Reimbursement

1. If an insured has a private HMO or 3rd party insurance and the claim is rejected, can we re-file to the Medicaid MCO for payment?

   Beneficiaries cannot have commercial HMO/MCO coverage and also be enrolled in a Medicaid MCO. However, if non-HMO private coverage denies payment for a service provided to a Medicaid MCO member, the claim for that service can be billed to the MCO for payment consideration. Please contact the MCO for billing assistance.

2. If you are unable to get an MCO to pay claims after a year, can you file the response from the MCO to SCDHHS?

   No, each MCO has a documented appeals process that should be followed when a provider disagrees with a denial. The provider may also contact the plan's assigned SCDHHS program manager for assistance after exhausting the appeals process. The SCDHHS does not serve as a "safety net", paying denied claims for services rendered to MCO members.

3. If an MCO is not paying for therapy visits should we then bill Medicaid?

   No - contact the Medicaid program manager for the health plan. You can reach the Medicaid health plan program managers by calling the Division of Care Management at 803-898-4614.

4. We have been told by our billing service that we cannot provide vision exam services to MCO beneficiaries. Is this true? Is it regulated by age?

   All Medicaid beneficiaries under age 21 are entitled to one comprehensive eye exam annually. The annual eye exam is paid by the MCO for MCO enrolled members, and by FFS Medicaid for FFS and MHN enrolled beneficiaries.

   Effective February 1, 2011, Medicaid beneficiaries age 21 and over are no longer eligible for vision services unless those services are either medically necessary, or the beneficiary is enrolled with an MCO that offers vision services. Claims for vision services covered by the MCO must be authorized by and filed to the MCO.