SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

HOSPITAL SERVICES PROVIDER MANUAL

OCTOBER 1, 2024

South Carolina Department of Health and Human Services

CONTENTS

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PROGRAM OVERVIEW

A hospital is defined as a general acute care institution licensed as a hospital by the applicable State of South Carolina (South Carolina or State) licensing authority and certified for participation in the Medicare (Title XVIII) Program.

All hospitals must be enrolled in the South Carolina Medicaid Program. In-state hospitals must also contract with the South Carolina Department of Health and Human Services (SCDHHS) to provide inpatient and outpatient services. Out-of-state hospitals within the medical service areas (normally within 25 miles of the State's borders) may follow the same contractual procedures as in-State providers. Please refer to the Provider Administrative and Billing Manual, Requirements for Provider Participation, for instructions regarding provider enrollment.

Hospitals located more than 25 miles from the South Carolina borders do not contract with SCDHHS. These hospitals must complete an enrollment form and sign a provider agreement. Out-of-state referrals by physicians for needed services not available within the South Carolina Medical Service Area (SCMSA) must be pre-authorized. 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. See "Out-of-State Services" in this manual for more information.

To receive Medicaid reimbursement for services, hospitals must meet the program requirements outlined in this manual.

Federal regulations require hospitals to certify the accuracy of the diagnostic and procedural information, as well as to attest to the accuracy of each claim before it is submitted.

Reimbursement for inpatient hospital admissions is made to a hospital on a prospective payment basis. All covered services are included in this payment, and the Medicaid beneficiary cannot be billed for any of these services. Services specifically excluded from coverage may be billed to Medicaid beneficiaries provided they are advised in advance that such services are non-covered.

Reimbursement for outpatient hospital services is based on a fee schedule. All covered services are paid by one of three Reimbursement Types. A Medicaid beneficiary cannot be billed for a non-covered service unless he or she is advised before the service is rendered that it is non-covered. A Medicaid beneficiary cannot be charged for services if he or she is unaware of his or her responsibility.

When a patient is Medicaid eligible for only part of an inpatient hospital stay, the non-covered portion may be billed to the patient. However, charges for the entire admission must appear on the UB-04 form.The system will prorate accordingly.

When an outpatient hospital stay crosses two months and the patient is only eligible for Medicaid for one of the months, the non-covered portion may be billed to the patient. Only bill Medicaid for the outpatient services that occurred during the period that the patient was Medicaid eligible.

If the hospital stay is for a non-covered procedure only, then no payment will be made by Medicaid; the patient may be billed. If the hospital stay is for a procedure that is covered and a procedure that is non-covered, payment for the covered procedure can be made. The patient may be billed for the non-covered procedure. Charges for the non-covered procedure must appear in the non-covered column on the UB-04 form. Refer to the *Billing Guidance* section for specific billing instructions.

OUT-OF-STATE SERVICES

The term 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. For additional guidance, including necessary prior approval and billing considerations for Out-of-State services, see Section 5 Utilization Management of this manual.

NOTE: References to supporting documents and information are included throughout the manual. This information is found at the following locations:

- Provider Administrative and Billing Manual
- Forms
- Section 4 - Procedure Codes

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COVERED POPULATIONS

ELIGIBILITY/SPECIAL POPULATIONS

Medicare/Medicaid (Dually Eligible)

Medicare is a hospital and medical insurance program administered by the Social Security Administration for eligible persons who have reached 65 years of age or have been determined blind, totally and permanently disabled, or who have end-stage renal disease. Dually eligible individuals also qualify for Medicaid coverage.

Medicare has two parts:

- Part A (Hospital Insurance) pays the expenses of a patient in a hospital, skilled nursing facility or at home when receiving services provided by a home health agency.
- Part B (Medical Insurance) helps pay for physician services, licensed provider services, outpatient hospital services, inpatient ancillary charges when Part A benefits are exhausted or nonexistent, medical services and supplies, home health services, outpatient physical therapy and other health care services.

Medicaid will pay the allowed amount less the amount paid by Medicare or the coinsurance, deductible and blood deductible amount, whichever is less. Medicaid does not cover any charges during Lifetime Reserve Days (LRD), the 91st to 150th day, or the continued stay when a patient has elected to use or not to use LRD. Medicaid does not cover a continued stay after LRDs are exhausted. Subsequent admissions in the same spell of illness are covered. Refer to the Special Coverage section for billing guidelines for LRD.

When a beneficiary's Medicare eligibility is limited to Part B coverage only, Medicaid pays for all inpatient services except for those ancillary services covered by Part B. It is very important to see the beneficiary's Medicare card to determine the extent of his or her coverage. If the Medicare card is not available, you may use the Medicare Direct Data Inquiry (DDI) to verify eligibility.

Claims submitted to SCDHHS that have been denied by Medicare for medical necessity based on Local Coverage Determination (LCD) will not be paid by Medicaid. If Medicare has an LCD in which the service/test is considered to be not medically necessary, then Medicaid will not pay the deductible, blood deductible or co-insurance for these non-covered charges. The notice of non-coverage by Medicare to notify patients that the service(s) is not covered may also serve as the notification to the patient that Medicaid will not cover the service. If the patient is given advance notice of non-coverage, then the patient may be billed for the non-covered charges.

All services rendered to dually eligible Medicare/Medicaid patients must be filed to Medicare first. Refer to Section 8 Billing Guidance in this manual for billing guidelines.

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ELIGIBLE PROVIDERS

PROVIDER MEDICAID ENROLLMENT AND LICENSING

Certification, Licensing, Contracts and Enrollment

Hospitals that are currently certified to participate in Title XVIII (Medicare) are deemed to meet all the requirements for participation in Title XIX (Medicaid). Additionally, the following conditions must be met:

- **Personnel:** All patients must be treated by or under the direct supervision of a physician licensed to practice medicine in the State. When ancillary personnel are to be used in patient care, the written plan of care must indicate the extent of their involvement. The physician must demonstrate continued interest by professional encounters during the course of treatment. Evidence of staff supervision must be documented in the patient's record when interns and residents are providing a service. Please refer to Professional Services for policy on Physician supervision.

- **Emergency Service Personnel:** A physician must screen all patients who arrive for treatment in the Emergency Room (ER) to assess level of care as mandated by COBRA/OBRA legislation.

- **Supervision:** South Carolina Medicaid requires a supervising entity (physician, dentist, licensed provider or any program that has a supervising health professional component) to be physically located in South Carolina or within the 25-mile radius of the South Carolina border.

For Hospital Certification and Licensing contact:

Department of Public Health (DPH)
Division of Certification and Licensing
2100 Bull Street
Columbia, SC 29201

To request a Medicaid enrollment packet, please contact Medicaid Provider Enrollment via the SCDHHS Provider Service Center (PSC) at 1-888-289-0709, submit an online request at http://www.scdhhs.gov/providers/contact-provider-representative, or you may submit a request in writing to:

Medicaid Provider Enrollment
Post Office Box 8809
Columbia, SC 29202-8809

In-State Hospitals

Hospitals that want to participate in the Healthy Connections Medicaid Program must submit a written request for participation to:

Department of Health and Human Services
Contracts Division
Post Office Box 8206
Columbia, SC 29202-8206

Copies of the Medicare/Medicaid Certification and Transmittal, Clinical Laboratory Improvement Act (CLIA) Certification, and End Stage Renal Disease (ESRD) Certification, if appropriate, must accompany the request. The provider will then be requested to submit cost report information. New facilities will be requested to submit a report of projected costs. If this information is satisfactory, SCDHHS will send the provider two copies of the contract and Provider Enrollment Forms. The provider will sign the contracts, complete the enrollment forms, and return all documents to the Contracts Division. The contracts will then be signed by the Director of SCDHHS, and one copy will be returned to the provider along with unique six-character provider numbers, one for inpatient and another for outpatient services. Provider numbers must be used on all claim forms, inquiries and adjustment requests. Hospitals that bill for professional services provided by hospital-based physicians will be assigned an additional provider number for billing these services.

Pediatric Inpatient Rehabilitation Providers

A facility licensed to provide inpatient rehabilitation services in accordance with state law that provides these services to children under age 21 exclusively or in a designated pediatric rehabilitation unit may be an eligible provider. Pediatric inpatient rehabilitation services must be provided within a Medicaid enrolled general acute care institution licensed as a hospital or specialized hospital, that provides inpatient rehabilitation to children under age 21 exclusively or in a designated pediatric rehabilitation unit.

Qualified providers interested in providing pediatric inpatient rehabilitation services must submit a written request to SCDHHS at:

Department of Health and Human Services
Bureau of Policy
Post Office Box 8206
Columbia, SC 29202-8206

Out-of-State Hospitals

To participate in the Medicaid program, an out-of-state hospital must enroll with South Carolina Medicaid by completing a provider enrollment package. By signing the provider enrollment forms, the provider agrees to payment at the South Carolina rate of reimbursement and to comply with all federal and state laws and regulations. Claims and all needed information must be submitted within

one year from the date of service or date of discharge for inpatient claims or reimbursement will be denied.

Out-of- state hospital claims must be sent in hard copy to:

Medicaid Claims Receipt
Post Office Box 1458
Columbia, SC 29202-1458

For assistance with out-of-state hospital claims, please contact the PSC at 1-888-289-0709 or submit an online inquiry at https://www.scdhhs.gov/contact.

For policies regarding organ transplants, please refer to the Organ Transplants subsection in Section 7 Special Coverage.

Clinical Laboratory Improvement Act (CLIA)

In accordance with federal regulations (42 CFR 493.1809), SCDHHS requires that all laboratory testing sites, including hospital laboratories, have a CLIA Certificate of Waiver, Certificate of Registration, or Regular Certificate (issued after successful completion of the lab survey), along with a unique 10-digit number, to perform laboratory tests. This 10-digit number must be on file with SCDHHS.

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COVERED SERVICES AND DEFINITIONS

INPATIENT HOSPITAL SERVICES

An inpatient is a patient who is admitted to a medical facility on the recommendation of a physician or dentist, is receiving specialized institutional and professional services on a continuous basis and is expected to require such specialized services for a period generally greater than 24 hours.

False labor with a subsequent delivery, a patient leaving against medical advice and then being re-admitted, and a patient who transfers from acute care to a psychiatric or rehabilitative unit will be paid as two separate admissions. All same-day discharges are paid at half the single-day DRG payment except normal deliveries, False Labor, Normal Newborn and Deaths. These exception DRGs receive the whole DRG payment. Same-day transfers are paid under the transfer payment methodology.

Exceptions to the 24-hour requirement for inpatients include but are not limited to deaths (including ER admission), false labor, deliveries, and medical transfers.

Note: Normal delivery/newborns, false labor, and death are paid a full DRG regardless of the length of stay.

Inpatient services are defined as those items and services which are medically appropriate to the inpatient hospital setting and meet the medical necessity requirements outlined in the criteria and policies of the Quality Improvement Organization (QIO). These items and services must be directed and documented by a licensed physician in accordance with hospital bylaws in a facility meeting hospital criteria.

Inpatient hospital reimbursement is based on the hybrid prospective payment system methodology. All services rendered during an inpatient stay are included in the Diagnosis Related Group (DRG) reimbursement. Outpatient services that result in an inpatient admission are deemed to be inpatient services and are included in the DRG payment. Outpatient services rendered on the day of admission are included in the DRG payment regardless of relation to the inpatient admission. All outpatient services rendered during an inpatient stay are included in the DRG payment, including charges for tests or procedures performed by another general acute care hospital. In such cases, the admitting hospital is responsible for reimbursing the performing hospital for its services. The formulas used to calculate inpatient hospital payments are located with the procedure code information associated with this manual.

The South Carolina Medicaid State Plan limits coverage of inpatient hospital services to general acute care hospital, psychiatric hospital and pediatric inpatient rehabilitation services for individuals under age 21 (For adults, inpatient rehabilitative services provided in a distinct medical rehabilitation

facility, or a separately licensed specialty hospital are not reimbursable). Medicaid will reimburse rehabilitation services rendered to Medicaid beneficiaries on an inpatient or outpatient basis at a general acute care hospital.

Inpatient Only Procedures

The Centers for Medicare and Medicaid Services (CMS) publishes a list of designated procedures that Medicare will pay for only when care takes place in a hospital setting. Any procedures not included on the list must be performed on an outpatient basis.

SCDHHS follows the **CMS Inpatient Only List** for designation of inpatient only procedures. A link to the Outpatient Prospective Payment System (OPPS), Addendum E, can be found below:

Hospital Outpatient Regulations and Notices | CMS

Covered Days

The number of days of care provided to Medicaid patients is always counted in units of full days. For Medicaid purposes, a day begins at midnight even if the hospital uses a different definition of a day. The day of discharge is not counted as a covered day. Services provided on the day of discharge beyond checkout time for the comfort or convenience of the patient are not covered under Medicaid and may be billed to the patient.

Admission/Discharge Criteria

An admission occurs when the acute inpatient hospital criteria are met, and the physician expects the patient to remain in the hospital longer than 24 hours. These criteria requirements are outlined in the criteria and policies of the QIO under contract with SCDHHS. If the acute inpatient hospital criteria are met, admission is then appropriate regardless of the time spent in the hospital.

A person is considered discharged when formally released from an acute care facility. A patient is also considered discharged (1) when the patient is transferred to another acute care facility, (2) when the patient is discharged to a long-term care facility, (3) when the patient dies, (4) when the patient leaves against medical advice, or (5) when the patient is transferred to a psychiatric or rehabilitation unit.

Types of Inpatient Admissions

Elective Admission

An elective admission occurs when a patient's condition requires non-urgent treatment that can be anticipated or scheduled in advance without posing a threat to the patient's health outcome. When a physician calls to schedule an admission for non-urgent treatment and finds a bed immediately available and admits the patient, the admission is still considered elective. Admissions for elective procedures must take place on a weekday unless there is a valid medical reason for a weekend admission. Friday is considered part of the weekend.

One-Day Admissions

A one-day admission occurs when a patient is admitted to a hospital one day and discharged anytime during the next calendar day. This stay may be billed as an inpatient admission when the admission criteria have been met.

Admission from an Observation Unit

When a patient is admitted to the hospital from an observation stay, bill the date the beneficiary was switched from observation to inpatient status as the first day of the inpatient admission. Only if the observation stay is unrelated to the inpatient admission, excluding the day of admission, can the observation days be billed as outpatient services. Observation stays related to and within 72 hours of the inpatient admission are considered inpatient services and are included in the DRG payment. Refer to Pre-Admission Services (72-hour Rule).

Readmission

A readmission occurs when a patient is admitted to the same or any other facility within 30 days of discharge for the same DRG or general diagnosis as the original admission. Readmissions are subject to post-payment review and may be paid as two separate admissions unless the post-payment reviewer denies one of the admissions.

Transfers

A patient is considered transferred when moved from one acute inpatient facility to another acute inpatient facility, or when transferred to a psychiatric unit or a rehabilitation unit within the acute inpatient facility. A transfer does not occur until the patient is moved by the transport team. SCDHHS will consider a transfer for social reasons provided the medical records justify the need for the transfer and the patient still requires acute hospital care.

Segmented Care/Leave of Absence

A hospital may place a patient on a leave of absence (LOA) when readmission is expected, and the patient does not require a hospital level of care during the interim period. Examples include but are not limited to situations where surgery could not be scheduled immediately, a specific surgical team was not available, bilateral surgery was planned, or when further treatment is indicated following diagnostic tests but cannot begin immediately. The hospital stay must be billed as one admission and charges for the LOA days must be shown as non-covered.

Mother/Newborn Admissions

Charges for the mother and newborn child must be separated and submitted on two claims. All charges associated with the mother must be submitted on one claim using the mother's Medicaid ID number. Charges associated with the newborn child must be submitted on another claim using the newborn's Medicaid ID number..Providers will need to contact the SCDHHS county office for a newborn's Medicaid ID number. The SCDHHS county office listing is located on the website at https://www.scdhhs.gov/site-page/where-go-help.

Exception

To ensure timely access to critical Zidovudine (AZT) therapy for at-risk newborns and to maximize patient compliance, SCDHHS allows the pharmacy or hospital provider to bill Medicaid using the mother's South Carolina Healthy Connections Medicaid card number when dispensing the initial six weeks home supply of AZT syrup. Billing this drug to the mother's Medicaid identification number is permissible only in those instances where the newborn has not yet been assigned a South Carolina Healthy Connections Medicaid card number at the time of discharge.

The Department of Public Health (DPH) has recommended that the first injection of the Hepatitis B series be administered while the infant is in the hospital. The hospital reimbursement is an all-inclusive payment for services rendered during that hospital stay and thus includes the Hepatitis B vaccine.

When billing for the administration of the Hepatitis B vaccine the appropriate procedure code is 3E0134Z, Introduction of Serum, Toxoid and Vaccine into Subcutaneous Tissue, Percutaneous Approach or 3E0234Z Introduction of Serum, Toxoid and Vaccine into Muscle, Percutaneous Approach. Administration of the Hepatitis B vaccine to infants will be disallowed unless the medical record documentation justifies its use.

Inpatient Covered Services

Accommodations

The Medicaid program sponsors semi-private or ward accommodations. A private room or other accommodations more expensive than semi-private will be allowed when such accommodations are certified as medically necessary by the attending physician or when the hospital only has private rooms. Private rooms will be considered medically necessary only when the patient's condition requires him or her to be isolated to protect his or her own health or welfare, or to protect the health and welfare of others. Patients requesting a private room or more expensive room may be billed the difference between the private/more expensive and the semi-private room rate.

Drugs

Drugs prescribed for and dispensed to an inpatient are covered and are included in the DRG payment. Those drugs furnished by a hospital to an inpatient for use outside the hospital are generally not covered as inpatient hospital services. However, if the drug or biological is deemed medically necessary to permit or facilitate the patient's departure from the hospital and a limited supply is required until the patient can obtain a continuing supply, the limited supply of the drug or biological is covered as an inpatient hospital service. Drugs furnished to a patient on discharge shall be limited to a maximum five-day supply and are covered as part of the inpatient stay.

The Hepatitis B vaccine and RespiGam/SYNAGIS® administered to an infant in the hospital are included in the hospital's DRG payment. For newborns, Medicaid will allow a six-week supply of AZT syrup to be billed by the hospital or pharmacy provider. The AZT syrup can only be billed under the mother's Medicaid ID number when the newborn does not have an assigned Medicaid ID number at the time of discharge.

Supplies, Appliances and Equipment

Items furnished by the hospital for the care and treatment of the patient during his or her inpatient stay are covered inpatient hospital services and are included in the DRG payment. Under certain circumstances, supplies, appliances and equipment used during the inpatient stay are covered even though they are taken with the patient when he or she is discharged. These are circumstances in which it would be unreasonable or impossible from a medical standpoint to limit the patient's use of the items to the periods during which the individual is an inpatient. Examples of items covered under this policy include, but are not limited to, cardiac valves, cardiac pacemakers and artificial limbs, which are permanently installed in or attached to the patient's body while an inpatient of the hospital.

Items such as tracheostomy tubes or drainage tubes that are temporarily installed or attached to the patient's body during inpatient treatment, are necessary to permit or facilitate the patient's release from the hospital and are required until the patient can obtain a continuing supply, are covered as an inpatient hospital service. Supplies, appliances, and equipment furnished to an inpatient for use only outside the hospital are not covered as inpatient hospital services.

Transportation of Self-Administered Oxygen Dependent Beneficiaries

Effective June 1, 2014, SCDHHS will amend the non-emergency transportation policy for self-administered oxygen dependent beneficiaries discharged from inpatient hospitals or ERs. The policy applies to beneficiaries who are admitted, as an inpatient of a hospital or hospital ER, are oxygen dependent and currently do not have their portable oxygen system in their possession, and do not require transportation via ambulance for their return trip to their residence for any other reason. The hospital is responsible for arranging and acquiring a portable oxygen system complete with all medically necessary accessories, upon discharge. Hospitals and ambulance providers will no longer receive reimbursement for non-essential, non-medically necessary ambulance transportation for self-administered oxygen dependent beneficiaries. All provider types and services are subject to post-payment review by the Division of Program Integrity.

It is the responsibility of both the hospital and Durable Medical Equipment (DME) provider to coordinate and dispense oxygen to the Medicaid beneficiary currently admitted to the hospital or ER for the appropriate mode of non-emergent transportation to be arranged with the transportation broker upon discharge. The dispensing DME provider will be responsible for arranging the return of the portable oxygen system dispensed by their company at the time of discharge from the admitting hospital facility.

SCDHHS will reimburse for a portable oxygen system, E0443 billed with a U1 modifier, and the dispensing DME provider will be reimbursed at a rate of $20.00 per occurrence. SCDHHS will limit the number of occurrences per patient to no more than three occurrences per calendar month. Services that exceed three occurrences per calendar month will not be reimbursed.

It is the responsibility of Emergency Medical Services providers whenever possible to transport oxygen dependent beneficiaries with the beneficiary's personal portable oxygen system in anticipation of the beneficiary's medical/health needs.

Services for Mental Disease

Medicaid patients admitted to a general acute care hospital for the treatment of mental disease are sponsored in the same way as patients for any other disease. Patients may be any age, and coverage is the same as for any other patient. Treatment furnished under the direction of the attending physician is covered.

Treatment for Medicaid patients in a psychiatric hospital is subject to the federal regulations regarding "institution for mental diseases" as cited in 42 CFR 441 Subpart D. Medicaid funds are available for inpatient psychiatric services rendered in a psychiatric hospital for individuals under age 21. If the beneficiary is receiving services immediately before he or she reaches 21, Medicaid will sponsor services until the beneficiary no longer requires the services or until the beneficiary reaches age 22, whichever is earlier. For further information, please call the PSC or submit an online inquiry at http://www.scdhhs.gov/providers/contact-provider-representative.

Pediatric Inpatient Rehabilitation Services

Pediatric inpatient rehabilitation services are designed to provide comprehensive, individually tailored care plans to meet the physical, developmental, social, psychological and educational needs of the patient and the patient's family**.**

Eligible beneficiaries

Children under twenty-one (21) years of age are eligible to receive medically necessary pediatric inpatient rehabilitation services under the Inpatient Hospital Services pursuant to 42 CFR 440.10.

Covered Services

Pediatric inpatient rehabilitation units are those designed to provide intensive rehabilitation therapy in a resource-intensive inpatient hospital environment for patients under 21 years of age, who, due to the complexity of their nursing, medical management, and rehabilitation needs, require, and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care.

Pediatric inpatient rehabilitation services are only considered by SCDHHS to be reasonable and necessary under 1862(a)(1)(A) of the Social Security Act if the patient meets all the SCDHHS policy requirements outlined below. SCDHHS requires determinations of whether pediatric inpatient rehabilitation stays for rehabilitation services are reasonable and necessary to be based on an assessment of each beneficiary's individual care needs.

Criteria and Limitations

The pediatric patient eligible to be transferred from acute care into an inpatient rehabilitation unit must meet the following criteria:

1. Have a comorbidity that falls at minimum but not limited to one of the conditions specified below:
    a. Arthritis: active, polyarticular rheumatoid, juvenile idiopathic, psoriatic, seronegative arthropathies, severe vasculitis with joint inflammation
    b. Advanced/Severe Osteoarthritis: osteoarthrosis, degenerative joint disease with two or more major weight-bearing joints (elbow, shoulders, hips, knees, not counting a joint with prosthesis) with joint deformity and substantial loss of range of motion and atrophy of muscles surrounding joint
    c. Brain injury: traumatic, anoxic, non-traumatic (ADEM, encephalopathy, encephalitis, meningitis, post-tumor removal or other causes)
    d. Burns (not requiring specialty burn center care)
    e. Cardiac conditions: endocarditis, myocarditis
    f. Congenital deformity
    g. General debility: medical and functional recovery or decondition resulting from extended hospitalization, complex medical conditions, complex orthopedic or neurosurgical procedures, or other acute medical illness
    h. Fractures affecting daily function and activity
    i. Major multiple trauma (including orthopedic)
    j. Neurological disorders: multiple sclerosis, motor neuron disease, polyneuropathy, muscular dystrophy, cerebral palsy.
    k. Oncology
    l. Respiratory insufficiency
    m. Spinal cord: injury (regardless of level, completeness, or etiology), tumor, and related issues (Guillain Barre, transverse myelitis, MOG-associated conditions, multiple sclerosis)
    n. Stroke (including pediatric stroke, AVM)
    o. Traumatic amputation

2. The comorbidity must cause a significant decline of functional impairment of ambulation and other activities of daily living immediately preceding the inpatient rehabilitation admission or it must result from a systemic disease activation immediately before admission (even in the absence of the admitting condition).
3. The patient’s condition must have the potential to improve with more intensive rehabilitation that is unique to inpatient rehabilitation and that cannot be appropriately performed in another care setting.

Pediatric inpatient rehabilitation services are not to be used as an alternative to completion of the full medical course of treatment in the referring hospital. A patient who has not yet completed the full medical course of treatment in the referring hospital is expected to remain in the referring hospital, with appropriate rehabilitation treatment provided, until such time as the patient has completed the full medical course of treatment.

Though medical management can be performed in an inpatient rehabilitation unit, patients must be able to actively participate in and benefit from the intensive rehabilitation therapy program provided in these units for the claim to be considered reasonable and necessary. Therefore, patients who are not able to actively participate in and benefit from the intensive rehabilitation therapy services because they are still completing their course of treatment in the referring hospital should remain in the referring hospital until they are able to do so.

Conversely, pediatric inpatient rehabilitation services are not appropriate for patients who have completed their full course of treatment in the referring hospital, but do not require intensive rehabilitation.

Medical Necessity Criteria

For pediatric inpatient rehabilitation care to be considered reasonable and necessary, services must demonstrate a reasonable expectation that the following criteria were met at the time of admission to the pediatric inpatient rehab unit.

- The patient must require the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, prosthetics/orthotics and/or cognitive education and therapeutic recreation), one of which must be physical or occupational therapy.

- The pediatric patient must require an intensive rehabilitation therapy program. Under current industry standards, this intensive rehabilitation therapy program consists of at least 3 hours of therapy per day at least 5 days per week, or at least 15 hours of intensive rehabilitation therapy within a 7 consecutive calendar day period, beginning with the date of admission to the pediatric inpatient rehabilitation unit. The minimum hours of required therapy may be adjusted on a case-by-case basis when a patient's age is taken into consideration. Documentation of adjustment to minimum hours of required therapy must be maintained in the patient's health record.

- The patient must reasonably be expected to actively participate in and benefit significantly from the intensive rehabilitation therapy program at the time of admission to the pediatric inpatient rehabilitation unit.

- The patient can only be expected to benefit significantly from the intensive rehabilitation therapy program if the patient's condition and functional status are such that the patient can reasonably be expected to make measurable improvement (that will be of practical value to improve the patient's functional capacity or adaptation to impairments) because of the rehabilitation treatment, and if such improvement can be expected to be made within a prescribed time frame. The patient need not be expected to achieve complete independence in the domain of self-care nor be expected to return to his or her prior level of functioning to meet this standard.

- The patient must require physician supervision by a rehabilitation physician, defined as a licensed physician who has specialized training and experience in pediatric inpatient rehabilitation.
  - The requirement for medical supervision means that the rehabilitation physician must conduct face-to-face visits with the patient at least 3 days per week throughout the patient's stay in the pediatric inpatient rehabilitation unit to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process.

  - Beginning with the second week of admission to the pediatric inpatient rehabilitation unit, a non-physician practitioner who is determined to have specialized training and experience in inpatient rehabilitation may conduct 1 of the 3 required face-to-face visits with the patient per week, provided that such duties are within the non-physician practitioner's scope of practice under applicable state law.

  - In the first week of the patient's pediatric inpatient rehabilitation stay, the rehabilitation physician is required to visit the patient a minimum of three times to ensure that the patient's plan of care is fully established and optimized to the patient's care needs in the pediatric inpatient rehabilitation unit.

  - For the second, third, fourth weeks of the stay, and beyond, SCDHHS will continue to require beneficiaries in the pediatric inpatient rehabilitation units to receive a minimum of three rehabilitation physician visits per week but will allow non-physician practitioners to independently conduct one of these three minimum require visits per week.

- The patient must require an intensive and coordinated interdisciplinary approach to providing rehabilitation.

- The required therapy treatments must begin within 1 business day from the day of admission to the pediatric inpatient rehabilitation unit.
  - Therapy evaluations are generally considered to constitute the beginning of the required therapy services. As such, they must be included in the total daily/weekly provision of therapies used to demonstrate the intensity of therapy services provided in a pediatric inpatient rehabilitation unit.

  - The standard of care for pediatric inpatient rehabilitation patients is individualized (i.e., one-on-one) therapy. Group therapies serve as an adjunct to individual therapies. In those instances, in which group therapy better meets the patient's needs on a limited basis, the situation/rationale that justifies group therapy must be specified in the patient's medical record.

- The patient must require the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics), one of which must be physical or occupational therapy.

Documentation Required to be Maintained in the Patient's Health Record
Documentation components must include at a minimum the following:

- Required Preadmission Screening Tool
- Required Individualized overall plan of care.
- Documentation of reasonable expectation that at the time of admission to the pediatric inpatient rehabilitation unit, the patient's condition is such that the patient can reasonably be expected to actively participate in, and significantly benefit from, the intensive rehabilitation therapy program.
- Industry-standard pediatric inpatient rehabilitation patient assessment instrument (e.g., WEEFIM). This is completed after admission to the pediatric inpatient rehabilitation unit and must be included with any requests for continued stay beyond the initial prior authorization.

Outpatient Hospital Services

Outpatient hospital services are diagnostic, therapeutic, rehabilitative, or palliative items or services that are furnished by or under the direction of a physician or dentist to an outpatient in an institution licensed and certified as a hospital. Outpatient services may include scheduled services, surgery, observation room and board, and emergency services provided in an area meeting licensing and certification criteria.

An outpatient is a patient who is receiving professional services at a hospital for a period generally not to exceed 24 hours. An outpatient may be admitted to a room by an attending physician for either daytime or overnight observation. For additional information on observation, refer to Outpatient Observation in this section.

Outpatient Observation
Observation services are furnished by a hospital on its premises and include the use of a bed and periodic monitoring by nursing or other staff. Such services must be reasonable and necessary to evaluate an outpatient's condition or to determine whether there is a need for admission as an inpatient. These services usually do not exceed one day and must be ordered verbally and/or authenticated by signature of a physician or another individual authorized by State licensure law and hospital bylaws to admit patients to the hospital. The period of observation begins when the physician orders observation and when the monitoring of the patient begins. Observation ends when ordered verbally and/or authenticated by signature of a physician or another individual authorized by State licensure law and hospital bylaws to discontinue such treatment.

The observation room revenue code (762 and 769) units do not multiply. Each 24 hours of observation can be filed on one claim for multiple dates of service. While observation services usually do not exceed 24 hours, they may exceed 24 hours in some cases and are not explicitly limited in duration.

Note: In cases where the observation stay must span two calendar days, to equal 24 hours, observation shall not be billed for both days.

Outpatient observation charges must be billed using either revenue code 762 or 769 for up to 24 hours of continuous service. The observation period shall commence when the patient is formally admitted to an observation room. The attending physician may admit the patient for daytime or overnight observation. Observation charges may be reimbursed in addition to the surgical and non-surgical payment.

Observation days prior to an inpatient admission can be billed as outpatient services when the observation stay is unrelated to the inpatient admission, excluding the day of admission. Bill the date the beneficiary was switched from observation to inpatient status as the first day of the hospital admission. Observation stays related to and within 72 hours of an admission are considered inpatient services and are included in the inpatient DRG payment. Refer to Section 8 Billing Guidance for specific billing instructions.

Observation shallonly be billed if the patient meets the conditions for observation. Do not substitute outpatient observation services for medically appropriate inpatient admissions. Test preparation, whether performed by the patient or the facility by itself, does not qualify for observation and observation must not be billed concurrently with the test. In addition, observation services cannot automatically be billed because the time for normal recovery from a surgical procedure is exceeded. Observation would be appropriate when the recovery period exceeds normal expectations for the type of surgery and when the patient's condition requires observation.

Treatment Room

The use of a treatment room may be appropriate for procedures that do not require the resources of a surgical suite or for facilities that do not have an endoscopic suite. Treatment room charges shall normally be limited to no more than two hours, and usually less. Treatment room charges are a substitute for those room charges and not an additional line item. It is not appropriate to show treatment room charges in order to augment reimbursement. Refer to Section 8 Billing Guidance for specific billing instructions.

Drugs

Drugs administered to patients during outpatient treatment are not separately reimbursed. The reimbursement for drugs and biologicals is included in the all-inclusive outpatient payment with the exception of the add-ons: Depo-Provera®, Vitrasert® and SYNAGIS®.

Self-Administered Drugs

Self-administered drugs (SADs) given in an outpatient setting are not separately reimbursed by SCDHHS. Payment for SADs is instead included in the all-inclusive outpatient reimbursement, to include dually eligible beneficiaries. Two factors are used in determining whether a drug is considered self-administered:

- The usual method of administering the drug.
- The form of the drug (i.e., oral, injected, etc.).

For example, oral medications provided to patients in an outpatient setting are considered SADs since such drugs are usually self-administered.

As a further illustration, according to these guidelines, insulin is excluded from coverage unless administered to the patient in an emergency (e.g., diabetic coma), in which case the SAD is covered in the all-inclusive ER reimbursement.

Clinical Lab Services
To comply with Title XIX of the Social Security Act, Section 1903(i)(7), Medicaid reimbursement for clinical lab services must not exceed the rates established by Medicare.

Rates for clinical lab procedures, as identified by the Centers for Medicare & Medicaid Services (CMS), will be updated yearly based on the Medicare Fee Schedule rates. The Medicaid Management Information Systems (MMIS) will identify Clinical Lab Panels and Individual Automated Tests and reimburse the amount based on the Automated Test Panel pricing schedule. Clinical lab panels will only reimburse one unit per date of service. Claims with multiple units of the same clinical lab panel on the same date of service will be rejected.

For clinical laboratory tests, 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. All the tests in the definition of a panel must be performed for the provider to use that panel's Current Procedural Terminology (CPT) codes. The physician must review the panels and not order individual, duplicative tests..

Laboratory Tests, EKGs and X-Rays
Laboratory tests, EKGs, and X-rays are covered under Medicaid if they are reasonable and necessary for the diagnosis or treatment of an illness or injury. The physician must specify the actual tests to be performed.

Laboratory tests, EKGs, X-rays, and similar ancillary services must be medically justified as a necessary part of the patient's care. To justify the use of many special tests where the final diagnosis is uncomplicated, the record must substantiate why a more complicated test was considered. The requirements for ancillary tests must be indicated and authenticated by signature of the physician. The results of the ancillary testing must be entered into the patient's record.

Note: SCDHHS will allow a hospital to bill for services performed at another laboratory, provided that the following requirements are met: (1) the hospital and the laboratory must have a written agreement that the laboratory will look solely to the hospital for reimbursement and will not independently bill South Carolina Medicaid for these services, (2) the arrangement will result in no additional cost to the South Carolina Medicaid program (e.g., no "mark-up" by the hospital, no administrative fees, no handling charges, etc.), and (3) the hospital must bill the charge which is submitted to all other payers. STwo bills for the same service are prohibited and SCDHHS shall not incur any additional expenses as the result of this practice.

Depo-Provera®, Vitrasert®, SYNAGIS® and IMPLANON®
Depo-Provera® may be billed in addition to a clinic visit when family counseling is provided or separately under the Treatment/Therapy/Testing (TTT) category. Vitrasert® may be billed in addition to a surgical claim. IMPLANON® is a single-rod implantable contraceptive that is effective for up to three years. Providers must use the appropriate Family Planning diagnosis codes and CPT codes for the insertion and removal of the device.

These codes must be billed using revenue code 636 and the following Healthcare Common Procedure Coding System (HCPCS) codes:

- Depo-Provera®, HCPCS code J1050
- Vitrasert®, HCPCS code J7310
- SYNAGIS®, HCPCS code 90378
- IMPLANON®, HCPCS code J7307

Long-Acting Reversible Contraceptives (LARCs)
LARCs provided in an inpatient hospital setting are considered an add-on benefit to the DRG reimbursement. SCDHHS will reimburse providers for LARCs through a gross-level credit adjustment. To process the LARC payment, hospitals are required to utilize the HCPCS code that represents the device, along with the appropriate ICD-PCS Surgical Code and the ICD-CM Diagnosis Code that best describe the services delivered. The LARC reimbursement will be processed as a gross level credit adjustment and will appear on a future remittance advice. Providers will receive a letter of notice and reconciliation report quarterly identifying the credit adjustment along with pertinent patient information to apply the credit to the correct patient account. The letter of notice will identify the Adjustment Reference Number and will be identified by the prefix LARC.

Covered LARCs:

- Levonorgestrel-releasing intrauterine contraceptive system (Kyleena®), 19.5 mg
- Levonorgestrel-releasing intrauterine contraceptive system (Liletta®), 52 mg
- Levonorgestrel-releasing intrauterine contraceptive system (Mirena®), 52 mg
- Intrauterine (IU) copper contraceptive (Paragard®)
- Levonorgestrel-releasing intrauterine contraceptive system (Skyla®), 13.5 mg
- Etonogestrel (contraceptive) implant system, including implant and supplies (IMPLANON®/ Nexplanon®)

- Permanent implantable contraceptive intra-tubal occlusion device(s) and delivery system (Essure). This requires a sterilization request form to be signed 30 days prior to the procedure.

Hospital-Based Crisis Stabilization Services
Hospital-based crisis stabilization services (CSH) are for beneficiaries experiencing a psychiatric or other behavioral health emergency who need immediate intervention to ameliorate the crisis and/or reduce acute symptoms. Located on the contiguous hospital campus grounds and linked to the hospital's general emergency department (ED), these outpatient services are delivered in an environment that operates as a psychiatric ED, specializing in the care of behavioral health patients with the goal of diverting those in mental health or substance use disorder crisis from the general ED to a site more specific to their needs. CSH services includes continuous 24-hour/seven days per week observation, diagnostic evaluation, and medication assessment in a calming, supportive, and comfortable environment that facilitates ongoing interaction between staff and patients and the availability of a variety of therapeutic interventions. Hospitals providing CSH services must be familiar with and pattern services after the Emergency Psychiatric Assessment, Treatment, and Health (EmPATH) model.

Individuals may present to the CSH unit in a variety of ways including but not limited to referrals from providers, emergency medical services transport, police transport, and walk-ins. The CSH staff will make a reasonable effort to obtain as much information from the individual(s) accompanying them to the unit. Patients initially presenting to the general ED must be medically cleared and triaged according to the Emergency Medical Treatment and Labor Act (EMTALA) prior to transferring to the CSH unit.

NOTE: If patient is screened as per EMTALA in the regular ED prior to transfer to the CSH unit, the hospital may submit claims related to that screening regardless of any further same day claims from the CSH unit.

Provider Qualifications
Hospital-based crisis stabilization services are delivered by a multidisciplinary team of diverse professionals including but not limited to the following:

- Board-certified psychiatrist/psychiatric provider such as a nurse practitioner
- Registered nurse
- Licensed independent social worker-clinical practice
- Licensed professional counselor
- Psychiatric/mental health assistants and psychiatric technicians
- Activity therapists
- Child-life specialists (for those units serving children and adolescents)

Peer support specialists

Services Provided through Hospital-Based Crisis Stabilization
Triage and Referral – Initial 23 hours of admission

- Once medically cleared, triage and referral services are performed in the CSH unit and must include an in person, face-to-face interaction between an individual and a CSH staff member. These services are provided to determine the scope of the emergency service the member requires. Determination of the scope is based on the acuity and intensity of the member's symptoms and/or distress and determines the most appropriate next step in treatment. This includes psychiatric diagnostic examination and may result in either further

evaluation, treatment activities, emergency stay – 72 hours in the CSH unit, or discharge planning and referral to community treatment providers.

- Triage and referral services are initiated as soon as possible and include a psychiatric assessment (face-to-face or via telehealth) no later than six hours after an individual is received in the CSH unit. The goal is to connect people to care and services expeditiously. The workflow should be organized to facilitate rapid completion of triage and referral services. For complex situations, nurse practitioners are encouraged to collaborate with a CSH psychiatrist to make a clinical determination for the course of treatment. Other disciplines including but not limited to nurses, social workers, and mental health aides, may assist the physician or psychiatric nurse practitioner with triage and referral services.
- Situations that may require triage and referral services include but are not limited to the following circumstances:
  - Requiring stabilization of crisis symptoms that can be resolved quickly
  - An individual may present to the ED requesting or requiring a prescription or refill for medication
  - An individual may present to the ED requesting or requiring an intramuscular injection
- Various activities and services may be performed during the triage and referral process including but not limited to:
  - Crisis risk assessments to identify level of risk of suicide and/or violence
  - Psychiatric diagnostic assessments
  - Psychosocial history
  - Basic health screening, vitals, other screening and emotional support as necessary
  - Unit orientation
  - Communication by CSH unit staff to relevant collateral contacts, discharge planning, and linkage to services in the community
  - Other specialized assessments (such as those for substance use disorders)

NOTE: Those providing CSH services are encouraged to use standardized or validated risk assessment tools (ex., the Columbia Suicide Severity Rating Scale) to assist in assessments.

For patients appropriate to discharge within the first 23 hours of services, unit staff must work in collaboration with the patient to arrange a successful discharge by discussing treatment preferences and community support. The patient must be discharged with a viable and manageable discharge plan.

Emergency Stay - Up to 72 Hours

Beneficiaries who have not been stabilized and discharged during the triage and referral phase (i.e., the first 23 hours) or those admitted with a serious behavioral health need that will require a longer stay, may receive CSH services for up to 72 hours.

An emergency stay up to 72 hours is indicated for an individual whose presenting symptoms are initially determined to be serious and where the clinical staff believe commencement of treatment must begin immediately, and/or where staff are evaluating a person for retention in an extended observation bed or admission to a psychiatric inpatient unit. Serious symptoms are those that have the potential to substantially impact an individual's safety to self or others, or ability to care for oneself in the community.

Situations that may require a full emergency visit include but are not limited to:

- An individual transported by Emergency Medical Services to the CSH unit
- An individual transported by law enforcement to the CSH unit
- An individual brought in against their will by family member or collateral contact and
- An individual requiring significant de-escalation or crisis intervention

An emergency stay up to 72 hours is initiated as soon as possible after an individual is determined to need the extended services, which include:

- A psychiatric or mental health diagnostic examination
- A full psychosocial assessment
- A basic medical examination
- A comprehensive psychiatric emergency treatment plan
- Comprehensive discharge planning, which results in a discharge plan and discharge summary, and
- Emergency stays up to 72 hours may include other examinations and assessments as clinically indicated by the individual's presenting problems and as requested by the psychiatrist

All activities and services provided during Triage and Referral must also be available and ongoing during an emergency stay up to 72 hours. In addition, short-term groups, individual and family psychotherapy, and other therapeutic interventions must be incorporated into the schedule of the milieu as needed and appropriate.

Provider Requirements

Crisis stabilization services are provided in specialized hospital-based emergency departments and observational units dedicated to behavioral health. These units must be designed, constructed, and operated in accordance with all applicable laws and regulations and:

- Adhere to an Emergency Psychiatric Assessment, Treatment & Healing (EmPATH) philosophy https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf
- Be located on the contiguous hospital campus grounds and linked to the emergency department for initial intake and or referral
- Contain a large climate-controlled space to serve as a therapeutic environment
- Provide separate adult and pediatric beds, bays, or spaces
- Provide rapid evaluation and comprehensive treatment planning by a psychiatrist or psychiatric prescribing provider
- Ensure access to clinical and nursing staff in the milieu
- Provide a dedicated, calming environment with a mix of recliner and open space with patient rooms for use based upon acuity
- Maintain a detailed behavioral health staff training plan
- Operate as a “no wrong door” facility. No wrong door means an approach to service that provides beneficiaries with, or links them to, appropriate service interventions regardless of where they enter the system of care. All beneficiaries arriving at the facility, regardless of mental or physical condition, cooperativeness, special needs, pregnancy, or otherwise shall be accepted. The facility may refer beneficiaries out for other care, such as medical needs, only when reasonably necessary and must ensure a warm hand off to the referral location.

Eligible Beneficiaries

Crisis stabilization services are available to Healthy Connections Medicaid full benefit beneficiaries experiencing a behavioral health or substance use crisis.

Covered Services
Covered services encompass psychiatric evaluation, diagnosis and initiation of treatment and include the following:

- Crisis stabilization and brief treatment interventions
- Crisis assessment to include suicide risk screening and safety planning
- Medication induction for opioid use disorder treatment
- Early and appropriate medication-assisted treatment
- Multidisciplinary team approach, which may include:
  - Psychiatrist
  - Registered Nurse
  - Social Worker/Mental Health Counselor
  - Psychiatric Nurse Practitioner
  - Psychiatric Assistant
  - Peer Support Specialist
- Coordination with existing community outpatient service providers to ensure continuity of care
- Proactive discharge planning and/or transfer to an appropriate level of care

Criteria and Limitations
Only SCDHHS approved facilities, approved based on the provider requirements above, may bill for crisis stabilization services. Reimbursement is based on a per hour rate (limited to 23 hours) **OR** a per diem rate (limited up to 3 days) per episode of care. The hourly rate will apply to patients stabilized and discharged prior to 24 hours. For patients requiring services beyond 23 hours, the per diem rate must be billed. There may be no more than three per diems per episode of care per patient. Hourly and per diem rates may not be billed for the same episode of care.

There are no limitations on the number of covered episodes of care for beneficiaries. Beneficiaries presenting to emergency departments are referred to these units only after a medical screening exam rules out the need for emergency medical care.

Billing
Only approved facilities may bill for crisis stabilization services. Reimbursement will be based on a per hour rate (limited to 23 hours) **OR** a per diem rate (limited to 3 days). The hourly rate will apply to patients stabilized and discharged prior to 24 hours. There may be no more than three per diems per episode of care. Hourly and per diem rates may not be billed for the same episode of care. The following procedure codes apply and must be tied to revenue code 919. The OP Multiplier is not applied to revenue code 919 or procedure codes S9484 and S9485.

Procedure Code	Description	Limitations
S9484	Brief Psychiatric Emergency, per hour, up to 23 hours, limit 23 hours per patient per crisis episode.	No PA required, only approved facilities may bill, limited to 23 units (hours), **cannot be billed with S9485 for encounter**

S9485	Extended Psychiatric Emergency, per diem, limit 3 per patient per crisis episode.	No PA required, only approved facilities may bill, Limited to 3 units (days), **cannot be billed with S9484 for encounter**

Intensive Outpatient Programs (IOP) and Partial Hospitalization Programs (PHP)

IOP and PHP provide clinical, diagnostic and treatment services to those with psychiatric issues at a level of intensity similar to an inpatient or residential program but on a less than 24-hour basis. The multidisciplinary services may include;

- Therapeutic milieu;
- Diagnostic assessment;
- Service planning;
- Nursing services;
- Psychiatric evaluation;
- Occupational therapy (in PHP settings);
- Medication management;
- Group, individual and family therapy, and
- Peer support services.

Occupational therapy is a required component of PHP level of care for Medicaid reimbursement.

IOP and PHP may be appropriate when a patient does not require a restrictive 24-hour inpatientsetting but does need a higher intensity of treatment services than standard outpatient care can provide. IOP and PHP provide a time-limited service to more thoroughly stabilize acute symptoms. They can be used as a “step down” from inpatient care or a “step up” from standard outpatient treatment, operating as a stand-alone level of care to stabilize a deteriorating condition and prevent hospitalization.

Utilization Management

Intensive Outpatient (IOP)

Admission to an IOP from an outpatient setting requires documentation describing medical necessity and recent/current behavioral health history that outlines the escalation of need for more intensive services. IOP cannot be the initial episode of care for a behavioral health condition.*

Partial Hospitalization (PHP)

Admission to a PHP from an outpatient setting requires documentation describing medical necessity and recent/current behavioral health history that outlines the escalation of need for more intensive services. PHP services are delivered under physician direction. The physician must participate in diagnosis, treatment planning and admission or discharge decisions. PHP cannot be the initial episode of care for a behavioral health condition.*

**While most admissions to IOP or PHP will have a history of standard outpatient treatment, there are circumstances where a member may be triaged and assessed in an emergency department or clinic setting and found to be appropriate for admission. In those instances, a crisis assessment may be considered the initial episode of care.*

All admissions to an IOP or PHP, whether from the community or an inpatient hospital, require a physician's order to receive reimbursement.

Billing Guidance

IOPs and PHPs are reimbursed on a per diem basis using a bundled rate that includes the array of multidisciplinary services provided in either program. Procedure codes, service limits and rates for PHP and IOP are shown below.

Procedure Code	Service Definition	Service Requirements and Limitations
S9480 (IOP Revenue Code 905	Intensive outpatient psychiatric services, per diem	Prior Authorization is required. The following criteria must be met: • Nine to 19 hours of intervention per week for adults (ages 18+) • Six to 19 hours of intervention per week for children/youth (ages 6-17)
H0035 (PHP Revenue Code 913	Mental health partial hospitalization treatment, less than 24 hours	Prior Authorization is required. The following criteria must be met:

		Minimum of four hours per day, five days per week for children/youth (ages 6-17) and adults (ages 18+)

Program Documentation Requirement Providers are required to maintain program documentation on-site that includes a detailed program description, admission criteria, services provided, and typical treatment schedule.

- The program description must give an overview of the IOP and/or PHP service, which shall describe treatment approach, types of providers serving the program, and staff to patient ratio.
- Admission criteria must describe the referral information required when an admission is facilitated from an acute setting as well as from a standard outpatient setting. .
- A sample weekly treatment schedule must be included that outlines the average array of daily services for IOP and/or PHP. This may be in calendar format with the treatment schedule clearly denoted by service type and frequency (ex., group therapy, individual therapy, family group therapy, etc.)

SCDHHS reserves the right to request this program documentation at any time. Utilization Management

Prior authorization is required for both IOP and PHP services. Stays beyond 30 calendar days will require a review of medical necessity for authorization of continued services. For each prior authorization request, the physician's order must be submitted along with the appropriate clinical documentation for review. Further information on how to submit prior authorization requests is available from SCDHHS's quality improvement organization, Acentra Health (https://scdhhs.acentra.com/).

Physician Services

The physician component (services for direct patient care) for outpatient services must be billed separately on a Health Insurance Claim (CMS-1500) form. Payment is based on the Physician's Medicaid fee schedule. All hospital-based physician services not included in the outpatient fee schedule may be billed under the hospital-based physician or group number assigned to the hospital, except hospital-based neonatologists and anesthesiologists, who must bill under their individual provider numbers. Please refer to the Medicaid Physicians, Laboratories, and Other Medical Professionals Provider Manual for specific policy and billing requirements.

When a physician establishes an office within a hospital or other institution, reimbursement for services and supplies furnished in the office must be determined in accordance with the "incident to a physician's professional service" criteria as outlined by federal regulation.

A distinction must be made between the physician's office and the institution of which the physician is the administrator or owner. For services to be covered, the auxiliary medical personnel must be members of the office staff rather than the institution's staff, and the cost of supplies must represent an expense of the physician's office practice.

Nutritional Counseling

Nutritional counseling services are covered for full-benefit Medicaid members who have a diagnosis of obesity or eating disorder when there is a chronic, episodic or acute condition for which nutrition therapy is a critical component of medical management. These may include inappropriate growth, metabolic disorders, genetic conditions that affect growth and feeding, metabolic syndrome or acute burns.

Nutritional counseling services may be billed when rendered by physicians, physician assistants, nurse practitioners and registered dietitians. Services performed by dietitians must be prescribed or referred by a physician. Providers must refer and follow the nutritional counseling policy as described in the Physician Services provider manual.

Note: For Healthy Connections Medicaid members who receive Medicare benefits, SCDHHS will only pay secondary payments to Medicare.

All services must be rendered within the South Carolina Medicaid Service Area (SCMSA). SCMSA is defined as South Carolina and adjacent areas within 25 miles of its borders.

The following billing instructions apply to fee-for-service only. For instructions on submitting claims to MCOs, please refer to the provider contract with the appropriate MCO.

Dietary evaluation and counseling services are covered when delivered in a hospital outpatient clinic, however, hospitals will not be reimbursed separately for the physician or dietitian services on a UB-04 claim form. Hospitals may enroll dietitians with their professional clinics and bill for their dietitians' services on the CMS-1500 form. Please note that the appropriate revenue code for hospitals to bill for Obesity Services is 942 Other Therapeutic Services – Education and Training, which is not a covered service with SCDHHS. Therefore, it is imperative that hospitals link licensed dietitians to their professional clinic group for payment of services.

Professional Services

The following professional services may be rendered in an inpatient, outpatient or clinic setting. Guidelines for coverage and reimbursement can be found in the Medicaid Physicians, Laboratories

and Other Medical Professionals Provider Manual. Services rendered must be billed on a CMS-1500 claim form.

Hospital-Salaried/Hospital-Based Physician
A hospital-salaried or hospital-based physician is a physician licensed to practice medicine or osteopathy. This individual is employed by a hospital; payment for the physician's 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 a health professional who performs such tasks as are approved by the State Board of Medical Examiners in the State where he or she renders services in a dependent relationship with his or her supervising physician and under personal supervision as defined in the Direct Physician Supervision section of the Medicaid Physicians, Laboratories, and Other Medical Professionals Provider 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 in the Medicaid Physicians, Laboratories, and Other Medical Professionals Provider Manual.

Certified Registered Nurse Anesthetist/Anesthetist Assistant
A Certified Registered Nurse Anesthetist (CRNA) or Anesthetist Assistant (AA) must be licensed to practice as a rngistered Nurse and CRNA/AA in the state where he or she is rendering services. CRNAs may work independently or under the supervision of an anesthesiologist. AAs may only work under the supervision of an anesthesiologist. CRNA services rendered by a hospital-based CRNA may be billed under the hospital-based physician's number assigned to that hospital. However, each CRNA must be enrolled in the Medicaid program and his or her individual CRNA provider number must appear on the CMS-1500 claim form.

Certified Nurse Midwife
A Certified Nurse Midwife (CNM) is defined as an advanced practice registered nurse who holds a master's degree in the specialty area, maintains an American Midwifery Certification Board certificate, and is trained to provide management of women's health care from adolescence beyond menopause, focusing on gynecologic and family planning services, preconception care, pregnancy, childbirth, postpartum, care of the normal newborn during the first twenty-eight days of life, and the notification and treatment of partners for sexually transmitted infections. A CNM performing medical acts must do so pursuant to a practice agreement in compliance with Section 40-33-34 of the Nurse Practice Act. Reimbursement is 100% of the physician rate.

Nurse Practitioner/Clinical Nurse Specialist
A Nurse Practitioner (NP) is defined as a registered nurse who has completed an advanced formal education program at the master's level or doctoral level acceptable to the board, and who demonstrates advanced knowledge and skill in assessment and management of physical and psychosocial health, illness status of persons, families, and groups. Nurse practitioners who perform

medical acts must do so pursuant to a practice agreement in compliance with Section 40-33-34 of the Nurse Practice Act. Reimbursement is 80% of the physician rate.

Clinical Nurse Specialist
Clinical Nurse Specialist or "CNS" means an advanced practice registered nurse clinician with a high degree of knowledge, skill and competence in nursing. This nurse shall hold a master's degree in nursing, with an emphasis in clinical nursing. These nurses are directly available to the public through the provision of nursing care to clients and indirectly available through guidance and planning of care with other nursing personnel. A CNS who performs medical acts is required to have physician support and to practice pursuant to a practice agreement as defined in item (45). A CNS who does not perform medical acts is not required to have physician support or to practice pursuant to a practice agreement as provided in Section 40-33-34.

Supervision
For Medicaid professional billing purposes, direct supervision means that the teaching physician is accessible as defined in Subsection I, and the teaching physician is responsible for all services rendered, fees charged, and reimbursement received.

Teaching Physician Policy

When interns or residents provide service, the following definitions apply:

- **Resident:** A resident is either 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.

- **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 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 residence program director, involves residents and/or medical students in the care of his or her patients, or supervises residents in caring for patients.

Services provided by residents under the direct supervision of a teaching physician are billable to Medicaid. For Medicaid professional component billing purposes, direct supervision means that the teaching physician is accessible, as defined in Subsection I, when the services being billed are provided by the resident. 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.

Teaching Physician Accessibility

Accessibility of the teaching physician while the resident is providing services is defined as follows:

- **Ambulatory:** 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 as needed, review the records of the encounter and laboratory tests, confirm or revise the diagnoses, and determine the course of treatment.

- **Inpatient:** 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, the definition of accessibility requires that the teaching physician be on the premises and immediately available to provide services during the entire procedure.

  – **All Other Procedures:** Accessibility for supervision of all other procedures 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.

Documentation Requirements

Documentation for services must include a description of the presence and participation of the teaching physician. The resident may document the encounter by including a note describing the involvement of the teaching physician. The teaching physician's signature is then adequate to confirm agreement. Documentation of an encounter by the teaching physician may make reference to 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 that will be billed as a professional charge.

Note: A hospital may bill Medicaid a clinic visit (facility charge) for patients seen by a resident even though the encounter has not been signed by the teaching physician.

NON-COVERED SERVICES

Convenience Items

Items provided for the convenience or comfort of the patient at his or her request are non-covered. Non-covered charges include but are not limited to the difference between a private and semi-private room when requested by the patient and not medically necessary. Items routinely covered in room rates must be offered to Medicaid patients under the same conditions as non-Medicaid patients.

Incidental Procedures

Incidental procedures are performed at the same time as major surgery in anticipation of possible future problems. Examples include but are not limited to incidental appendectomies, incidental scar excisions, simple lysis of adhesions, puncture of ovarian cysts and simple repair of hiatal hernias. 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. Incidental procedures must not be included on the claim.

Cosmetic Procedures

Cosmetic surgery or expenses incurred in connection with such services are non-covered under Medicaid. Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt (i.e., as soon as medically feasible) repair of accidental injury or for the improvement of the functioning of a malformed body part. This does not apply to surgery for therapeutic purposes which coincidentally also serves some cosmetic purpose.

Repair of the following birth defects is not considered cosmetic surgery: cleft lip, cleft palate, webbed fingers and toes, congenital ptosis and other birth defects that impair bodily function.

Experimental/Investigational Procedures

Procedures that are experimental/investigational are non-covered. Procedures that are performed in only a few medical centers across the United States are considered part of this group. Exemptions are made for approved clinical trials. Refer to Administrative and Billing Manual for details about clinical trials.

Partial Hospitalization

Partial hospitalization rendered in an outpatient hospital setting is non-covered by Medicaid. Partial hospitalization is a comprehensive, structured program that uses a multidisciplinary team to provide comprehensive coordinated services within an individual treatment plan to individuals diagnosed with one or more psychiatric disorders.

Infertility Procedures

Any medications, tests, services or procedures performed for the diagnosis or treatment of infertility are non-covered. Codes related to hysterosalpingography are non-covered by Medicaid.

Hospital Acquired Conditions (HACs), Other Provider Preventable Conditions (OPPCs), and Never Events (NEs)

Medicaid is mandated to meet the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for Provider Preventable Conditions (PPCs).

PPCs are clearly defined into two separate categories: Healthcare Acquired Conditions and OPPCs or NEs.

Healthcare Acquired Conditions include HACs. OPPCs refer to OPPCs and NEs (surgery on a wrong body part, wrong surgery on a patient, surgery on a wrong patient, etc.).

No reduction in payment for a PPC will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

Reductions in provider payment(s) may be limited to the extent that the identified PPCs would otherwise result in an increase in payment(s).

Non-payment of PPCs shall not prevent access to services for Medicaid beneficiaries. The Medicaid participant shall not be billed for these events.

PPCs must meet the following criteria:

- The PPC must be reasonably preventable as determined by a root cause analysis or some other means.
- The PPC must be within the control of the provider.
- The PPC must be clearly and unambiguously the result of a preventable mistake made and provider procedures not followed, and not an event that could otherwise occur.
- The PPC must result in significant harm. The OPPCs for consideration will be limited to those that yield a serious adverse result. Serious adverse result is defined as one that results in death, a serious disability or a substantial increase in the duration and/or complexity of care that is well beyond the norm for treatment of the presenting condition. A serious disability is defined as a major loss of function that endures for more than 30 days, is not present at the time services were sought, and is not related to the presenting condition.
- Any process for identifying non-payable events must actively incorporate elements of case-by-case review and determination. While the source and cause of some adverse events may be clear, most would require further investigation and internal root cause analysis to determine the cause of the serious preventable event and to assign ultimate accountability.

Inpatient Acute Care Hospitals, Ambulatory Surgery Centers (ASCs), Physicians and Other Practitioners are held accountable for NEs while Inpatient Acute Care Hospitals are also held accountable for HACs and OPPCs.

The non-payment policy includes the following NEs and OPPCs:

NEs:

- Surgery on a wrong body part or site.
- Wrong surgery on a patient.
- Surgery on the wrong patient.

OPPCs:

- Post-operative death in normal healthy patient.
- Death/disability associated with use of contaminated drugs, devices or biologics.
- Death/disability associated with use of device other than as intended.
- Death/disability associated to medication error.
- Maternal death/disability with low-risk delivery.
- Death/disability associated with hypoglycemia.
- Death/disability associated with hyperbilirubinemia in neonates.
- Death/disability due to wrong oxygen or gas.

Providers can view the Appendix I HACs List on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs.html.

The All Patient Refined (APR)-DRG software will identify diagnoses that meet the definition of a HAC, OPPC or NE. The grouper software will then ignore the HAC, OPPC, or NE and assign a DRG as if it were not present. The proposed regulation also extends the non-payment policy to Medicaid contracts. Therefore, the Managed Care plans will not be required to pay for HACs, OPPCs and NEs.

As referenced earlier in the policy, no reduction in payment for a PPC will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider (Present on Admission).

5
UTILIZATION MANAGEMENT

PRIOR AUTHORIZATION

Quality Improvement Organization (QIO)

SCDHHS contracts for external utilization review services with a QIO. The QIO review consists of:

- Pre-surgical review for all hysterectomies.
- Select preauthorization review.
- Support documentation review.

All Medicaid hospital claims are subject to both prepayment and post-payment review by SCDHHS and/or the QIO. Payment will be denied or reduced if any of the following reasons were determined: procedures were not followed, services were not medically necessary, or the proper diagnosis and procedure codes were not indicated (resulting in improper DRG coding for inpatient claims or upcoding for outpatient claims). If the claim has been paid, action will be taken to recoup the payment.

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. Telephone or written approval is not a guarantee of Medicaid payment. All cases are subject to retrospective review to validate the medical record documentation.

Prior Authorization

SCDHHS contracts with a QIO, to perform pre-surgical review of select surgical procedures. Providers must submit all appropriate clinical information along with the Request for Prior Approval Review to the QIO.

Requests for prior authorizations from QIO may be submitted using one of the following methods:

QIO Customer Service: 1-855-326-5219
QIO Fax: 1-855-300-0082
For provider issues email: atrezzoissues@kepro.com.

Prior approval requests for beneficiaries enrolled in a MCO must be handled by the MCO. For a current list of participating MCOs with plan contact information, see the Managed Care Supplement.

Requesting providers are responsible for providing the PA number to any facility or medical provider who will submit a Medicaid claim related to the service.

A list of procedure codes requiring prior authorization from the QIO can be found on the provider portal.

Medically Complex Children Waiver (MCCW) Emergency Services

Authorization is not required for services provided in a hospital emergency department or for an admission to a hospital through the emergency department. However, the physician component for inpatient services does require authorization. The hospital must contact the Primary Care Provider (PCP) for authorization within 48 hours of the member's admission. Specialist referrals for follow-up care after discharge from a hospital also require PCP authorization.

Instructions for Obtaining Prior Authorization

The responsibility for obtaining pre-admission/pre-procedure review rests with either the attending physician or the hospital. The requesting provider must submit all necessary supporting documents including the Request for Prior Approval Review to QIO. A list of procedure codes requiring supporting documentation from the QIO can be found in Section 4-Procedure Codes of this manual.

The QIO reviewer will screen the medical information provided using the appropriate QIO or InterQual criteria for non-physician review.

If criteria are met, the procedure will be approved, and an authorization number assigned. The provider will be notified of the approval and authorization number. Enter this number in field 63 of the UB-04 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 the attending physician for additional supporting documentation.

The physician reviewer will document any additional information provided, as well as his or her decision regarding the medical necessity and appropriateness of the procedure.

Review personnel will assign an approval number (if the procedure is approved), and notification of the authorization number will be given to the physician's office.

If the physician reviewer cannot approve the procedure based on the additional information, he or she will document the reasons for the decision. The QIO review personnel will notify the attending physician's office of the denial.

Procedure for Reconsideration of Denial of Prior Approval

- The 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 a pre-procedure or post-procedure review. The request must be in writing to QIO.

- If a case is denied upon reconsideration, the determination is final and binding upon all parties (CFR 478.38).

Out-of-State Services

Services provided to Medicare/Medicaid beneficiaries in the SCMSA do not require prior approval from Medicaid. 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.

The South Carolina Medicaid program will compensate medical providers outside the SCMSA in the following situations:

- When a beneficiary traveling outside the SCMSA needs emergency medical services and the beneficiary's health would be endangered if care were postponed until his or her return to South Carolina. Emergency medical services are determined by the diagnosis codes listed on the claim, and medical review.

- Out-of-state referrals by physicians when needed services are not available within the SCMSA.

- All pregnancy-related services, including delivery.

Out-of-state hospital services are limited to true emergencies or those services for which prior approval from SCDHHS has been obtained. A true emergency is described as an accident or disease in which the health of the beneficiary would be endangered if care and services were postponed until return travel to South Carolina.

Out-of-State Referrals by Physicians When Needed Services Are Not Available Within the SCMSA

Except in emergency situations, approval must be requested prior to the out-of-state service. For out-of-state referrals, the South Carolina referring physician must contact Physician Services via the PSC at 1-888-289-0709, an online inquiry at http://www.scdhhs.gov/providers/contact-provider-

representative, or by fax at 803-255-8255 to obtain prior approval. Written requests must be submitted to:

SCDHHS
Division of Physician Services
Attn: Out-of-State Coordinator
Post Office Box 8206
Columbia, SC 29202-8206

The written request must include all of the following information:

- Beneficiary's name and Medicaid number.
- Date of service (State as "tentative" if unscheduled at the time of request).
- Diagnosis (past and current history if pertinent to show medical necessity).
- An explanation as to why the physician believes these services must be rendered out-of-state instead of within the SCMSA.
- Name, address, and telephone number of the out-of-state provider(s) who will render the medical services (for example, hospitals and physicians involved in the patient's medical treatment).
- Identification of any services that are considered experimental and/or investigational, sponsored under a research program, or performed in only a few medical centers across the United States.

Transportation may be provided to Medicaid patients who are referred out-of-State, as well as to the patient's escort, when necessary. Transportation and 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 to make the necessary travel arrangements. Once the out-of-state referral is approved, the provider must notify the beneficiary that if transportation is needed, the beneficiary may contact the SCDHHS transportation broker in his or her region.

Note: Medicaid will accept and review for medical necessity any out-of-State claims from medical providers who did not seek approval before filing the claim. However, experience has shown that these providers put themselves at an otherwise avoidable risk of non-payment or delayed payment.

Foster Children Residing Out of the SCMSA
The Department of Social Services (DSS) will be responsible for all Medicaid-eligible foster children when they reside out-of-state. The SCDHHS county case manager assigned to the case will 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 be contacted via the PSC at +1 888 289 0709 or by submitting an online inquiry at http://www.scdhhs.gov/providers/contact-provider-representative for two reasons:

- The coordinator must determine whether the medical services can be reimbursed through the Medicaid program or whether DSS will reimburse the medical provider.
- If Medicaid can reimburse for the services, proper enrollment and billing information needs to be sent to the medical providers involved.

Ancillary and Other Out-of-State Services

Other healthcare services are compensable under the South Carolina Medicaid Out-of-State Program. For specific out-of-state referrals, please contact the PSC or submit an online inquiry.

Prior Authorizations for Inpatient Admissions

All acute care hospital admissions, except deliveries and births, must be prior authorized by the QIO. Requests for emergency admissions must be made within five business days of the admission. The prior authorization request may be initiated by either the physician or the hospital. The prior authorization number, however, must be shared with all providers involved with the admission.

Hospital services occurring prior to a Medicaid member's Medicaid eligibility determination do not require prior approval. However, for the appropriate and timely claims processing of a claim in the case of retroactive eligibility, the provider must obtain an authorization number in support of determination of the medical necessity in accordance with the "Time Limit for Submitting Claims" section in the Provider Administrative and Billing manual. For members in the FFS Medicaid program, providers can contact QIO for authorization number requests and consideration for payment for services rendered to members with retroactive Medicaid eligibility. Patients with Medicare as primary payer is only required to obtain a prior authorization if Medicare does not make a payment, or the service is not covered by Medicare and Medicaid then becomes primary. Please note that MCOs will continue to authorize services according to their specific plans for enrolled beneficiaries (members).

Requests for prior authorizations from QIO may be submitted using one of the following methods.

QIO Customer Service: 1-855-326-5219
QIO Fax: 1-855-300-0082
For provider issues email: atrezzoissues@kepro.com

Prior Authorizations for Pediatric Inpatient Rehabilitation Services

For recipients under 21 years of age, pediatric inpatient rehabilitation services must be pre-authorized by the SCDHHS QIO for beneficiaries in the FFS program and by the beneficiary's MCO for the Managed Care Program.

Requests for prior authorizations from the QIO must include at minimum the following documentation:

- Required Preadmission Screening Tool
- Required Individualized overall plan of care.
- Documentation of reasonable expectation that at the time of admission to the pediatric inpatient rehabilitation unit, the patient's condition is such that the patient can reasonably be expected to actively participate in, and significantly benefit from, the intensive rehabilitation therapy program.

Requests for prior authorizations from the QIO may be submitted using one of the following methods:

QIO Customer Service: +1-855 326 5219
QIO Fax: 1-855-300-0082
For provider issues email: atrezzoissues@kepro.com

Providers must submit prior authorization requests at least 2 business days prior to the patient's discharge from their acute care to the Pediatric Inpatient Rehabilitation unit. The prior authorization must include an estimated length of stay. Providers must request an authorization extension when the length of stay is determined to be longer than initially anticipated.

For pediatric inpatient rehabilitation services for MCO members, providers must follow the MCO policy and procedures.

Outpatient Therapies

For recipients aged 21 and over, physical, occupational and speech therapy (PT/OT/ST) treatment services performed in an outpatient hospital setting must be pre-authorized by the QIO. 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.

InterQual criteria for outpatient rehabilitation will be used to support medical necessity. QIO authorizes therapy treatment for a specific length of time upon provider request. The provider must perform a concurrent review to re-evaluate the patient's condition and response to treatment. If additional therapy treatment is needed, the provider must submit documentation supporting medical necessity. Hospital providers are required to submit the revenue code and the applicable CPT procedure code as defined in the CPT reference guide for the specified therapy. For therapy procedures defined in 15-minute sessions, SCDHHS will define 15 minutes as one unit of service.

Patients with Medicare as primary payor are required to obtain a prior authorization only if Medicare does not make a payment or the service is not covered by Medicare and Medicaid then becomes primary. Please note that MCOs will continue to authorize services according to their specific plans for enrolled beneficiaries (members).

Requests for prior authorizations from QIO may be submitted using one of the following methods:

QIO Customer Service: 1-855-326-5219
QIO Fax: 1-855- 300-0082
For provider issues email: atrezzoissues@kepro.com

Back/Spinal Surgery and Other Back Procedures

Back/spinal surgery and other back procedures require prior authorization. The QIO is responsible for reviewing and approving prior authorization requests using InterQual criteria.

Services Not Related to the Terminal Illness

Services provided by hospitals for care not related to terminal illness must be pre-approved by the hospice provider. The hospital will contact the hospice provider for confirmation that the service does not relate to the terminal illness and a prior authorization number to be included on the provider's claim form. The prior authorization number on the hospice claim certifies that the services provided are not related to the terminal illness or are not included in the hospice plan of care. If the authorization number is not included on the claim form, it will be rejected and returned to the provider. Services that require prior authorization are:

- Hospital
- ER
- Pharmacy
- Mental Health
- Drug, Alcohol, and Substance Abuse Services
- Audiology
- Psychologist Services
- Speech Therapy
- Occupational Therapy
- Ambulatory Surgery Clinics
- Medical Rehabilitation Services

- School-Based Services
- Physical Therapy
- Private Duty Nursing
- Podiatry
- Health Clinics
- County Health Departments
- Home Health
- Home- and Community-Based Services
- DME

The authorization number must be entered in field 63 of the UB-04 form. Claims submitted by these service providers without the required hospice authorization will be rejected. If billing issues cannot be resolved with the hospice, contact PSC at +1 888 289 0709 or submit an online inquiry at http://www.scdhhs.gov/providers/contact-provider-representative for assistance.

6
REPORTING/DOCUMENTATION

OUTPATIENT MEDICAL RECORDS

When a patient is seen on repeat outpatient visits, the patient's record must show that the supervising physician is keeping abreast of the patient's progress and need for continuing care. If the patient's condition warrants more than one visit per month, the record must reflect a specific plan of care that justifies the need for these visits.

Outpatient medical records must also meet the standards outlined in the Provider Administrative and Billing Manual and in Medical Record and Documentation Requirements in this section.

7
SPECIAL COVERAGE

SPECIAL COVERAGE ISSUES

Administrative Days

SCDHHS sponsors administrative days for Medicaid-eligible patients (regardless of age) who no longer require acute hospital care but are in need of nursing home placement that is not available at that time. Medicaid sponsors administrative days in any South Carolina acute care hospital contracted within the South Carolina service area. The patient must meet either Medicaid intermediate or skilled level of care criteria.

Coverage for administrative days may begin with the day of discharge from acute care. It is not necessary to allow for patient grace days. Medicaid coverage terminates once a nursing home bed becomes available within the South Carolina service area. If the patient or family refuse to accept the bed, the patient is then responsible for charges incurred for any remaining days.

Dually eligible beneficiaries (Medicare/Medicaid) may be eligible for administrative days if they are below Medicare's skilled level of care or have exhausted their Medicare benefits. If the beneficiary is below Medicare's skilled level of care, the initial claim must include a copy of the hospital Issued Notice of Non-Coverage (HINN) letter. If the Medicare benefits are exhausted, a statement from a representative of the hospital indicating the date benefits were exhausted must accompany the initial bill. If available, Medicare LRD must be exhausted before administrative days can be approved.

Hospitals with swing beds may furnish administrative days only when all swing beds are occupied.

Level of Care Determination

LTL is responsible for assessing administrative days beneficiaries to determine if the beneficiary meets the intermediate or skilled Medicaid level of care criteria. A Long-Term Care Assessment Form (DHHS Form 1718) will be completed. Community Long Term Care (CLTC) will determine a level of care or tentative level of care. The tentative level of care is reserved for those beneficiaries who are expected to be admitted to a nursing facility within 14 days. Level of care determinations will be documented on either a Level of Care Certification Letter (DHHS Form 185) or Community Long Term Care Notification Form (DHHS Form 171). Either of these forms can be used when billing administrative days.

Once a certification letter is issued, CLTC will close the case. It will be the responsibility of the hospital staff to assure that the client continues to meet the level of care criteria. If the beneficiary goes from administrative days to acute care and back to administrative days within the same hospital stay, a new certification letter or notification form does not have to be completed.

Before an administrative day beneficiary transfers to a nursing home, the hospital discharge planner must contact CLTC and request the client's case be reopened. CLTC will reprocess the case to ensure that the client continues to meet the level of care criteria for Medicaid-sponsored nursing home care. A certification letter will be sent to the nursing home upon the client's discharge.

Note: Do not contact CLTC when a beneficiary enters a nursing home as Medicare-skilled. In these cases, certification letters do not apply and will not be issued. CLTC must be notified when a beneficiary is transferred to another hospital for administrative days coverage.

If the beneficiary has been discharged from the hospital and was seen by CLTC while in the hospital, administrative days can be billed using either the Notification Form (DHHS Form 171) issued with the tentative level of care or a Certification Letter (DHHS Form 185) which may have been issued based on the status of the beneficiary when seen by CLTC.

Retroactive Certification

In cases of retroactive Medicaid or where a dually eligible beneficiary has been denied or has exhausted Medicare benefits, the CLTC area office may complete a certification retroactive to the date of admission to the Administrative Days Program or the date Medicare benefits were exhausted. The Certification Letter (DHHS Form 185) will be issued based on current conditions. If the beneficiary does not appear to meet level of care criteria at present but appeared to meet level of care criteria for the date of request based on the medical records, CLTC will put an end date on the Certification Letter. Support documentation such as copies of the medical record or any correspondence from Medicare may be requested from the hospital to ensure the patient met the level of care criteria for the period for which Medicaid coverage is being requested.

If the beneficiary has been discharged from the hospital and was never seen by CLTC, the hospital must contact the Administrative Days Program representative. The hospital will be asked to send the beneficiary's discharge summary and provider's progress notes from the inpatient admission for review. SCDHHS staff will then determine if the beneficiary is eligible for administrative days.

Hospital-Issued Notification Letters

When the hospital determines that acute care is no longer necessary, the hospital must issue to the patient a Notification of Administrative Days letter. When a nursing home bed becomes available, issue the Notice of Termination of Administrative Days letter. The hospital has the option of giving a three-day grace period if the patient needs time to arrange for the transfer. The Notice of Termination of Administrative Days must be included in the patient's record and be available to SCDHHS if requested. The patient has the right to appeal the termination of administrative days.

Dually Eligible Beneficiaries

Dually eligible beneficiaries who fall below Medicare's skilled level of care or have exhausted their Medicare benefits may be eligible for administrative days. If the beneficiary is below Medicare's skilled level of care, the initial claim must include a copy of the HINN letter. If the Medicare benefits are exhausted, a statement from a representative of the hospital indicating the date benefits were

exhausted must accompany the initial bill. If available, Medicare LRD must be exhausted before administrative days can be approved. If Medicare grace days are provided, administrative days cannot be billed for these days.

Medical Record Requirements

A discharge summary must be completed when a patient is discharged from acute care. If during the administrative days period, the condition of the patient changes to acute, a new admission is warranted. However, an admitting history/physical and discharge summary must be completed for each acute care stay. Ifone medical record is used for both the acute and administrative days stay, an “interim type” discharge summary outlining the acute stay must be included in the patient’s file.

If the beneficiary goes from administrative days to acute care and back to administrative days within the same hospital stay, a new Certification Letter or Notification Form does not have to be completed. However, the beneficiary must meet the Medicaid skilled or intermediate level of care criteria for each administrative day’s period.

Billing Notes

When acute care is terminated, the hospital must administratively discharge the patient and bill Medicaid as usual. Administrative days shall not be billed in cases under QIO reconsideration until the final QIO determination has been issued.

It is recommended that administrative day’s claims be filed monthly. Bill revenue code 100 (all-inclusive fee) to reflect all charges applicable to administrative days. Reimbursement for administrative days is an all-inclusive per diem rate depending upon the level of care; it includes drugs and supplies. Administrative days may be billed as routine or ventilator-dependent. Ancillary services rendered to patients in administrative days may be billed under the hospital outpatient provider number and will be reimbursed according to the outpatient fee schedule.

The following documentation must be sent to SCDHHS with the initial claim for administrative days:

- LTL Level of Care Certification Letter (DHHS Form 185) or CLTC Notification Letter (DHHS Form 171).
- Notification of Administrative Days Coverage letter.
- A signed statement that a nursing home bed was not available.
- Medicare’s HINN (when appropriate).

Subsequent administrative days claims must be submitted with a dated statement indicating the unavailability of a nursing home bed on a monthly basis. Documentation to support a weekly nursing home bed search must be kept in the patient’s medical record or on another form.

All claims for administrative days must be submitted in hard copy to:

SCDHHS
Division of Hospital Services
Attn: Administrative Days Program Representative
Post Office Box 8206
Columbia, SC 29202-8206

Note: Administrative days claims are subject to all third-party regulations and will be rejected if the patient has skilled nursing coverage.

Administrative days claims must meet the Medicaid policy on time limits for submitting claims. Please refer to the Provider Administrative and Billing Manual for this information. An exception to this policy is retroactive eligibility.

For retroactive eligibility, administrative days claims must be received within six months of the beneficiary's eligibility determination. The claim must be one that can be processed without additional information from the provider or from another third party and must be error free. Claims must be submitted in hard copy form with a note attached explaining that the case involves retroactive eligibility.

You are encouraged to call your provider representative for assistance with problem claims to make certain you are reimbursed for all services within the time limit.

Physician Services

Physicians who are treating patients in administrative days can bill for services rendered using the same procedure codes that they use for their patients in nursing homes and rest-home facilities. Providers must reference the CPT guide for the applicable CPT codes.

The specific code used will depend on whether the patient is new or established and on the level of care given. Physician services must be billed on the CMS-1500 claim form using place of service 21.

One limited examination per 30 days is required for all administrative day patients. Visits must be medically necessary. Additional visits may be allowed if medical justification is submitted. Please refer to the Medicaid Physicians, Laboratories, and Other Medical Professionals Provider Manual for billing instructions.

SPECIAL COVERAGE GROUPS

Organ Transplants and Transplant-Related Services

South Carolina Medicaid covers medically necessary and non-investigational/experimental organ and tissue transplant and transplant-related services. SCDHHS will only support the referral of patients for an evaluation to 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 SCMSA (more than 25 miles from the South Carolina borders). For a complete list of CMS-approved

centers, visit the CMS website at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Transplant.html

Covered transplant services fall into two groups:

Group I: includes corneal and kidney transplants for which coverage is applicable in all medically necessary instances without restriction and without prior approval.

Group II: includes pancreas, bone marrow, heart, liver, liver with small bowels, and lung transplants when medically necessary and clinically acceptable. Coverage of these transplants is limited to facilities within the geographic boundaries of South Carolina and require prior approval. All authorization requests for pancreas, bone marrow, heart, liver, liver with small bowel and lung transplants will be evaluated utilizing uniform professional and administrative guidelines as to medical necessity.

The contracted Quality Improvement Organization (QIO) will be responsible for in-state or out of state evaluations and transplant requests, the determination of medical necessity and issuance of an authorization determination letter for the services of a member in the FFS program.

In addition to completing the Transplant Prior Authorization Request Form, the request from the provider must also include a letter from the attending physician with the following patient information:

- Description of the type of transplant needed.
- Current medical status.
- Course of treatment.
- The name of the center to which the patient is being referred.

Upon approval, QIO will issue an authorization number to the requesting provider with instructions for its use. The approval letter will serve as authorization for the following services:

- pre-transplant services (medically necessary services rendered in preparation for the transplant within 72 hours prior to the transplant event/surgery),
- the transplant event (surgery and services rendered through discharge),
- post-transplant services (medically necessary services from discharge up to 90 days from the date of discharge).

The transplant authorization number must be included on all claims submitted for reimbursement. The Transplant Prior Authorization Request Form can be found in the forms section of the Physicians Services Provider Manual webpage.

QIO 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.

Please note that the approval of a transplant evaluation does not guarantee the approval of the actual transplant.

Requests for prior authorizations from QIO may be submitted using one of the following methods:

QIO Customer Service: 1-855-326-5219
QIO Fax: 1-855-300-0082
For provider issues email: atrezzoissues@kepro.com

Once the authorization letter is received, the provider must notify the beneficiary that if transportation is needed, the beneficiary may contact the SCDHHS transportation broker in his or her region.

Hysterectomy

Medicaid requires pre-admission surgical justification for hysterectomies by QIO. Prior authorization must be obtained even if the surgery follows a delivery. Providers must use the Request for Surgical Justification for Hysterectomy Form and the Consent for Sterilization Form with each request. There is a 30-day wait period from the date the Consent for Sterilization Form is signed before the surgery is performed. InterQual criteria will be used for screening prior authorization requests. For urgent and emergent hysterectomy cases, the 30-day wait is not required, however the reason for the emergency must be provided by the physician. The claim will be reviewed retrospectively.

Requests for prior authorizations from QIO may be submitted using one of the following methods:

QIO Customer Service: 1-855-326-5219
QIO Fax: 1-855-300-0082
For provider issues email: atrezzoissues@kepro.com

A hysterectomy must be medically necessary and meet the following requirements:

- The beneficiary or her representative, if any, must be informed orally and in writing that the hysterectomy will render the beneficiary permanently incapable of reproducing.
- The beneficiary or her representative, if any, must sign and date the Consent for Sterilization Form, DHHS 687, prior to the hysterectomy.

The Consent for Sterilization Form is acceptable when signed after the surgery only if it clearly states that the patient was informed before the surgery that she would be rendered incapable of reproduction.

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 acknowledgment 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 available 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.

Retroactive Eligibility
Medicaid reimburses for a hysterectomy in cases of retroactive eligibility only if the physician certifies one of the following in writing:

- The individual was informed before the surgery that the hysterectomy would make her permanently incapable of reproducing.
- The individual was already sterile before the hysterectomy and the physician who performs the hysterectomy certifies in writing that the individual was sterile at the time of the hysterectomy. The certification must state the cause of sterility.
- The individual required a hysterectomy because of a life-threatening emergency and the physician who performed the hysterectomy certifies in writing that the hysterectomy was performed under a life-threatening situation in which the physician determined that prior acknowledgment was not possible. The certification must include a diagnosis and description of the nature of the emergency.

Elective Sterilization

For all elective sterilizations, SCDHHS requires the provider and beneficiary to complete a Consent for Sterilization Form located with the form information associated with this manual. The Consent for Sterilization Form (DHHS Form 687) has been designed to meet all federal requirements associated with elective sterilizations. The physician must submit a properly completed Consent Form with his or her claim so that all providers including clinics and hospitals may also be reimbursed.

Definitions as Described in the Code of Federal Regulation

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. All sections of the Consent for Sterilization Form must be completed when submitted with the claim for payment. Each Sterilization Claim and Consent Form is reviewed for compliance with federal regulations.

Requirements

For Medicaid to reimburse for an elective sterilization the following requirements must be met:

- The Consent for Sterilization 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 beneficiary cannot be institutionalized or mentally incompetent. If the physician questions the mental competency of the individual, he or she may contact the PSC at +1 888 289 0709 or submit an online inquiry at https://www.scdhhs.gov/providers/contact-provider-representative.

- The individual must voluntarily give consent, all questions must be answered and all topics in the Consent Form discussed. (A witness of the beneficiary'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 beneficiary after Parts I, II and III are completed.

- At least 30 days, but not more than 180 days, must pass 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

- Premature Delivery: The informed consent must have been signed at least 30 days prior to the expected date of delivery. In cases involving a cesarean 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 beneficiary. At least 72 hours must have elapsed since the informed consent was given. An explanation must accompany the Consent Form.

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 beneficiary to be sterilized is:
  - In labor or childbirth.
  - Seeking or obtaining an abortion.
- Under the influence of alcohol, controlled substances, or other substances which may affect the beneficiary's judgment.

Consent for Sterilization Form
If the Consent Form was correctly completed and meets all federal regulations, then the claim will be approved for payment. If the Consent Form does not meet the federal regulations, the claim will reject and a letter sent to the physician explaining the rejection.

If the Consent Form is not submitted attached to the claim, the claim will be rejected and a new claim will need to be filed complete with the Consent for Sterilization Form attached.

Listed below are explanations of each field 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.

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 fields: 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 as 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 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 Consent Form must be dated on the same date as the sterilization or after. The date is not a correctable error if the date is prior to the sterilization without detailed medical record documentation. In the license number field, put the rendering physician's Medicaid legacy Provider ID or NPI number. Either the group or individual Medicaid legacy 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

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 provided for any of the following criteria:

- Morbid Obesity (BMI of 35 or greater).
- Abdominal mesh that mechanically interferes 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.)

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 for the implantable device by utilizing the appropriate HCPCS code with the FP modifier (service provided as part of Family Planning program) appended, and the professional service will be reimbursed utilizing the appropriate CPT code must also, have the FP modifier appended. Hysterosalpingogram and Radiological Supervision and Interpretation must be billed as follow-up procedures 90 days after the sterilization. A Consent for Sterilization Form must be completed and submitted with the claim. Federal guidelines for sterilization procedures will remain a requirement which includes completing and submitting a Consent for Sterilization Form.

Sterilization Services:

- Tubal ligation following a vaginal delivery by a method except laparoscope.

- Tubal ligation following C-section or other intra-abdominal (tubal ligation as the minor procedure) surgery.
- Ligation, transection of fallopian tubes; abdominal or vaginal approach.
- Occlusion of fallopian tubes by device.
- Laparoscopic sterilization by fulguration or cauterization.
- Laparoscopic sterilization by occlusion by device.
- Vasectomy.

Provision of the services listed above must always be billed via hardcopy with a copy of the Consent for Sterilization form attached.

Non-Covered Services
Services beyond those outlined in this section that are required to manage or to treat medical conditions and/or diseases, whether such procedures are also related to Family Planning, are not covered under the Family Planning Program. 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 shall not be billed using an FP modifier (service provided as part of Family Planning program) or Family Planning diagnosis code. 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.
- Colposcopy and biopsy of cervix/vagina performed to identify and treat medical conditions
- 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.

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

Gender Transition

Services and procedures related to gender transition are not covered.

Abortions

Non-Elective Abortions

All non-elective abortions including spontaneous, missed, incomplete, septic, hydatidiform mole, etc., require only that the medical record show such a diagnosis. If unable to determine whether the patient was in the process of an abortion from the hospital records, SCDHHS will ask the hospital to obtain additional physician's office or clinic notes and/or ultrasound reports. Medical procedures necessary to care for a patient with ectopic pregnancy are not modified by this section and are compensable services.

Therapeutic Abortions

SCDHHS requires documentation for all claims submitted for therapeutic abortions. This includes claims for the attending physician, the anesthesiologist, the hospital, etc.

Pursuant to 42 CFR 441.203 and 441.206, 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 is required and 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. A blank Abortion Statement can be found with the Forms information associated with this manual.

Billing Notes for Abortions

When billing for any type of abortion, the principal procedure code must be the abortion. Vaginal delivery codes shall not be used to report an abortion procedure. The only exception to this rule is when the physician delivers the fetus, the gestation is questionable, and there is probability of survival. The medical record must contain documented evidence that the physician delivered the fetus.

- Non-elective abortion procedure codes must be used for spontaneous, incomplete, inevitable, missed, septic, hydatidiform mole, or other non-elective abortions with appropriate diagnosis code. Refer to Section 4 Covered Services and Definitions of this manual for non-elective abortion procedures.
- For dates of service on or before September 30, 2015, ICD-9-CM diagnosis codes for elective therapeutic abortions are located on the SCDHHS website on the webpage.
- For dates of services on or after October 1, 2015, elective therapeutic abortions must ONLY be billed with ICD-10-CM diagnosis O04 range and Z33.2.

- Refer to procedure code information on the provider portal for elective therapeutic abortion procedure codes.
- Legible medical records must be included with all abortions and must include admission history and physical, discharge summary, pathology report, operative report, physician progress notes, etc.
- For dates of service on or before September 30, 2015, ICD-9-CM diagnosis codes that do not require documentation are located on the SCDHHS website on the webpage.

For dates of service on or after October 1, 2015, the following ICD-10-CM diagnosis codes that do not require documentation:

ICD-10 CODE	DESCRIPTION
O01.0	CLASSICAL HYDATIDIFORM MOLE
O01.1	INCOMPLETE AND PARTIAL HYDATIDIFORM MOLE
O01.9	HYDATIDIFORM MOLE, UNSPECIFIED
O02.81	INAPPROPRIATE CHANGE IN QUANTITATIVE HUMAN CHORIONIC GONADOTROPIN (HCG) IN EARLY PREGNANCY
O02.0	BLIGHTED OVUM AND NONHYDATIDIFORM MOLE
O02.89	OTHER ABNORMAL PRODUCTS OF CONCEPTION
O02.9	ABNORMAL PRODUCT OF CONCEPTION, UNSPECIFIED
O02.1	MISSED ABORTION
O36.4XX0	MATERNAL CARE FOR INTRAUTERINE DEATH, NOT APPLICABLE OR UNSPECIFIED
O36.4XX1	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 1
O36.4XX2	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 2
O36.4XX3	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 3
O36.4XX4	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 4
O36.4XX5	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 5
O36.4XX9	MATERNAL CARE FOR INTRAUTERINE DEATH, OTHER FETUS
O42.00	PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR WITHIN 24 HOURS OF RUPTURE, UNSPECIFIED WEEKS OF GESTATION
O42.019	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR WITHIN 24 HOURS OF RUPTURE, UNSPECIFIED TRIMESTER
O42.90	PREMATURE RUPTURE OF MEMBRANES, UNSPECIFIED AS TO LENGTH OF TIME BETWEEN RUPTURE AND ONSET OF LABOR, UNSPECIFIED WEEKS OF GESTATION

ICD-10 CODE	DESCRIPTION
O42.919	PRETERM PREMATURE RUPTURE OF MEMBRANES, UNSPECIFIED AS TO LENGTH OF TIME BETWEEN RUPTURE AND ONSET OF LABOR, UNSPECIFIED TRIMESTER
O42.011	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR WITHIN 24 HOURS OF RUPTURE, FIRST TRIMESTER
O42.012	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR WITHIN 24 HOURS OF RUPTURE, SECOND TRIMESTER
O42.013	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR WITHIN 24 HOURS OF RUPTURE, THIRD TRIMESTER
O42.02	FULL-TERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR WITHIN 24 HOURS OF RUPTURE
O42.911	PRETERM PREMATURE RUPTURE OF MEMBRANES, UNSPECIFIED AS TO LENGTH OF TIME BETWEEN RUPTURE AND ONSET OF LABOR, FIRST TRIMESTER
O42.912	PRETERM PREMATURE RUPTURE OF MEMBRANES, UNSPECIFIED AS TO LENGTH OF TIME BETWEEN RUPTURE AND ONSET OF LABOR, SECOND TRIMESTER
O42.913	PRETERM PREMATURE RUPTURE OF MEMBRANES, UNSPECIFIED AS TO LENGTH OF TIME BETWEEN RUPTURE AND ONSET OF LABOR, THIRD TRIMESTER
O42.92	FULL-TERM PREMATURE RUPTURE OF MEMBRANES, UNSPECIFIED AS TO LENGTH OF TIME BETWEEN RUPTURE AND ONSET OF LABOR
O42.10	PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE, UNSPECIFIED WEEKS OF GESTATION
O42.111	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE, FIRST TRIMESTER
O42.112	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE, SECOND TRIMESTER
O42.113	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE, THIRD TRIMESTER
O42.119	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE, UNSPECIFIED TRIMESTER
O42.12	FULL-TERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE

Questions or difficulty with the processing of claims for abortion services may be directed to the PSC at +1 888 289 0709 or you may submit an online inquiry at http://www.scdhhs.gov/providers/contact-provider.

Reduction Mammaplasty

Reduction mammaplasty for large, pendulous breasts on a female may be considered medically necessary and not a cosmetic procedure when InterQual screening criteria is met. Prior authorization is required for all ages.

Adolescent Female Reduction Mammaplasty

Surgery must be delayed, when possible, to allow the ultimate contour and shape of the breast to develop and avoid the possible complications of deformity from scar tissue and continued growth developing after surgery.

Repeat Female Reduction Mammaplasty

Repeat female reduction mammaplasty may be considered when supporting documentation meets InterQual screening criteria.

Reconstructive Breast Surgery

Reimbursement is allowed for reconstructive breast surgery following a mastectomy when performed for the removal of cancer or for prompt repair of accidental injury.

Reimbursement is also allowed for the reconstruction of both breasts following a bilateral mastectomy when medical evidence supports the removal of both breasts because of the high incidence for the development of cancer in the unaffected breast.

Prior authorization must be obtained. The QIO is responsible for prior authorization 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 DME program for women who have undergone any type of mastectomy.

For a list of codes requiring Prior Authorization, see “Procedure Codes Requiring Prior Authorization” in Section 4 Covered Services and Definitions.

Gynecomastia

Although unilateral or bilateral mastectomy in a male is rarely indicated, this procedure may be allowed when medically necessary. The attending physician must obtain prior authorization. The South Carolina Medicaid Program Request for Prior Approval form and all necessary documentation must be submitted to the QIO. InterQual screening criteria applies.

Adolescent Male Gynecomastia

Surgery must be delayed, when possible, to allow the enlargement of the adolescent male mammary glands to regress.

Repeat Male Gynecomastia

Repeat male gynecomastia may be considered when supporting documentation meets InterQual screening criteria.

Obesity Covered Services

Bariatric Surgery

Bariatric surgery is a covered service for members who meet InterQual guidelines for medical necessity.

Prior authorization for bariatric surgery procedures is required from the QIO. InterQual screening criteria applies.

Panniculectomy

Panniculectomy is the surgical excision of the abdominal apron containing superficial fat in obese individuals. The panniculectomy procedure includes a lipectomy. Abdominoplasty is the excision of excessive skin and subcutaneous tissue. The abdominoplasty is considered an add-on procedure to the panniculectomy and includes a lipectomy.

The following conditions must be met for coverage by Medicaid:

- It is medically necessary for the individual to have such surgery.
- The surgery is performed to correct an illness that was caused by the pannus or aggravated by the pannus.

Prior authorization is required, and requests may be submitted to the QIO. InterQual screening criteria applies.

Obesity Non-Covered Services

Medicaid does not cover the following services:

- Supplemental fasting
- Intestinal bypass surgery
- Gastric balloon surgery

Positron Emission Tomography (PET) Scans

SCDHHS will reimburse for certain PET scans. PET scan reimbursement is limited to two per 12 months. PET scans will be covered only for the staging and restaging of cancer malignances. They must 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.

Dental Services

Adults

Beneficiaries over the age of 21 may be eligible for dental services when 1) they have a special healthcare needs diagnosis, or 2) services are delivered in preparation for or during treatment for one or more of the following conditions:

- Organ transplants
- Chemotherapy for cancer treatments
- Radiation of the head and/or neck for cancer treatments
- Total joint replacement
- Heart valve replacement
- Treatment of trauma-related injuries administered in a hospital or outpatient facility

Children Under Age 21

Comprehensive dental services for beneficiaries under 21 years of age are covered services. Emergency and non-emergency dental services may be provided in the hospital setting for patients who are physically or mentally handicapped, patients needing health maintenance supervision, or patients who for other reasons or conditions are unable to be treated in an office setting.

Outpatient hospital providers are not required to obtain prior authorization for dental services delivered in their facility. The prior authorization will be issued to the dental provider by the SCDHHS' Administrative Service Organization (ASO), DentaQuest. Outpatient hospital providers must submit their claims with a copy of the approved authorization issued to the dental provider.

For further information regarding dental services, please contact the PSC at +1 888 289 0709 or submit an online inquiry at http://www.scdhhs.gov/providers/contact-provider-representative.

End Stage Renal Disease (ESRD) and Dialysis

The following guidelines define policy and procedures as they relate to patient services and providers involved in end-stage renal disease treatments.

Medicare/Medicaid (Dually Eligible)

Medicare is the primary sponsor for ESRD services. Medicaid reimburses as primary sponsor for the initial 90-day waiting period required for Medicare coverage. If Medicare coverage is denied after the 90-day waiting period, notify PSC at +1 888 289 0709 or submit an online inquiry at http://www.scdhhs.gov/providers/contact-provider-representative.

Medicaid will not reimburse for ESRD services after the initial 90-day waiting period when a Medicare determination is still pending. 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.

Claims submitted to Medicaid prior to the patient being enrolled with Medicaid as an ESRD patient will be rejected. All ESRD Enrollment Medicaid Recipient Forms must be submitted to:

SCDHHS
Division of Hospital Services
Attn: ESRD Representative
Post Office Box 8206
Columbia, SC 29202-8206

Inpatient Dialysis
When an ESRD patient is hospitalized, the hospitalization may or may not be due to a renal-related condition. Medicaid sponsors all medically necessary services related to renal disease care according to the above guidelines regardless of the reason for admission.

Outpatient Dialysis
Medicaid will sponsor outpatient services related to end-stage renal disease treatment under the guidelines outlined above provided the patient is enrolled with Medicare and Medicaid as an ESRD patient and the hospital is certified as a hospital-based ESRD facility. The facility is responsible for ESRD enrollment of the patient with Medicare and Medicaid. See the ESRD Enrollment Medicaid Recipient, DHHS Form 218, located with the forms associated with this manual. The initial outpatient claim must indicate the date of the first dialysis treatment and certify that a Medicare application has been submitted.

Home Dialysis
Medicare is the primary sponsor for patients receiving home dialysis services and Medicaid, if available, is the secondary sponsor. The Social Security Administration does not require a 90-day delay for home services and Medicare will reimburse from the initial course of treatment.

If Medicare denies coverage for a patient on a program of home dialysis, Medicaid will sponsor treatment only if the hospital is certified for such procedures. Note that being certified for maintenance dialysis does not automatically certify the facility for home dialysis.

The hospital-based facility is responsible for the procurement, delivery, and maintenance of the equipment and supplies. The reimbursement rate includes all medically necessary services for home dialysis. Additional charges for home supplies or equipment are not covered and claims indicating such will be denied.

Kidney Transplants

Please refer to “Organ Transplants” in this section for additional information.

Hyperbaric Oxygen Therapy

Hyperbaric oxygen (HBO) therapy is a modality in which the entire body is exposed to oxygen under increased atmospheric pressure.

Covered Conditions

Reimbursement for HBO therapy is limited to that which is administered in a chamber (including the one-man unit) for the following conditions only:

- Acute carbon monoxide intoxication
- Decompression illness
- 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, when loss of function, limb or life is threatened.
- Acute peripheral arterial insufficiency.
- Preparation and preservation of compromised skin grafts.
- Chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management.
- Osteoradionecrosis as an adjunct to conventional treatment.
- Cyanide poisoning.
- Actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment.
- Soft tissue radionecrosis as an adjunct to conventional treatment.

Pain Management Services

The complaint of pain remains the single greatest reason for seeking medical attention. It is of the utmost importance that any medical provider seeks the source of the pain as well as work to relieve and resolve the pain. Patient history must be reviewed to ensure all areas of treatment have been explored. The primary objectives of pain management must be to:

- 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.

External Infusion Pumps
The condition of external infusion pumps is covered for the following conditions:

- 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.

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.

Non-Covered External Infusion Pumps
While a member is an inpatient in a hospital, external infusion pumps are non-covered for insulin in the treatment of diabetes mellitus.

Spinal Cord Neurostimulators
The implantation of spinal cord neurostimulators will be covered for the treatment of severe and chronic pain. InterQual screening criteria applies.

The implantation of the neurostimulator may be performed on an inpatient or outpatient basis according to medical necessity.

Implantable Infusion Pumps
The use of implantable infusion pumps is covered for the following conditions:

- 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 either of the following applies:
  - The disease is unresectable.
  - The patient refuses surgical excision of the tumor.
- Anti-Spasmodic Drugs for Severe Spasticity — 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 such as oral anti-spasmodic drugs, because either these methods fail to adequately control the spasticity or produce intolerable side effects.
  - Prior to pump implantation, the patient must have responded favorably to a trial intrathecal dose of the anti-spasmodic drug.
- 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, as determined by the following criteria:

- Medical documentation must reflect the coordination and treatment of the cause of pain.
- The patient's history must indicate that he or she would not respond adequately to non-invasive methods of pain control, such as systemic opioids (including attempts to eliminate physical and behavioral abnormalities that may cause an exaggerated reaction to pain).
- A preliminary trial of intraspinal opioid drug administration must be undertaken with a temporary catheter to monitor acceptable pain relief and an acceptable degree of side effects (including effects on the activities of daily living).

Determinations may be made on coverage of other uses for implantable infusion pumps if the provider can verify the following:

- The drug is reasonable and necessary for treatment of the individual patient.
- It is medically necessary that the drug be administered by an implantable infusion pump.
- The FDA-approved labeling for the pump must specify that the drug being administered and the purpose for its administration is an indicated use for the pump.

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 non-compensable as pain management or pain therapy services.

SPECIAL COVERAGE GROUPS

Family Planning Services

Family Planning services are defined as services that prevent or delay pregnancies and do not include abortion or abortion-related services. These services include pregnancy prevention services for males (vasectomies) or females of reproductive age (typically between the ages of 10–55 years).

Family Planning is a limited benefit program available to men and women who meet the appropriate federal poverty level percentage to be eligible. Family Planning provides coverage for physical examinations, Family Planning services, Family Planning-related services, and some preventative health screenings. Family Planning promotes the increased use of primary medical care; however, beneficiaries enrolled in this program only receive coverage for a limited set of services. Services provided to men and women enrolled in Family Planning that are not specifically outlined below are the sole responsibility of the beneficiary.

Examinations, Visits, Biennial Physical Examinations, Family Planning Counseling and screenings are not covered in the ASC, ESRD and Infusion Center Clinic Settings.

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, both Medicare and

Medicaid, patients must be filed to Medicare first. Some Family Planning services which are non-covered by Medicare are reimbursed by Medicaid.

For billing procedures, contact the PSC at +1 888 289 0709, submit an online inquiry, https://www.scdhhs.gov/providers/contact-provider-representative, or refer to the Physicians Services Provider Manual.

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 Medicaid providers. Family planning services are defined as services that prevent or delay pregnancies and do not include abortion or abortion-related services. They include Family Planning examinations, counseling services related to pregnancy prevention, contraceptives, Family Planning related laboratory services, etc., and sterilizations (including vasectomies) with a completed sterilization Consent Form. All Family Planning services must be billed using the appropriate CPT or HCPCS code with the FP modifier (service provided as part of Family Planning program) and/or appropriate Family Planning diagnosis code. Hospital claims for Family Planning services are not required to report the FP modifier.

Non-Covered Services

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

The following are also not considered Family Planning services:

- For dates of service on or before September 30, 2015, routine gynecological exams (diagnosis code V72.3) in which contraceptive management is not provided.
- For dates of service on or after October 1, 2015, routine gynecological exams (diagnosis codes Z01.411, Z01.419, and Z01.42) in which contraceptive management is not provided.
- Services normally rendered for pregnancy prevention that are rendered for other medical purposes (e.g., administering Depo-Provera for endometriosis).
- 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. Some examples of these include:
- Sterilization by hysterectomy.
- Abortions.
- Hospital charges incurred when a beneficiary enters the hospital for sterilization purposes, but then opts out of the procedure.
- Removal of an IUD due to a uterine or pelvic infection.

- Colposcopy and biopsy of cervix/vagina to identify and treat medical conditions.
- Diagnostic or screening mammograms.
- Medical complications requiring treatment (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.

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

Long-Acting Reversible Contraceptives (LARCs)
Any LARC billed to SCDHHS by a pharmacy will be shipped directly to the provider's office for insertion. Providers shall bill Medicaid only for reimbursement of the insertion of the device, and not the device itself, when it is obtained and billed through the pharmacy benefit.

Providers ordering LARCs through the pharmacy benefit must order them through the following specialty pharmacies:

- Paragard® — Direct +1 877 727 2427
- Mirena®/Skyla® — CVS +1 803 551 1030
- IMPLANON®/Nexplanon® — CVS +1 800 571 2767

The option for providers to purchase these devices directly and bill them via the traditional buy and bill mechanism will continue. All Family Planning services must be billed using the appropriate CPT or HCPCS code with an FP modifier (service provided as part of Family Planning program) and/or appropriate diagnosis code.
Note: Pregnancy testing (when the test result is negative) is a reimbursable Family Planning service in two situations:

1. The test is provided at the time Family Planning services are initiated for an individual.

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.

Covered LARCs:

- Kyleena® J7296
- Liletta® J7297
- Mirena® J7298
- ParaGuard® J7300
- Skyla® J7301
- IMPLANON® J7307

Sterilization

For policy, documentation and billing guidance related to sterilizations please refer to the Elective Sterilization within Section 7, Special Coverage Issues of this manual.

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 and psychosocial needs of the patient's family and caregiver.

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

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 hospice services:

- Nursing care provided by or under the supervision of a registered nurse.
- Medical social services provided by a social worker who has at least a bachelor's degree and is working under the direction of a physician.
- Physicians' services provided by the hospice medical director or physician member of the interdisciplinary group.
- Short-term inpatient care provided in either a participating hospice inpatient unit or a participating hospital or nursing home that additionally meets the special hospice standards regarding staffing and patient care.
- Medical appliances and supplies, including drugs and biologicals. Only those supplies used for the relief of pain and symptom control related to terminal illness are covered.
- Home health aide services and homemaker services.
- Physical therapy, occupational therapy and speech-language pathology services.
- Counseling services provided to the terminally ill individual and the family members or other persons caring for the individual at home.

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 that must be waived include:

- 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 services:
  - Provided (either directly or under arrangement) by the designated hospice.
  - Provided by another hospice under arrangements made by the designated hospice. Provided by the individual's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for the services.

8
BILLING GUIDANCE

OUTLIERS
A cost outlier occurs if a hospital's estimated costs exceed a specified amount above the DRG base payment; the MMIS will automatically calculate outliers.

Cost outlier thresholds are established using statewide data. Additional information regarding these calculations may be obtained by calling the Division of Acute Care Reimbursement at +1 803-898-1040.

DEPO-PROVERA
When revenue code 636 and J1050 are listed on an inpatient claim an add-on payment for Depo-Provera will be added to the DRG payment.

INPATIENT SERVICES
Payment Calculations for Inpatient Claims (DRG reimbursement types) can be found at:

(Payment Calculations for Inpatient Claims Reimbursement)

PEDIATRIC INPATIENT REHABILITATION SERVICES
Reimbursement for pediatric inpatient rehabilitation services will be an all-inclusive per diem rate, and will cover all facility charges, equipment, supplies, drugs, all necessary services and activities rendered during the patient stay. Qualified providers must file hospital claims indicating revenue code = 100 for pediatric inpatient rehabilitation services. Charges for the professional services of the physician or therapy providers are not included in the rate.

OUTPATIENT SERVICES
Medicaid outpatient hospital services are paid by a fee schedule. Outpatient services are divided into three major categories. The category and Reimbursement Types for outpatient services are as follows:

- Outpatient Surgical Services — Reimbursement Type 1
- Outpatient Non-Surgical Services — Reimbursement Type 5
- TTT Services — Reimbursement Type 4

The outpatient fee schedule is designed to reimburse for actual services rendered. Only one category of service, based on the highest classification billed, is paid per claim; however, each category can include an additional reimbursement for clinical lab services. Reimbursement is based

on the fee schedule rate, or the charges reflected on the claim, whichever is less. All outpatient services, except for clinical lab services, will be subject to an outpatient hospital multiplier.

The fee schedule can be found on the SCDHHS website.

Outpatient Surgical Services — Reimbursement Type 1

When an outpatient claim includes a covered CPT surgical procedure code, it will be paid as a Reimbursement Type 1. The total payment for Reimbursement Type 1 equals the rate assigned to the surgery and the established rate for clinical lab services when applicable. The surgery rate includes charges for non-clinical laboratory and radiology services, anesthesia, blood, drugs and supplies, nursing services, use of the operating room and recovery room, and all other services related to the surgery. Pre-surgical services performed prior to the actual day of outpatient surgery must be reflected on the same bill as the surgery and must not be submitted as a separate bill.

Multiple surgical procedures will be paid at the highest surgical rate. A list of surgical procedure codes and their rates can be found on the SCDHHS website. Surgeries covered by Medicaid that are not on this list will be assigned a rate by SCDHHS. Diagnostic and therapeutic procedures, non-surgical CPT codes, are not reimbursed as surgeries by Medicaid and will be paid at the next appropriate Reimbursement Type.

The following services may be paid as add-ons to Reimbursement Type 1 claims:

- Observation room
- Vitrasert® implant
- Depo-Provera®
- SYNAGIS®
- Kyleena®
- Liletta®
- Mirena®
- Paragard®
- Skyla®
- IMPLANON®/Nexplanon®
- Essure, permanent implantable contraceptive intra-tubal occlusion device(s) and delivery system (Essure)

  This add-on service requires a Consent for Sterilization form to be signed 30 days prior to the procedure.

Outpatient Non-Surgical Services — Reimbursement Type 5

An outpatient claim is classified as non-surgical, Reimbursement Type 5, when the claim shows an ER, clinic visit, or treatment room without an appropriate CPT surgical procedure code present. The total payment for Reimbursement Type 5 equals the all-inclusive rate and the established rate for clinical lab services when applicable. The rate includes all services performed during the day of the visit except for the allowed add-ons listed below and clinical lab services. This would include patients that are sent to multiple areas of the hospital for additional services. Reimbursement Type 5 with an ER service is paid as an all-inclusive fee determined by the level of the diagnosis, i.e., non-emergent, urgent, or emergent visit. ER claims with multiple diagnosis codes will be paid at the highest level. Reimbursement Type 5 with clinic services or a treatment room is paid an all-inclusive fee based on Level 1 (non-emergent) regardless of the diagnosis codes. A list of diagnosis codes by reimbursement level can be found on the SCDHHS website. Diagnosis codes covered by Medicaid that are not on the list will be assigned a payment level by SCDHHS.

Only one payment per day will be made for ER, clinic visit, and/or treatment room for the same or related diagnosis. Medical records may be requested to verify that the services were unrelated.

The following services may be paid as add-ons to Reimbursement Type 5 claims:

- Observation room
- Vitrasert® implant
- Depo-Provera®
- SYNAGIS®
- IMPLANON®
- Kyleena®
- Liletta®
- Mirena®
- Paragard®
- Skyla®
- Essure, permanent implantable contraceptive intra-tubal occlusion device(s) and delivery system (Essure)

This add-on service requires a Consent for Sterilization Form to be signed 30 days prior to the procedure.

Treatment/Therapy/Testing (TTT) Services — Reimbursement Type 4

An outpatient claim falls into the TTT category when it does not meet either of the previous two criteria. The total payment for Reimbursement Type 4 services equals the rate for the revenue code or CPT code as outlined in the outpatient fee schedule and the established rate for clinical lab services when applicable.

Payment for Reimbursement Type 4 services is based on the revenue code, or the procedure code as indicated on the fee schedule. A list of the CPT codes and the Medicaid reimbursement can be found on the SCDHHS website.

Revenue codes that do not require a CPT code may be reimbursed as an all-inclusive rate per unit of service or per date of service. Multiple revenue codes may be reimbursed per date of service. TTT services may be span billed for the same or related diagnosis.

The payment amounts for TTT services include all related non-physician services.

Pre-Admission Services (72-hour Rule)

Outpatient services rendered to a beneficiary within the three days prior to the date of the beneficiary's admission are deemed to be inpatient services and are included in the inpatient DRG. This provision applies when the outpatient services are related to the admission, i.e., they are furnished in connection with the principal diagnosis that necessitates the patient's admission as an inpatient. For example, if a patient is admitted on a Wednesday, services provided by the hospital on the previous Sunday, Monday and Tuesday are included in the inpatient DRG payment.

All outpatient services rendered on the day of an inpatient admission are included in the DRG payment regardless of diagnosis. Pre-admission services may not be billed separately as outpatient services.

Cancelled or Incomplete Surgery

When there are charges associated with surgery such as operating room, anesthesia, or recovery room and the surgery is incomplete or canceled, Medicaid can be billed.

Specimen Collection Fees

Specimen collection fees are not billable to Medicaid as a separate line item. Specimen collection fees are considered part of the specimen test.

Immunizations

Immunizations are compensable as part of Early and Periodic Screening, Diagnostic, and Treatment.

Organ Transplants and Transplant-related Services

Billing and Reimbursement Policy

Providers must enter the prior authorization number issued by QIO in the appropriate authorization field of all UB-04 and the CMS-1500 claim forms submitted for reimbursement. All general surgery guidelines apply when billing for organ transplants including keratoplasty. Reimbursement for transplants include technical services and professional services, which are billed separately from each other. For kidney transplants, if Medicare coverage is primary, 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.

Providers must follow the guidance below when billing for transplant and transplant-related services:

FFS Members

- Corneal transplants and related services
  Medically necessary corneal transplants delivered to FFS members will be reimbursed by SCDHHS. The reimbursement to the hospital includes all technical services, including donor testing and preparation. Professional services are compensable separately using the appropriate Code of Procedural Terminology (CPT) codes for Keratoplasty. The Ambulatory Surgery Centers (ASC) will be reimbursed for the transplant surgical procedure and the corneal tissue must be submitted with the appropriate HCPCS procedure code for 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.

- All other transplants and transplant-related services

  Only QIO-approved authorizations will be considered for reimbursement. Provider must file claims for FFS members to the South Carolina Healthy Connections Medicaid for all the approved transplants and transplant-related services which include:

  - pre-transplant services (medically necessary services rendered in preparation for the transplant within 72 hours prior to the transplant event/surgery)),
  - the transplant event (surgery and services rendered through discharge),
  - Medically necessary post-transplant services from discharge up to 90 days post discharge.

MCO Members

- All transplants and transplant-related services
  Medically necessary transplants delivered to a MCO member will be covered by the MCO plan. Providers must file the claims to the MCO following the MCO's billing guidance.

MEDICAID MANAGED CARE

MCO Program Billing Notes

- To avoid risk of non-payment for services, all hospital providers must check the beneficiary's eligibility to see if the beneficiary is enrolled in a Medicaid MCO. Services rendered to a beneficiary who is enrolled in a Medicaid MCO require the rendering provider to follow the prior approval and/or coordination of care as directed by the Medicaid MCO.
- Hospital providers must file claims for Medicaid MCO program members to the MCO. Claims must be filed in accordance with the Medicaid MCO's claim filing procedures. Claims submitted to SCDHHS for MCO program members will be rejected if services are within the MCO's scope of service.

- A beneficiary's program status on date of admission to the hospital will determine which program requirements the hospital will follow.

When reporting inpatient and outpatient data to the Office of Research and Statistics for Medicaid MCO program members, the payer carrier code (item 50A-C) must list the carrier code assigned to the MCO.

Managed Care Organization (MCO) Emergency Room Services

The MCO must make provisions for and advise all Medicaid MCO program members of the provisions governing, in- and out-of-service area use of emergency visits. The MCO is responsible for payment to providers and for determining whether an emergency exists for Medicaid MCO program members. The MCO must make prompt payment for covered emergency services that are furnished by providers that have no contractual arrangements with the MCO to provide such services.

For additional information on the MCO program, please call the Bureau of Managed Care at 803-898-4614.