.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Covered Services (Cont'd.)

2. The test is provided after the initiation of family planning services, when the patient may not have used the method properly, or when the patient is having an unusual response to the family planning method.

Non-Covered Services

Family Planning services **required** to manage or to treat medical conditions and/or diseases, whether or not such procedures are also related to preventing or delaying pregnancy, are **not** covered eligible. Services to address side effects or complications (*e.g.,* blood clots, strokes, abnormal Pap smears, etc.) associated with various family planning methods requiring medical interventions (*e.g.,* blood clots, strokes, abnormal Pap smears, etc.) other than changing the birth control method should **not** be billed using an FP modifier or Family Planning diagnosis code.

Many procedures that are performed for "medical" reasons also have family planning implications. When services other than Family Planning are provided during a family planning visit, these services must **be billed separately using the appropriate CPT/HCPCS codes and modifiers if applicable.** Examples of these services include:

- Sterilization by hysterectomy
- Abortions
- Hospital charges incurred when a beneficiary enters an outpatient hospital/facility for sterilization purposes, but then opts out of the procedure
- Inpatient hospital services
- Removal of an IUD due to a uterine or pelvic infection
- Colposcopy and biopsy of cervix/vagina performed to identify and treat medical conditions
- Diagnostic or screening mammograms
- Treatment of medical complications (for example, perforated bowel or bladder tear) caused by, or following a Family Planning procedure
- Any procedure or service provided to a woman who is known to be pregnant
- Removal of contraceptive implants due to medical complications
- Services to a woman who has been previously sterilized
- Routine gynecological exams (diagnosis code V72.31) in which contraceptive management is not provided

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Non-Covered Services (Cont'd.)

Note: Beneficiaries are allowed one permanent sterilization procedure per lifetime.

Family Planning Visits

Initial Family Planning Visit

New patients will receive an initial family planning exam before contraceptives or other family planning procedures are prescribed. A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years. This visit must be billed using the appropriate level of CPT evaluation and management codes **99201 – 99205** with an FP modifier.

The initial visit requires the establishment of the medical record, an in-depth evaluation of an individual including a complete physical exam, an establishment of baseline laboratory data, contraceptive and sexually transmitted disease prevention counseling, medically necessary lab tests, and an issuance of supplies or prescriptions. The initial Family Planning Physical Assessment is an integral part of the initial Family Planning visit. The following services, at a minimum, **must** be provided during the initial visit:

- History
- Height, blood pressure, and weight check
- Thyroid palpation
- Breast and the axilla examination accompanied by instructions for a self-breast examination
- Abdominal examination and liver palpation
- Auscultation of the heart and the lungs
- Pelvic evaluation to include bimanual and recto-vaginal examination with cervical visualization
- Examination of extremities for edema and varicosity
- Testicular, the genital, and the rectal examination for males

Annual Visit

The annual visit is the re-evaluation of an established patient requiring an update to the medical record, interim history, complete physical examination, appropriate diagnostic laboratory tests and/or procedures, family planning counseling, and adjustment of contraceptive management as indicated. This visit should be billed using the appropriate level of CPT evaluation and management codes **99212 – 99215** with an FP modifier. The following services must be provided during the annual visit:

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Family Planning Visits (Cont'd.)

- Updating of entire history and screening, noting any changes
- Counseling and education, as necessary, regarding pregnancy prevention and/or sexually transmitted diseases
- Laboratory tests
- Issuance of birth control supplies or prescription

Periodic Revisit

The periodic revisit is a follow-up of an established patient with a new or an existing family planning condition. These visits are available for multiple reasons such as change in contraceptive method due to problems with that particular method (*e.g.*, breakthrough bleeding or the need for additional guidance) or issuance of birth control supplies. This visit should be billed using the appropriate level of CPT evaluation and management codes **99211 – 99215** with an FP modifier. For CPT codes 99212-99215, the following services, at a minimum, must be provided during the revisit:

- Weight and blood pressure check
- Interim history
- Symptom appraisal as needed
- Documentation of any treatment and/or counseling including administration and/or issuance of contraceptive supplies

Note: Testing and/or treatment for STIs are a reimbursable service only when it takes place at an initial or annual visit.

Family Planning Counseling Visits

The Family Planning Counseling/Education visit is a **separate** and distinct service using the appropriate CPT codes **99401** or **99402** with an FP modifier. Family Planning Counseling/Education is a **face-to-face** interaction to enhance a patient's comprehension of, or compliance with, his or her family planning method of choice. These services are for the purpose of providing education/counseling **above and beyond** the routine contraceptive counseling that is included in the clinic/office visit.

Note: This service may not be billed on the same day as an office or a clinic visit **(including an EPSDT visit), antepartum visit, postpartum visit, or family planning exam.**

Family Planning Eligibility Category Only

Effective January 1, 2011, the Centers for Medicare and Medicaid services has approved for South Carolina to provide Family Planning services to individuals under the State Plan option. Services are now available to men and women with a family income at or below 185% FPL and who are ineligible for any other category or program. Services will

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Family Planning Eligibility Category Only (Cont'd.)

include a Family Planning yearly exam, birth control, permanent sterilization procedures (vasectomy and tubal ligation), lab tests, and the first treatment for some sexually transmitted infections. SCDHHS may authorize coverage for any or all of the three calendar months preceding the month of application.

An application is necessary to determine if the man or woman qualifies for Family Planning Only services, or a full array of services under another eligibility category. If the beneficiary becomes eligible for full coverage of Medicaid benefits, she will have the option of being terminated from the Family Planning Eligibility Category Only and transferred to the appropriate eligibility category that will enable her to receive the full range of Medicaid covered services as well as Family Planning services.

The Family Planning Eligibility Category Only promotes the increased use of primary medical care. Services provided to men and women under the State Plan that are not pregnancy prevention or related to covered sexually transmitted infections (STI) services are the responsibility of the patient.

Note: If a medical condition and/or problem is identified and the provider is unable to offer free or affordable care, the provider should refer the beneficiary to their local health department for a listing of primary care providers who will provide services based on the woman's income.

Family Planning services provided to men and women under the Family Planning Eligibility Category Only are billed using the appropriate CPT code or HCPCS code with an FP modifier and diagnosis code. When a Pap smear is sent to an outside lab for screening, the lab staff must be notified that the patient is an –Family Planning Eligibility Category Only participant so they can bill using an appropriate diagnosis code and an FP modifier to ensure proper payment.

Covered Services Under the Family Planning Eligibility Category Only

Section 4 contains a list of procedure and diagnosis codes that are currently approved for use under the Family Planning Eligibility Category Only. While there are codes that may be considered Family Planning services other than the ones listed, they are not covered for this eligibility group of women. This list will be updated periodically as codes are approved or deleted. All Family Planning services **must** be billed using a family planning modifier (FP) and approved family planning diagnosis code.

Effective January 1, 2008, if, during an initial or annual family planning evaluation/management visit, any of six specific STIs is identified, one

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Family Planning Eligibility Category Only (Cont'd.)

course of antibiotic treatment from the approved drug list (see Section 4) will be allowed per calendar year under the Family Planning Eligibility Category Only. The six STIs are: syphilis, chlamydia, gonorrhea, herpes, candidiasis, and trichomoniasis. Any copayments for the medications will be the responsibility of the patient.

Neither STI testing nor STI treatment are covered during any visit other than initial and/or annual visits.

Breast and Cervical Cancer Early Detection Program (Best Chance Network)

The South Carolina Breast and Cervical Cancer Early Detection Program (Best Chance Network) provides coverage for women under the age of 65 who have been diagnosed and found to be in need of treatment for either breast or cervical cancer or pre-cancerous lesions (CIN 2/3 or atypical hyperplasia). For further information, providers or beneficiaries may call toll free 1-888-549-0820.

Department of Health and Environmental Control

SCDHEC provides outreach and direct FP services as part of the waiver and will assist women in finding a primary care physician or clinic to provide Family Planning services. Participants in the FP program can call toll free (800) 868-0404 for more information about covered services, and health department locations. Also, SCDHEC contracts with private physicians who will offer FP services to participants.

Elective Sterilization

SCDHHS is required to have a completed sterilization consent form that meets the federal regulations for all charges associated with elective sterilization. Photocopies are accepted if legible. The physician should submit a properly completed consent form with his or her claim so that other providers involved with the sterilization procedure may also be reimbursed.

Definitions (as stated in the Code of Federal Regulations; 42.CFR441.251)

Sterilization – Any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing.

Institutionalized Individual – An individual who is:

- Involuntarily confined or detained under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness or
- Confined, under a voluntary commitment, in a mental hospital or other facility for the care and treatment of mental illness.

Mentally Incompetent Individual – Means an individual who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Definitions (as stated in the Code of Federal Regulations; 42.CFR441.251) (Cont'd.)

All sections of the Sterilization Consent form (DHHS Form 1723) must be completed when submitted with the claim for payment. Each sterilization claim and consent form are reviewed for compliance with federal regulations (42CFR 441.250 – 441.259, F).

Requirements

For Medicaid financial coverage of an elective sterilization for a male or female, the following requirements must be met:

- The Sterilization Consent Form must be signed at least 30 days prior to, but no more than 180 days prior to, the scheduled date of sterilization.
- The individual must be 21 years old at the time the consent form is signed.
- The patient cannot be institutionalized or mentally incompetent. If the physician questions the mental competency of the individual, he or she should contact the PSC at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us.
- The individual must voluntarily give consent. All questions must be answered and all topics in the consent form discussed. (A witness of the patient's choice may be present during the consent interview.) The family planning counseling or family planning education/instruction procedure code may be billed when this service is rendered and documented.
- A copy of the consent form must be given to the patient after Parts I, II, and III are completed.
- At least 30 days, but not more than 180 days, must have passed between the signing of the consent form and the date of the sterilization procedure. The date of the beneficiary's signature is not included in the 30 days (*e.g.*, day one begins the day after the signature). No one can sign the form for the individual.

Exceptions to the 30 day waiting period are:

- Premature Delivery – The informed consent must have been signed at least 30 days prior to the expected date of delivery. In cases involving a Caesarean section, the scheduled date of the C-section is considered the expected date of delivery. At least 72 hours must have elapsed since the informed consent was given.
- Emergency Abdominal Surgery – The emergency does not include the operation to sterilize the patient. At least 72 hours must have elapsed since the informed consent was given. An explanation must accompany the consent form.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Requirements (Cont'd.)

Note: If the beneficiary is pregnant, premature delivery is the only exception to the 30-day waiting period.

Informed consent may not be obtained while the patient to be sterilized is:

- In labor or childbirth
- Seeking or obtaining an abortion
- Under the influence of alcohol or other substances which may affect the patient's judgment.

Sterilization Consent Form

If the consent form is correctly completed and meets the federal regulations, the claim can be approved for payment. If the consent form does not meet the federal regulations, the claim will be rejected and a letter sent to the physician explaining the rejection. If the consent form is not submitted with the claim, the claim will be rejected. If the line is rejected, a new claim must be submitted with the consent form. A sample copy of the consent form and instructions can be found in the Forms section of this manual.

Listed below is an explanation of each blank that must be completed on the consent form and whether it is a correctable error.

Consent to Sterilization

- Name of the physician or group scheduled to do the sterilization procedure. (If the physician or group is unknown, put the phrase "OB on Call"): Correctable Error.
- Name of the sterilization procedure (*e.g.*, bilateral tubal ligation): Correctable Error.
- Birth date of the beneficiary (The beneficiary must be 21 years old when he or she gives consent by signing the consent form 30 days prior to the procedure being performed.): Correctable Error.
- Beneficiary's name (Name must match name on CMS-1500 form.): Correctable Error.
- Name of the physician or group scheduled to perform the sterilization or the phrase "OB on call;" Correctable Error.
- Name of the sterilization procedure: Correctable Error.
- Beneficiary's signature. (If the beneficiary signs with an "X," an explanation must accompany the consent form.): **Non-correctable error.**
- **Date of Signature: Non-correctable error without detailed medical record documentation.**
- Beneficiary's Medicaid ID number (10 digits): Correctable Error.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Sterilization Consent Form (Cont'd.)

Interpreter's Statement

If the beneficiary had an interpreter translate the consent form information into a foreign language (*e.g.*, Spanish, French, etc.), the interpreter must complete this section. If an interpreter was not necessary, put "N/A" in these blanks: Correctable Error.

Statement of Person Obtaining Consent

- Beneficiary's name: Correctable Error.
- Name of the sterilization procedure: Correctable Error.
- Signature and date of the person who counseled the beneficiary on the sterilization procedure: This date must be the same date of the beneficiary's signature date.
  - Signature is not a correctable error.
  - Date is not a correctable error without detailed medical record documentation.
  - If the beneficiary signs with an "X," an explanation must accompany the consent form: Not a correctable error without detailed medical record documentation.
- A complete facility address: An address stamp is acceptable if legible.

Physicians Statement

- Beneficiary's name: Correctable Error.
- Date of the sterilization procedure (This date must match the date of service that you are billing for on the CMS-1500.): Correctable Error.
- Name of the sterilization procedure: Correctable Error.
- Estimated Date of Confinement (EDC) is required if sterilization is performed within the 30-day waiting period and the beneficiary was pregnant. At least 72 hours are required to pass before the sterilization procedure may be done: Correctable Error.
- An explanation must be attached if emergency abdominal surgery was performed within the 30-day waiting period. At least 72 hours are required to pass before the sterilization, and the sterilization procedure may not be the reason for the emergency surgery.
- Physician signature and date: a physician's stamp is acceptable. The rendering or attending physician must sign the consent form and bill for the service. The physician's date must be dated the same as the sterilization date or after.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Sterilization Consent Form (Cont'd.)

The date is not a correctable error if the date is prior to the sterilization without detailed medical record documentation. In the license number blank, put the rendering physician's Medicaid Provider ID or NPI number (the same number that is in block 33 on the CMS-1500 claim form). Either the group or individual Medicaid Provider ID or NPI is acceptable.

Billing Notes for Sterilization and Other Related Procedures

Under the following circumstances, bill the corresponding sterilization procedure codes:

Essure Sterilization Procedure

Effective with dates of service prior to May 31, 2010, SCDHHS will reimburse for the Essure Sterilization procedure only when certain criteria are met. This procedure is available to women who have risk factors that prevent a physician from performing a safe and effective laparoscopic tubal ligation. Reimbursement will be provide for any of the following criteria:

- Morbid Obesity (BMI of 35 or greater)
- Abdominal mesh that mechanically interferers with the laparoscopic tubal ligation
- Permanent colostomy
- Multiple abdominal/pelvic surgeries with documented severe adhesions
- Artificial heart valve requiring continuous anticoagulation
- Any severe medical problems that would contraindicate laparoscopy because of anesthesia considerations. (This must be attested in the request for prior approval that general anesthesia would pose a substantial threat to beneficiaries life.)

Effective with dates of service on or after June 1, 2010, SCDHHS removed the prior authorization and criteria requirements for the Essure sterilization procedure. The procedure will be covered when performed in an inpatient or outpatient hospital setting or in a physician's office. SCDHHS will reimburse the implantable device by utilizing the Healthcare Common Procedure Coding System (HCPCS) code A4264, and the professional service will be reimbursed utilizing the CPT code 58565.

Procedure code 58340 (hysterosalpingogram) and 74740 (radiological supervision and interpretation) should be billed as follow-up procedures 90 days after the sterilization. When billing for Family Planning Eligibility Category Only beneficiaries an FP modifier must be billed. A

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Billing Notes for Sterilization and Other Related Procedures (Cont'd.)

Sterilization Consent form must be completed and submitted with the claim.

Federal guidelines for sterilization procedures will remain a requirement which includes completing and submitting a sterilization consent form.

58605 – Tubal ligation following a vaginal delivery by a method except laparoscope

58611 – Tubal ligation following Caesarian section or other intra-abdominal (tubal ligation as the minor procedure) surgery

58600 – Ligation, transection of fallopian tubes; abdominal or vaginal approach

58615 – Occlusion of fallopian tubes by device

58670 – Laparoscopic sterilization by fulguration or cauterization

58671 – Laparoscopic sterilization by occlusion by device

55250 – Vasectomy

When billing for a vaginal delivery as well as a tubal ligation performed on the same date of service, the tubal ligation must be billed using modifier 79 to ensure proper reimbursement.

Use of procedure codes 55250, 58600, 58605, 58611, 58615, 58670, and 58671 should always be billed hardcopy with a copy of the Sterilization Consent form attached.

Salpingectomy and/or Oophorectomy (58700 and 58720) – The operative report must be submitted with the claim. The medical record must reflect medical necessity for the procedure performed. Reimbursement using these codes is not allowed if performed as a sterilization procedure, unless a copy of the Sterilization Consent form is attached.

Dilation and Curettage – When a D&C is performed at the same time as sterilization, medical necessity for the D&C must be clearly documented in the patient's operative report.

SPECIALTY CARE SERVICES

This section of the manual contains policies and guidelines for services that are primarily performed and billed by specialty physicians who treat specific body systems. However, all physicians are subject to all guidelines in this manual.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Medical Review

All services provided and billed are contingent upon medical necessity. SCDHHS reserves the right to request documentation to substantiate medical necessity at any time.

Certain procedures are always subject to medical review on a pre-payment basis. These procedures are listed in their respective specialty areas in this manual. If a claim is denied for reasons of "Not Medically Necessary," the provider may request a reconsideration. The request should be in writing and sent to the Division of Hospital Services at the following address:

SCDHHS
Division of Hospital Services
Post Office Box 8206
Columbia, SC 29202-8206

If the claim is denied a second time, the provider has the right to request an appeal within 30 days of the notice of denial. The request for an appeal should be in writing and sent to the Division of Appeals and Hearings at the following address:

SCDHHS
Division of Appeals and Hearings
Post Office Box 8206
Columbia, SC 29202-8206

If a hearing is necessary, a date will be arranged by the Division of Appeals and Hearings for the appellant and SCDHHS to formally review the claim(s).

Prior Authorization

Medicaid contracts with KePRO, our Quality Improvement Organization (QIO) contractor, for utilization review services and prepayment authorization of hysterectomies. Certain other procedures are subject to prior authorization through the Division of Hospital Services. For specific details, refer to the “Utilization Review” heading in Section 1 of this manual.

General Medical Guidelines – Specialty Services

Consultations

A consultation is a request for an opinion and/or advice only. A consultation may involve a complete or a single organ system examination, followed by a written report in the patient's medical record.

The attending physician makes the request and continues in the role of primary physician unless he releases the patient to the consultant. The request for a consultation must be documented in the patient's record. The date the attending physician turns the patient's care over to the consultant

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Consultations (Cont'd.)

should be documented, and the initial physician ceases billing.

When the consultant assumes responsibility or management of a portion or all of the patient's condition, services are considered subsequent hospital visits, office visits, or concurrent care.

A follow-up consultation involves the consultant's re-evaluation of a patient on whom he or she has previously rendered an opinion or advice. As in initial consultations, the consultant provides no patient management or treatment.

Coverage – Consultation may be covered when the following conditions are met:

- A consultation or follow-up consultation is requested from a physician whose specialty or sub-specialty is different from the attending physician, for the opinion and/or advice in the further evaluation or management of the patient.
- Multiple consultations for the same patient must be determined to be medically necessary. Each consultation should relate to a different diagnosis or document that unusual circumstances exist, such as severity of condition or complexity of care.

Exclusions – Situations in which consultations generally are excluded from coverage are as follows:

- Physicians within the same specialty who are partners cannot be paid consultation fees for visits to the same patient unless one partner's sub-specialty is unique to a particular situation.
- Consultations required by hospital rules and regulations, or consultations between colleagues who exchange medical opinions as a matter of courtesy and normally without charge, are not covered.
- Anesthesia consultations are not covered on the same date as surgery or the day prior to surgery, if part of the pre-operative assessment.
- Follow-up consultations are not covered when the total or specific care of a patient is transferred from the attending physician to the consultant.

Initial Inpatient Consultation – Using the CPT guidelines for terminology and levels of service, one initial consultation is allowed per patient per admission.

Follow-up Inpatient Consultation – After an initial consultation, a maximum of two follow-up consults may be billed using the CPT guidelines.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Consultations (Cont'd.)

Documentation must reflect the request for the follow-up consultation and indicate that the consulting physician has not assumed responsibility for any portion of the patient's care. The third follow-up visit and all subsequent visits during that hospitalization must be billed with subsequent hospital visit codes.

Office or Other Outpatient Consultations – Use the CPT guidelines for terminology and levels of service.

Referral

A referral is the transfer of the total or specific care of a patient from one physician to another and does not constitute a consultation. Use proper codes for initiation of treatment (*i.e.*, office or hospital visit codes).

PSYCHIATRIC AND COUNSELING SERVICES

For Behavioral Health Procedures and Policies refer to the "Rehabilitative Behavioral Health Services Manual" located on our Web site at http://www.scdhhs.gov/.

NEPHROLOGY AND END STAGE RENAL DISEASE (ESRD) SERVICES

The following guidelines define policy and procedures as they relate to patient services and providers involved in End Stage Renal Disease treatments

Medicare/Medicaid – Dual Eligibility

Medicare is the primary sponsor for ESRD services. Medicaid reimburses based on the fee schedule for dually eligible beneficiaries.

Medicaid reimburses as primary sponsor for the initial 90-day waiting period required for Medicare coverage. Providers must notify their program manager immediately if Medicare coverage is denied after the 90-day waiting period at PSC at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us.

Medicaid will not reimburse for ESRD services after the initial 90-day waiting period if the Medicare determination is still pending. The claims will reject for a 960 edit code. If Medicare denies coverage, Medicaid will then reimburse for these services. Send your edit correction form, with edit code 960 and the Medicare denial letter attached, to the following address:

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

Medicaid will not reimburse as primary sponsor for any Medicare covered services until a denial of eligibility from the Social Security Administration is received. Medicare does not require the 90-day waiting period for individuals who are candidates for a renal transplant or for those on home dialysis.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Medicare/Medicaid – Dual Eligibility (Cont'd.)

Claims submitted to Medicaid prior to the patient being enrolled with Medicaid as an ESRD patient will be rejected for edit code 957. All patient ESRD enrollment forms must be submitted to Medicaid concurrently with the initial course of treatment and application to Social Security for Medicare coverage.

Medicaid Only – Reimbursement Guidelines

CPT Codes 90935 – 90999: Physician-related Dialysis Procedures

In Center Dialysis – Medicaid reimburses the nephrologist or other supervising internist an all-inclusive monthly fee for the supervision of ESRD services. These services are defined as monthly supervision of medical care, dietetic services, social services, and procedures directly related to the physician's role in the treatment of end stage renal disease.

If billing for a complete month of treatment supervision, the monthly code should be used. The date of service should be the last date in the month and the "days" unit block should be a "one," indicating one full month of supervision.

The monthly ESRD code includes all services rendered to the patient for all days of the month. Office visits should not be billed in addition to the monthly supervision. Special procedures may be billed separately (*e.g.*, shunt revision, cannula declotting).

If the patient is hospitalized, or for some reason did not have a full month of in-center treatments, the partial month procedure code should be used with the appropriate number of days of supervision in the days/unit column on the CMS-1500 claim form and the appropriate "to" and "from" dates of service.

Inpatient Dialysis – If an ESRD patient is hospitalized, the hospitalization may or may not be due to a renal-related condition. In either case, the patient must continue dialysis.

Inpatient dialysis usually requires more intense physician involvement for a prolonged period and/or multiple visits. Physicians will be reimbursed for inpatient dialysis services to either acute renal failure (ARF) or ESRD patients on a fee-for-service basis. These services should be charged with the CPT codes 90935 – 90947. Guidelines are the same for inpatient dialysis whether the patient is ARF or ESRD.

Complications or hospitalization for reasons not related to dialysis or the treatment of dialysis may be charged separately. However, when dialysis codes are charged, hospital visits may not be charged for the same date of service.

Visits may be charged on alternate dialysis days when applicable. Special procedures (*e.g.*, an EKG) may be charged when clearly justified as a service outside of the normal dialysis management.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Medicaid Only – Reimbursement Guidelines (Cont'd.)

For inpatient dialysis services Medicaid will apply the same rules as it does for all reasonable charge determinations. The services must meet the following criteria:

- They must be covered physician services.
- They must be medically necessary.
- They must be personally furnished by the physician.
- They must be within the requirements under Part B Medicare.

Home Dialysis – Medicare is the primary sponsor for patients receiving home dialysis services and Medicaid, if available, is the secondary sponsor of coinsurance and deductibles. The Social Security Administration does not require a delayed period for home services, and Medicare will reimburse from the initial course of treatment.

In this case, Medicaid will not reimburse for home treatments during the first ninety days of services as primary sponsor, but will pay coinsurance and deductibles.

In certain instances where Medicaid is the primary sponsor, the physician supervising the home dialysis patient should adhere to policies for in-center supervision. Reimbursement will be per full month of supervision, or per day for partial months. The monthly supervision fee includes all the services outlined for the alternate method of reimbursement. A home training supervision fee is allowed for the first month of home dialysis in addition to the regular monthly fee for treatment supervision.

Dialysis Training – Dialysis training is a covered service for ESRD patients. The initial completed course (90989) and per training session (90993) should be billed for training services for any mode (self, peritoneal, or hemodialysis). The initial course is allowed only once in a lifetime. Training services for self-dialysis performed after the initial course is completed (retraining) are compensable on a per day basis, and under the following Medicare guidelines:

- The patient changes from one mode of dialysis to another.
- The patient's home dialysis equipment changes.
- The patient's dialysis setting changes.
- The patient's dialysis partner changes.
- The patient's medical condition changes (the patient must continue to be an appropriate patient for self-dialysis).

Home support services (*e.g.,* reviewing the patient's technique and instructing him or her in any corrections) are not compensable as training services. Support services are included in the monthly or partial month ESRD supervision fees.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

OPHTHALMOLOGY AND OPTOMETRY

South Carolina Medicaid does not differentiate in the vision care fee schedule for services commonly performed by an optometrist or an ophthalmologist. Covered services for Optometrist are based on the SCDHHS policy and the South Carolina Board of Examiners in Optometry.

Routine vision services for beneficiaries over the age of 21 are non-covered services. Routine vision services include routine eye exams, refractions, corrective lenses and glasses.

Procedure codes utilized must be applicable within the provider's scope of practice. To report services provided in the office, home, hospital, or other institutional medical facility without specific ophthalmologic services, providers must use evaluation and management (E&M) codes listed in the CPT manual.

If an E&M code is used for the treatment of a disease, it cannot be used in conjunction with a comprehensive exam code for that treatment on the same date of service. The provider must bill either the E&M code or the comprehensive exam code. Providers must refer to the CPT manual to determine with E&M code is most appropriate. When using these 99000 series codes the patients record must reflect the level of service performed. Providers must have written documentation (medical justification) to warrant the use of these codes. During post-payment reviews (audits), auditors will monitor these codes closely to ensure that they reflect the documentation recorded, as defined by CPT definitions. The use of these E&M codes will count toward the 12 visits allowed to patients during the fiscal year.

Part I – Vision Care Services

Vision care services are defined as those that are reasonable and necessary for the diagnosis and treatment of conditions of the visual system and the provision of lenses and/or frames as applicable. Referrals from local DSS offices or staff, medical screenings, schools, and patient's actual complaints of vision problems constitute justification to provide eye exams and other vision services. Providers should note these referrals and complaints in the patient's records. Vision Screenings are a non-covered service.

Exam and Glasses for Beneficiaries Under 21

One full comprehensive eye examination is covered every 365 days. Refer to the CPT book to determine the correct procedure code for a new patient or for an established patient, as applicable.

When medically necessary, other services are covered during the 365-day period.

A complete set of glasses is provided every 365 days when medically necessary. Repairs and replacements during the year are not authorized.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Exam and Glasses for Beneficiaries Under 21 (Cont'd.)

Beneficiaries are responsible for any loss of glasses or breakage not related to manufacturing defects.

EXCEPTION: If frame and lenses are destroyed due to a house fire, natural disaster, or an automobile accident, a replacement pair is authorized. Providers must submit documentation with the prescription request such as fire department or police department reports as proof of incident.

If a beneficiary has cataract surgery or the prescription changes at least one-half diopter (0.50) during the 365-day period, only additional lenses (not frames) will be covered. Providers must document this medical justification in the patient's medical record.

Contact lenses are allowed for medical necessity only. Documentation must indicate the need for contact lenses over glasses. Replacement contact lenses are not covered for 365 days following the date of service.

Treatment for medically necessary non-refractive diseases and accidents are non-covered and are subject to review by the Division of Program Integrity within South Carolina Medicaid.

Non-Covered Services

The following services are non-covered under the Vision Care program:

- Routine eye exams
- Refractions
- Lenses and frames
- Optometric hypnosis
- Broken appointments
- Special reports

Guidelines for Lenses and Frames

Prescription requests must be written in language common to all health care practitioners dealing with vision problems. Criteria for the prescription form requests include, but are not limited to, the following:

- Unaided visual acuity at distance and near should be 20/30 or less. Aided and unaided visual acuities must be stated in the patient's records.
- Corrective lenses must be at least plus or minus 0.50 sphere or more, or plus or minus 0.50 cylinder or more in each eye; or 0.75 in one eye.
- Vertical and horizontal prisms will be authorized if medically necessary. The prescription must be remedial and not training in nature.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Guidelines for Lenses and Frames (Cont'd.)

- Replacement of lenses requires medical justification.

When requesting a change in lenses, lens powers must differ from the most recent prescription by an axis change of at least 15 degrees or 0.50 diopter change in sphere or cylinder power. New lenses must also improve visual acuity by at least one line on a standard visual acuity chart.

A beneficiary is not automatically entitled to a new pair of glasses each year or each time an examination is performed. A replacement pair is covered when the prescription changes at least one half diopter (0.50) or the beneficiary has had eye surgery. If a beneficiary breaks the lenses or frame in a pair of glasses previously provided, but the frames are not among those available through the contract sample kit, a new pair of lenses and frames must be authorized and ordered through the eyewear contractor. Use the current CPT manual to file the dispensing fee.

Lens replacements, due to Rx change, can only be fitted to a Medicaid-approved frame as listed in the Medicaid Frame Kit. If a patient elects to use their own non-Medicaid frame, they will be financially responsible for the lenses and the request should not be sent to Robertson Optical Lab as a Medicaid request.

Guidelines for Contact Lenses

Daily wear contact lenses are covered for beneficiaries younger than 21 year of age, if medically necessary, when the prescription of glasses is not suitable for the patient.

If contacts are dispensed, replacement of contacts or glasses will not be covered for one year. While daily wear contacts are a covered item, extended wear contacts are non-covered. **Contact lens procedure codes are per lens and the correct number of units should be indicated in the "units" column of the claim form**.

File for payment using the examination date as the date of service. Use CPT procedure codes for the fitting and dispensing of contact lens. These codes include the contact lens fitting, all follow-up visits, solutions, and supplies. This reimbursement does not include the initial eye examination.

Special Requests: If the covered contacts do not meet the needs of the patient, providers can contact the PSC at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us before dispensing the contacts. Written medical justification may be required.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Procedure Codes for the Contact Lens Products

Procedure codes for contact lens products are as follows:

V2500 – Contact lens, PMMA, spherical, per lens

V2501 – Contact lens, PMMA, toric or prism ballast, per lens

V2510 – Contact lens, gas permeable, spherical, per lens

V2511 – Contact lens, gas permeable, toric, and prism ballast per lens, or a high plus or minus gas permeable post cataract, per lens

V2520 – Contact lens, hydrophilic, spherical, per lens

V2521 – Contact lens, hydrophilic, toric or prism ballast, per lens

V2755 – UV lens, per lens

V2599 – Unlisted Contact Code. (Providers must contact the program area via the PSC or an online inquiry before using this code.) However, if the service is for an aphakic lens this procedure may be used. The fee for the aphakic lens is $45 per lens. For other unlisted contact codes, the provider must contact the PSC or submit an online inquiry for instructions

Dispensing Codes for Contact Lenses and Glasses

The following dispensing codes and fees for contacts may be used when applicable to the service performed by the provider:

92310 – Prescription of optical and physical characteristics of and fitting of contact lenses, with medical supervision of adaptation; corneal lenses. **The dispensing procedure is bilateral and the fee listed is for both eyes.**

92311 – Prescription of a corneal lens for aphakia. **The dispensing procedure is unilateral and the fee listed is for one eye.**

92312 – Prescription of corneal lenses for aphakia. **The dispensing procedure is bilateral and the fee listed is for both eyes.**

92313 – Prescription of a corneoscleral (large lens). **The dispensing procedure is unilateral and the fee listed is for one eye.**

92340 – Fitting of spectacles, except for aphakia**. This code should only be filed when the glasses are physically received at the physicians' office for the dispensing of glasses. The date of service when filing this procedure should always be the date the eye exam was performed.**

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Dispensing Codes for Contact Lenses and Glasses (Cont'd.)

Ordering Eyeglasses for Eligible Beneficiaries

An eligible beneficiary is one who is in possession of an active Medicaid card, which is presented to the physician's office requesting the glasses and is under the age of 21. The physician's office ordering the glasses, not Robertson Optical, must insure that the beneficiary is currently eligible in the Medicaid program before ordering eyewear. Providers can verify eligibility by swiping the card or by using the Web tool.

If the patient is not Medicaid eligible and your office orders glasses that are consequently produced, Robertson Optical will be denied payment due to lack of eligibility. Robertson Optical is then authorized to bill the ordering physician for the cost of the eyewear. **In no case will Robertson Optical be liable for the cost of the eyewear due to the physician's office not verifying eligibility status of the beneficiary.**

Physicians are to use the date of the examination on the Rx form when submitting it to Robertson Optical. This is required to ensure that beneficiaries are eligible for another pair of glasses a full 365 days afterward.

Prescription Requests

For prescription request via the US postal service or fax please follow the guidelines listed below:

- A copy of the patient's card and a notation of the date/time eligibility were verified must be documented and attached to the prescription request. Request to the vendor that does not include this information will not be processed.
- The Prescription Request Form, which is available by contacting Robertson Optical, must be completed entirely and submitted to the vendor following the initial visit and exam if the patient needs glasses. The date of the exam must be used on the prescription request form. A sample copy of the form can be found in the Forms section of this manual.
- If the hard copy Rx form is not completed correctly, Robertson Optical will inform the provider's office of any discrepancy that cannot be corrected. The contact will be made on the same day the Rx is received by either calling (the preferred method of contact) or faxing the incomplete Rx form back to the prescriber. Prescriptions submitted by mail or fax will be processed secondary to those submitted via the Internet. Shipping time for the completed job for all normal stock lenses, which must be ground and/or cut, edged and framed at the Robertson Optical

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Prescription Requests (Cont'd.)

laboratory, shall be limited to seven working days after the receipt of a properly completed hard-copy prescription form from the physician's office.

- Authorized glasses will be mailed within five working days after receipt of the prescription request. Special prescriptions should arrive within 10 working days. The vendor will notify the prescriber regarding any special prescriptions that will require additional time to process.

For prescription request via the Internet based electronic prescription system please the guidelines listed below:

- In our move to a paperless environment, this will be the preferred method of prescription submission. The system will be secure and meet all Health Insurance Portability and Accountability Act (HIPAA) requirements for transmission of protected health information (PHI).

  The electronic system has been created so that no prescription can be submitted until all required fields are completed. The physician's office must attest that the Medicaid ID number is correct and eligibility has been verified. Shipping time for the completed job for all normal stock lenses, which must be ground and/or cut, edged and framed at Robertson Optical laboratory, shall be limited to five (5) working days after receipt of Internet submission.

- The software needed for the electronic Rx system is available for download at http://www.robertsonoptical.com/. Following the download, your office must contact Robertson Optical for a password at (803) 254-9381. Once the initial set-up is completed, the system will retain provider related information for future use. Please review the attachment to this bulletin for a tutorial on the software system.

- Providers must use their National Provider Identifier (NPI) when completing an Rx request. Robertson optical will no longer be accepting the South Carolina legacy provider number when prescription requests are received. If providers have multiple locations linked to the same NPI, both the electronic and paper prescription process will accommodate these multiple locations and allow the provider to designate the location for shipping.

If a beneficiary has had a pair of glasses during the current year and is not eligible for another pair in the same year, this discrepancy will be reported to the physician's office immediately. Robertson Optical will return the Rx form indicating to the prescriber that the beneficiary has had a pair of eyewear in the current year and will provide the date when

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Prescription Requests (Cont'd.)

the beneficiary is eligible for another pair, if the beneficiary is still Medicaid eligible. Physicians are responsible for re-verifying eligibility status of the patient on the date the beneficiary is eligible for a new pair of glasses, before resubmitting the request.

Note: Delays in receiving eyewear or any other complaints dealing with Robertson Optical must be reported by SC Medicaid providers immediately. **The complaint must be sent, in writing via fax or mail, to Robertson Optical management staff and a copy to the SC Medicaid program staff.** Provider's offices are not to give the telephone number of Robertson Optical to Medicaid beneficiaries to check status of production or non-receipt of eyewear. It is the physician's responsibility to check with Robertson Optical staff and inform the beneficiary the status of their glasses.

Robertson Optical Laboratories, Inc.
411 Commerce Drive NE
Columbia, SC 29223
Phone: (803) 254-9381
Toll Free: (800) 223-0731
Fax: (803) 254-1978 (local)
http://www.robertsonoptical.com/

Preparing the Prescription Request Form

To request eyewear for eligible Medicaid beneficiaries, providers can fax or mail the request, but must use only the current four-part prescription forms provided upon request from the vendor. To obtain a supply of these forms contact the current eyewear Medicaid vendor.

Providers can fax the completed prescription request form and a photocopy of the beneficiary's Medicaid card with the date eligibility was established. The request can also be mailed to the vendor.

Note: Always use the vendor's prescription form when requesting glasses. No other prescription form is acceptable.

Make sure the information on the form is legible, correct, and meets quality standards. If any items are missing, the form will be returned. The information should be typed or handwritten in black ink. Print hard enough on the form that the information can be read on all copies.

Attach a photocopy of the beneficiary's Medicaid card with the date eligibility was verified with the prescription request. Verify that Medicaid covers the service requested. Verify that the patient does not have third party insurance.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Preparing the Prescription Request Form (Cont'd.)

Note: If the patient has other insurance, including Medicare, file all the services provided to those insurers first. If those insurers pay more than what Medicaid allows, Medicaid will not pay any other charges and the beneficiary cannot be billed for any additional fees. However, if the patient and the doctor have agreed to see the patient as a private pay patient, the doctor can bill the beneficiary for any additional fees not covered by Medicaid.

Time Limits for Processing Prescriptions Time

The time for shipping requirements will begin the day Robertson Optical receives the properly completed Rx form from the physician's office. An Rx received after 4:00 p.m. EST will be viewed as the next business day. An Rx received on the weekend, after 4:00 p.m. EST Friday through 8:00 a.m. EST Monday, will be viewed as received on Monday. An official state holiday will not be counted as a working day.

Shipping time for the completed job to the prescriber for all normal stock lenses which must be ground and/or cut, edged, and framed at Robertson Optical laboratory shall be limited to **five working days** after receipt of Internet submission or **seven working days** after the receipt of a properly completed hard-copy prescription form from the prescriber.

The shipping time to the provider for frame and lenses which are special requests, must be shipped within **10 working days** of Internet submission or **12 working days** after the receipt of a properly completed hard-copy prescription from the date received or sooner. Examples of special requests include: poly-carbonated lenses, Rx with cylinder power on both eyes at least three diopters or higher, and/or those which require factory preparation or fitting into ophthalmic frames, special high Rx, plus or minus bifocals, and special lens grinding.

Part II - Diagnostic Ophthalmology Services

Diagnostic services included in the CPT coding range 92018-92287 are compensable as separate procedures if performed as a distinct and individual service and not included in the ophthalmological or E/M exam, with the following restrictions:

Covered Services

Refractions – The determination of the refractive state is allowed as a separate procedure in addition to the ophthalmology exam. To report, use the CPT procedure code 92015 for refraction. No modifier is necessary for this procedure code.

Medicaid will also reimburse for Medicare-denied refractions. Claims should be submitted with the procedure code 92015 on a CMS-1500 claim form. DO NOT INDICATE MEDICARE COVERAGE ON THE CLAIM or send the Medicare EOMB as this would be considered possible third payer and reject the claim. Do not use a modifier.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Covered Services (Cont'd.)

Ophthalmoscopy - Routine ophthalmoscopy (direct or indirect) is a part of general and specific ophthalmologic services, whenever indicated. It is not reported separately. Ophthalmoscopy, extended (92225, 92226), with retinal drawing, as for retinal detachment, melanoma, with interpretation and report, may be billed in addition to an ophthalmological exam or an E/M services procedure code. If medically necessary, this code may be billed one time per eye per date of service.

Visual Field Examination – This exam is compensable when medically indicated as separate from the ophthalmological or E/M exam.

Ocular Prosthesis – The prescription and fitting of ocular prostheses are covered as professional services. The actual prosthesis is payable only to a DME provider, with prior authorization. Medicaid will not pay an ocularist directly for this procedure. The service must be billed under the physician's provider number, and the service must be performed under the supervision of an ophthalmologist. The 26 modifier is not necessary when the code defines the professional component.

Vision Therapy–The following procedures are allowed for vision therapy services only:

- **95999**–Unlisted neurological or neuromuscular diagnostic procedure (Support documentation of therapy service must be attached to the claim.)
- **96110**–Developmental testing; limited (*e.g.*, Developmental Screening Test II, Early Language Milestone Screen) with interpretation and report
- **96111**–Developmental testing; extended (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report
- **96116**–Neurobehavioral status exam (clinical assessment of thinking, reasoning, and judgment, *e.g.*, acquired knowledge, attention, language, memory, planning, and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report.

Note: If an eye examination indicates a need for corrective lenses, the examining provider doing the comprehensive exam must complete the course of treatment.

This includes the eye examination, the submission of a prescription (Rx) for ordering the glasses to the Medicaid current eyewear contractor, and the dispensing of

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Covered Services (Cont'd.)

eyewear on site when the glasses are received. In no instance can an examining provider do the examination for glasses only and not order and dispense the eyewear for the patient.

Providers who do not wish to have the facility dispense the eyewear must, beforehand, make arrangements and schedule an appointment for the patient with another provider to dispense the eyewear for them.

In all cases, the examining provider must make the arrangements for this provision and schedule appointments for patients before treating Medicaid beneficiaries. If this type of arrangement cannot be done, providers should not examine these patients and must refer them to another provider who can do the examination and dispense the eyewear on site.

Frames must be selected from the Medicaid frame kit that is required of all dispensing providers upon enrollment in the Medicaid program. Providers are required to display these frames for patients to make a selection. The frame kit can be purchased through the current Medicaid vendor producing the eyeglasses upon request. Contact the PSC at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us for more details on ordering the kit.

Non-Covered Services

Glare Testing–This is considered non-standardized and has not been proven effective in the diagnosis of visual disabilities. Therefore, no separate reimbursement is allowed for this procedure.

Schirmer Test–This is considered an integral part of the ophthalmological or E/M exam. Separate reimbursement for this test is not allowed.

Sensorimotor Exam (92060)–This exam is included in the ophthalmological exam or the E/M exam and is not reimbursable as a separate procedure.

Orthotic or Pleoptic Training–Non-covered

Color Vision Examination–Non-covered

Dark Adaptation Examination–Non-covered

Radial Keratotomy–Non-covered

Transitional and Progressive Lenses–Non-covered

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Non-Covered Services (Cont'd.)

Vision Screenings – Non-covered

Part III - Ocular Surgery

All eye surgeries are subject to the general criteria specified under the heading "General Surgical Guidelines" in this section.

Post-Operative Management of Cataract Surgery – South Carolina Medicaid allows optometrists to bill for post-operative management only for the following CPT procedure codes: 66821, 66825, 66983, 66984, and 66985. These are global codes and cover both the surgical care and post-operative management.

In order for an optometrist to bill and be reimbursed for the post-operative management of these patients, ophthalmologists must bill these codes with a 54 modifier, which will allow for the surgical care only. Optometrists must bill these codes using the 55 modifier only if the ophthalmologists bill with a 54 modifier. If the ophthalmologists do not use a modifier, then they will be reimbursed for the entire global fee, which includes both the surgical care and post-operative management.

Intraocular Lenses – Physicians who supply these lenses may bill using the codes listed below. These codes are for the supply of lenses and should be billed in addition to the surgical procedure.

- **V2630** – Anterior chamber angle fixation lens
- **V2632** – Posterior chamber lens

Ptosis – Lid correction procedures are covered only when there is documented medical necessity for the improvement of visual disabilities. Services must be preauthorized by KePRO, the Quality Improvement Organization (QIO) contractor, for utilization review.

Note: Simple blepharoplasty is considered a cosmetic procedure and therefore non-compensable.

Keratoplasty – Corneal transplants are compensable. Physician reimbursement includes only the surgery. Reimbursement to the hospital includes all technical services including donor preparation.

Special Ophthalmological Services

The following medical ophthalmology codes may be billed separately from an ophthalmology exam or an evaluation and management services code. These codes may be billed one time per eye per date of service when medically necessary.

92225 – Ophthalmoscopy, extended, with retinal drawing, as for retinal detachment, melanoma with interpretation and report; initial

92226 – Ophthalmoscopy, extended; subsequent

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Special Ophthalmological Services (Cont'd.)

92230 – Fluorescein angioscopy with interpretation and report

92235 – Fluorescein angiography (includes multiframe imaging) with interpretation and report

92240 – Indocyanine-green angiography (includes multiframe imaging) with interpretation and report

92260 – Ophthalmodynamometry

92270 – Electro-oculography with interpretation and report

92275 – Electroretinography with interpretation and report

92285 – External ocular photography with interpretation and report for documentation of medical progress

92286 – Special anterior segment photography with interpretation and report; with specular endothelial microscopy and cell count

92287 – Special anterior photography with luorescein angiography

Use of Modifiers With Procedure Codes

If it is medically necessary to repeat an ophthalmology procedure on the same date of service and the procedure is bilateral (*i.e.*, the procedure is for both eyes), then the total charge amount for both eyes must be listed on the first line and again on the line recording the repeated procedure.

In order for the claim to process, the modifier on the first line must be "00" (two zeros), and the modifier on the line recording the repeated procedure must be (76). This is the only time these two modifiers should be used. It is imperative that the medical record of this patient indicates and justifies the medical necessity of repeating this service on the same day. The use of two modifiers indicates that the procedure was done bilaterally on the first occurrence and again bilaterally on the second occurrence. Indicate a (1) in the Units column for the number of units on each line.

If it is medically necessary to repeat an ophthalmology procedure on the same date of service and the procedure is unilateral (*i.e.*, the procedure is for one eye), then the total charge amount for one eye must be listed on the first line and again on the line recording the repeated procedure. On the first line, the modifier must be (LT) for the left eye and on the second repeat of the procedure, the modifier must be (RT) for the right eye. The medical record of the patient must indicate and justify the medical necessity for filing the procedure for each eye. These modifiers cannot be used if the procedure is bilateral, where the fee listed is for both eyes. Modifiers LT and RT should not be used for surgical procedures. Indicate on the Units column a (1) for the number of units on each line. REMINDER: In all cases, the fee listed for all ophthalmological

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Use of Modifiers With Procedure Codes (Cont'd.)

procedures is for both eyes, unless otherwise indicated.

The use of modifiers XX, XY, WC, or AP will result in rejected claims. Modifier 50, indicating bilateral procedures, should only be used for surgical procedures performed by a surgeon and should not be used for office procedures.

OTORHINOLARYNGOLOGY (ENT)

General ENT Services

Diagnostic or treatment procedures usually included in an otorhinolaryngologic exam are reported as an integrated medical service and should not be reported separately.

Microsurgical Techniques–CPT 69990 is a procedure code that describes "microsurgical techniques requiring use of operating microscope." It can be billed in addition to the primary surgical procedure if it is not an inclusive part of the surgical procedure and if the documentation supports the use of microsurgical techniques. It is not for visualization of the operative field alone, but is intended to be employed when the surgical services are performed using the techniques of microsurgery.

If the use of the operating microscope is an inclusive component of a procedure, the use of the operating microscope cannot be unbundled and billed as 69990. The Centers for Medicare and Medicaid Services does not pay separately for services that should be paid together.

Endoscopic Procedures – Refer to guidelines for endoscopic procedures under "General Surgery Guidelines" heading in this section.

Uvulopalatopharyngoplasty–Documentation (admission history and physical and operative report) is required with claims submitted for this procedure. The record must substantiate medical necessity as well as clarify the procedures performed.

Septoplasty, Turbinectomy–These and any other nasal reconstructive surgeries are covered only when there is a loss or serious impairment of bodily function, usually as a result of trauma, and the surgery restores the disabled function. The office record must document the functional deficit or the need for prompt correction.

Speech and Hearing Services

Services rendered by ENT specialists or therapists supervised by a physician are compensable using the series 92502 – 92595 in the CPT with the following restrictions:

- Speech and Hearing Therapy (92507 – 92508) – Non-compensable. Refer to "Specialized Speech and Hearing Services for Children Under 21" below regarding services for children.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Speech and Hearing Services (Cont'd.)

- Vestibular Function Test Without Recording (92531 – 92534) – Non-compensable (included in visit code).
- Ear Protector Attenuation Measurements (ear plugs) – Non-compensable.
- Hearing Aids and Hearing Aid Accessories – Must be pre-authorized and obtained through the SCDHEC. Services are limited to children under age 21. For prior approval, send request to:

  Division of Children's Rehabilitative Services
  Box 101106, Mills Complex
  Columbia, SC 29211
  (803) 898-0784

- Ear Molds – To report, physicians must use the following supplemental codes:
  - **V5264** – Ear mold, not disposable, any type
  - **V5265** – Ear mold, disposable, any type
  - Use modifiers RT (right side) and LT (left side) to indicate which ear.
  - These codes are allowed four times every 12 months per ear for children under age 21.
- Cochlear Device Implantation – Requires prior approval from KePRO one of the following methods:

  KePRO Customer Service: 1-855-326-5219
  KePRO Fax: 1-855-300-0082

- Specialized Speech and Hearing Services for Children Under 21 – Services are available through clinics certified by SCDHEC and through individual speech language pathologists/audiologists who are licensed by the South Carolina State Board of Examiners in Speech-Language Pathology and Audiology and enrolled with the South Carolina Medicaid program. Speech/language and audiology services rendered by these providers must be pre-authorized by SCDHEC, DDSN, or a school district. ENT specialists who provide these specialized services in their office or clinic may apply for certification. If certified by SCDHEC, the physician must enroll as a speech and hearing clinic with South Carolina Medicaid in order to obtain payment for these services (for children under 21). For information on SCDHEC certification requirements, you may write to:

  Department of Health and Environmental Control

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Speech and Hearing Services (Cont'd.)

Clinic Certification
2600 Bull Street
Columbia, SC 29201

CARDIOLOGY

Cardiography

Physicians performing these services in their office may bill for the complete procedure code, which includes the tracing, interpretation, and report. Those providers interpreting the recording only must use the code that stipulates interpretation and report only. The modifier 26 is not necessary when the code clearly defines the professional component only (interpretation and/or report).

For more detail regarding EKG interpretations, refer to *Radiology Reimbursement Limitations* under the "Radiology and Nuclear Medicine" heading in this section.

Cardiac Catheterization

The cardiologist must bill for the catheterization that describes the procedure and technique utilized; fragmenting the codes is not allowed.

If medically indicated, intracardiac electrophysiological procedures may be billed in addition to the catheterization angiogram procedure.

Cardiac Magnetic Resonance Imaging (MRI) of the Heart – Procedure codes 75557, 75559, 75561, 75563 are used to report the physician's attendance and participation in the MRI of the heart. When filing for this procedure, bill appropriate MRI code depending on level of service. Use modifier 26 when billing the professional component only. The technical portion will be reimbursed to the hospital under the revenue code for MRI. Medical necessity for both the MRI and heart catheter (if needed) must be documented in the beneficiary's chart. The procedure should be performed in lieu of heart catheterization, when possible. The code will be allowed reimbursement only once per date of service, regardless of how many sessions or images are performed.

Vascular Studies

Reimbursement to a provider for services purchased from an outside supplier or lab is not allowed. Reimbursement is only allowed to the provider who performed the service and is enrolled with South Carolina Medicaid.

Independent physiology labs performing monitoring services must be enrolled for participation. The physician requesting the service may only bill for the interpretation of the study if performed.

Thermography is non-covered.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

PULMONARY MEDICINE

Oxygen therapy given in the office is compensable when medically indicated and clearly identifiable as a separate procedure. Documentation must be submitted with the claim.

Questions regarding oxygen therapy equipment for home use should be directed to the PSC at 1-888-289-0709. Providers may also submit on online inquiry at http://www.scdhhs.gov/contact-us for additional information.

To report tracheostomy tube change in the office setting, use code S1814. This may be used in addition to the appropriate level office E/M visit codes.

Code 95827 should be billed for the overnight sleep apnea study.

ALLERGEN AND CLINICAL IMMUNOLOGY

For the initial visit per patient, the appropriate level E/M code may be charged. For follow up visits without physician involvement, the minimal established office E/M code, 99211, may be used in addition to the allergen immunotherapy codes. Follow-up visits requiring physician involvement may be charged using the appropriate level E/M code if and only if other identifiable services are provided at that time. Procedure code 99211 does not count towards a beneficiary's ambulatory visit limit of 12. The limit is only applicable to beneficiaries age 21 or older.

Allergy Testing

Allergy testing is performed to determine a patient's sensitivity to particular allergens and is based on the findings of a complete history and physician exam of the patient. The performance and evaluation of selective cutaneous and mucous membrane tests are a compensable service. The number of tests performed should be dependent upon the history, physical findings, and clinical judgment. Claims should be filed using the appropriate codes 95004 through 95075 with the number of tests performed (if indicated in the description of the code) reported in the Days/Units column of the claim form.

Allergen Immunotherapy

Allergen immunotherapy is performed by providing injections of pertinent allergens to the patient on a regular basis with the goal of reducing the signs and symptoms of an allergic reaction or prevention of future anaphylaxis. This is usually done with allergen dosages that gradually increase over a period of months.

Procedure code 95115 or 95117 is used each time the patient comes into the office for an immunotherapy injection. These codes are for professional services only and do <u>not</u> cover reimbursement for antigen extract or venom. Procedure code 95115 is used to report a single injection. Procedure code 95117 is used to report two or more injections. The minimal established Evaluation and Management (E/M) office visit may be filed in addition to this code for observation purposes.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Allergen Immunotherapy (Cont'd.)

Other visit codes may only be used in addition to the allergen immunotherapy if another identifiable service is provided at that time. Only one E/M visit code is allowed per day.

Procedure codes 95120 – 95134 are non-covered.

Venom Codes

The previous supplemental venom codes have been deleted because there are not any national code descriptions for these local codes. Please refer to the most current CPT manual for venom codes and descriptions for any allergy testing.

Antigen/Antigen Preparation

Procedure codes 95144 through 95170 can be used for the supervision and provision of vials of antigen or venom. The physician mixes and stores the vials for specific patients, in the office setting. Refer to CPT guidelines when billing for these services. It is important to follow the individual descriptions of each code to determine whether to bill by vial or dose. The appropriate number of units must be indicated on the claim.

Rapid Desensitization

Procedure code 95180 is used for rapid desensitization procedure (*e.g.,* insulin, penicillin). This code includes the professional services and supervision each hour by the physician, but does not include the cost of the desensitization mixture. The Days/Units column of the claim form should indicate the number of hours required for the desensitization procedure. Use code 95199 to bill for the desensitization mixture and attach the invoice for the cost of the mixture.

Sublingual Administration

Antigens administered sublingually (*i.e.,* by placing drops under the patient's tongue) are non-covered. Antigens are covered only when administered by injection.

DERMATOLOGY

Visits and treatments for dermatological services must be medically necessary. Services provided for cosmetic reasons are non-covered.

The acne diagnosis code (706.1) is covered only when the patient is 18 years of age or younger (non-covered beginning on the 19th birthday), and the acne condition is infected, cystic, or pustular.

Support documentation is not required for billing purposes; however, the patient's record must clearly document the condition and medical necessity.

The keloid scar diagnosis 701.4 is covered only in severe cases with pain, intractable itching, or interference with range of movement.

Support documentation is not required for billing purposes; however, the patient's record must clearly document the condition and medical necessity.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

ONCOLOGY AND HEMATOLOGY

Chemotherapy Administered in a Physician's Office

When a patient receives the entire regimen of chemotherapy in an office setting, including lab work, hydration, premedication, and all chemotherapy agents, CPT codes 96401 – 96542 would be the appropriate codes to bill. These procedures indicate an infusion or injection by the physician or an employee of the physician. The following are appropriate codes to bill:

- If the patient received chemotherapy over four hours in the office via IV infusion:

  96413 – Chemotherapy administration, intravenous infusion technique; up to an hour, single or initial substance/drug

  96415 – Each additional hour, 1 to 8 hours

  J Codes – Appropriate medication charges

- E/M Services (CPT codes 99201 – 99215) are allowed when a separate and identifiable medical necessity exists and is clearly documented in the patient's chart. The physician should not routinely bill an E/M service for every patient prior to chemotherapy administration. Only one E/M service is billable per patient per day.
- Prolonged Services (CPT codes 99354 and 99356) may be billed in addition to the E/M code when there is more than an hour of actual face-to-face physician time required beyond the usual service for the level of the E/M code billed. This code should only be used when the physician's expertise is medically necessary in evaluating and managing the patient over a prolonged period and specific documentation describes the content and duration of the service.
- Critical Care Services (CPT codes 99291 – 99292) should only be used in situations requiring constant physician attendance of an unstable or critically ill patient. These codes should only be used in situations significantly more complex than other chemotherapy situations.

If a physician or physician group leases space in a clinic or hospital, they may bill for the chemotherapy administration and drugs provided **all** the following criteria are met:

- They are using their own employees, equipment, supplies, and drugs.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Chemotherapy Administered in a Physician's Office (Cont'd.)

- The services are provided in the leased area of the hospital designated as an office.
- The patient is not a registered inpatient or outpatient of the hospital.

A physician's office within an institution must be confined to a separately identified part of the facility that is used solely as the physician's office and cannot be construed to extend throughout the entire institution. Services performed outside the "office" area will be subject to coverage rules applicable to services furnished outside the office setting.

A distinction must be made between the physician's office practice and the institution. For services to be covered, auxiliary medical staff must be office staff rather than institution staff, and the cost of supplies must represent an expense to the physician's office practice. The physician must directly supervise services performed by his or her employees outside the office area; the physician's presence in the facility as a whole would not be sufficient.

If services are provided in an inpatient, outpatient, or infusion center setting, the physician can only bill for the E/M service and/or prolonged care, critical care services when appropriate. Reimbursement for chemotherapy administration, drugs, supplies, equipment, and nursing are included in the hospital or infusion center's reimbursement.

Inpatient and Outpatient Hospital Services

Services or supplies administered by the hospital or hospital employees are considered a part of the overall hospital service and are reimbursable only under the hospital allowable costs. A physician who is either salaried or contracted by the hospital, and who performs services under contract or employment, may not bill for those services separately under his or her individual Medicaid provider number. The contracting hospital may claim these services under the professional fees allowable for the hospital under their hospital-based physician Medicaid number.

Billing Notes

Infusion start and stop time should be clearly documented. Start time does not include the E/M service or delivery of adjunctive therapy by a nurse or physician.

Codes 96409 and 96420, chemotherapy administrations, push technique, are only for pushing a chemotherapy agent and are not to be billed when pushing premedications or providing other incidental services. Only one push technique code will be allowed per day. These codes cannot be billed when given in a hospital setting.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Billing Notes (Cont'd.)

If routine maintenance (flushing with heparin and saline) of an access device is the only service rendered, and is rendered by the nurse, the office visit code 99211 is appropriate.

Therapeutic or Diagnostic Infusions codes should only be billed when a therapeutic or diagnostic agent other than chemotherapy must be infused over an extended period of time. Payment of these codes is considered bundled into the payment for chemotherapy infusion when administered simultaneously. Separate payment is allowed when these services are administered sequentially or as a separate procedure. These codes cannot be billed in a hospital setting or in addition to prolonged service codes.

Blood transfusions may be billed only when the physician or an employee of the physician actually performs the transfusion. It should be billed per unit of blood. If the transfusion requires prolonged physician attendance, then it is appropriate to charge for this service. The medical record must substantiate this service. If hospital personnel administer the blood transfusion, it is reimbursable only under the hospital allowable costs.

A listing of Chemotherapy Drug Codes can be found in Section 4 of this manual. The codes include the cost of the drug only, not the administration. Chemotherapy agents provided by a hospital are considered a technical cost and may not be charged by a physician. The hospital is reimbursed for all technical costs.

GASTROENTEROLOGY

Diagnostic procedures are defined in codes 91010-91299. Services listed are covered as separate procedures if medically necessary and justified.

Obesity is now recognized as a disease state. Policy is currently being written and will be published at a later date.

The following services are non-covered by Medicaid:

- Supplemental fasting
- Intestinal bypass surgery
- Gastric balloon for treatment of obesity

The following procedures to treat obesity are covered based on InterQual criteria. KePRO must preauthorize all claims for these services. Approval will be based on medical records that document established InterQual criteria.

Gastric Bypass Surgery/Vertical-Banded Gastroplasty (Gastric Stapling)

Gastric bypass surgery and vertical banded gastroplasty are performed for patients with extreme obesity. Medicaid **may** cover gastric bypass surgery and vertical-banded gastroplasty if the surgery meets **both** of the following criteria:

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Gastric Bypass Surgery/Vertical-Banded Gastroplasty (Gastric Stapling) (Cont'd.)

- It is medically appropriate and necessary.
- It is to **correct an illness** that caused the obesity or was aggravated by the obesity.

Prior authorization is required from KePRO. InterQual criteria will be used to screen all requests.

An annual evaluation will be required for all individuals who receive gastric bypass surgery or vertical-banded gastroplasty. This evaluation will be used by Medicaid to assess the long-term effectiveness of these procedures in the treatment of obesity.

Panniculectomy

Panniculectomy is the surgical excision of the abdominal apron containing superficial fat in obese individuals. The procedure codes, 15830 (Lipectomy) and 15847 (Abdominoplasty), can be covered by Medicaid if:

- It is medically appropriate and necessary for the individual to have such surgery.
- The surgery is performed to correct an illness caused by or aggravated by the pannus.

Prior authorization is needed and should be obtained by submitting documentation to KePRO via fax, email, or website. InterQual criteria apply.

Gastrostomy Button Device Feeding Tube Kit

Effective April 1, 2007, the SCDHHS will reimburse CPT code 91299, Unlisted Diagnostic Gastroenterology procedure, for the supply item Gastrostomy Button Device Feeding Tube. This service will be covered for beneficiaries under the age of 21 when performed in the physician's office setting to cover the cost associated with purchasing the device.

Claims must be processed on a CMS-1500 claim form and include a copy of the invoice and appropriate documentation supporting the medical necessity of the device.

PHYSICAL MEDICINE AND THERAPY

The physician or licensed therapist may perform physical, occupational, and speech therapy services in a physician office setting. A licensed therapist performing these services must do so under the direction of a physician in order for services to be covered. Therapists must meet all applicable Medicaid provider qualifications and state licensure regulations specified by the South Carolina Department of Labor, Licensing, and Regulation (LLR). Licensed individuals must adhere to any provisions as required by LLR. Only a physician can be reimbursed for these services.

One hour of treatment per visit is compensable. Only the procedures

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Physical Medicine and Therapy (Cont'd.)

requiring the physician or therapist's direct (one-on-one) patient contact are covered. Evaluation and management services may be reported separately if the patient's condition requires a significant, separately identifiable E/M service that is above and beyond the usual pre-service and post-service work associated with the procedure.

At a minimum, physical therapy services must improve or restore physical functioning as well as prevent injury, impairments, functional limitations and disability following disease, injury or loss of a body part.

Occupational therapy must prevent, improve, or restore physical and/or cognitive impairment following disease or injury.

Speech language pathology must improve or restore cognitive functioning, communication skills and/or swallowing skills following congenital or acquired disease or injury.

For adults over 21 years of age, reimbursement is allowed for physical, occupational, and speech therapies performed under the following guidelines. The patient's record must substantiate at least **ONE** of the following requirements for therapy:

- The attending physician prescribes therapy in the plan of treatment during an inpatient hospital stay and therapy continues on an outpatient basis until that plan of treatment is concluded.
- The attending physician prescribes therapy as a direct result of outpatient surgery.
- The attending physician prescribes therapy to avoid an inpatient hospital admission.

Effective with dates of service on or after June 1, 2012, for beneficiaries age 21 and over, physical, occupational, and speech therapies (PT/OT/ST) performed in an outpatient hospital setting require prior authorization.

InterQual criteria for outpatient rehabilitation will be used to support medical necessity. KePRO will authorize the initial evaluation and the first four weeks of therapy upon request. At four weeks, a concurrent review is performed to re-evaluate the patient's condition and response to treatment. At that time the provider may request up to an additional eight weeks of therapy.

Specialized physical, occupational, and speech therapy services for children under 21 years of age are available through rehabilitation centers certified by SCDHEC, and through individual licensed practitioners. Policy guidelines are located in the Private Rehabilitative Therapy and Audiological Services provider manual on our Web site at www.scdhhs.gov.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Physical Medicine and Therapy (Cont'd.)

Effective with dates of service on or after October 1, 2012, SCDHHS will require prior authorization (PA) for Rehabilitative Therapy for Children. The checkpoint will apply to private rehabilitative providers as well as to those performed in the outpatient hospital clinic. Requests for therapy services for all children that exceed the fiscal year checkpoints for combined rehabilitative therapy services (105 hours or 420 units) must be submitted to KePRO for authorization. KePRO will use InterQual's Outpatient Rehabilitation criteria for medical necessity determinations. Requests for therapy services may be submitted by the primary care physician or physical, occupational or speech therapist but must follow the guidelines outlined in the Private Rehabilitative Therapy and Audiological Services provider manual.

The following codes are non-covered: 97010 – 97039 and 97545 – 97546.

Biofeedback therapy is a non-covered service.

Osteopathic Manipulative Treatment

Osteopathic Manipulative Treatment (OMT) is allowed as a separate procedure when medically necessary, justified, and performed by a physician, or licensed physical therapist employed by the physician. These procedures should be reported using procedure codes 98925 – 98929.

An E/M office code may be billed in addition to an OMT code if the E/M service performed is documented as a significant, separately identifiable service.

CHIROPRACTIC SERVICES

SCDHHS provides Medicaid reimbursement for a limited array of chiropractic services provided to Medicaid beneficiaries. Coverage is limited to treatment by means of manual manipulation of the spine for the purpose of correcting a subluxation demonstrated on x-ray. For the purposes of this program, "subluxation" means an incomplete dislocation, off centering, misalignment, fixation, or abnormal spacing of the vertebrae anatomically that is demonstrable on a radiographic film (x-ray).

It is the provider's responsibility to ensure that services provided are due to medical necessity and are documented in the patient's medical charts, and that the beneficiary's Medicaid eligibility is current before chiropractic services are provided.

The provider should check the beneficiary's Medicaid card before rendering services. Providers must call the toll-free number 1-888-549-0820 listed on the back of the Medicaid insurance card to verify eligibility every time the Medicaid beneficiary is seen for chiropractic services. Eligibility changes on the first of each month. If services are provided, and are later denied because eligibility was not checked,

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

CHIROPRACTIC SERVICES (CONT'D.)

Medicaid will not pay for the services and providers should not bill the patient for these services.

Eligible Medicaid beneficiaries, regardless of age, are allowed **6** chiropractic visits per year, commencing on July 1 of each year.

Provider Qualifications

To qualify as a Medicaid provider for chiropractic services, an individual must be licensed by the South Carolina Board of Chiropractic Examiners as a Doctor of Chiropractic. In order to participate in the Medicaid program, a chiropractor must enroll with Medicaid and receive a Medicaid ID number. Both individual chiropractors and chiropractic groups are eligible to enroll. For questions regarding enrollment, please contact Medicaid Provider Enrollment at 1-888-289-0709.

Medical Necessity

Medicaid will only pay for services that are medically necessary. The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment. Additionally, the manipulative services rendered must have a direct therapeutic relationship to the patient's condition. Spinal axis aches, strains, sprains, nerve pains, and functional mechanical disabilities of the spine are considered to provide therapeutic grounds for chiropractic manipulative treatment. Most other non-spinal diseases and pathological disorders (*e.g.,* rheumatoid arthritis, muscular dystrophy, multiple sclerosis, pneumonia, and emphysema) are not considered therapeutic grounds for chiropractic manipulative treatment.

Covered Services

Billing for chiropractic manipulative treatment is limited to one procedure per visit and one visit per day, with a maximum of **eight** visits during a state fiscal year (July 1 – June 30), with no exceptions. Effective July 1, 2009, eligible Medicaid beneficiaries, regardless of age, will be allowed **eight** chiropractic visits per state fiscal year Providers must call the toll-free telephone number on the back of the Medicaid insurance card to verify a patient's current eligibility and number of visits used to date during the current state fiscal year. Visits not used in one year do not carry over to the next year.

Note: For dually eligible Medicaid and Medicare beneficiaries, Medicare is the primary payer. Bill all chiropractic services to Medicare first. Once a dually eligible beneficiary has exhausted his or her Medicare-allowed chiropractic services, Medicaid reimbursement for chiropractic services is no longer available.

Covered Services (Cont'd.)

Medicaid-reimbursable chiropractic manipulative treatment services are limited to the following three procedure codes only:

- **Chiropractic Manipulative Treatment (CMT); Spinal, 1 to 2 Regions**

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Covered Services (Cont'd.)

- Procedure Code = 98940
- Unit of Service = 1 treatment
- Frequency = 1 per day

- **Chiropractic Manipulative Treatment (CMT); Spinal, 3 to 4 Regions**
  - Procedure Code = 98941
  - Unit of Service = 1 treatment
  - Frequency = 1 per day
- **Chiropractic Manipulative Treatment (CMT); Spinal, 5 Regions**
  - Procedure Code = 98942
  - Unit of Service = 1 treatment
  - Frequency = 1 per day

Radiologic Examination (X-ray)

Billing for radiologic examination is limited to two x-rays per beneficiary per state fiscal year (July 1 – June 30). Medicaid-reimbursable radiology services are limited to the following:

- **Radiologic Examination; Spine, Entire, Survey Study; Anteroposterior and Lateral**
  - Procedure Code = 72010
  - Unit of Service = 1 x-ray
- **Radiologic Examination; Spine, Cervical; Anteroposterior and Latera**l
  - Procedure Code = 72040
  - Unit of Service = 1 x-ray
- **Radiologic Examination; Spine, Thoracic; Anteroposterior and Lateral**
  - Procedure Code = 72070
  - Unit of Service = 1 x-ray
- **Radiologic Examination; Spine, Thorocolum-bar; Anteroposterior and Lateral**
  - Procedure Code = 72080
  - Unit of Service = 1 x-ray
- **Radiologic Examination; Spine, Lumbosacral;**

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PROGRAM REQUIREMENTS

Radiologic Examination (X-ray) (Cont'd.)

Anteroposterior and Lateral

- Procedure Code = 72100
- Unit of Service = 1 x-ray

X-Rays

The documenting radiographic film (x-ray) must have been taken at a time reasonably proximate to the initiation of the course of treatment. Unless the chiropractor concludes that more specific x-ray evidence is warranted, an x-ray is considered reasonably proximate if it was taken no more than six months prior to the initiation of a course of chiropractic treatment. Neither a magnetic resonance image (MRI) nor computerized axial tomogram (CAT scan) may be used instead of an x-ray to document subluxation.

The x-ray is required Medicaid documentation and must be maintained in the patient's medical record. X-ray films must have permanent identification of the patient's name, the date the film was taken, and the name of the facility where taken. Films must be marked right or left side. If the x-ray was taken elsewhere (*e.g.*, doctor's office or other medical facility), the written report must be present in the patient's medical record.

Documentation

As a condition of participation in the South Carolina Medicaid program, providers are required to maintain and allow appropriate access to clinical records that fully disclose the extent of services provided to the Medicaid patient. The maintenance of adequate records is regarded as essential for the delivery of appropriate services and quality medical care.

Providers must be aware that these records are key documents for post-payment review. In the absence of appropriately completed clinical records, previous payments may be recovered by SCDHHS. It is essential for the provider to conduct internal record reviews to ensure that services are medically necessary and that service delivery, documentation, and billing comply with Medicaid policies and procedures.

Clinical Records

Providers are required to maintain a clinical record on each Medicaid patient that includes documentation of all Medicaid-reimbursable services. This documentation must be sufficient to justify Medicaid participation. Clinical records must be current and consistently organized, meet documentation requirements, and provide a clear description of services rendered and progress toward treatment goals. Clinical records should be arranged logically, so that information may be easily reviewed, copied, and audited.

Clinical records must be retained for a period of three years. If litigation,

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Clinical Records (Cont'd.)

claims, or other actions involving the records are initiated prior to the expiration of the three-year period, the records must be retained until completion of the action and resolution of all issues or until the end of the three-year period, whichever is later.

Each Medicaid patient's clinical record must include, at a minimum, the following:

- A Release of Information form signed by the patient authorizing the release of any medical information necessary to process Medicaid claims and requesting payment of government benefits on behalf of the patient
- The initial written physician prescription (original or fax) and documentation of subsequent prescriptions required after every third visit
- Patient history to include the following:
  - A general patient history, including review of systems
  - Chief complaint/systems causing patient to seek chiropractic treatment
  - Onset and duration of symptomatic problem, which may include quality and character of problem; intensity; frequency; location and radiation; onset; duration; aggravating or relieving factors; prior interventions and treatments, including medications; and secondary complaints
  - Family history (if indicated)
  - Past health history to include general health statement; prior illnesses; surgical history; prior injuries or traumas; past hospitalizations; medications; allergies; and pregnancies and outcomes.
- A physical examination report to include:
  - Evaluation of the musculoskeletal and nervous system
  - Evaluation of the cardiovascular and gastrointestinal systems, and of the eye, ear, nose, and throat (both vascular and endocrine), if appropriate to symptoms causing patient to seek chiropractic treatment
  - Analytical procedures used to determine vertebral subluxation (level and severity) and contraindications to treatment (*e.g.*, inspection, palpation)
- Radiographic film (x-ray) and interpretation
- A written report/assessment of the patient's condition, including

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Clinical Records (Cont'd.)

the precise area of subluxation

- A treatment plan
- Clinical service notes

Treatment Plan

If an evaluation indicates that treatment is warranted, the chiropractor must develop and maintain a treatment plan that outlines short- and long-term goals, as well as the recommended scope, frequency, and duration of treatment. The treatment plan should serve as a comprehensive plan of care by outlining the service delivery that will address the specific needs of the patient. The treatment plan must be individualized and should specify the problems to be addressed, goals and objectives of treatment, types of interventions to be utilized, planned frequency of service delivery, criteria for achievement, and estimated duration of treatment. The treatment plan must contain the signature and title of the chiropractor and the date signed.

The individualized treatment plan should be reviewed and updated according to the level of progress. If a determination is made during treatment that additional services are required, these services should be added to the treatment plan. When long-term treatment is required, a new treatment plan must be developed each year. In the event that services are discontinued, the chiropractor must ensure that the reason for discontinuing treatment is indicated in the treatment plan.

Clinical Service Notes

Chiropractic services must be documented by clinical service notes. A clinical service note is a written summary of each treatment session. The purpose of these notes is to record the nature of the patient's treatment by recording the service provided and summarizing the patient's participation in treatment.

Clinical service notes should do the following:

- Furnish a pertinent clinical description of the activities that took place during the session, including an indication of the patient's response to treatment as related to stated goals and objectives
- Reflect delivery of a specific billable service as identified in the patient's treatment plan
- Document that the services rendered correspond to billing as to date of service, type of service rendered, and length of time of service delivery

Error Correction Procedures

The patient's clinical record is a legal document; therefore, extreme caution should be used when altering any part of this record. Appropriate error correction procedures must be followed when correcting an error in

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Error Correction Procedures (Cont'd.)

the patient's clinical record.

Errors in documentation should never be totally eradicated, and correction fluid should never be used. Draw one line through the error, enter the correction, and add signature (or initials) and date next to the correction. If warranted, an explanation of the correction may be appropriate. In extreme circumstances, having the corrected notation witnessed may be appropriate.

NEUROLOGY

Neurological testing procedure codes are 95805-95999. These codes include the technical component, interpretation, and the physician's professional services. Physicians doing only the interpretation must use the 26 modifier with the appropriate procedure code. All procedures must be medically justified.

Nerve Conduction Studies are covered as medically necessary when performed with needle electromyography (EMG) studies to confirm the diagnosis. It is recommended by the American Association of Neuromuscular and Electrodiagnostic Medicine (AANEM) that the nerve conduction study and a needle EMG be performed together to ensure an accurate diagnosis. Neurological testing procedure codes 95805 - 95999 include the technical component, the interpretation, and the physician's professional services. Physicians performing only the interpretation must use the 26 modifier with the appropriate procedure code. All procedures must be medically justified.

Nerve conduction studies must be billed using CPT guidelines indicating each nerve and all site(s) along the nerve, not each site. Codes that indicate "each nerve" will multiply for payment, and must be submitted on one line with the number of tests (or hours) indicated in the "units" column on the claim form. Claims submitted with more than the allowed amount of units will reject with Edit Code 713. Providers may submit the edit correction form with documentation for medical review. If justified, reimbursement may be made to the provider.

HYPERBARIC OXYGEN THERAPY

For purposes of coverage, hyperbaric oxygen (HBO) therapy is a modality in which the entire body is exposed to oxygen under increased atmospheric pressure.

Covered Conditions

Program reimbursement for HBO therapy will be limited to that which is administered in a chamber (including the one-man unit) for the following conditions:

- Acute carbon monoxide intoxication
- Decompression illness

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PROGRAM REQUIREMENTS

Covered Conditions (Cont'd.)

- Gas embolism
- Gas gangrene
- Acute traumatic peripheral ischemia (HBO therapy is a valuable adjunctive treatment to be used in combination with accepted standard therapeutic measures, when loss of function, limb, or life is threatened.)
- Crush injuries and suturing of severed limbs (As in the previous conditions, HBO therapy would be an adjunctive treatment employed when loss of function, limb, or life is threatened.)
- Meleney ulcers (The use of hyperbaric oxygen in any other types of cutaneous ulcer is not covered.)
- Acute peripheral arterial insufficiency
- Preparation and preservation of compromised skin grafts
- Chronic refractory osteomyelitis that is unresponsive to conventional medical and surgical management
- Osteoradionecrosis as an adjunct to conventional treatment
- Cyanide poisoning
- Actinomycosis, but only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment
- Soft tissue radionecrosis

Non-Covered Conditions

No program payment may be made for HBO in the treatment of the following conditions:

- Cutaneous, decubitus, and statis ulcers
- Chronic peripheral vascular insufficiency
- Anaerobic septicemia and infection other than clostridial
- Skin burns (thermal)
- Senility
- Myocardial infarction
- Cardiogenic shock
- Sickle cell crisis
- Acute thermal and chemical pulmonary damage (*i.e.,* smoke inhalation with pulmonary insufficiency)

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Non-Covered Conditions (Cont'd.)

- Acute or chronic cerebral vascular insufficiency
- Hepatic necrosis
- Aerobic septicemia
- Non-vascular causes of chronic brain syndrome (Pick's disease, Alzheimer's disease, Korsakoff's disease)
- Tetanus
- Systemic aerobic infection
- Organ transplantation
- Organ storage
- Pulmonary emphysema
- Exceptional blood loss anemia
- Multiple sclerosis
- Arthritic disease
- Acute cerebral edema

Reasonable Utilization Parameters

Payment should be made where HBO therapy is clinically practical. HBO therapy should not be a replacement for other standard, successful therapeutic measures. Depending on the response of the individual patient and the severity of the original problem, treatment may range from less than one week to several months duration, with the average being two to four weeks. The medical necessity for use of hyperbaric oxygen for more than two months, regardless of the condition of the patient, should be reviewed and documented before further reimbursement is requested.

Topical Application of Oxygen

This method of administering oxygen does not meet the definition of HBO therapy as stated above. Also, its clinical efficacy has not been established. Therefore, no reimbursement is allowed for the topical application of oxygen.

Enrollment

Hyperbaric units must be contracted with a hospital even if certified as a freestanding clinic by the Centers for Medicare and Medicaid Services. This contractual agreement with the hospital involves reimbursement for the technical portion of the therapy only.

Billing Procedures

Technical Component – All technical services must be billed on the UB-04 hospital claim form. Payment for outpatient hyperbaric therapy is allowed. Inpatient therapy cannot be billed separately as the fee is

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Billing Procedures (Cont'd.)

included in the hospital DRG or per diem rate.

Professional Component–If a physician directly supervises the HBO therapy, procedure codes for HBO may be billed on the CMS-1500 claim form. No modifier is necessary. The professional component should be coded as one of the following:

- Initial Treatment – An initial treatment is compensable only once per course of treatment for a specific diagnosis. HBO initial treatment is not billed in units of time, but rather the first day of the initial therapy.
- Subsequent Care – All subsequent HBO therapy treatments must be coded as such. Subsequent therapy is defined as any length of therapy following the initial treatment on any given day. If two subsequent treatments are performed on the same date of service (at different times of the day), a second charge may be used with a 76 modifier. HBO therapy is not billed in units of time, but rather in episodes of treatment.

GENERAL SURGERY GUIDELINES

Coverage Guidelines

Criteria outlined in this section are contingent upon demonstrated medical necessity. The medical record must substantiate the need for surgical services including information to support the medical justification. Compensable services include correcting conditions that meet any of the following criteria:

- Conditions that directly threaten the life of the beneficiary
- Conditions that have the potential for causing irreparable physical damage
- Conditions that can result in the loss or serious impairment of a bodily function
- Conditions that can result in the impairment of normal physical growth and development
- Conditions that result from trauma and must be promptly corrected (*i.e.,* as soon as medically feasible)

When care is furnished outside of these conditions, documentation must be included in the medical record, or when designated, justification must be attached to the CMS-1500 claim form for payment. This includes the history and physical, operative report, discharge summary, and pathology report.

If a claim is submitted that requires support documentation, and the

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Coverage Guidelines (Cont'd.)

required documentation is not attached to the claim form, the claim will be rejected. In this case, the documentation must be attached to the Edit Correction Form (ECF) for review. A sample copy of the ECF can be found in the Forms section of this manual.

Note: All unlisted procedure codes must have documentation attached to the claim form to ensure equitable pricing of the procedure.

To avoid delay in the processing of your claim, do not use an unlisted code when a descriptive code is available. All unlisted codes suspend for review and pricing.

If the reviewer finds a code comparable for the procedure, the unlisted code will be priced at the same rate as the descriptive code. The reviewer may also choose to notify the provider of the proper code to use for future reference.

Limitations

Certain surgical procedures are routinely not covered. These non-covered procedures typically fall into one of the following categories:

- Do not restore a bodily function
- Are performed for cosmetic reasons
- Have an alternative non-operative treatment
- Frequently are performed for less than adequate diagnostic indications
- Are not proven effective
- Are experimental/investigational in nature
- Are for the convenience of the patient

No reimbursement will be made for subsequent procedures that do not add significantly to the complexity of the major surgery or are rendered incidentally and performed at the same time as the major surgery (*e.g.*, incidental appendectomies, incidental scar excisions, puncture of ovarian cysts, simple lysis of adhesions, simple repair of hiatal hernias).

Exploratory Procedures

If a procedure is carried out through the laparotomy incision, the physician may choose to bill for either the laparotomy or the actual procedure performed during the surgery; most likely, it will be the code that reimburses the higher rate. In any case, South Carolina Medicaid will sponsor payment for either the procedure or the laparotomy, not both.

Under the same principle, when a surgical procedure is performed through an endoscope, the diagnostic endoscopy is inclusive in the reimbursement. The physician may be reimbursed for either the endoscopic procedure or the diagnostic endoscopy, not both.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Exploratory Procedures (Cont'd.)

When endoscopy procedures are performed in the office, small supplies and materials provided by the physician over and above those usually included with the office visit may be billed using procedure code 99070. A minor surgical tray may also be billed using procedure code 99070.

Multiple Surgery Guidelines

Multiple surgeries include separate procedures performed through a single incision, or separate procedures performed through second and subsequent incisions or approaches. All surgical procedures for the same date of service should be filed on one claim form when possible.

Payment Guidelines

When multiple surgeries are performed at the same operative session, the procedure that reimburses the highest established rate will be considered the primary procedure and will be reimbursed at 100% of the established rate. All second and subsequent surgeries performed at the same operative setting will be reimbursed at 50% of the established rate. Procedure codes that are exempt from multiple procedure reduction as outlined by the AMA in the Current Procedural Terminology Standard Edition are reimbursed at 100%.

A vaginal delivery and tubal ligation performed on the same date of service will not be affected by this policy. Both procedures are reimbursed at 100%, even when performed on the same day. Use the 79 modifier on the tubal ligation to ensure correct reimbursement.

Modifiers

Listed services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance must be identified by the addition of the appropriate modifier code, which must be reported by adding a two-digit number (modifier) placed after the procedure number. Modifiers commonly used in surgery are listed in the surgery section of the CPT and in Section 4 of this manual. Only the first modifier indicated will be used to process the claim – Medicaid will key only the first modifier indicated for each procedure.

Billing

Claims for surgery must be filed using the CPT code that most closely describes the surgical procedure that was performed. When this is not applicable, an unlisted procedure code may be used and the appropriate documentation should be attached to the claim form for adequate reimbursement.

Claims for more than one surgical procedure performed at the same time by the same physician must be billed as follows:

- On a single claim form, unless more than six procedures are performed

  Note: If more than one surgical procedure is billed for the same

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Billing (Cont'd.)

DOS on different claims, the second claim that processes may reject. To avoid this delay, file all surgical procedures for the same DOS on one claim form.

- Only for subsequent procedures which add significantly to the major surgery or are not incidental to the major surgery
- Using the appropriate modifier (Medicaid will key the first modifier indicated for each procedure only)
- With charges listed separately for each procedure

When identical procedures (not bilateral) are billed for the same day, the first should be billed without a modifier, and the second with modifier 51. If the same procedure is billed a third time, the claim must be filed hardcopy with supporting documentation.

Modifier 62 should be used to indicate that the skills of two surgeons were required. Modifier 66 should be used to indicate circumstances requiring a surgical team. These modifiers will ensure proper reimbursement for each provider involved.

Modifier 52 should be used to describe reduced services. Modifier 53 is used to describe a discontinued procedure. Both modifiers will be reimbursed at 50% when billed with a surgical procedure.

Separate Procedures Performed on the Same Date of Service

When two separate surgical procedures are performed on the same date of service at different operative sessions, both procedures will be allowed 100% of the established rate.

To report, submit the second procedure with the 78 or 79 modifier. This will ensure that both procedures will be paid at 100%. If not reported in this manner, the lower priced of the two procedures will be reimbursed at 50%. All surgical procedures performed on the same date of service should be filed on the same claim form whenever possible.

Procedure Codes That Multiply

Occasionally the CPT defines certain procedure codes as "each," indicating the possibility of multiple procedures. When filing these types of codes, list the code one time for the date of service and bill the appropriate number of units in the “units” column of the claim form and the total charge for the number of units billed. If there is only one surgical procedure for the date of service and multiple units are billed, payment for codes that multiply will be 100% of the established rate for the first unit and 50% for each additional unit(s) filed. If a surgical procedure with a higher established rate is performed on the same date of service, the higher established rate will be allowed and the code(s) to multiply will pay 50% of the established rate per unit filed.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Automatic Adjustments to Paid Surgical Procedures

All surgical procedure codes for the same patient and same date of service should be filed on the same claim form. This ensures that the correct procedure will reimburse at 100% of the established rate. At times, however, surgical codes are filed on separate claim forms, causing incorrect payments and the need for adjustments.

Automatic adjustments work in the following manner: When a claim for a surgical procedure code is submitted, the system will review the paid claims history for that patient, date of service, and provider. If there is no previously paid surgical code(s) on file for that date of service, the surgery will pay at 100% of the established rate. If, however, there is a previously paid surgery on file for that patient, date of service, and provider, the system will compare the previously paid surgery and the newly submitted surgical code. It will then determine which of the codes should correctly reimburse the provider at 100%. If the newly submitted surgical code should pay at 100%, the system will make an automatic adjustment against the previously paid surgical code by subtracting 50% of the previously paid procedure from the amount to be reimbursed for the newly submitted surgical code. Therefore, the newly submitted surgical code will be allowed at 100% although the payment may not reflect the full amount due because of the recoupment of 50% of the previously paid procedure.

When the system reviews paid claims history for a patient, date of service, and provider, and finds that the previous surgical claim paid correctly at 100% and the second surgical claim should pay at 50% of the established rate, there will be no adjustment as the claim will pay correctly.

Bilateral Surgery

To report a bilateral procedure, bill the first procedure with no modifier, and the second procedure with a 50 modifier. Report on two lines instead of one. A bilateral procedure billed with only one line will result in underpayment. Codes with bilateral descriptions may not be billed with a 50 modifier.

Claims filed for an assistant surgeon performing a bilateral procedure should be filed hardcopy with documentation using the 80, 81, or 82 modifier on both lines of the procedure code that is bilaterally performed.

Bilateral procedures will be reimbursed at 100% for the first procedure, and 50% for the second procedure (same as multiple procedures). If the bilateral procedure is billed in conjunction with another procedure that is normally reimbursed at a higher rate than the bilateral procedure, then each of the bilateral procedures will be reimbursed at 50%.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Billing Procedures

Surgical endoscopic procedures **always include** the diagnostic endoscopy. Therefore, the diagnostic endoscopy code is not allowed in addition to the surgical endoscopy for the same anatomical site.

Under the same principle, when a surgical procedure is performed through an endoscope, the diagnostic endoscopy is inclusive in the reimbursement. The physician may be reimbursed for either the endoscopic procedure, or the diagnostic endoscopy, not both.

Endoscopic procedures do not require a 26 modifier when performed in the inpatient or outpatient hospital setting.

When two endoscopic procedures are performed on the same date of service, the first procedure should be reported without a modifier, and the second procedure should be reported with modifier 51.

Surgical Supplies

Refer to "Supplies" under the heading "Additional Ambulatory Services" in this section for more detail.

Ambulatory Surgical Services

Many surgical procedures ordinarily performed on an inpatient or outpatient basis consistent with sound medical practice can be performed in an Ambulatory Surgical Center (ASC) for less cost. South Carolina Medicaid recognizes these procedures as compensable if performed in an ASC and included on the ASC list of covered procedures.

Surgeons should utilize only those ASC facilities contracted with South Carolina Medicaid for their Medicaid patients. South Carolina Medicaid reimburses the ASC for the facility charges under strict guidelines. Each ASC contracted is provided with a list of covered procedures (which is subject to change from time to time).

Note: The surgeon should verify with the ASC that the elective procedure is covered under ASC guidelines**.**

To bill for the professional service, the surgeon should submit claims following the usual surgical guidelines, using place of service "24."

Surgical Package

Guidelines

The surgical package includes postoperative care for 30 days following surgery. Postoperative services rendered and billed during this 30-day period will be rejected for an 854 edit code. Normal postoperative care is considered part of the surgical package and includes office examinations and all hospital follow-up visits, including discharge management. Hospital and office E/M visits are allowed up to and including the day of surgery.

Emergency room services and critical care are not considered part of the

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Guidelines (Cont'd.)

surgical package. They may be billed in addition to the surgery performed. For guidelines on delivery admissions, refer to "Perinatal Care" under the heading "Obstetrics and Gynecology" in this manual section.

Surgical procedures that are billed within 30 days prior to a paid office or hospital visit will suspend for review. If applicable, the office or hospital visit(s) will be recouped and the surgery claim will process for payment. The surgical procedure may be rejected with edit 855. In that case, return the edit correction form and indicate that the surgery should be paid and the visits should be recouped.

Ambulatory Surgical Services

Complications or services rendered for a diagnostic reason unrelated to the surgery may be billed with a separate examination code if the primary diagnosis reflects a different reason for the service.

To report postoperative visits unrelated to surgery, submit the visit code(s) with modifier 24 or 25. The medical record must substantiate that a visit(s) was justified outside of the surgical package limitation.

Follow-up care in the office and/or hospital may be billed if the surgery is an exception to the surgical package. **A complete table of codes that are considered part of the surgical package is located in Section 4 of this manual ("Procedure Codes").**

Assistant Surgeon

Guidelines

All guidelines that apply to the primary surgeon also apply to the assistant surgeon. The CPT surgical procedure codes (10000 – 69999) that allow an assistant surgeon's fee are listed in Section 4 of this manual ("Procedure Codes").

Note: These allowances are subject to change and should be used as a reference only.

When billing for the assistant surgeon's fee, the modifier 80, 81, or 82 must accompany all procedure codes filed. Assistant surgeons must be physicians. Medicaid will not reimburse non-physician surgery assistants.

If, due to unforeseen circumstances, the surgery did require an assistant, and an assistant surgeon is not allowed for the surgical procedure, Medicaid will review the claim for reimbursement. Documentation must be attached to the Edit Correction Form and submitted to the Department of Medical Services Review for reconsideration. The medical record must justify the special need for an assistant surgeon.

An assistant surgeon will be reimbursed at 20% of the total allowable fee per procedure.

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PROGRAM REQUIREMENTS

Billing

An assistant surgeon must use the same CPT procedure codes as the primary operating surgeon. The assistant surgeon modifier is the only modifier required for each procedure billed. Medicaid will only key the first modifier indicated.

The claim for the assistant surgeon must be submitted with a different individual provider number (rendering physician) from the primary surgeon. The assistant surgeon must be enrolled with South Carolina Medicaid in order to receive reimbursement.

Claims filed for an assistant surgeon performing a bilateral procedure should be filed using the 80, 81, or 82 modifier.

SURGICAL GUIDELINES FOR SPECIFIC SYSTEMS

Integumentary System

Lesion Removal

Excision/treatment of non-malignant dermal lesions and other dermal anomalies are not covered routinely. However, Medicaid will provide coverage of these anomalies if the therapy conforms with accepted treatment standards of the particular problem and meets **one** of the following conditions:

- The lesion is pre-cancerous or suspected to be cancerous by physical findings, appearance, or changes in characteristics.
- The anomaly is symptomatic with documented history (ulceration, inflammation, infection, chronic itching) that results in repeated office visits for the condition.
- The anomaly causes pain, irritation, or numbness that result in the functional impairment of bodily functions or normal growth and development.
- At least two alternative methods of treatment (*i.e.*, steroid injection, compression, silicone gel treatment, etc.) have been attempted and found ineffective.
- The anomaly is responsible for the loss of a bodily function and the treatment restores the disabled function.

Medicaid will not provide coverage for excision/treatment of non-malignant dermal lesions and dermal anomalies under the following circumstances:

- The treatment is performed for cosmetic or emotional purposes.
- The therapy is experimental or investigational.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Lesion Removal (Cont'd.)

Supporting documentation is required for a claim submitted for a lesion and a dermal anomaly removal or revision with diagnosis codes 701.4 and 709.2. Medicaid will **not** cover treatment that is considered to be experimental, investigational (*i.e.*, chemical peels, cryosurgery, dermabrasion, punch grafts, bleomycin, interferon, and verapimil injections), or done for cosmetic or emotional purposes.

Keloid/Scar Conditions

Medicaid will provide coverage of excision and/or treatment of a Keloid scar and scar conditions and fibrosis of the skin if the therapy conforms to accepted standards of the particular problem and meets one of the following conditions:

- The scar causes functional impairment which interferes with daily living.
- The scar is symptomatic with a history of ulceration or inflammation that causes repeat office visits. At least two methods of treatment such as radiation (silicone gel treatment), compression, steroids, and laser surgery have been tried and failed.
- There is a history of repeated infections with the scar.

Claims for the above treatments must be accompanied by documentation that supports the criteria as outlined above. Medicaid will not provide coverage for excision and/or treatment of nonmalignant dermal lesions, dermal anomalies and Keloid/scar conditions under the following circumstances:

- The treatment is performed for cosmetic or emotional purposes.
- The therapy is experimental or investigational.

Examples include chemical peels, cryosurgery, dermabrasion and punch grafts.

Skin Grafts (15100, et. al.)

Providers should follow CPT guidelines when billing for skin grafts. Procedures are identified by size and location of the defect (beneficiary area) and the type of graft. Skin graft codes that pertain to subsequent (each additional square centimeter) areas should be billed in units.

Destruction Codes (17000, et. al.)

Treatment must be medically indicated according to the criteria set forth in the guidelines previously stated. Procedure codes 17360 and 17380 are considered cosmetic and therefore non-compensable.

Cosmetic Procedures

Cosmetic surgery or expenses incurred in connection with such services are non-covered. Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Cosmetic Procedures (Cont'd.)

repair of accidental injury (*i.e.*, as soon as medically feasible), or for the improvement of the functioning of a malformed body member. This exclusion does not apply to surgery for therapeutic purposes which coincidentally also serves some cosmetic purposes.

Cosmetic otoplasty is not covered under normal circumstances. Payment will be considered for otoplasty procedures for children under 21, but only if there is documented evidence of psychological trauma because of their appearance. A psychiatric evaluation performed by a psychiatrist recommending treatment, plus pertinent medical documentation, must be attached to the claim. Lack of – or insufficient documentation will result in a rejected claim. All otoplastic procedures must be preauthorized by KePRO, the Quality Improvement Organization (QIO) contractor.

Repair of the following birth defects is not considered cosmetic surgery: cleft lip, cleft palate, clubfoot, webbed fingers and toes, congenital ptosis, and other birth defects which impair bodily functions.

Chemosurgery (Moh's Technique)

Codes 17311 – 17315 are compensable if medically justified and not performed for cosmetic purposes.

Mohs micrographic surgery is defined by the American Medical Association's (AMA) *Current Procedural Terminology* as a technique for the removal of complex or ill-defined skin cancer with the histologic examination of 100% of the surgical margins. It requires a single physician to act in two integrated but separate and distinct capacities: surgeon and pathologist.

Prior Authorization for Mammaplasty and Mastectomy and Reconstructive Procedures

Reduction mammaplasty and gynecomastia, mastectomy procedures must be preauthorized by KePRO using InterQual criteria. A Request for Prior Approval form must be used when submitting a request for these services. A sample copy of the Request for Prior Approval form can be found in the Forms section of this manual. The attending physician shall obtain prior authorization and submit all necessary documentation to KePRO.

The following policies should be followerabiesd for reduction mammaplasty and gynecomastia:

- Prior authorization (PA) is required for all ages.
- Photographs must be submitted with all requests.
- Pathology/operative reports are no longer needed.
- KePRO will conduct all reviews.
- Physicians are responsible for verifying beneficiary eligibility prior to the PA request being submitted.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Prior Authorization for Mammaplasty and Mastectomy and Reconstructive Procedures (Cont'd.)

- Physicians are responsible for providing the PA number to any facility or medical provider who will submit a Medicaid claim.

Reduction Mammaplasty

Reduction mammaplasty for large, pendulous breasts on a female may be considered medically necessary when InterQual screening criteria are met. Prior Authorization is required for all ages. A claim is reviewed for medical necessity and must be submitted with the preoperative assessment from the patient's record.

Reconstructive Breast Surgery

Reimbursement is allowed for reconstructive breast surgery following a mastectomy performed for the removal of cancer or for prompt repair of accidental injury. Prior authorization and/or support documentation must be obtained. KePRO is responsible for prior authorization and support documentation requests. InterQual screening criteria applies.

Breast reconstruction done for cosmetic reasons is non-covered. Augmentation is non-covered under all circumstances. Payment is made for special bras through the Durable Medical Equipment program for women who have undergone any type of mastectomy.

Gynecomastia

Although unilateral or bilateral mastectomy in a male is rarely indicated, this procedure may be allowed when medically necessary. Prior authorization must be obtained by the attending physician.

South Carolina Medicaid Request for Prior Approval Form and all necessary documentation should be sent to KePRO. InterQual screening criteria applies.

Male Gynecomastia

Repeat Male Gynecomastia may be considered when supporting documentation meets InterQual screening criteria.

Musculoskeletal System

Facial Reconstructive Codes

Certain facial reconstructive procedures are covered. The criteria are contingent upon medical necessity as outlined in the General Surgery guidelines. Justification includes result of severe trauma and/or congenital malformations. Each claim must have support documentation attached. If there is no documentation, the claim will be rejected.
If the reconstructive process must be performed in stages, each claim

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Facial Reconstructive Codes (Cont'd.)

must have documentation that includes all prior stages. A consultant for the specialty will review each claim and make a determination.

Under no circumstances is payment allowed for reconstructive surgery performed for cosmetic reasons alone.

Fracture Repair (For Acute Care of an Injured Part)

All codes listed in the musculoskeletal section of the CPT are considered surgical packages with the exceptions of those listed in this manual.

The original application of a cast, splint, strapping, or traction device is included in the treatment of a fracture or dislocation and may not be billed separately.

Grafts

Most bone, cartilage, and fascia graft procedures include the obtaining of the graft by the operating surgeon. When the assistant surgeon obtains the graft for the operating surgeon, the additional service may be identified and reported separately (20900-20926).

Casts

Application – The original application of a cast, splint, strapping, or traction device is included in the treatment of a fracture or dislocation and may not be billed separately except for the application of a halo type body cast, Risser jacket, turnbuckle jacket, body cast, or hip spica cast. Supplemental codes A4580 (plaster) or A4590 (fiberglass) can be billed additionally for cast supplies.

Plaster casts for rehabilitation are compensable using the appropriate CPT codes for the upper or lower extremity. Reimbursement includes the actual application of the cast. Supply codes may be billed in addition to the application.

Synthetic casts (fiberglass) are covered, but may only be billed one time during the patient's course of treatment. A delayed or non-union replacement or the replacement of a patellar-tendon-bearing (PTB) cast is covered.

Replacement – The application of a cast, splint, strapping, or traction device is reimbursable if it is a replacement or subsequent replacement to the original cast, splint, strapping, or traction device.

Removal – Codes for cast removals are reimbursable only if another physician applied the cast.

Repair – To report any repairs made to a cast, use the supplemental codes A4580 – cast supplies (plaster), or A4590 – cast supplies (fiberglass).

Cast Codes – Cast codes 29035, 29040, 29044, 29046, 29305, and 29325 will reimburse in an outpatient setting when the physician applies the cast. If these codes are applied by a hospital technician, then no reimbursement to the physician will be allowed.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Casts (Cont'd.)

Application or Strapping–If cast application or strapping is provided as an initial service (*e.g.*, casting of a sprained ankle or knee) in which no other procedure or treatment (*e.g.*, surgical repair, reduction of a fracture or joint dislocation) is performed or is expected to be performed by a physician rendering the initial care only, use the casting, strapping, and/or supply code (99070) in addition to an evaluation and management code as appropriate.

Splints

Plaster splints–Plaster splints are compensable using the appropriate CPT-4 codes for the upper or lower extremity. The reimbursement includes the materials used as well as the actual application of the splint.

Synthetic splints–Synthetic splints (fiberglass) are covered, but may only be billed one time during the patient's course of treatment. Any replacement is non-covered and cannot be billed except a PTB, delayed, or non-union cast.

Custom Splints–Custom-made splints are recognized as a viable part in the patient's rehabilitative period of treatment. Reimbursement is allowed for these splints only when made by a licensed orthotist or occupational therapist. To report any repairs or adjustments made to a splint, use code 99070.

Prefab Splints–Prefabricated splints (velcro closure) are non-compensable under the Physician Services program.

Orthotic Supplies

Refer to the heading "Durable Medical Equipment/Supply" in this section.

Cardiovascular System

Vascular Injection Procedures

Listed services for injection procedures include necessary local anesthesia, introduction of needles or catheters, injection of contrast medium with or without automatic power injection, and/or necessary pre- and post-injection care specifically related to the injection procedure. For injection procedures in conjunction with cardiac catheterization, refer to "Cardiology" under the "Specialty Care Services" heading in this section.

Radiological vascular injections performed by a single physician are compensable separate from the radiology service. Catheters, drugs, and contrast media are not included in the listed service for these injection procedures.

For insertion of a Swan-Ganz catheter **not** associated with cardiac catheterization, use procedure codes from the 36000 range (in lieu of a heart cath code).

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Implantable Vascular Access Portal/Catheter

For port-a-cath maintenance, use the appropriate J codes, supply codes, and office visit code when applicable. Do not use an unlisted CPT code for catheter maintenance.

Digestive System (et. al.) (40490 – 49999)

Contralateral Inguinal Exploration

Medicaid will reimburse for a contralateral inguinal exploration when a unilateral herniorrhaphy has been performed on an infant (under age five years). To report this service, use procedure code 49500 along with the procedure code for herniorrhaphy and attach support documentation for medical review.

Gastric Bypass

Refer to "Gastroenterology" under the heading "Specialty Care Services" in this section regarding treatment of obesity and gastric bypass procedures.

Urinary System (50010 - 53899)

Services listed in this section are covered when medically necessary, with the following restrictions:

- Endoscopic Procedures – Follow guidelines for endoscopic procedures under General Surgery guidelines.
- Urodynamics (51725 – 51798) – These procedures may be billed in addition to the appropriate surgical code (Cystourethroscopy). Reimbursement includes equipment and supplies.

  When performed (and billed) on the same DOS as the surgery, these services are not considered surgical and will be reimbursed at 100% of the established rate. Use code 51798 when billing the measurement of post-void residual urine by ultrasound. Documentation should include the urine measurement.
- Urinary Supplies – Refer to the "Durable Medical Equipment/Supply" heading in this section.
- Lithotripsy – Percutaneous, extracorporeal shock wave, and cystourethroscope lithotripsy are covered services when medically necessary. The physician is reimbursed only for the professional service. If the procedure is performed bilaterally, bill on two lines adding no modifier to the first procedure, and a 50 modifier to the second (bilateral) procedure.

Male Genital System

Routine newborn circumcisions are non-covered services.

Circumcisions to be performed due to medical justification require prior approval, which must be granted utilizing the "**Request for Prior**

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Male Genital System (Cont'd.)

Approval Review" form found in the "Forms" portion of the appendices section of the manual. Support documentation must accompany the form and be faxed "Attention Circumcision Review" to 803-255-8255. Cosmetic reconstruction of the penis is non-compensable without medical justification. Prior approval must be granted by Medical Services Review before services are considered for payment.

Penile implants are non-covered unless prior approval is obtained. Reimbursement will not be allowed for penile prosthesis if the only reason is sexual dysfunction. The criteria for approval are based on medical necessity. Examples would be chronic depression as a result of sexual dysfunction or a paraplegic with decubitus problems who would benefit from better condom urine drainage.

The following support documentation is required:

- Summary of psychiatric care
- The medical condition that surgery is expected to improve
- History and physical

As with cosmetic reconstruction, prior approval must be granted by KePRO, the Quality Improvement Organization (QIO) contractor. A complete list of procedures requiring prior authorization is located in Section 4 of this manual.

Sterilization requirements are the same as for females. (Refer to "Elective Sterilization" under the "Obstetrics and Gynecology" heading in this section.)

Nervous System (61000 – 64999)

No special restrictions apply other than those defined in the general surgery and pain therapy guidelines.

Spinal Procedures for Injection of Anesthetic Substance

Codes 62274 – 62279 are reimbursed for the initial placement of an indwelling catheter for anesthesia purposes. Subsequent injections of the anesthetic agent are not allowed under the injection code. For maintenance of an epidural, see "Anesthesia Services" and "Pain Management Services" in this section.

Implantable Infusion Pumps

An implantable infusion pump is covered when used to administer anti-spasmodic drugs intrathecally (*e.g.*, Baclofen) to treat chronic intractable spasticity in patients who have proven unresponsive to less invasive medical therapy as determined by the following criteria:

- As indicated by at least a six-week trial, the patient cannot be maintained on non-invasive methods of spasm control.
- Prior to pump implantation, the patient must have responded favorably to a trial intrathecal dose of the anti-spasmodic drug.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Implantable Infusion Pumps (Cont'd.)

Each claim will be reviewed for these criteria. Claims submitted without documentation will reject.

Implantable infusion pumps are also covered for treatment of pain. Refer to the heading "Pain Management Services" in this section for more detail.

UTILIZATION REVIEW SERVICES

SCDHHS contracts for utilization review services with KePRO, the current QIO contractor.

The QIO review consists of:

- Pre-surgical justification for all hysterectomies
- Select preauthorization review
- Support documentation review
- A retrospective review of a sample of paid inpatient/outpatient hospital claims
- Select project studies as determined by SCDHHS

Screening criteria may be obtained upon request from KePRO. Any questions or concerns should be directed to KePRO customer service at 1-855-326-5219 or emailed to atrezzoissues@KePRO.com. Please be advised that a beneficiary should not contact KePRO directly.

Telephone or written approval from the QIO is not a guarantee of Medicaid payment. All cases will be subject to retrospective review to validate the medical record documentation.

SCDHHS reserves the right to review retrospectively any case that has received prior approval to assure accuracy and compliance with South Carolina Medicaid guidelines and federal requirements.

Prior Approval for Hysterectomy

All prior approval requests for hysterectomies must be in writing. Forms are accepted via fax, email, or website using the South Carolina Medicaid Program Surgical Justification Form and Consent for Sterilization Form (DHHS 1723). Copies of these forms are located in the Forms section of this manual. Completed forms must be submitted at least 30 days prior to the scheduled date of surgery.

All requests for prior authorizations **must** be submitted via facsimile, email, or website to KePRO. Requests for prior authorization must be submitted **before** the service is rendered. Exceptions to this policy include emergency, urgent case or retroactive eligibility. Emergency or urgent cases **must also** be submitted for approval via facsimile before the claim is sent to processing.

Prior authorization, support documentation, quality assurance, and quality

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Prior Approval for Hysterectomy (Cont'd.)

care inquires must be submitted to KePRO using one of the following methods:

KePRO Customer Service:	1-855-326-5219
KePRO Fax:	1-855-300-0082
For Provider Issues email:	atrezzoissues@KePRO.com

KePRO urgent and emergent hysterectomy cases will be reviewed retrospectively. Please refer to Special Coverage Issues in this section for additional Medicaid policies for hysterectomies. Cases that do not meet the QIO criteria will be referred for physician review. The physician will use clinical judgment to determine whether the proposed treatment was appropriate to the individual circumstances of the referred case. Pre-approved cases will not be subject to retrospective review by the QIO. However, SCDHHS reserves the right to review any paid claim and recoup payment when medical necessity requirements are not met. The patient and physician shall make the final decision as to whether to undergo surgery. Medicaid will not sponsor the hospital-related expenses associated with the surgery if the QIO physician consultant determines that the proposed surgery is not appropriate.

Medicaid Prior Approval from KePRO

Refer to Section 4 of this manual for a list of the CPT and ICD-9 codes that require either prior authorization or support documentation submitted to KePRO

Instructions for Obtaining Prior Approval

The responsibility for obtaining pre-admission/pre-procedure review rests with the attending physician. The physician must submit all necessary documents, including the Request for Prior Approval Review Form, to KePRO.

Requests for prior authorizations from KePRO may be submitted using one of the following methods:

KePRO Customer Service:	1-855-326-5219
KePRO Fax:	1-855-300-0082
For Provider Issues email:	atrezzoissues@KePRO.com

The QIO reviewer will screen the medical information provided, using appropriate QIO or InterQual criteria for non-physician review

If criteria are met, the procedure will be approved and an authorization number assigned. Notification of the approval and authorization number will be given by written confirmation to the physician. Write this number in block 23 of the CMS-1500 claim form.

If criteria are not met or a case is otherwise questioned, the QIO reviewer will refer the procedure request to a physician reviewer. If the physician reviewer cannot approve the admission/procedure based on the initial information provided, he or she will make a reasonable effort to contact

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Instructions for Obtaining Prior Approval (Cont'd.)

the attending physician for additional supporting documentation of the need for the procedure.

The physician reviewer will document any additional information provided, as well as his/her decision regarding the medical necessity and appropriateness of the procedure.

Review personnel will assign an authorization number (if the procedure is approved), and a written copy of the authorization number will be sent to the physician.

If the physician reviewer cannot approve the procedure based on the additional information, he or she will document the reasons for the decision. QIO review personnel will attempt to notify the attending physician's office of the denial.

QIO will verify all initial procedure denial decisions by issuing written notices to the attending physician.

The attending physician may request a reconsideration of the initial denial decision by submitting a written request outlining the rationale for recommending the procedure. Reconsideration may be requested whether the case was pre-procedure or post-procedure reviewed. The request should be in writing to KePRO. If a case is denied upon reconsideration, the determination is final and binding upon all parties (CFA 473.38).

Points of Emphasis for Prior Authorization

KePRO **will accept medical review documentation via facsimile, telephone, or via their website.** Providers are responsible for verifying beneficiary eligibility prior to the PA request being submitted and again prior to performing a service. Eligibility and managed care enrollment status may change during the time a request is submitted and approved and the actual date the procedure is performed.

PA request for beneficiaries enrolled in a managed care organization (MCO) must be handled by the MCO. If you have any additional questions regarding the MCO you may contact the MCO's Provider Services department, or the Division of Care Management at (803) 898-4614. Contact information for the MCOs is located in the Managed Care Supplement.

Physician providers are responsible for providing the PA number to any facility or medical provider who will submit a Medicaid claim.

The hysterectomy policy has changed. Refer to the heading "Prior Approval for Hysterectomies from KePRO" in this section for more detail.

For instructions on how to obtain a prior authorization from KePRO, refer to the heading "Medicaid Prior Approval from KePRO" in this section.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

ORGAN TRANSPLANTATION

KePRO will provide direct oversight of the Medicaid transplant program. SCDHHS will only support the referral of patients for an evaluation to Centers for Medicare and Medicaid Services (CMS) certified transplant centers. This will include certified facilities that are contracted with SCDHHS as well as certified facilities that are located outside of the South Carolina medical service area (less than 25 miles of the South Carolina borders). For a complete listing of transplant services requiring prior authorization by KePRO, please see Section 4 of this manual.

Group I – Kidney and Corneal

Kidney Transplantation

Medicaid will reimburse for kidney transplants. Professional services, including the nephrectomy and transplantation of the new organ, performed by a physician team, are reimbursed separately. Inclusive charges are compensable for the services rendered on behalf of the Medicaid-eligible beneficiary. Medicare coverage is primary and Medicaid will only pay if Medicare benefits are either not available or have been denied.

A Medicare denial of benefits must accompany the claim, and the patient must be End Stage Renal Disease (ESRD) enrolled with Medicaid. (Refer to “Nephrology and End Stage Renal Disease Services” under the heading “Specialty Care Services” in this section.)

Corneal Transplantation (Keratoplasty)

Corneal transplants are compensable. The reimbursement to the hospital includes all technical services, including donor testing and preparation.

Professional services are compensable using CPT codes 65710-65755. All general surgery guidelines apply when billing for keratoplasty.

SCDHHS will cover the cost of the corneal tissue when a corneal transplant is performed in an Ambulatory Surgical Center (ASC). The ASC will be reimbursed for the transplant surgical procedure and the corneal tissue must be submitted with the HCPCS procedure code V2785 (processing, preserving, and transporting covered tissue). ASC providers must attach a copy of the invoice reflecting the cost of the tissue along with the claim to avoid delays in payment.

Transportation for Medicaid Beneficiaries Requiring Group I Transplants

Transportation arrangement for Group I transplants are coordinated through the Division of Preventive Care. For information on the transportation program, you may call the PSC at 1-888-289-0709, submit an online inquiry at http://www.scdhhs.gov/contact-us, or write to:

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Transportation for Medicaid Beneficiaries Requiring Group I Transplants (Cont'd.)

SCDHHS
Division of Preventive Care
Post Office Box 8206
Columbia, SC 29202

Group II - Bone Marrow (Autologous Inpatient and Outpatient, Allogenic Related and Unrelated, Cord, and Mismatched), Pancreas, Heart, Liver, Liver with Small Bowel, Liver/Pancreas, Liver/Kidney, Kidney/Pancreas, Lung and Heart/Lung, Multivisceral, Small Bowel

All Group II organ transplants, with the exception of Bone Marrow (Autologous Inpatient and Outpatient, Allogenic Related and Unrelated, Cord, and Mismatched), require prior authorization from KePRO. Referral requests for organ transplants to both in-state and out-of-state centers must be submitted to KePRO before services are rendered.

Requests for prior authorizations from KePRO may be submitted using one of the following methods:

KePRO Customer Service:	1-855-326-5219
KePRO Fax:	1-855-300-0082
For Provider Issues email:	atrezzoissues@KePRO.com

In addition to completing the Transplant Prior Authorization Request Form, the request must also include a letter from the attending physician with the following patient information:

- The description of the type of transplant needed
- The patient's current medical status
- The patient's course of treatment
- The name of the center to which the patient is being referred

Upon approval, KePRO will issue an authorization number to the requesting physician with instructions for its use. The transplant authorization number must be included on all claims submitted for reimbursement. Transplant Prior Authorization Request Form can be found in the Forms section of this manual.

KePRO reserves the right to make recommendations to the provider for services at a certified center that has provided transplant services to Medicaid beneficiaries in the past. Please note that the approval of a transplant evaluation **does not** guarantee the approval of the actual transplant.

The appropriate transplant team, utilizing uniform professional and administrative guidelines, will determine medical necessity and clinical acceptability. For more information please contact KePRO at 1-855-326-5219.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

ANESTHESIA SERVICES

Anesthesia services consist of services rendered by a physician, a certified registered nurse anesthetist (CRNA), or anesthetist assistant (AA) other than the attending surgeon or his or her assistant, and shall include the administration of a spinal or rectal anesthesia, or a drug, or other anesthetic agent. The agent may be administered by injection or inhalation, except by local infiltration, the purpose and effect of which administration is the obtaining of muscular relaxation, loss of sensation, or loss of consciousness. The reporting of anesthesia services is appropriate by or under the responsible supervision of a physician.

CPT codes 00100 – 01999 are accepted for the billing of anesthesia services. Use of the surgical procedure code will result in a rejection. When multiple surgical procedures are performed during the same period of anesthesia, only the anesthesia procedure code for the major procedure should be billed and the total time should reflect coverage for all procedures. Base time associated with the procedure code will be automatically assigned from the procedure code billed.

There is no additional payment for anesthesia services rendered by the attending surgeon or assistant surgeon when performed on an inpatient or outpatient basis.

Time Reporting

Anesthesia time involves the continuous, actual presence of the anesthesiologist or the medically directed CRNA/AA. It starts when the anesthesiologist begins to prepare the patient for anesthesia care in the operating room and ends when the anesthesiologist is no longer in continuous, actual attendance.

South Carolina Medicaid only accepts actual time when billing for anesthesia services. **Report time in minutes in the units field (Item 24g) of the CMS-1500 claim form.**

Example:

Anesthesia Start Time – 1:15
Anesthesia Stop Time – 2:45
Total Anesthesia Time Billed in Minutes – 90

Modifiers of Anesthesia Services

Unless anesthesia services are provided and billed as supervision, the administration of anesthesia must be personally provided by the physician, who remains in constant attendance of the patient. Anesthesiologists must indicate this by using the AA modifier in conjunction with the appropriate anesthesia CPT code.

Anesthesiologists billing as a member of the anesthesia team, for supervision of anesthesia services rendered by a CRNA/AA, resident, or intern, must use the modifier listed below which best reflects the situation:

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Modifiers of Anesthesia Services (Cont'd.)

QY – Medical direction of one CRNA by an anesthesiologist

QK – Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals

AD – Medical direction of more than four concurrent procedures involving qualified individuals.

Anesthesia procedures that involve both a supervising anesthesiologist and a CRNA/AA will have reimbursement divided so that the anesthesiologist receives 57% and the CRNA/AA will receive 47% of the established reimbursement rate for the procedure. The anesthesiologist will bill his or her services using the QY modifier and the CRNA will bill using QX.

If the complexity of a surgery or complications that develop during surgery require both the CRNA and the anesthesiologist to be involved completely and fully in a single anesthesia case, both providers may bill for their services. **The complexity of service or complications must be clearly documented in the patient's records and submitted with the claim.** The anesthesiologist must bill using the AA modifier. The CRNA must bill using the QZ modifier. These claims must be filed hardcopy with documentation supporting the need for both professionals.

Routine scheduling of a CRNA/AA, resident, or intern to assist an anesthesiologist in the care of a single patient <u>does not</u> justify medical necessity.

CRNAs billing for services rendered under the medical direction of a surgeon must indicate this by using the QZ modifier in conjunction with the appropriate CPT anesthesia code. CRNAs working under the medical direction of a surgeon will be reimbursed at 87% of the anesthesiologist reimbursement rate.
CRNA/AAs billing for services rendered as a member of the anesthesia team, under the supervision of an anesthesiologist, must indicate this by using the QX modifier in conjunction with the appropriate CPT anesthesia code.

The following CPT modifiers are non-covered:

P1 – A normal healthy patient

P2 – A patient with mild systemic disease

P3 – A patient with severe systemic disease

P4 – A patient with severe systemic disease that is a constant threat to life

P5 – A moribund patient who is not expected to survive without the operation

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Modifiers of Anesthesia Services (Cont'd.)

P6 – A declared brain-dead patient whose organs are being removed for donor purposes

The monitored anesthesia care modifiers QS, G8, and G9 do not describe medical direction involved in the anesthesia procedure. The monitored anesthesia care modifiers describe the type of anesthesia care. It is important to use a modifier that describes the medical direction involved as the first modifier when using more than one. Medicaid only accepts one modifier.

Anesthesia Risk Factors

Procedures

The 99100 – 99140 risk factor codes are non-covered.

Intubation

Payment is allowed for intubation (31500) performed in the ICU or emergency room by an anesthesiologist or CRNA. Intubation is considered a regular part of anesthesia services and may not be a fragmented charge when performed in conjunction with anesthesia services.

Catheter Placement

Anesthesiologists are reimbursed for placement of central venous, subclavian, arterial, or Swan-Ganz catheters in addition to anesthesia services. CRNA/AAs will not be reimbursed for these codes. The anesthesiologist files these codes with **no modifier**.

36010*	36555	36620
36011	36556	36625
36012	36568	36640
36013	36569	93503 (Swan-Ganz)
36014	36580	
36015	36584	

*This code may not be billed in addition to general anesthesia procedure codes.

Spine and Spinal Cord Puncture for Injection

Medicaid reimburses personally performing anesthesiologists and CRNAs for the following spine and spinal cord puncture codes. Either the anesthesiologist or CRNA may bill for the codes listed below without a modifier, but not both.

62272	62282	62291	62318
62273	62284	62292	62319
62280	62287	62310	

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Spine and Spinal Cord Puncture for Injection (Cont'd.)

62281 62290 62311

For placement of the continuous epidural catheter, an anesthesiologist or CRNA, personally performing or supervised, bills 62319 with the appropriate modifier.

Laboring Epidural

The continuous epidural codes for the vaginal delivery (01967) and a vaginal delivery becoming a caesarean (01968) reimburses a flat rate regardless of the time involved. The anesthesiologist and CRNA must bill with the appropriate modifier indicating personally performed or as part of an anesthesia team.

When a vaginal delivery becomes a Caesarean section and the catheter remains in place for the Caesarean section, you must bill for the vaginal delivery (01967) and then use the add-on code 01968. CPT code 01968 is an add-on code and therefore must be billed in conjunction with the 01967.

If the Caesarean section is performed under general anesthesia you may bill the time for the Caesarean section only, using procedure code 01961 in addition to the labor and delivery epidural (01967).

For a scheduled Caesarean section, an anesthesiologist or CRNA bills (01961) with payment based on time.

When a tubal is performed at a later surgical session and the same catheter remains in place and is redosed, it is not appropriate to bill general anesthesia based on time. A procedure code from 62273, 62281 – 62282, or 62310 – 62319 would be appropriate.

Anesthesia Consultations

Consultative services rendered on behalf of any direct or indirect patient care are included in the basic value of the anesthesia payment and may not be charged separately. However, if an anesthesiologist is requested to consult with another physician or hospital anesthetist, or examines a patient to determine the appropriate anesthetic agent and does not furnish direct anesthesia services or assume direct supervision of the anesthesia service, then the anesthesiologist may bill a separate consultation code based on the appropriate level of service.

The anesthesiologist may bill a consultative code if the surgery is cancelled. An anesthesiologist may not charge a consultative service in addition to any anesthesia service (either for supervision or direct care).

Fragmented Charges

Services considered an integral part of anesthesia services, such as blood gases, venipuncture, oxygen capacity, blood transfusions, administration of medications, intubation in the operating room, etc., are non-compensable when billed separately.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

PAIN MANAGEMENT SERVICES

The complaint of pain remains the single greatest reason for seeking medical attention. Pain is defined as an unpleasant sensory and emotional experience associated with actual or potential tissue damage. The condition is considered chronic pain when it has been present continuously or intermittently for six months or more, or it has extended two to three months beyond the expected recovery time. It is of utmost importance that medical providers seek the source of the pain in addition to working to relieve and resolve the pain. Patient history must be reviewed to ensure all areas of treatment have been explored. Appropriate referrals for concurrent medical or psychological treatment must be made. This requires all physicians, not just pain specialists, to understand the pain symptoms and their underlying cause.

The primary objectives of pain management must be to accomplish the following:

- Eliminate the use of optional health care services for primary pain complaints
- Increase physical activities and return the patient to productive activity
- Increase the patient's ability to manage pain and related problems
- Reduce the use and misuse of medication
- Decrease the intensity of subjective or illusory pain

The policies outlined in the remainder of the “Pain Management Services” segment apply to physicians of all specialties.

Documentation Requirements

Patient records must indicate medical necessity and are subject to post-payment review. Documentation in the record must indicate the treatment process, which includes the service(s) to be provided, diagnostic procedures, and treatment goals. Goals should be specific according to patient needs and the services to be rendered.

Progress summaries must be documented at a minimum of every three months. The summaries must address the patient's progress toward treatment goals, appropriateness of services rendered, and recommendations for the continued need for services.

Evaluation and Management (E/M) Visits

Medicaid beneficiaries (age 21 and older) are limited to 12 ambulatory care visits per year, beginning on July 1st of each year. Beneficiaries are financially responsible for any visits beyond this limit. It is important to keep this limitation in mind, especially for critically or terminally ill patients who require regular physician visits.

All covered ancillary services, including other diagnostic lab and x-ray

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Evaluation and Management (E/M) Visits (Cont'd.)

services, are compensable. Surgical and diagnostic procedures, hospital care, and other medically necessary services are reimbursed regardless of the number of ambulatory visits used by the patient.

One office or inpatient consultation necessary for screening a beneficiary focusing on identifying the cause of the pain and developing a pain management plan will be covered. When the consultant assumes responsibility for a portion or all of the patient's condition, appropriate office visit or subsequent hospital care codes should be used after the initial consultation. Consultative services related to any direct or indirect patient care are included in the basic value of an anesthesia payment and cannot be billed separately.

Evaluation and management guidelines apply to office, inpatient, and outpatient hospital care for pain management.

Postoperative Pain Management

Physicians billing for postoperative pain management should bill procedure code 62310 (single) or 62318 (continuous) when the insertion of the epidural catheter is for purposes other than surgical anesthesia. These codes include an allowance for insertion of the needle or catheter into the epidural space, and an allowance for injecting the drug or medication through the portal. If a continuous epidural is used for surgical anesthesia and remains in for postoperative pain, an additional insertion cannot be billed for management of the postoperative pain. Procedure codes 62310 and 62318 should be billed with no modifier for the initial insertion.

Procedure code 01996 should be billed for daily management of the epidural analgesia on days subsequent to the day of insertion of the epidural catheter. Up to five days of postoperative pain management may be allowed without additional documentation to justify the extended service. Unless a separately identifiable service has been rendered on the same day, do not bill any other service, including an E/M code with procedure code 01996.

Modifier QZ or AA must be used with procedure code 01996. Refer to the heading "Anesthesia Services" in this manual section for a description of these modifiers.

External Infusion Pumps

The condition of external infusion pumps is covered for the following:

- Opioid drugs for intractable cancer pain
- Treatment for acute iron poisoning or iron overload
- Chemotherapy for liver cancer
- Treatment for thromboembolic disease and/or pulmonary embolism

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

External Infusion Pumps (Cont'd.)

Other uses of the external infusion pump may be reimbursable if the provider can document the medical necessity and appropriateness of this type of therapy and pump for the individual patient. Prior approval must be requested in writing for a condition other than those listed above.

Spinal Cord Neurostimulators

Neurostimulator now require prior authorization by KePRO, the quality improvement organization. For a complete list of procedures that require prior authorization, please see Section 4 of this manual. The implantation of spinal cord neurostimulators will be covered for the treatment of severe and chronic pain. Implantation of this device, related services and supplies, may be covered if InterQual criteria are met.

The implantation of the neurostimulator may be performed on an inpatient or outpatient basis according to medical necessity.

Procedure codes 63650, 63655, or 63685 may be used to bill for the implantation.

Implantable Infusion Pumps

The use of implantable infusion pumps is covered for the following conditions:

- Chemotherapy treatment of liver cancer
- Delivery of anti-spasmodic drugs for severe spasticity
- Treatment of chronic intractable pain

Chemotherapy for Liver Cancer

The implantable pump is covered for the treatment of liver cancer in patients in whom the metastases are limited to the liver, and where one of the following applies:

- The disease is unresponsive.
- The patient refuses surgical excision of the tumor.

Anti-Spasmodic Drugs for Severe Spasticity

An implantable infusion pump is covered when used to administer antispasmodic drugs intrathecally (*e.g.,* Baclofen) to treat chronic intractable spasticity in patients who have proven unresponsive to less invasive therapy when both of the following criteria are met:

- As indicated by at least a six-week trial, the patient cannot be maintained on non-invasive methods of spasm control such as oral anti-spasmodic drugs, because these methods either fail to adequately control the spasticity, or they produce intolerable side effects.
- Prior to pump implantation, the patient must have responded favorably to a trial intrathecal dose of anti-spasmodic drug.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Treatment of Chronic Intractable Pain

An implantable pump is covered when used to administer opioid drugs (*e.g.*, morphine) intrathecally or epidurally for the treatment of severe or chronic intractable pain in patients who have a life expectancy of at least three months, and who have proven unresponsive to less invasive medical therapy when ALL of the following criteria have been met:

- Coordination must be made with other attending physicians in order to identify and treat the cause of the pain, rather than symptoms, if at all possible.
- The patient's history must indicate that he or she would not respond adequately to non-invasive methods of pain control.
- A preliminary trial of intraspinal opioid drug administration must be undertaken with a temporary catheter to monitor acceptable pain relief, degree of side effects, and patient acceptance.

Procedure code 62350 may be used to bill for the placement of the epidural catheter that is to be hooked up to an implantable infusion pump.

Refilling and maintenance of the implantable pump will be allowed when administered by a physician. Procedure code 96522 will be allowed one time per month unless documented medical necessity warrants additional units.

Determinations may be made on coverage of other uses for implantable infusion pumps if the provider can verify ALL of the following:

- The drug is reasonable and necessary for treatment of the individual patient.
- It is medically necessary that the drug be administered via an implantable infusion pump.
- The FDA-approved labeling for the pump specifies that the drug being administered and the purpose for its administration is an indicated use for the pump.

Nerve Blocks

Physicians are reimbursed for injection of anesthetic agents for nerve blocks. Anesthesiologists bill for these services using procedure codes 64400–64530 with **no modifier**. Procedure codes 20552 and 20553 for trigger point injections may also be billed by the anesthesiologist with **no modifier**.

Injecting any substance through the needles, including small amounts of contrast to confirm the position of the needle, is considered an integral part of the procedure and is not reimbursed separately.

When destruction of the facet joint nerve is performed following the block, only the codes for the nerve destruction should be billed, since their allowance includes the nerve block procedure.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Post-Payment Review

Post-payment review of pain management services will be conducted regularly, at which time documentation of treatment and methods of resolving the source of the pain will be requested from the provider.

Non-Reimbursable Services

There is no reimbursement to physicians or CRNAs for the setup or subsequent daily management of patient-controlled analgesia (PCA) pumps. Behavioral modification, physical therapy, psychiatric services, and related services are also non-compensable as pain management or pain therapy services.

PATHOLOGY AND LABORATORY SERVICES

In accordance with federal regulations (42CFR 493.1809), all laboratory testing sites (except for physician's offices) are required to have an appropriate Clinical Laboratory Improvement Amendments (CLIA) certificate. CLIA is a regulatory program administered by the Centers for Medicare and Medicaid Services. For more detail, refer to the CLIA subheading in this section.

Pathology includes services rendered by attending physicians and pathologists. Hospital laboratories should reference the Hospital Services Medicaid Provider Manual. Independent laboratories will be covered in this section.

General Guidelines

Laboratory services/tests must be ordered by the attending physician, appropriate to the study of the patient (*i.e.*, consistent with the diagnosis and treatment of the patient's condition and medically necessary for the appropriate care of the patient). Medicaid reimbursement will generally include obtaining the specimen, the performance of the test, supplies used in the performance of the test, and recording of the test(s). In addition, the reimbursement includes reporting of the test results.

The date of service for all billing must be the date the specimen was collected. For specimen collections that span more than a 24-month period, the date of service should be reported as the date the collection began. For laboratory tests that require a specimen from stored collections, the date of service should be defined as the date the specimen was obtained from archives. Procedures reimbursed in components will be identified later and separate allowable handling fees will be defined in this section.

Reimbursement Methodology

In accordance with Title XIX of the Social Security Act, Medicaid reimbursement for laboratory fees cannot be higher than the Medicare fee schedule established for laboratory services

It is further mandated that only the actual provider of the service or the provider performing the test may charge and receive Medicaid reimbursement. Providers cannot bill Medicaid patients when Medicaid

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Reimbursement Methodology (Cont'd.)

would have paid for the lab service if the appropriate billing procedures and referral procedures had been followed.

Services or supplies administered by the hospital or hospital employees are considered a part of the overall hospital service and are reimbursable only under the hospital allowable costs. A physician who is either salaried or contracted by the hospital, and who performs services under contract or employment, may not bill for those services separately under his or her individual Medicaid provider number. The contracting hospital may file for these services under the professional fees allowable for the hospital under their hospital-based physician's Medicaid number.

Attending Physician Services

Guidelines

The attending physician is responsible for the study of the patient, medical necessity, and appropriateness of procedures ordered. Physicians may not bill for lab tests performed outside their offices. Physicians may not bill a patient for lab services performed in the office that are normally covered by Medicaid when the service would have been paid if a Medicaid claim was submitted, provided the physician has accepted the patient's Medicaid benefits for the office visit or other procedure on the same date.

The performance of a test(s) prior to seeing the patient is a screening procedure and is not compensable. The only exceptions are pregnancy tests and prenatal lab work.

All laboratory tests must be ordered for the appropriate diagnosis and treatment of the patient's illness. Laboratory services requested or performed as general screening services are non-compensable, with the exception of services rendered under the healthy adult physical as outlined in the Preventive Care section. General health panels are non-compensable. Fertility tests are non-compensable. Routine paternity tests are non-covered, but medically necessary exceptions will be considered. Claims must be submitted with documentation justifying the service.

Chlamydia Rapid Test – CPT code 87270 is used to report the chlamydia rapid test.

Venipuncture

A separate handling charge for blood products drawn through venipuncture is allowed and compensable. To report a routine venipuncture, use procedure code 36415. Finger/heel/ear stick for collection of specimen(s) will be included in the office visit or lab test reimbursement and may not be billed separately. Filing for only the collection of specimen(s) is permissible, but an office visit or lab test reimbursement charge cannot be filed for the same date of service. The physician or clinic provider may charge a separate venipuncture code if

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Venipuncture (Cont'd.)

he or she provided the entire diagnostic lab service or only extracted the blood for referral to an outside lab.

Catheterization

Urine specimens collected by all methods are not considered a separate compensable charge. The patient is also not liable for the charge since the collection fee is considered part of the lab test or office examination. The provider may charge for a separate catheterization regardless of whether the specimen was collected for a test in the office or for referral to an outside laboratory.

Automated Chemistry Tests and Panels

Guidelines

Clinical laboratory tests are covered under Medicaid if they are reasonable and necessary for the diagnosis or treatment of an illness or injury. A physician who orders a series of clinical lab tests must specify the actual tests to be performed. If a panel is requested, the professional judgment of the physician must dictate the medical necessity of the complete panel instead of an individual test. Likewise, individual tests ordered by a physician must indicate a medical reason for the individual test in lieu of a panel that is less expensive.

Automated Multi-Channel Chemistry Tests

The following list contains tests that are frequently performed as groups and combinations. If three or more of the tests are performed on the same date of service, they will be grouped together and paid according to the number of tests performed. Duplicate payments and payments that are not consistent with Medicaid policy will be recouped at post-payment review.

82040	82565	83690	84100	84478
82150	82947	83718	84132	84520
82310	82960	83719	84155	84550
82374	82962	83721	84160	
82435	82977	83735	84295	
82465	83540	84075	84450	
82550	83615	84078	84460	

Pathology Panels

Medicaid recognizes the current CPT terminology as acceptable criteria for billing organ or disease-oriented panels. Please refer to the current CPT for guidelines.

Reimbursement Policy

The AMA CPT-approved codes for organ and disease panels include CPT codes 80048 – 80076. In accordance with CMS policy and the CPT guidelines, South Carolina Medicaid is now requiring providers to follow the 2004 CPT coding for these panels. Along with

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Reimbursement Policy (Cont'd.)

this change, providers billing for automated multi-channel chemistry tests may bill these tests individually as described in the CPT coding manual. The system will bundle specific tests and reimburse one rate based on the number of tests performed. Claims with less than three of these tests will pay each individual test based on the fee schedule. The list above identifies those codes, when billing three or more, that are bundled to pay one rate based on the number of tests. A provider may also bill for individual tests that are assigned to a panel. If the individual tests are included on the list, these tests will also bundle when three or more are filed on the same claim form and pay one rate based on the number of tests.

Clinical Pathology Services

South Carolina Medicaid will recognize both a professional and technical component for all pathology codes. These codes will require the 26 modifier if the service was provided in the hospital setting.

All of the following pathology codes require a 26 modifier in a hospital setting:

83020	88108	88245	88309	88348
83912	88125	88248	88311	88349
84165	88130	88261	88312	88355
85390	88140	88262	88313	88356
85576	88155	88263	88314	88358
86255	88160	88267	88318	88362
86256	88161	88269	88319	88365
86320	88162	88280	88321	88371
86325	88172	88283	88323	88372
86327	88173	88285	88325	89060
86334	88182	88289	88329	
87164	88230	88300	88331	
87207	88233	88302	88332	
88104	88235	88304	88342	
88106	88237	88305	88346	
88107	88239	88307	88347	

Blood

Medicaid requires that the securing supplier of blood products bill those products or packed cells. If a hospital laboratory secures the packed cells and washes, then the hospital must charge for the blood. A physician, clinic, or other non-securing provider may not bill for the blood. In addition to the products, the securing provider may only bill for additional type and cross matching, if appropriate, and the transfusion.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Professional Pathology Services

Professional Pathology Services

A pathologist may charge for a clinical lab interpretation if requested by the attending physician and reported as a contribution to direct patient care. This diagnostic procedure must be charged using procedure code 80500 and 80502 for limited and comprehensive services, respectively.

Interpretation of clinical lab tests will not be reimbursed. Only charges for consultations on clinical lab tests may be recognized. A professional component modifier is not required (26). General consultation procedures 99251 – 99255 are not compensable for professional clinical lab services.

Anatomical

Medicaid recognizes the expertise of professional pathology services when charged separately for the interpretation of all anatomical and surgical tissues. Postmortem examinations (88000 – 88099) are non-covered by Medicaid.

Blood Smears, Bone Marrows, and Blood Bank Services

Procedure code 85060 is compensable as a professional service. The 26 modifier is not required when performed in a hospital setting.

Bone marrows, including smears, aspiration, staining, biopsy, and interpretation, are compensable as separate professional services. Care should be taken when coding bone marrow interpretation procedures. Code 85097 is compensable as a professional component when performed in a hospital or office setting. The 26 modifier is not required.

Blood bank services are covered. No modifier is required when performed in a hospital setting (86077 – 86079).

Cytopathology and Surgical Pathology

CPT procedures 88104 through 88399 include accession, handling, and reporting. The handling and interpretation of surgical tissues must be charged separately if rendered by a pathologist in a hospital or office when only the professional interpretation is necessary, using a distinct physician provider number and a 26 modifier. Only an independent laboratory may charge for the total lab procedure when the laboratory has actually performed the total service (*i.e.*, both technical and professional component related to the surgical tissue).

Medicaid recognizes the current CPT terminology as criteria for billing procedure codes 88300 – 88309.

Some surgical pathology codes (88300 – 88319 and 88329 – 88365) will multiply by units for payment. When filing a claim, list the appropriate CPT code for the date of service one time and the number of units in the Days/Units column and the total charges for the number of units billed.

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PROGRAM REQUIREMENTS

Cytopathology and Surgical Pathology (Cont'd.)

A frequency limitation of 10 units has been placed on these codes. Services exceeding 10 units will require documentation.

Pap Smears

Medicaid reimburses a pathologist for a professional interpretation of a Pap smear with procedure code 88141. An attending physician must specifically order code 88155 with definite hormonal evaluation.

Medicaid covers pap smears for dually eligible Medicare/Medicaid beneficiaries who have exceeded the Medicare Frequency limit. When the Medicare denial is received, the charges should be billed using the CMS-1500 claim form. Refer to the heading "Cancer Screening Services" in this section for frequency limitations.

Specimen Referrals

The pathologist should use procedure codes 88321 and 88323 to designate review and report of referred material only. Procedure code 88325 is used for comprehensive consultation with review of medical records and specimens, with report, on referred material.

Referral Out-of-State

Specimens must be referred to a South Carolina Medicaid-enrolled independent laboratory, pathologist, or hospital. Out-of-state referrals to non-enrolled providers are not compensable through the Medicaid program. Providers cannot bill Medicaid beneficiaries when Medicaid would have paid the lab service if appropriate billing and referral procedures had been followed.

Billing and Coding Requirements

Professional component services constitute the professional interpretation and report and must be charged using the 26 modifier. Claims for professional pathology services indicating a hospital as the place of service will be rejected if submitted without the 26 modifier. Only anatomical, surgical, and the clinical pathology procedures listed earlier in this section are reimbursable with a 26 modifier.

Technical component services are those services usually performed by a hospital in the administration of a hospital lab. These services include payment for a lab technician, equipment, and supplies. Only a hospital may bill for separate technical lab services.

Total lab procedures are a combination of both the professional and technical components. Usually an independent laboratory or a private practicing physician performing his or her own lab services is the only provider eligible for a total lab reimbursement rate. Pathologists and laboratories may bill for beneficiaries that are in the Family Planning Eligibility Category Only, but a valid family planning diagnosis code must be present on the claim, along with the FP modifier.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Genetic Studies

Medicaid will reimburse for genetic studies if ordered by an attending physician and requested as a direct diagnosis and treatment tool. The genetic study may be ordered as a preventive measure; however, the prevention must have a direct correlation with the treatment of the patient and the patient's family, or serve as an inhibitor to institutionalization. Medicaid will not reimburse for genetic research.

Chromosome Analysis

Genetic centers are permitted to fragment chromosome charges into the "tissue culture for chromosome analysis" charge (codes 88230 – 88239) and the analysis charge (codes 88245 – 88269). Chromosome studies must be medically necessary.

In addition, reimbursement may be allowed for the following expanded services: extended chromosome analysis, R-Bands, and Fragile X analysis.

The following conditions may be used as indications of analysis:

- Intellectual disabilities
- Dysmorphic fractures
- Multiple congenital abnormalities
- Abnormal sexual development
- Abnormalities of growth
- Certain types of malignancies

Genetic Studies Also Covered by Medicaid

Lysosomal enzyme analysis for developmental regression – (*e.g.*, Tay-Sachs disease). Indications are as follows:

- Growth failure
- Development regression
- Clouding of corneas
- Hepatosplenomegaly
- Coarsening of facial features
- Abnormalities of skeletal system

Amino acid analysis for infants and children – The following indications must be present:

- Feeding abnormalities
- Growth failure
- Development failure

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Genetic Studies Also Covered by Medicaid (Cont'd.)

- Seizures
- Uncommon acidosis

Organic acid analysis for infants – The following indications must be present:

- Feeding abnormalities
- Unexplained acidosis
- Growth failure
- Seizures

Carbohydrate analysis for infants and children – One of the following conditions must be present:

- Cataracts
- Hepatosplenomegaly
- Jaundice
- Growth failure
- Acidosis
- Seizures

Other tests for infants and children – These tests include the following:

- Metabolic screen
- Alpha fetoprotein
- Sialic acid
- Sulfate incorporation

Amniocentesis for prenatal diagnosis – Allowable for the following categories of patient:

- Women over 35 years of age
- Previous child with chromosomal disorder
- Multiple spontaneous abortions
- Patients with neural tube defects
- Patients at risk for having children with X-linked disorder (*i.e.*, hemophilia or Duchenne muscular dystrophy, or metabolic disorders such as Tay-Sachs disease)

Tests for the detection of other genetic diseases – These include the following:

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Genetic Studies Also Covered by Medicaid (Cont'd.)

- Skeletal Dysplasias
- Huntington's Disease
- Sickle Cell
- Hemoglobinopathies

Independent Laboratories

Enrollment

Medicaid requires that all enrolled independent laboratories meet Clinical Laboratory Improvement Amendments. (CLIA) regulations. CLIA is a regulatory program administered by the federal Centers for Medicare and Medicaid Services.

Information concerning CLIA regulations and participation may be obtained through SCDHEC's Division of Certification at (803) 545-4205. For Medicaid enrollment information, call or write to:

Medicaid Provider Enrollment
Post Office Box 8809
Columbia, SC 29202-8809
1-888-289-0709

All independent laboratories must be certified by CMS to perform laboratory tests. CLIA certification must be on file with Medicaid Provider Enrollment. Procedures performed and/or charged when the lab is not certified to perform that particular test will be rejected. Medicaid will not reimburse for services performed prior to certification or prior to enrollment. Independent laboratories that have not enrolled in CLIA also cannot bill Medicaid beneficiaries directly for any services rendered.

Billing Notes

Whenever an independent laboratory charges Medicaid with an unlisted procedure, support documentation is required. Since SCDHHS and most independent laboratories recognize the mutual benefits of automated claims processing, steps should be taken to insure timely and efficient claims submission.

When a laboratory initiates a new lab test(s) or a new combination, notification should be sent to the Pathology program manager. This preliminary process will quicken the assignment of a code and approval for Medicaid payment.

Independent laboratories must submit charges on a CMS-1500 claim form with the appropriate CPT or supplemental code. The place of service must be an "81" and the date of service when the test was performed must be

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Billing Notes (Cont'd.)

indicated.

Independent labs may bill for beneficiaries who are in the Family Planning Eligibility Category Only. A valid family planning diagnosis and modifier must be present on the claim.

Clinical Laboratory Improvement Amendments (CLIA)

Certification Requirements

As described above, Medicaid requires that all enrolled independent laboratories meet CLIA regulations. In accordance with federal regulations (42CFR 493.1809), SCDHHS requires that in order to perform laboratory tests, all laboratory testing sites must have one of the following CLIA certifications:

- Certificate of Registration
- Certificate of Accreditation or Partial Accreditation
- Certificate of Compliance
- Certificate of Waiver
- Physician Performed Microscopy Procedures (PPMP) Certificate

In addition, each site must have an assigned unique 10-digit certification number. Information concerning CLIA regulations and participation guidelines may be obtained from SCDHEC at (803) 545-4203 or by writing to:

SCDHEC
Division of Certification
2600 Bull Street
Columbia, SC 29201-1708

Claims Editing

Claims will be denied for lab services delivered by any lab site meeting one or more of the following descriptions:

- A lab that does not have CLIA certification
- A lab that submits claims for services not covered by CLIA certificate
- A lab that submits claims for services rendered outside the effective dates of the CLIA certificate

Individual physicians who are members of a group should bill under the group number. The CLIA editing is based on the provider number in field 33 of the CMS-1500. For more detailed information, refer to Section 3 of this manual ("Billing Procedures").

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Lab Procedures

The following sections indicate the lab procedures allowed for each type of certification. Current CLIA information can be found on the Internet at http://www.cms.hhs.gov/clia/.

Labs issued a **Certificate of Registration**, **Certificate of Accreditation or Partial Accreditation**, or **Certificate of Compliance** are allowed to perform and bill for the following procedures:

80048 – 89399 – All pathology and lab procedures

78110 – Plasma volume, radiopharmaceutical volume-dilution technique (separate procedure); single sampling

78111 – Plasma volume, radiopharmaceutical volume-dilution technique (separate procedure); multiple areas

78120 – Red cell volume determination (separate procedure); single sampling

78121 – Red cell volume determination (separate procedure); multiple samplings

78122 – Whole blood volume determination, including separate measurement of plasma volume and red cell volume (radiopharmaceutical volume-dilution technique)

78130 – Red cell survival study

78191 – Platelet survival study

78270 – Vitamin B-12 absorption study (*e.g.*, Schilling test); without intrinsic factor

78271 – Vitamin B-12 absorption study (*e.g.*, Schilling test); with intrinsic factor

78272 – Vitamin B-12 absorption studies combined, with and without intrinsic factor

P7001 – Culture and sensitivity urine only

Labs issued a **Certificate of Waiver** are limited to performing only the following procedures:

80061 – Lipid panel

80101 – Drug screen; single drug class, each drug class

81002 – Urinalysis, by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketone, leukocytes, nitrite, pH, protein specific gravity, urobilinogen, any number of constituents; non-automated, without microscopy

81003 – Urinalysis, by dipstick or tablet reagent for bilirubin,

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Lab Procedures (Cont'd.)

glucose, hemoglobin, ketone, leukocytes, nitrite, pH, protein specific gravity, urobilinogen, any number of constituents; automated, without microscopy

81007 – Bacteriuria screen, exp culture/dips

81025 – Urine pregnancy test, by visual color comparison methods

82044 – Albumin, urine, microalbumin, semiquantitative (*e.g.*, reagent strip assay)

82055 – Alcohol (Ethanol; any specimen except breath)

82120 – Amines, vaginal fluid, qualitative

82270 – Blood, occult; feces, one to three simultaneous determinations

82465 – Cholesterol, serum, total

82523 – Collagen cross links; any links

82570 – Creatinine; other source

82947 – Glucose; quantitative

82950 – Glucose; post glucose dose (includes glucose)

82951 – Glucose; tolerance test (GTT), three specimens (includes glucose)

82952 – Glucose; tolerance test, each additional beyond three specimens

82962 – Glucose, blood, by glucose monitoring device(s) cleared by the FDA specifically for home use

82979 – Glutathione Reductase RBC

82985 – Glycated protein

83001 – Gonadotropin; follicle stimulating hormone (FHS)

83002 – Gonadotropin; luteinizing hormone (LH)

83026 – Hemoglobin; by copper sulfate method, non-automated

83036 – Hemoglobin; glycated

83518 – Immunoassay analyte not antibody, single step method

83605 – Luctate (Actic acid)

83718 – Lipoprotein, direct measurement; high-density cholesterol (HDL cholesterol)

83986 – pH, body fluid, except blood

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Lab Procedures (Cont'd.)

84460 – Transferase; alanine amino (ALT) (SGPT)

84478 – Triglycerides

84703 – Gonadotropin chorionic qualitative

84999 – Unlisted chemistry procedure

85013 – Blood count; spun microhematocrit

85014 – Blood count; other than spun hematocrit

85018 – Blood count; hemoglobin

85610 – Prothrombin time

85651 – Sedimentation rate, erythrocyte; non-automated

86294 – Immunoassay for tumor antigen, qualitative or semiquantitative; (EG, bladder tumor antigen)

86308 – Heterophile antibodies; screening

86318 – Immunoassay for infectious agent antibody, qualitative or semiquantitative, single step method (*e.g.*, reagent strip)

86618 – Antibody; borellia bufgdorferi (Lyme Disease)

87077 – Culture, bacterial; aerobic isolate, additional methods for definitive identification, each isolate

87449 – Infectious agent antigen detection by enzyme immunoassay technique qualitative or semiquantitative; multiple steo method, not otherwise specified, each organism

87804 – Infectious agent antigen detectin by immunoassay with direct optical observation; influenza

87880 – Streptococcus, screen, direct

87076 – Anerobic isolate, additional methods required for definitive identification, each isolate

87077 – Aerobic isolate, additional methods required for definitive identification, each isolate

The following code is non-covered:

84830 – Ovulation tests by visual color comparison methods for human luteinizing hormone

Labs issued **PPMP Certificate**s are allowed to perform the above listed procedures for Certificate of Waiver **AND** the following procedures:

G0026 – Fecal Leukocyte examination

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Lab Procedures (Cont'd.)

G0027 – Semen analysis

Q0111 – Wet mount, including preparations of vaginal, cervical, or skin specimens

Q0112 – All potassium hydroxide (KOH) preparations

Q0113 – Pinworm examinations

81000 – Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy

81001 – Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrate, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy

81015 – Urinalysis; microscopic only

81020 – Urinalysis; two or three glass test

89190 – Nasal smear for eosinophil

The following codes are non-covered services:

Q0114 – Fern test

Q0115 – Post-coital direct, qualitative examinations of vaginal or cervical mucous

OUT-OF-STATE (OOS) SERVICES

Treatment Rendered Outside the South Carolina Medical Service Area

The term South Carolina Medical Service Area (SCMSA) refers to the state of South Carolina and areas in North Carolina and Georgia within 25 miles of the South Carolina state border. Charlotte, Augusta, and Savannah are considered within the service area. Medicare/Medicaid beneficiaries do not require prior approval from Medicaid for covered services from providers located within the SCMSA.

The South Carolina Medicaid Program will compensate medical providers outside the SCMSA in the following situations:

- Emergency medical services for beneficiaries traveling outside the SCMSA whose health would be endangered if necessary care were postponed until their return to South Carolina. This includes all pregnancy-related services and delivery.
- When a SCMSA physician certifies that needed services are not available within the SCMSA and properly refers the beneficiary to an out-of-state provider

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Prior Approval

In all but emergency situations, the **referring physician** should request approval prior to the out-of-state service. Referrals should be made to an out-of-state provider only when the procedure or service is not available within the SCMSA. All available resources must have been considered and indicated in the request to SCDHHS for the out-of-state referral. The referring physician is the one most aware of the client's medical history and needs, and will best be able to justify the necessity for the out-of-state referral.

Prior to contacting SCDHHS, the **referring physician** must first contact any out-of-state provider who will render a service to the client and inform them of the client's medical status. The out-of-state provider must confirm, in writing, that he or she will enroll in the South Carolina Medicaid program and will accept Medicaid reimbursement as payment in full. The written confirmation must be submitted to SCDHHS along with the completed Referral Request form for out-of-state services.

The **referring physician** must complete the "Referral Request for Out-of-State Services" form. A sample copy of the form can be found in the Forms section of this manual. The written requests for out-of-state referral must include the following information:

- Beneficiary's name and Medicaid number
- Date of service (state as "tentative" if unscheduled at the time of request).
- An explanation as to why you feel these services must be rendered out-of-state versus within the SCMSA
- Name, address, telephone, and fax number of the out-of-state providers(s) who will render the medical services. (For example: hospital and physicians(s) involved in that patient's medical treatment)A copy of the beneficiary's medical records for the past year relating to the treatment of the condition
- Any experimental and/or investigational services identified by the referring physicians that are sponsored under a research program, or performed in only a few medical centers across the United States

SCDHHS reserves the right to determine, on the basis of medical advisement, that the needed medical services, or necessary supplementary resources, are more readily available in the other state. SCDHHS will reject referrals for the following reasons:

- All information required on the referral form is not provided with the requested attached documentation.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Prior Approval (Cont'd.)

- The provider rendering the service(s) is not willing to enroll in South Carolina Medicaid and adhere to the enrollment criteria.
- The provider rendering the service(s) will not accept the South Carolina Medicaid reimbursement as payment in full.

To obtain approval for out-of-state referrals, the out-of-state coordinator can be reached by fax at (803) 255-8255, or by mail at:

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

The **referring physician** is responsible for communicating with the out-of-state provider coordinating services for the patient. Patients being referred out of state, as well as their escorts, can be provided transportation when necessary. Transportation and any other assistance are only provided when there are no other means available to the patient to meet the needs connected with out-of-state travel. Adequate advance notice, as well as prior approval, is mandatory in order to make the necessary travel arrangements. SCDHHS' Division of Preventive Care handles transportation arrangements. Providers should contact the PSC at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us for additional information.

When a beneficiary is in one of the Medicaid Managed Care Organizations (MCOs), the requests for out-of-state services must be completed through the MCO. For assistance with authorizations for MCO-enrolled members, providers should contact the MCO's Provider Services department, or the Division of Care Management at (803) 898-4614. Contact information for the MCOs is located in the Managed Care Supplement.

Exceptions to Prior Approval

Medicaid will accept and review for medical necessity out-of-state claims from medical providers who did not seek any type of approval before filing their claim. However, experience has proven that these providers put themselves at an otherwise avoidable risk of non-payment or delayed payment due to the lack of knowledge of the South Carolina Medicaid claim filing policies and procedures.

Foster Children Residing Out of the SCMSA

The South Carolina Department of Social Services (DSS) will be responsible for all Medicaid-eligible foster children when they reside out of state. The county case manager assigned to the case should assist with medical services. Prior approval is not required for services rendered to foster children who live out of state; however, medical necessity remains a requirement. The out-of-state coordinator must to be contacted for two reasons:

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Foster Children Residing Out of the SCMSA (Cont'd.)

1. The coordinator must determine whether the medical services can be reimbursed through the Medicaid program or whether DSS will reimburse the medical provider.
2. If Medicaid can reimburse for the services, proper enrollment and billing information needs to be sent to the medical providers involved.

Providers must contact the PSC at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us for additional information.

Retroactive Eligibility

When retroactive eligibility for Medicaid is granted, the beneficiary is responsible for notifying the medical provider that retroactive eligibility has been granted.

For additional information regarding retroactive eligibility, refer to Section 1 of this manual.

Dually Eligible Beneficiaries

When a beneficiary has both Medicare and Medicaid, Medicare is considered the primary payer. However, if the beneficiary does not have Part A benefits, medically necessary inpatient hospital services will require approval.

In order to verify eligibility on Medicare/Medicaid patients, contact the PSC at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us.

Ancillary and Other OOS Services

Other health care services are compensable under the South Carolina Medicaid Out-of-State program. For out-of-state referral questions, please contact the PSC, submit an online inquiry, or write to SCDHHS for more information. For professional claims, providers should write to:

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

For institutional claims, providers should write to:

Medicaid Claims Receipt
Post Office Box 1458
Columbia, SC 29202-1458

RADIOLOGY AND NUCLEAR MEDICINE

Policy Guidelines

Radiology services are those procedures performed by a radiologist or primary care physician in conjunction with an x-ray, ultrasound, CAT scan, or MRI. Radiological services are covered only when such services are consistent with the diagnosis and treatment of an illness or injury. **Screening procedures are not compensable** unless outlined as covered items in this manual.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

High-Tech Radiology

Effective July 1, 2011, SCDHHS contracted with MedSolutions for prior authorizations (PA) of high-tech radiology procedures. All CT, CTA, MRI, MRA, Pet Scans, Nuchal Cardiac Imaging, and 3D Rendering Imaging CPT 76376-76377 will now require a PA. Please see Section 4, for a list of all radiology procedure codes requiring prior authorization.

Providers may request a prior authorization by:

- Telephone: (888) 693-3211 – Available Monday through Friday, 8:00 a.m. to 9:00 p.m. (EST)
- Fax: (888) 693-3210 – Available 24 hours a day
- Online: http://www.medsolutionsonline.com/ – Available 24 hours a day
- Customer Service: (888) 693-3211 – Available Monday through Friday, 8:00 a.m. to 9:00 p.m. (EST)

The prior authorization request applies to all high-tech imaging studies that are received in an outpatient setting that are elective, non-emergency, and diagnostic procedures. Prior authorization requests are not required for high-tech imaging studies that are performed in an emergency room or an inpatient hospital or for a 23-hour observation stay.

The following Medicaid beneficiaries do not require prior authorization through MedSolutions:

- Dually Eligibles (beneficiaries with both Medicare and Medicaid)
- Beneficiaries in the Family Planning Only Program
- Beneficiaries that are incarcerated (including those in DJJ Facilities)
- Illegal Aliens
- Beneficiaries enrolled in an MCO Health Plan
- Beneficiaries with Private Primary HMO coverage
- Beneficiaries in Hospice
- Beneficiaries in the Palmetto Senior Care program (PACE)
- Beneficiaries in the Health Opportunities Account Program

Providers must refer members in an MCO to the appropriate MCO provider in order to determine if prior authorization applies to radiology services.

For any outpatient emergency study, providers may render the necessary care first, and then seek prior authorization within five business days of the date of service. MedSolutions will conduct a retrospective review to

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

High-Tech Radiology (Cont'd.)

determine if the request was for an urgent condition and medically necessary. An emergency procedure is defined as one that is performed on a patient facing immediate loss of life or limb.

For outpatient urgent studies, providers should contact MedSolutions to request an expedited prior authorization review and provide the necessary clinical information. An urgent procedure is defined as any request for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations: (a) could seriously jeopardize the life or health of the Medicaid MCO member's ability to regain maximum function, based on a prudent layperson's judgment, or (b) in the opinion of a practitioner with knowledge of the Medicaid MCO member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request. Moreover, urgent care services must be rendered within 12 hours in order to avoid the likely onset of an emergency medical condition.

Any changes in a study, rendering location, or CPT coding (upcoding or downcoding) require an update to the prior authorization request. Providers should contact MedSolutions by phone to update this information.

Prior authorization requests must be approved prior to the delivery of the service except in cases of an emergency or urgent nature or in cases where the beneficiary was not enrolled in Medicaid at the time the procedures were performed. Providers must submit any prior authorization requests where the beneficiary received retroactive Medicaid eligibility to the South Carolina Healthy Connections program staff. The provider must also, submit a copy of the retroactive Medicaid letter and all other related clinical information along with the request in order to be considered for approval.

If the rendering provider is also the interpreting provider, the procedure must be submitted with no modifier. No further payment will be made to any additional provider for this procedure.

The following guidelines apply for rendering provider who do not high-tech radiology interpretation:

1. If the rendering provider is submitting the technical component of the procedure, use modifier TC along with the procedure code performed. If the claim is submitted in the UB format, modifier TC will be assumed. No further payment will be made to any additional provider for the technical component of this procedure.
2. If the rendering provider is submitting the professional component of the procedure, use modifier 26 along with the procedure code

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

High-Tech Radiology (Cont'd.)

performed. No further payment will be made to any additional providers for the professional component of this procedure.

Radiology Components

Radiology services are divided into the following defined components:

- **Professional Component** – Includes the physician's supervision, interpretation, and report, and, when appropriate, the physician's administration of an injection or catheterization. The professional component is recognized only when the imaging procedure is performed in an institution and that institution provides the technical services. Payment is made to the physician or radiologist who performed the interpretation and written report at the time of the diagnosis for treatment. Interpretations done solely for quality control purposes of the facility are non-covered.
- **Technical Component** – Includes equipment, supplies, and technician fees.

Complete Procedure – Is a combination of both professional and technical services. All services must be rendered and/or provided by a single provider.

Settings

Office Setting – Medicaid will reimburse for both the professional and technical components of radiological procedures performed in an office setting. The procedures must be medically necessary and consistent with the diagnosis and treatment of the patient's condition. Providers must use the appropriate 70000 series procedure code with no modifier. Reimbursement for radiological services performed in the office setting includes the interpretation and written report and all technical charges including equipment, films, contrast mediums, and technician services.

Hospital Setting – Medicaid will reimburse for the professional component of radiological services rendered in the inpatient and outpatient hospital setting. Services rendered in the inpatient or outpatient hospital setting should always be billed with a 26 modifier indicating the professional component only. Reimbursement for the professional component includes the supervision (when applicable), interpretation, and written report. Reimbursement for the technical component of services rendered in the hospital setting will be made to the facility where the services were rendered.

Documentation

Medicaid requires that an attending physician order all radiology services. The imaging requests or charge slip and report must be included in the patient's records. Services performed in an office or clinic must be documented and described in the patient's record and retained for filing.

Services rendered in a hospital setting must be adequately documented,

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Documentation (Cont'd.)

including the above-cited records by the physician, with corresponding records retained by the hospital.

Radiology Reimbursement Limitations

When both the emergency room physician and radiologist or cardiologist interpret an x-ray or EKG done in the ER, payment will be made for the interpretation and report that directly contributes to the diagnosis and treatment of the patient. The specialty of the physician rendering the service will not be the primary factor considered. The interpretation billed by the cardiologist or radiologist is payable if the interpretation is performed at the time of the diagnosis and treatment of the patient. Separate payment to the hospital medical staff is not made for interpretations performed solely for quality control and liability purposes under hospital policy.

Reinterpretations, unordered images, and second opinions are non-compensable. Post-payment reviews indicating unnecessary radiological procedures and interpretations will result in recoupment of any Medicaid payments. Medical necessity must be documented for additional or repeat procedures for the same date of service (*i.e.*, additional images were needed, patient in congestive heart failure, catheter placement, etc.).

Billing Notes

Modifiers – For use with CPT 70000 range codes:

- 26 modifier – Use modifier if only professional services were provided (*e.g.*, the supervision, interpretation, and report was provided, but not the technical component.
- 00 modifier – Use if no modifier or a 00 modifier indicates both the professional and technical components were provided. **Do not bill the professional and technical components separately.**
- 76 modifier – Use modifier 76 if both professional and technical services were provided (complete procedure) on a repeat radiological procedure on the same date of service.
- TC modifier – Use for equipment, supplies, and technical fees.

Supervision and Interpretation Codes – When a procedure is performed along with the supervision and interpretation of a radiology procedure, both the procedure code that is outside the 70000 series and the supervision and interpretation code in the radiology series should be billed.

Unlisted Procedure Codes – Each section of the procedure codes includes unlisted procedure codes for services that are not assigned a specific procedure code. When filing a claim with an unlisted procedure code, always include a complete description of the service. This may be accomplished by attaching appropriate justification (*e.g.*, a narrative

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Billing Notes (Cont'd.)

summary, operative report, discharge summary, or pathology report) to the claim form. Unlisted procedure codes without proper justification attached to the claim will be rejected.

Diagnostic Radiology

Medicaid requires that all facilities providing screening and diagnostic mammography services meet Food and Drug Administration (FDA) regulations. Medicaid claims for mammography services will be edited to ensure FDA criteria are met. Medicaid will not reimburse for mammography services performed by providers who are not certified. The provider cannot bill Medicaid beneficiaries for these denied services.

An FDA certificate for screening mammography services must be in the provider's enrollment file. For enrollment information, call or write to:

Medicaid Provider Enrollment
Post Office Box 8809
Columbia, SC 29202-8809
1-888-289-0709

CPT procedures in the 70010 – 76499 range are compensable if ordered by an attending physician and deemed medically necessary for the diagnosis and treatment of the patient's condition.

Routine chest x-rays without a diagnostic reason are non-compensable. Only medically necessary chest x-rays are compensable. See the "Cancer Screening" guidelines for coverage of mammograms.

Radiological procedures performed as a screening mechanism, without a diagnostic reason for justification, are non-covered.

Separate consultative procedures are non-covered if the radiology procedure was performed with a written report to the attending physician.

Diagnostic Ultrasound

Some ultrasound procedures are recorded as complete, limited, or repeat procedures. Full documentation must justify the use of the complete procedure code. See the OB/GYN section for pregnancy-related guidelines.

Radiation Oncology

CPT codes 77261 – 77799 are recognized for the treatment planning, radiation physics, treatment delivery, and treatment management of radiation oncology.

A preliminary evaluation/consultation of the patient is allowed prior to the decision to treat and should be identified by the appropriate evaluation and management code. Once the therapist assumes responsibility for the treatment and care of the patient, a separate consultation or visit code is not allowed.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Clinical Treatment Planning

Codes 77261 – 77299 recognize services rendered in the treatment planning process. These services include test interpretation, tumor localization, treatment volume determination, time/dosage determination, treatment modality, number and size of ports, and selection of treatment devices. Codes 77261, 77262, and 77263 reflect professional services only. Codes 77280, 77285, and 77290 have both professional and technical components and require a 26 modifier when performed in a hospital setting.

Medical Radiation Physics

Codes 77300 – 77399 recognize the services of the physician and physicist involved in radiation physics, dosimetry calculation, construction of treatment devices, and other special services. Code 77336 should be used to report the continuing radiation physics consultation including quality assurance per week of therapy. Code 77370 may be used to bill for a consultation with the physicist or radiotherapist in unusual situations. These situations must be documented in the patient's file. These codes do not require the 26 modifier.

Radiation Treatment Delivery

Radiation treatment delivery codes (77401 – 77416) reflect the technical portion of radiation therapy services. Twelve codes represent four energy levels of treatment delivery (megavoltage) within three categories of simple, intermediate, and complex. These codes represent individual sessions of service delivery or daily services. Multiple treatment sessions on the same date of service are allowed as long as there is a distinct break in therapy services and the individual session is furnished at a regular treatment session. Reimbursement is based on date of service as indicated per line on the claim form. These codes should not be billed with the 26 modifier.

Clinical Treatment Management

Clinical treatment management codes (77419 – 77431) reflect the professional (physician) component of treatment on a weekly basis. These codes are used to describe the physician's weekly radiotherapy management services at all energy levels. A weekly unit is equal to five fractions, or treatment sessions, regardless of whether the fractions are furnished on consecutive days and without regard to the actual time period in which the services are provided.

If, at the final billing of the treatment course, there are three or four fractions beyond a multiple of five, those three or four fractions are considered a week. If there are one or two fractions beyond a multiple of five, reimbursement for these sessions is considered as having been covered through prior payment.

When the patient receives a mixture of simple, intermediate, and/or complex services, bill the code that represents the majority of the

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Clinical Treatment Management (Cont'd.)

fractions furnished during the five-fraction week. For example, an intermediate weekly treatment is billed when, in a grouping of five fractions, the patient received three intermediate and two simple fractions.

Procedure code 77431 cannot be used to fill in the last week of a long course of therapy. This code is used to indicate management of a complete course of treatment consisting of only one or two fractions or treatments.

Hyperthermia (77600 – 77620)

Treatments include external and internal procedures. Hyperthermia is used only as an adjunct to radiation therapy or chemotherapy. It may be initiated by microwave, ultrasound, low energy radio-frequency conduction, or by probes.

Clinical Brachytherapy (77750 – 77799)

The listings for these codes include hospital admission and daily visit, dilation, and insertion and removal of applicators. They do not include preparation of the element, calculation of the dosage, or loading of the element.

Nuclear Medicine

CPT codes 78000 – 79999 are recognized for services related to diagnostic and therapeutic nuclear medicine. These procedures may be performed and charged separately, or as part of a course of treatment. Radioimmunoassay tests are found in the clinical pathology section of the CPT codebook.

Diagnostic

Please note that high-tech radiology codes require prior authorization. See Section 4 for the list of applicable codes. Codes 78000 – 78999 recognize the professional and technical components of diagnostic nuclear medicine by body system. These services should be billed with a 26 modifier if performed in an inpatient or outpatient hospital setting. If the physician provided the services in an office setting, then bill the appropriate code with no modifier. Code A4641 is the code for any radiopharmaceutical that is not otherwise classified by a CPT or HCPCS code. Code A9500 is for the billing of Sestamibi (Cardiolite) per unit dose. Code A9502 is for the billing of Tetrofosmin per unit dose, and A9505 is for Thallous Chloride (TL201). In addition to these codes, there is a code, A9600, for the injection of Strontium-89 Chloride, which is a therapeutic radiopharmaceutical. Physicians should not bill for radionuclides supplied by a hospital.

Magnetic Resonance Imaging

Please note that high-tech radiology codes require prior authorization. See Section 4 for the list of applicable codes. Codes 79000 – 79999 recognize the professional and technical components of therapeutic nuclear medicine. These services should be billed with a 26 modifier if performed in an inpatient or outpatient hospital setting. Procedure

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Magnetic Resonance Imaging (Cont'd.)

code 79900 may be used to charge for therapeutic radionuclides. Physicians should not bill for radionuclides supplied by a hospital.

Positron Emission Tomography (PET) Scans

Please note that high-tech radiology codes require prior authorization. See Section 4 for the list of applicable codes. Codes 78608, 78609, and 78111 – 78816. PET scan reimbursement is limited to one per 12 months. PET scans will be covered only for the staging and restaging of cancer malignances.

Staging:

- The stage of the cancer remains in doubt after completion of a standard diagnostic workup, including conventional imaging (computed tomography [CT], magnetic resonance imaging [MRI], or ultrasound); or
- The use of a PET scan could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient; and
- Clinical management of the patient would differ depending on the stage of the cancer identified.

Restaging:

- Detecting residual disease
- Detecting suspected recurrence or metastasis
- Determining the extent of a known recurrence
- Potentially replacing one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient

PET scans should not be utilized for screening purposes. The use of PET scans to monitor tumor response during a planned course of therapy is not covered. Restaging only occurs after a course of treatment is completed. The clinical applications for coverage include services relating to Brain Cancer, Breast Cancer, Colorectal Cancer, Esophageal Cancer, Head and Neck Cancers, Lung Cancer, Lymphoma, Melanoma, Refractory Seizures, Solitary Pulmonary Nodule, and Thyroid Cancer. PET scans will be subject to retrospective review to include paid inpatient/outpatient hospital claims and physician claims. Documentation must be maintained in the beneficiary's medical records to support the medical necessity of the procedure.

To bill for the radiopharmaceutical diagnostic imaging agents on a CMS-1500 claim form, use HCPCS code A9552.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Independent Imaging Centers and Mobile Imaging Units

Medicaid will reimburse for services provided by freestanding imaging centers, mobile ultrasound units, and mobile imaging units when these services are consistent with the diagnosis and treatment of an illness or injury.

Enrollment

Freestanding imaging centers and mobile imaging units must be enrolled with SCDHHS in order to be compensated for services provided. Mobile imaging units must meet SCDHEC certification. Freestanding imaging centers and mobile ultrasound units must be certified by the Medicare carrier.
For enrollment information, please call 1-888-289-0709 or visit the Web site at http://provider.scdhhs.gov.

Reimbursement

Independent imaging centers, mobile ultrasound units, and mobile imaging units may only be reimbursed for the technical portion of an x-ray or other imaging service. Separate reimbursement for the professional interpretation of the imaging may be made to the radiologist or other physician. The interpreting physician must be enrolled with South Carolina Medicaid as an in-state provider.

Mobile units may bill the following codes for set-up and transportation in addition to the x-ray or EKG when the patient would require special transportation provisos. These codes should be billed with no modifier:

Q0092 – Set-up of portable x-ray equipment in nursing facility, per radiological procedure (other than re-takes of the same procedure)

R0070 – **Round trip** transportation of portable x-ray equipment and personnel to nursing home, per trip to facility or location; one patient seen

R0075 – **Round trip** transportation of portable x-ray equipment and personnel to nursing home, per trip to facility or location; more than one patient seen, per patient

R0076 – **Round trip** transportation of portable EKG to facility or location; per patient

Charges should be submitted on a CMS-1500 claim form with the following restrictions:

- All CPT procedure codes should be submitted with a TC (technical component) modifier.
- Separate charges for injection of contrast mediums, dyes, or catheterizations are not allowed.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

PODIATRY SERVICES

Podiatry services are those services that are responsible and necessary for the diagnosis and treatment of foot conditions. These services are limited to the specialized care of the foot as outlined under the laws of the state of South Carolina.

Podiatric services for beneficiaries over the age of 21 are non-covered services.

Office Examinations

Level of service guidelines must be followed as described in the current CPT. Podiatric exams may be charged at all levels of services as medically necessary for new or established office E/M visits.

Services

Treatment of Subluxation of the Foot

Subluxation of the foot is defined as partial dislocation to displacement of joint surfaces, tendons, ligaments, or muscles of the foot.

Reasonable and necessary diagnosis and treatment (except by the use of orthopedic shoes or other supportive devices for the foot) of symptomatic conditions such as osteoarthritis, bursitis, tendonitis, etc., that result from or are associated with partial displacement of foot structures are covered services. Surgical correction of a subluxed foot structure that is either an integral part of the treatment of a foot injury, or that is undertaken to improve the function of the foot, or that is undertaken to alleviate an induced or associated symptomatic condition, is a covered service. The presentation of symptoms is clearly the paramount factor in coverage. Surgical and non-surgical treatments undertaken for the sole purpose of correcting the subluxed structure of the foot as an isolated entity are not covered.

Treatment of Flat Foot

The term “flat foot” is defined as a condition in which one or more of the arches of the foot have flattened out. Services directed toward the care or correction of such a condition is not covered. However, the services or procedures required to make the initial diagnosis may be considered reasonable and necessary and are covered.

Supportive Devices for the Feet

Orthopedic shoes and other supportive devices for the feet are not covered unless the shoe is an integral part of a leg brace.

Prosthetic Shoe

A prosthetic shoe (a device used when all or a substantial portion of the front part of the foot is missing) can be covered as a terminal device (*i.e.*, a structural supplement replacing a totally or substantially absent foot). The beneficiary should be referred to a Durable Medical Equipment supplier for such devices.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Excision of Nail

Procedure code 11750 indicates a partial or total permanent nail removal. Separate billing is not to be used for the medial and lateral borders of the same toe. The number of toes should be indicated if multiple toes are corrected at the same time.

Plantar Warts

Treatment for Verruca vulgaris and intractable plantar keratoma are covered services.

Mycotic Nail

Mycotic nail and other infections of the feet and toenails require professional services that are outside the scope of routine foot care and are covered services if the subsequent criteria are met. Treatment of a fungal (mycotic) infection of the toenail can be covered under the following circumstances:

- Clinical evidence of mycosis of the toenail
- Medical documentation that the patient has either a limitation of ambulation requiring active treatment of the foot; or, in the case of a non-ambulatory patient, a condition that is likely to result in significant medical complications in the absence of such treatment

Routine Foot Care

Routine foot care includes the cutting or removal of corns or calluses, the trimming of nails, and other hygienic and preventative maintenance care.

Reimbursement is allowed under the medical conditions listed below when the patient is under the active care of a physician. It is essential that the patient has seen a physician for treatment and/or evaluation of the complicating disease process during the six months prior to the date of service. It is recommended that a letter noting the podiatrist's examination be sent to this physician. The allowable conditions are as follows:

- Diabetes mellitus
- Chronic thrombophlebitis
- Peripheral neuropathies involving the feet associated with:
  - Malnutrition and vitamin deficiency
  - Malnutrition (general, pellagra)
  - Alcoholism
  - Malabsorption (celiac disease, tropical sprue)
  - Pernicious anemia
  - Carcinoma
  - Diabetes mellitus
  - Drugs and toxins

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Routine Foot Care (Cont'd.)

- Multiple sclerosis
- Uremia (chronic renal disease)

In evaluating whether the routine services can be reimbursed, a presumption of coverage is made where the evidence available discloses certain physical and/or clinical findings consistent with the diagnosis, and indicative of surface peripheral involvement.

The presumption of coverage is applied when a physician rendering the routine foot care has identified one Class A finding as noted below, two Class B findings, or one Class B and two Class C findings as follows:

Class A Findings:

- Non-traumatic amputation of the foot or an integral skeletal portion thereof

Class B Findings:

- Absent posterior tibial pulse
- Absent dorsalis pedis pulse
- A minimum of three trophic changes as follows:
  - Hair growth (decrease or absence)
  - Nail changes (thickening)
  - Pigmentary changes (discoloration)
  - Skin texture (thin, shiny)
  - Skin color (rubor or redness)

Class C Findings:

- Claudication
- Temperature changes (*e.g.*, cold feet)
- Edema
- Paresthesias (abnormal spontaneous sensations in the feet)
- Burning

Additional services ordinarily considered routine may also be covered if they are performed as a necessary and integral part of otherwise covered services, such as diagnosis and treatment of diabetic ulcers, wounds, and infections.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Nursing Home Visits

Podiatry care may be rendered to patients in nursing or rest home facilities, provided the service is medically necessary and meets the policies defined in this manual. Podiatry care must be requested by one of the following:

- The attending physician
- The patient
- The patient's family when the patient is incompetent
- Nursing service*

* Nursing service requests must be documented in the patient's chart. The podiatrist's records must indicate who made the request for services in this situation.

FEDERALLY QUALIFIED HEALTH CENTER SERVICES

The following billing procedures apply to the Federally Qualified Health Center (FQHC) program:

CORE SERVICES

In 1992, the Healthcare Financing Administration (now CMS) issued Medicare regulation for the FQHC program. The FQHC laws established a set of health care services called "FQHC services" for which Medicare and/or Medicaid must cover on a reasonable cost basis when provided by an FQHC. For any questions concerning cost reports and cost settlements, please contact the PSC at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us.

The subsections below outline a list of services referred to as FQHC core services. Core services are reimbursed using encounter codes.

Encounter Services

Currently the definition of a visit is a face-to-face encounter between an FQHC patient and a physician, physician assistant, nurse practitioner, certified nurse midwife, chiropractor, clinical psychologist, or clinical social worker, during which a Medicaid-covered FQHC core service is furnished. The South Carolina Medicaid program does not cover nutrition, health education, social work, or other related ancillary services unless noted in this section. For billing purposes, SCDHHS has deemed a "visit" an "encounter." Physicians and practitioners providing services under the FQHC program must meet the regular Medicaid enrollment requirements to provide services to Medicaid patients.

Only one encounter code is allowed per day with the exception of the psychiatry and counseling encounter, which can be billed in addition to another encounter on the same day. FQHC services are covered when furnished to patients at the center, in a skilled nursing facility, or at the client's place of residence. Services provided to hospital patients, including emergency room services, are not considered FQHC services.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Physician Services

Physician services refer to the professional services (diagnosis, treatment, therapy, surgery, and consultation) that a physician performs at the center.

Physician Assistant, Nurse Practitioner, and Certified Nurse Midwife

Physician assistant, nurse practitioner, and certified nurse midwife services refer to the professional services performed by one of these providers who:

- Is employed by or receives payment from the FQHC
- Is under a physician's general (or direct, if required by state law) medical supervision
- Provides services according to clinic policies or any physician's medical orders for the care and treatment of the patient
- Provides the type of services that a certified nurse midwife, nurse practitioner, or physician assistant is legally permitted by the state to perform
- Provides the type of services that Medicare/Medicaid would cover if provided by a physician or incidental to physician services

Clinical Psychologist and Clinical Social Worker Services

Clinical psychologist and clinical social worker services refer to professional services performed by one of these providers who:

- Is employed by or receives compensation from the FQHC
- Provides services of any type that the professional is legally permitted to perform by the state in which the services are furnished
- Provides the type of services that Medicaid would cover if furnished by a physician

Services and Supplies

Supplies, lab work, injections, etc., are not billable services. These services and supply costs are included in the encounter rate when provided in the course of a physician, physician assistant, nurse practitioner, certified nurse midwife, chiropractor, clinical psychologist, and/or clinical social worker visit. The types of services and supplies included in the encounter are:

- Commonly provided in a physician's office
- Commonly provided either without charge or included in the FQHC's bill (*i.e.*, lab tests)
- Provided as incidental, although an integral part of the above provider's services
- Provided under the physician's direct, personal supervision to the extent allowed under written center policies

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Services and Supplies (Cont'd.)

- Provided by a clinic employee
- Not self-administered (drug, biological)

Pneumococcal Vaccine

The pneumococcal vaccine is billed using procedure code 90732. If a medical encounter is billed in addition to 90732, documentation must clearly support the medical necessity for the encounter. Refer to "Special Clinic Services" in this section.

Influenza Vaccine

The influenza vaccine is billed using one of the following procedure codes: 90658, Q2035, Q2036, Q2037, Q2038 or Q2039. If a medical encounter is billed in addition to the influenza vaccine procedure code, documentation must clearly support medical necessity for the encounter. Refer to "Special Clinic Services" below.

Encounter and Ancillary Service Coding

All encounter codes and ancillary services listed in this section must be billed under the FQHC provider number. Only one encounter code may be billed per day, with the exception of the Psychiatry and Counseling Encounter, which can be billed in addition to another encounter on the same day. The most appropriate encounter code must be billed based on the service(s) provided. All supplies, lab work, injections, surgical procedures (unless noted in the "Special Clinic Services" section of this manual), etc., are included in the encounter code reimbursement. The only fragmented services billable on a fee-for-service basis are listed under "Special Clinic Services."

Medical Encounter – T1015

All medical encounters must be billed using the procedure code T1015 unless otherwise specified. A medical "visit" (encounter) is defined as a face-to-face encounter between a patient and the physician, physician assistant, nurse practitioner, chiropractor, or certified nurse midwife during which an FQHC core service is provided. FQHC providers will be reimbursed their contracted encounter rate, and are allowed only one medical encounter per day, even if the patient sees more than one professional at the visit or on that day. The use of this code counts toward the ambulatory visit limit for beneficiaries age 21 or older.

Maternal Encounter – T1015 (With TH Modifier)

All maternal care encounters must be billed with procedure code T1015 with a "TH" modifier. FQHC providers will be reimbursed their contracted rate for all maternal services rendered. The use of this procedure code and a "TH" modifier will not affect the beneficiary's number of allowable ambulatory visits. IUDs, the technical component of ultrasounds, and non-stress tests may be billed separately. Refer to "Family Planning" and "Special Clinic Services" coding guidelines below.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Psychiatry and Counseling Encounter – T1015 (With HE Modifier)

For Behavioral Health policies and procedures please refer to the "Rehabilitative Behavioral Health Services Manual" located on our Web site at http://www.scdhhs.gov/.

HIV/AIDS Encounter – T1015 (With P4 Modifier)

SCDHHS allows FQHCs to bill for HIV- and AIDS-related services using code T1015, with the P4 modifier.

The use of this code and the P4 modifier will not count toward the beneficiary's ambulatory visit limit if the beneficiary is age 21 or older. Charges for such services will be reimbursed at the contract rate.

Family Planning services

FQHCs should identify Family Planning services by using an FP modifier. Providers may sometimes use the FP modifier in association with the medical encounter code T1015 (for example, when a person comes to the clinic for a medical reason and the physician also counsels him or her on family planning). The provider should bill T1015, the medical encounter code, and the FP modifier in section 24D on the CMS-1500 claim form. Family Planning services will not affect the patient's allowable number of ambulatory visits.

Preventive Services

Preventive measures are defined as any routine service exam for adults or children when the procedures are performed in the absence of an illness or complaint(s). Generally, the South Carolina Medicaid program requires that a complaint or illness be recorded before a service is compensable. The exceptions to this policy are the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program and the Healthy Adult Physical Exams program.

The EPSDT program provides preventive health services to Medicaid-eligible children from birth to age 21 through periodic medical screenings. An EPSDT screening is considered an encounter. A screening and an encounter code may not be billed on the same date of service. All EPSDT screenings must be billed using the appropriate CPT codes (99381 – 99385 and 99391 – 99395). EPSDT screening should be billed at the FQHC contract rate. For additional program policy information, refer to the "EPSDT" heading in this section.

The Medicaid program sponsors adult physical exams under the following guidelines:

- The exams are allowed once every **two** years per patient.
- The patient must be 21 years of age or older.
- Encounter code T1015 should be billed for this service, and diagnosis code V70.9 should be used.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Preventive Services (Cont'd.)

This encounter code may also be offered to dually eligible Medicare and Medicaid clients until Medicare covers physicals. If a patient has both Medicare and Medicaid, bill Medicaid directly.

For additional program policy guidelines, refer to "Adult Physical Exams" under the heading "Preventive Care Services" in this section.

Special Clinic Services

Listed below are procedures that may be billed in addition to an encounter code:

- J7300 – Paraguard IUD
- J7307 – Etonogestrel Implant (Implanon™)
- J7302 – Levonorgestrel-releasing intrauterine contraceptive (Mirena), 52mg
- J1055 – Depo-Provera for family planning
- J1950 – Leuprolide Acetate, per 3.75 mg
- 59025 – TC – Non-stress test, technical component
- 90658 – Influenza vaccine
- Q2035 – Influenza vaccine
- Q2036 – Influenza vaccine
- Q2037 – Influenza vaccine
- Q2038 – Influenza vaccine
- Q2039 – Influenza vaccine
- 90732 – Pneumococcal vaccine
- A4264 FP – Perm Intratubal Occ Device (Essure)

Non-stress tests, EKGs, and x-rays performed in the center must be billed using the appropriate CPT-4 code with a TC modifier indicating the technical component only. The professional component is reimbursed through the encounter code that may be billed (if appropriate). If the patient is referred to a radiologist, cardiologist, etc., for interpretation, the specialist's services are reimbursed fee-for-service following Medicaid policy for their specialty.

When a procedure is performed in the center and the Medicaid fee-for-service reimbursement is **greater than** the FQHC encounter rate, the CPT4 procedure code should be billed **in place of** the encounter code.

Dental Services

For dental program policy guidelines, please contact the DentaQuest Call Center at 1-888-307-6553.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

FQHC Crossovers

Crossover claims must be filed initially to the assigned FQHC Medicare intermediary. Upon payment from Medicare, the claim must be filed to Medicaid on the CMS-1500 claim form showing the payment received from Medicare.

CLINIC-BASED PHYSICIAN POLICY

All hospital services must be billed under the CBP number.

Hospital Services

The Clinic-Based Physician (CBP) program covers the billing for physician, certified nurse midwife, and nurse practitioner services rendered by FQHC providers at a hospital.

All services provided to hospital patients (including emergency room services) by a FQHC provider must be billed under the CBP program. These services must be billed using the Physician's Current Procedural Terminology (CPT) codes and will not be cost-settled.

Providers must bill for these services using the CBP provider number (Section 33) and rendering physician, certified nurse midwife, or nurse practitioner's Medicaid provider number (Section 24K) on the CMS-1500 claim form.

RURAL HEALTH CLINICS (RHC)

Rural Health Clinic (RHC) services are primarily ambulatory, outpatient office type services furnished by physicians and other approved providers at a clinic located in a rural area. When a rural area has been designated as a shortage area by the U.S. Census Bureau and has been certified for participation in Medicare in accordance with 42 CFR Part 405, Subpart X and 42 CFR Part 491, Subpart A, a RHC certified under Medicare will be deemed to have met the standards for certification under Medicaid.

RHCs must be under the medical direction of a physician and have a health care staff that includes one or more physicians and one or more nurse practitioners or physician assistants. The staff may also include ancillary personnel who are supervised by the professional staff. The staff must be sufficient in numbers to provide the services essential to the operation of the clinic or the center. A physician, nurse practitioner, nurse midwife, or physician assistant must be available to furnish patient care services at all times during the RCH's hours of operation. The mid-level nurse practitioner, nurse midwife, or physician assistant must be available at least 50 percent of the RHC's clinical hours.

The RHC and clinical staff must be in compliance with applicable federal, state, and local laws for licensure, certification, and/or registration.

The authority for RHC services is found in Sections 1861(aa), 1102 and 1871, of the Social Security Act, and at 42 CFR Part 405, Subpart X; 42 CFR Section 440.20(b); and 42 CFR Part 491, Subpart A.

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PROGRAM REQUIREMENTS

Beneficiaries Enrolled in a Managed Care Plan

A beneficiary enrolled in a Medicaid Managed Care Program, such as a Managed Care Organization (MCO) or a Medical Home Network (MHN), must receive all health care services through that plan. Each plan specifies services that are covered, those that require prior authorization, the process to request authorization and the conditions for authorization. Refer to Section 1 of this manual for information on how to verify a beneficiary's enrollment in a managed care plan.

All questions concerning services covered by or payments from a managed care plan must be directed to the appropriate plan. Medicaid does NOT process prior authorization requests for services to be provided to a Medicaid beneficiary who is enrolled in a capitated managed care plan when the services are included in the contract with the plan. Providers requesting prior authorization for services for a client enrolled in a managed care plan will be referred to that plan. A list of MCOs and MHNs with which Medicaid has a contract to provide health care services is available on our Web site at http://www.scdhhs.gov/. Please note that Medicaid staff makes every effort to provide complete and accurate information on all inquiries as to a beneficiary's enrollment in a managed care plan. Because eligibility information as to which plan the patient must use is available to providers, a "fee for service" claim will not be paid even when information is given in error by Medicaid staff.

Billing

Services may be billed electronically or on paper, using the CMS-1500 claim form. Medicaid encourages electronic billing. When claims are submitted electronically, mistakes can be corrected immediately, and claims are processed without delays. The following billing procedures apply to the RHC program.

Core Services

Core services are reimbursed through encounter codes using an all-inclusive rate (up to the current year's RHC cap or CMS-approved rate) that reflects the cost of service. RHC core services are outlined in the manual subsections below.

Encounter Services

Currently the definition of a visit is a face-to-face encounter in the RHC setting (or client's home) between a client and the physician, physician assistant, nurse practitioner, certified nurse midwife, chiropractor, clinical psychologist, or clinical social worker, as required by state law, during which an RHC core service is furnished. For billing purposes, SCDHHS has deemed a "visit" an "encounter."

Only one encounter code is allowed per day with the exception of the Psychiatry and Counseling encounter, which can be billed in addition to another encounter on the same day.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Encounter Services (Cont'd.)

RHC services are covered when furnished to clients at the clinic, skilled nursing facility, or the client's place of residence. Services provided to hospital patients, including emergency room services, are not considered RHC services.

Physician Services

Physician services refer to professional services (diagnosis, treatment, therapy, surgery, and consultation) that a physician performs at the clinic, a nursing facility, or the client's place of residence.

Physician Assistant, Nurse Practitioner, and Certified Nurse Midwife

Physician assistant, nurse practitioner, and certified nurse midwife services refer to the professional services performed by one of these providers who meets the following requirements:

- Is employed by or receives payment from the RHC
- Is under a physician's general (or direct, if required by state law) medical supervision
- Provides services according to clinic policies or any physician's medical orders for the care and treatment of the client
- Provides the type of services that Medicare/Medicaid would cover if provided by a physician or incidental to physician services

Services and Supplies

Supplies, injections, etc., are not billable services. These services and supply costs are included in the encounter rate when provided in the course of a physician, physician assistant, nurse practitioner, certified nurse midwife, chiropractor, clinical psychologist, and/or clinical social worker visit. The types of services and supplies included in the encounter are:

- Commonly provided in a physician's office
- Commonly provided either without charge or included in the RHC's bill (*i.e.*, lab tests)
- Provided as incidental, although an integral part of the above provider's services
- Provided under the physician's direct, personal supervision to the extent allowed under written center policies
- Provided by a clinic employee
- Not self-administered (drug, biological)

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Synagis Vaccine

The synagis vaccine is covered for beneficiaries younger than 2 years of age and is billed using procedure code 90732. If a medical encounter is billed in addition to 90732, documentation must clearly support the medical necessity for the encounter. Refer to "Special Clinic Services" below.

Pneumococcal Vaccine

The pneumococcal vaccine is covered for beneficiaries over the age of 19 and is billed using procedure code 90732. If a medical encounter is billed in addition to 90732, documentation must clearly support the medical necessity for the encounter. Refer to "Special Clinic Services" below.

Influenza Vaccine

The influenza vaccine is covered for beneficiaries over the age of 19 and is billed using procedure code 90658. If a medical encounter is billed in addition to the influenza vaccine procedure code, documentation must clearly support medical necessity for the encounter.

Application of Fluoride Varnish

The application of topical fluoride varnish, using HCPCS D1206 is covered for children up to three years old during an EPSDT well-child visit. The best practices of the American Academy of Pediatrics recommend that children up to three years old who are at high risk for dental caries should receive fluoride varnish application in their primary care physician's office during their EPSDT well-child visit two times per year (once every six months) and in their dental home two times per year (once every six months).

In coordination with application of fluoride varnish, primary care physician offices must provide anticipatory guidance on oral health to parents or caregivers to promote oral health to children and families.

Laboratory Services

All laboratory services (including the six laboratory tests required for RHC certification) must be billed to Medicaid under your fee-for-service Medicaid provider identification number. Laboratory services cannot be billed using your RHC provider number.

Non-stress tests, EKG's, and x-rays performed in the center must be billed using the appropriate CPT-4 code with a TC modifier indicating the technical component only. The professional component is reimbursed through the encounter code that may be billed (if appropriate). If referred to a radiologist, cardiologist, etc., for interpretation, their services are reimbursed fee-for-service following Medicaid policy for their specialty service.

Hospital Care Services provided by medical professionals of the clinic are compensable under the special clinic service guidelines.

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PROGRAM REQUIREMENTS

Encounter and Ancillary Service Coding

The following coding guidelines must be followed for RHC services. All encounter codes and ancillary services listed in this section must be billed under the RHC provider number. Only one encounter code may be billed per day, with the exception of the Psychiatry and Counseling Encounter, which can be billed in addition to another encounter on the same day.

The most appropriate encounter code must be billed based on the service(s) provided. All supplies, injections, surgical procedures, etc., are included in the encounter code reimbursement. The only fragmented services billable on a fee-for-service basis are listed under "Special Clinic Services" below.

Medical Encounter – T1015

All medical encounters must be billed using the procedure code T1015 unless otherwise specified. A medical "visit" (encounter) is defined as a face-to-face encounter between a patient and the physician, physician assistant, nurse practitioner, chiropractor, or certified nurse midwife during which an RHC core service is provided. RHC providers will be reimbursed their contracted encounter rate and are allowed only one medical encounter per day, even if the patient sees more than one professional at the visit or on that day. The use of this code counts toward the ambulatory visit limit for beneficiaries age 21 and older. are allowed 12 ambulatory care visits (ACVs) per year, commencing on July 1st of each year. Beneficiaries under age 21 are exempt from this limitation.

Maternal Encounter – T1015 (With TH Modifier)

All maternal encounters must be billed using code T1015, with a "TH" modifier. RHC providers will be reimbursed their contracted rate for all maternal services rendered. The use of this procedure code and a "TH" modifier will not affect a beneficiary's number of allowable ambulatory visits. The following may be billed separately, please refer to the "Family Planning" and "Special Clinic Services" sections below for coding guidelines.

Psychiatry and Counseling Encounter – T1015 (With HE Modifier)

For all Behavioral policies and procedures please refer to the "Rehabilitative Behavioral Health Services Manual located at http://www.scdhhs.gov/.

HIV/AIDS Encounter – T1015 (With P4 Modifier)

SCDHHS allows the RHC to bill for HIV- and AIDS-related services using code T1015, with the P4 modifier. The use of this code and the P4 Modifier will not count toward the ambulatory visit limit for beneficiaries aged 21 or older. Charges for such services will be reimbursed at the contract rate.

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Family Planning Services

The RHC will identify Family Planning (FP) services by using the FP modifier. Providers may use the FP modifier in association with the medical encounter code T1015 (for example, when a person comes to the clinic for a medical reason and the physician counsels on family planning).

When billing, providers should bill T1015, the medical encounter code, and the FP modifier in Section 24D on the CMS-1500 claim form. Family Planning services will not affect the patient's allowable number of ambulatory visits.

Preventive Services

Preventive measures are defined as any routine service exam for adults or children when the procedures are performed in the absence of an illness or complaint(s). Generally, the South Carolina Medicaid program requires that a complaint or illness be recorded before a service is compensable. The exceptions to this policy are the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program and the Healthy Adult Physical Exams.

The EPSDT program provides preventive health services to Medicaid-eligible children from birth to age 21 through periodic medical screenings. An EPSDT screening is considered an encounter. A screening and an encounter code may not be billed on the same date of service. All EPSDT screenings must be billed using the appropriate CPT codes (99381 – 99385 and 99391 – 99395). EPSDT screening should be billed at the RHC contract rate. For additional program policy information, refer to the "EPSDT" heading in this section.

The Medicaid program sponsors adult physical exams under the following guidelines:

- The exams are allowed once every **two** years per patient.
- The patient must be 21 years of age or older.
- Encounter code T1015 should be billed for this service, and diagnosis code V70.9 should be used.

This encounter code may also be offered to dually eligible Medicare and Medicaid clients until Medicare covers physicals. If a patient has both Medicare and Medicaid, bill Medicaid directly.

For additional program policy guidelines, refer to *Adult Physical Exams* under the heading "Preventive Care Services" in this manual section.

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PROGRAM REQUIREMENTS

Special Clinic Services

Listed below are procedures that may be billed in addition to an encounter code:

11975 – Insertion, implantable contraceptive capsules

11976 – Removal, implantable contraceptive capsules

11977 – Removal with reinsertion, implantable contraceptive capsules

58300 – Insertion of Intrauterine Device (IUD)

58301 – Removal of Intrauterine Device (IUD)

J1055 – Depo-Provera for Family Planning

J1950 – Leuprolide Acetate, per 3.75mg

J7300 – Paraguard IUD

J7302 – Leveonorgestri-Release IUD Contraceptive 52 mg

J7307 – Etonogestrel, Implanon

S4989 – Progestasert IUD

90657, 90658, Q2035, Q2036, Q2037, Q2038, Q2039 – Influenza Vaccine (over the age of 19)

90732 – Pneumococcal vaccine (over the age of 19)

D1206 – Application of Fluoride Varnish (under the age of 3)

A4264 FP – Perm Intratubal Occ Device (Essure)

Non-stress tests, EKGs, and x-rays performed in the center must be billed using the appropriate CPT-4 code with a TC modifier indicating the technical component only. The professional component is reimbursed through the encounter code that may be billed (if appropriate). If referred to a radiologist, cardiologist, etc., for interpretation, their services are reimbursed fee-for-service following Medicaid policy for their specialty service.

RHC Medicare/Medicaid Dual Eligibility Claims

Claims for RHC services must be filed initially to the Medicare intermediary. Upon payment from Medicare, the claim must be filed to Medicaid on the CMS-1500 claim form showing the payment received from Medicare. Medicaid will pay the difference up to the provider's RHC rate.

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PROGRAM REQUIREMENTS

RHC REIMBURSEMENT METHODOLOGY

Effective January 1, 2001, the South Carolina Medicaid program implemented an alternative payment methodology for the reimbursement of Rural Health Clinics (RHCs). The alternative payment methodology is a cost-based, retrospective, reimbursement system. Reimbursement for medically necessary services shall be made at 100% of the all-inclusive rate per encounter as obtained from the Medicare intermediary. Actual cost information, to include Medicare annual RHC rate caps, shall be obtained from Medicare Intermediary at the end of the RHC's fiscal reporting period to enable SCDHHS to determine the reimbursement due for the period. Provider-based RHCs with less than 50 beds will receive reimbursement at 100% of Medicare reasonable costs not subject to the RHC rate cap. For provider-based RHCs, actual cost and utilization information based on the RHC's fiscal year shall be obtained from the HCFA-2552-96 actual cost report.

WRAP-AROUND PAYMENT METHODOLOGY

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection ACT (BIPA) of 2000 require the determination of supplemental payments for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) contracting with Medicaid Managed Care Organizations (MCOs). These supplemental payments are calculated and paid to ensure that these providers receive reimbursement for their services to Medicaid MCO beneficiaries at least equal to the payment that would have been received under the traditional fee for service methodology. These determinations, generally referred to as Wrap-Around payments, are mandated by BIPA 2000 to be completed at least every four months. SCDHHS performs these determinations quarterly and prepares a final reconciliation at the providers year-end. Submission of quarterly and annual MCO encounter data and payment information that is required for these wrap-around payment determinations is the responsibility of each MCO contracting with FQHCs and RHCs. The quarterly and annual reconciliation processes are incorporated into the agency's State Plan for Medical Assistance, Section 4.19-B. MCO responsibilities are contained in the July 2009 MCO Contract (Sections 2.2, 5.1 and 10.2) and the MCO Policies and Procedures Guide.

Questions relating to the RHC Reimbursement Methodology or Wrap-Around payments should be directed to the SCDHHS Division of Ancillary Reimbursements at (803) 898-1040.

SPECIAL COVERAGE GROUPS

Pediatric Anesthesia Services

Effective June 1, 2008, the South Carolina Department of Health and Human Services (SCDHHS) will expand its coverage of anesthesia services to allow board eligible and/or board certified Pediatric

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Pediatric Anesthesia Services (Cont'd.)

Intensivists to be reimbursed for a limited number of anesthesia Current Procedural Terminology (CPT) codes. Board eligible and/or board certified Pediatric Emergency Medicine Physicians may also be reimbursed for this service if they practice in a facility where a board eligible and/or board certified Pediatric Anesthesiologist and/or a board eligible and/or board certified Pediatric Intensivist is on staff. In addition, the Pediatric Intensivist or Pediatric Emergency Medicine Physician must have a current Pediatric Advanced Life Support (PALS) certification.

The physician seeking authorization will be required to enroll with the SCDHHS by submitting an attestation form. All claims must be filed with a "G9" modifier that will identify the claim as reimbursable under this policy. The allowed codes are:

00120	00532	00862	01380	01850
00140	00540	00892	01390	01860
00145	00550	00902	01420	01920
00220	00560	00920	01462	01922
00300	00635	00940	01490	01926
00350	00700	01112	01620	01951
00400	00702	01130	01670	01952
00410	00740	01200	01680	01953
00520	00800	01220	01730	01924
00524	00810	01340	01820	

The Pediatric Sub-Specialist Program

SCDHHS will reimburse an enhanced rate to certain pediatric sub-specialists that meet the enrollment requirements. Reimbursement for certain Evaluation and Management codes will be based on a fee schedule not to exceed 120% of Medicare and 100% of Medicare for most other covered Current Procedural Terminology (CPT) codes.

Pediatric Sub-Specialist Program Participation Requirements

To be eligible for participation in this program, a physician must meet the following criteria:

- Practice within the South Carolina Medicaid Service Area. The South Carolina service area is defined as within twenty-five miles of the state line.
- At least 85% of total practice, including after-hours patients, is dedicated to children age 18 years or younger.
- Practice in at least one of the following sub-specialties:
  - Adolescent Medicine
  - Allergy
  - Cardiology
  - Cardiothoracic Surgery

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Pediatric Sub-Specialist Program Participation Requirements (Cont'd.)

- Critical Care
- Developmental – Behavioral
- Emergency Medicine
- Endocrinology
- Gastroenterology/Nutrition
- Genetics
- Hematology/Oncology
- Infectious Disease
- Neonatology
- Eephrology
- Neurology
- Neurological Surgery
- Ophthalmology
- Orthopedic Surgery
- Otolaryngology
- Psychiatry
- Pulmonology
- Radiology
- Rheumatology
- Surgery
- Urology
- Other pediatric subspecialty areas as may be determined by SCDHHS

- Complete and return a copy of the attestation statement found in the Forms section of this manual.

Convenient Care Clinics – Place of Service 17

Effective with dates of service on or after August 1, 2012, the SCDHHS provider enrollment policy will now allow Convenient Care Clinics (CCC) to enroll as a provider group for billing purposes. CCCs are located in retail stores, supermarkets, and pharmacies and are able to treat uncomplicated minor illnesses and provide preventative healthcare services. They are often referred to as retail clinics, retail-based clinics, or walk-in medical clinics.

CCCs must bill Medicaid using the Place of Service (POS) code 17 as

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Convenient Care Clinics – Place of Service 17 (Cont'd.)

defined by the American Medical Association Current Procedural Terminology for a walk-in retail health clinic. Covered services for this POS are limited to episodic care and wellness/preventative services. Wellness/preventative services are covered for beneficiaries five years of age and older and are clearly outlined in this manual. Episodic care services involve examinations and/or treatment for minor illness such as allergies, earaches, sore throats, etc. Episodic care for minor injuries includes examinations and/or treatment for blisters, burns, bug bites, etc.

In order to maintain the Primary Care Medical Home model, CCC must provide information regarding any service performed in the facility to the beneficiary's primary care physician (PCP) for both fee-for-service and the Medical Home Network (MHN). The MHN shall not issue a referral number to approve payment for services rendered until supporting documentation has been received. CCC is required to send information regarding a service to the PCP by facsimile within 24 hours of the visit and maintain confirmation of receipt of the facsimile in the patient's file.