SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Henry McMaster GOVERNOR
Robert M. Kerr DIRECTOR
P.O. Box 8206 > Columbia, SC 29202
www.scdhhs.gov

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MEDICAID BULLETIN

TO: **All Providers**

SUBJECT: **Administrative and Billing Provider Manual Updates**

Effective July 1, 2024, the South Carolina Department of Health and Human Services (SCDHHS) is updating and clarifying policies in the Provider Administrative and Billing Manual. These policy changes will be added to the Provider Administrative and Billing Manual available on SCDHHS' website by July 1, 2024. Upcoming administrative and billing updates include:

Health Records Retention
SCDHHS is updating its policy related to health records retention. The following requirements apply to the retention of records for the purposes of the Healthy Connections Medicaid program only. Other state or federal rules may require longer retention periods. For Healthy Connections Medicaid purposes:

- All fiscal and health records shall be retained for a minimum period of four years after the last payment was made for services rendered.
- Hospitals and nursing homes are required to retain such records for six years after the last payment was made for services rendered.

If any litigation, claim, audit or other action involving the records has been initiated prior to the expiration of the applicable retention period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the applicable retention period, whichever is later.

Health Records Documentation
SCDHHS is clarifying its policy related to health records date and signature requirements, documenting progress notes and services billed as follows:

- All clinical entries in the health record, including progress or treatment notes must be complete, legible and authenticated, in written or electronic form, by the person responsible for providing or evaluating the service.
- Health records must be signed and dated at the time of service, or the rendering provider must attest to the date and time as appropriate to the media. In cases where a provider is attesting to the date and time, information including the rendering provider and date and time of the service must be verifiable.
- Different providers may add information to the same progress or treatment note. When this occurs, each provider must sign his or her entry, verifying the work they performed.
- The health records media must have the capability to identify changes to an original entry such as addendums, corrections, deletions and patient amendments. When making changes, the date, time, author making the change and reason for the change must be included.
- Undocumented, undated and unsigned record amendments, corrections or addendums will not be accepted.
- Any changes to the original entry must contain enough information to determine the date when the service was performed or ordered.
- A progress or treatment note must support the diagnosis of the condition, medical necessity and detail the extent of the service performed. This is used to ensure the service is billed with the correct and appropriate level of procedure code, as defined in the Current Procedural Terminology or the Healthcare Common Procedure Coding System nomenclatures and descriptors, or as indicated in SCDHHS' policy.
- The record must contain sufficient information to identify the patient, date of service and services provided. Each visit or encounter must be patient and visit specific.
- All required documentation must be present in the health record before a provider files claims for reimbursement.
- All services performed must be recorded in the member's health record which must be available as required by the participating provider agreement.

Medical Necessity Definition

SCDHHS is clarifying its medical necessity definition to cite the South Carolina Code of Regulations 126-425 (A)(9).

Appeals

SCDHHS is clarifying its policy related to the appeal process. The appeal process is a formal process of last resort to resolve or settle a dispute. Providers must exhaust the claim reconsideration process (when applicable) before requesting an appeal. Information about the reconsideration process is included in the Billing Procedures section of the Provider Administrative and Billing Manual. A provider must file the appeal in writing and must include a

copy of the notice of adverse action or the remittance advice reflecting the reconsideration denial. More information about filing an appeal is available on SCDHHS' website.

South Carolina's Healthy Connections Medicaid managed care organizations (MCOs) are responsible for the authorizations, coverage and reimbursement related to the services described in this bulletin for Healthy Connections Medicaid members who are enrolled in an MCO.

Providers should direct any questions related to this bulletin to the Provider Service Center (PSC). PSC representatives can be reached at (888) 289-0709 from 7:30 a.m.-5 p.m. Monday-Thursday and 8:30 a.m.-5 p.m. Friday. Providers can also submit an online inquiry at https://www.scdhhs.gov/providers/contact-provider-representative.

Thank you for your continued support of the South Carolina Healthy Connections Medicaid program.

/s/
Robert M. Kerr