SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

# PHYSICIANS SERVICES PROVIDER MANUAL

SEPTEMBER 1, 2025

South Carolina Department of Health and Human Services

# CONTENTS

# 1
# PROGRAM OVERVIEW

The State of South Carolina (South Carolina or State) Medicaid program recognizes professional medical services that are medically necessary unless limitations are noted within the Other Service Limitations section of this manual. Information in this manual includes South Carolina Medicaid policies for general medical care, such as office exams.

These services are predominantly billed to Medicaid by Primary Care Physicians (PCPs), such as family physicians, internists, general practitioners, obstetricians/gynecologists (OB/GYN), pediatricians, Nurse Practitioners (NPs) and Certified Nurse Midwives (CNMs). However, the guidelines are written for all providers rendering services to South Carolina citizens who are Medicaid beneficiaries.

**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

# 2
# ELIGIBLE PROVIDERS

## PROVIDER QUALIFICATIONS

### Physician

For Medicaid billing purposes, the term “physician” includes Doctor of Medicine and Doctor of Osteopathy currently licensed in the state in which they are rendering services by that state’s Board of Medical Examiners.

### Hospital-Based Physician

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

### Physician’s Assistant

A physician assistant (PA) may provide medically necessary covered services if the services provided are allowed by State Law and consistent with the agreement between the PA and the PA’s supervising physician. PAs providing services to Healthy Connections beneficiaries must be enrolled as South Carolina Medicaid providers.

Services rendered and billed under the PA’s individual National Provider Identifier (NPI) number are reimbursed at 80% of the current Medicaid Family and General Practitioners physician’s fee schedule for professional services.

### Nurse Practitioner

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, and 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.

### 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 act agreement in compliance with Section 40-33-34 of the Nurse Practice Act.

### Licensed Midwife

A Licensed Midwife is defined as a person who is not a medical or nursing professional licensed by the South Carolina Department of Public Health (SCDPH), for the purpose of providing specifically defined prenatal, delivery and postpartum services to low-risk women. Regulations can be found on the SCDPH website at R.61-24.pdf (sc.gov).

### Certified Registered Nurse Anesthetist (CRNA)

A CRNA must be licensed to practice as a registered nurse in the state in which he or she is rendering services and currently certified by the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists. A recent graduate is a new graduate of an advanced formal education program for nurse anesthetists accredited by the national accrediting organization who must achieve certification within one year of graduation. Upon obtaining certification, recent graduates must notify Provider Enrollment to continue practicing as a Medicaid provider. CRNAs may work under the medical direction of a surgeon or under the supervision of an anesthesiologist. CRNAs working under the medical direction of a surgeon or under the supervision of an anesthesiologist will be reimbursed at 50% of the physician rate. CRNAs not working under the direction of an anesthesiologist or supervised by a physician will be reimbursed 90% of the physician rate.

### Anesthesiologist Assistant (AA)

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

### Licensed Pharmacist

A licensed pharmacist is defined as an individual health care provider licensed by the South Carolina Board of Pharmacy to engage in the practice of pharmacy. A pharmacist is a learned professional authorized to provide patient care services within the scope of their knowledge and skills. A pharmacist providing services to Healthy Connections beneficiaries must be enrolled as a South Carolina Medicaid provider and have an individual National Provider Identifier (NPI) and shall be affiliated with the pharmacy that the services will be paid to. The service a pharmacist renders is limited to those that are allowed under State Law.

### Dietitian

A dietitian is defined as any individual meeting the licensure and educational requirements in South Carolina and/or the border states of Georgia and North Carolina. All services must be rendered within the South Carolina Medicaid Service Area (SCMSA). The SCMSA is defined as South Carolina and adjacent areas within 25 miles of its borders.

### Paramedical Professionals

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

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

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

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

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

- Licensed to practice as a registered nurse,

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

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

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

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

Services rendered and billed under the NP individual NPI number are reimbursed at 80% of the physician's fee schedule for Evaluation and Management (E&M) codes and all professional codes, and 100% for supplies and pathology services. Fee schedules are located on the South Carolina Department of Health and Human Services (SCDHHS) website at https://www.scdhhs.gov.

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

To request a CNP/CNS Enrollment Form, contact Provider Enrollment at (888) 289-0709.

### Optician

An optician fits and dispenses corrective lenses for the correction of a person's vision.

### Self-Employed Optometrist

A self-employed licensed provider who examines the eyes to evaluate health and visual abilities, diagnoses eye diseases and conditions of the eye and visual system and provides necessary treatment such as eyeglasses and contact lenses.

### Chiropractors

To qualify as a Medicaid provider for chiropractic services, an individual must be licensed by the South Carolina Board of Chiropractic Examiners as a Doctor of Chiropractic. In order to participate in the Medicaid Program, a chiropractor must enroll with Medicaid and receive a Medicaid ID number. Both individual chiropractors and chiropractic groups are eligible to enroll. For questions regarding enrollment, please contact Medicaid Provider Enrollment at +1 888 289 0709.

### Psychiatric and Counseling Services

Psychiatric and psychotherapy services must be prescribed by an individual listed below:

- Physician/Psychiatrist
- Psychiatric NP

SCDHHS will reimburse an eligible provider for covered psychiatric and psychotherapy services personally provided by the physician or NP or by an allied professional under the direct supervision of the physician/NP. Allied professionals rendering the service cannot be directly reimbursed under the Medicaid Physician Services program. All allied professionals must be under the direct supervision of the physician/NP to whom reimbursement is made. Covered services differ based on the provider providing the service.

Medicaid reimburses for medically necessary services delivered by the following allied professional under the supervision and direction of a physician or NP:

- LMSW — A master's or doctoral degree from a social work program accredited by the Council on Social Work Education and one year of experience working with the population to be served.

All allied professionals are responsible for providing services within their scope of practice as prescribed by South Carolina State Law. Interns are not eligible to provide services to Medicaid beneficiaries and their services are non-billable.

### Subsection I: Accessibility of the Teaching Physician

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

#### Ambulatory Services

Accessibility of the teaching physician for supervision of ambulatory services requires the teaching physician to be present in the clinic or office setting while the resident is treating patients. The physician is thus immediately available to review the patient's history, personally examine the

patient, if necessary, review the records of the encounter and laboratory tests, confirm or revise the diagnoses, and determine the course of treatment.

**Inpatient Services**

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

**Procedures**

Minor Procedures

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

All Other Procedures

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

## Special Coverage Groups

**Pediatric Anesthesia Services**

Board-eligible and/or board-certified Pediatric Intensivists are allowed to be reimbursed for a limited number of anesthesia Current Procedural Terminology (CPT) codes. Board-eligible and/or board-certified pediatric emergency medicine physicians may also be reimbursed for this service if they practice in a facility where a board-eligible and/or board-certified pediatric anesthesiologist and/or a board-eligible and/or board-certified pediatric intensivist is on staff. In addition, the pediatric intensivist or pediatric emergency medicine physician must have a current Pediatric Advanced Life Support (PALS) certification. Anesthesia services performed by a Pediatric Intensivist or Pediatric Emergency Medicine Physician must be filed with modifier G9 listed as the first modifier on the claim form.

**The Pediatric Sub-Specialist Program**

SCDHHS will reimburse an enhanced rate to certain pediatric sub-specialists that meet the enrollment requirements. Fee schedules are located on the SCDHHS website at http://www.scdhhs.gov.

**Pediatric Sub-Specialist Program Participation Requirements**

To be eligible for participation in this program, a provider must meet the following criteria:

- Practice within the SCMSA. The South Carolina service area is defined as within 25 miles of the State line.
- At least 85% of total practice, including after-hours patients, is dedicated to children age 18 years or younger.
- Practice in at least one of the following sub-specialties recognized by the American Board of Pediatrics available at https://www.abp.org/:
  - Adolescent Medicine
  - Allergy
  - Cardiology
  - Cardiothoracic Surgery
  - Child Abuse Pediatrics
  - Critical Care
  - Developmental — Behavioral
  - Emergency Medicine
  - Endocrinology
  - Gastroenterology/Nutrition
  - Genetics
  - Hematology/Oncology
  - Infectious Disease
  - Neonatology
  - Nephrology

  - Neurology
  - Neurological Surgery
  - Ophthalmology
  - Orthopedic Surgery
  - Otolaryngology
  - Psychiatry
  - Pulmonology
  - Radiology
  - Rheumatology
  - Surgery
  - Urology
  - Other pediatric subspecialty areas as may be determined by SCDHHS

- Complete and return a copy of the attestation statement found in the forms section of the Physician Services Provider Manual.

## PROVIDER ENROLLMENT AND LICENSING

### Clinics and Ancillary Services

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

These providers include physical therapists, occupational therapists, speech therapists and audiologists. Facilities and private therapists providing rehabilitative services must meet certain qualifications. Guidelines for these services are outlined in the Rehabilitative Therapy and Audiological Services Provider Manual available online at www.scdhhs.gov.

### EPSDT Provider

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

- Registered nurses working in county health department offices must meet the standards for performing EPSDT screenings established by SCDPH.
- Registered nurses who perform screenings in schools must have successfully completed the SCDHHS-approved Child Health Maintenance Course. A physician must be available for consultation, if necessary.
- Registered nurses in physicians' offices or clinics who assist in the performance of EPSDT screenings must do so under the direct supervision of a physician/NP who assumes responsibility for quality of care. They are encouraged to successfully complete the SCDPH course.
- Registered nurses in physicians' offices or clinics who assist in the performance of EPSDT screenings must do so under the direct supervision of a physician/NP who assumes responsibility for quality of care. They are encouraged to successfully complete the SCDPH course.

### Maternal Fetal Medicine Physician Ultrasound Override

Providers must register as a Maternal Fetal Medicine (MFM) specialist in order to receive an authorization number to bypass the limitation on antenatal ultrasounds. The provider's medical license must have the MFM specialty designation to be accepted.

To register as an MFM specialist, providers must send a written request by mail or fax to:

Medicaid Provider Enrollment
PO Box 8809
Columbia, SC 29202-8809
Fax: (803) 870-9022

Questions may be directed to the PSC at (800) 289-0709 or providers may submit an online inquiry at Contact a Provider Representative | SCDHHS.

### Hyperbaric Oxygen (HBO) Therapy Units

Hyperbaric units must be contracted with a hospital even if certified as a freestanding clinic by the Centers for Medicare and Medicaid Services (CMS). This contractual agreement with the hospital involves reimbursement for the technical portion of the therapy only.

### Independent Laboratories

Medicaid requires that all enrolled independent laboratories meet Clinical Laboratory Improvement Amendments (CLIA) regulations. CLIA is a regulatory program administered by CMS.

Information concerning CLIA regulations and participation may be obtained through South Carolina Department of Public Health (SCDPH Division of Certification) at 803-545-4540. For Medicaid enrollment information, call or write to:

Medicaid Provider Enrollment
PO Box 8809
Columbia, SC 29202-8809
(888) 289-0709

All independent laboratories must be certified by CMS to perform laboratory tests. CLIA certification must be on file with Medicaid Provider Enrollment. Procedures performed and/or charged when the lab is not certified to perform a particular test will be rejected. Medicaid will not reimburse for services performed prior to certification or prior to enrollment. Independent laboratories that have not enrolled in CLIA also cannot bill Medicaid beneficiaries directly for any services rendered.

### Clinical Laboratory Improvement Amendments (CLIA)

Just as Medicaid requires all enrolled independent laboratories meet CLIA regulations, in accordance with federal regulations (42CFR 493.1809), SCDHHS requires that in order to perform laboratory tests, all laboratory testing sites must have one of the following CLIA certifications:

- Certificate of Registration
- Certificate of Accreditation or Partial Accreditation
- Certificate of Compliance
- Certificate of Waiver

- Physician Performed Microscopy Procedures (PPMP) Certificate

In addition, each site must have an assigned unique 10-digit certification number. Information concerning CLIA regulations and participation guidelines may be obtained from SCDPH at (803) 545-4540 or by writing to:

SCDPH
Division of Certification
2100 Bull Street
Columbia, SC 29201-1708

### Independent Imaging Centers and Mobile Imaging Units

Freestanding imaging centers and mobile imaging units must be enrolled with SCDHHS in order to be reimbursed for services provided. Mobile imaging units must meet SCDPH certification. Freestanding imaging centers and mobile ultrasound units must be certified by Medicare.

For enrollment information, contact provider enrollment at (888) 289-0709 or visit the website at Contact a Provider Representative | SCDHHS

# 3
# COVERED SERVICES AND DEFINITIONS

## PRIMARY CARE SERVICES

These services are predominantly billed to Medicaid by Primary Care Providers (PCPs) such as family physicians, internists, general practitioners, OB/GYNs, pediatricians, certified nurse midwives and nurse practitioners. However, guidelines are written for all physicians rendering services to South Carolina citizens who are Medicaid beneficiaries.

SCDHHS will reimburse an enhanced rate to physician Primary Care Providers (PCP) who meet the enrollment requirements. Fee schedules are located on the SCDHHS website at http://www.scdhhs.gov.For additional information, providers may contact the Provider Service Center (PSC) at (888) 289-0709 or submit an online inquiry at Contact a Provider Representative | SCDHHS for more information.

## PHYSICIAN SERVICES

Physician services rendered either in the patient's home, a hospital, a skilled nursing facility (SNF), a physician's office, a clinic, or elsewhere are defined as those services provided by, or under the personal supervision of, an individual licensed under State Law to practice medicine or osteopathy in the state in which he or she is rendering services. When billing for services, the provider of service must be the same as the provider of service noted in the patient's medical record, unless working in an exceptional situation such as supervision, or Fee-For-Time Compensation Arrangements. Additionally, Medicaid providers must bill actual charges for their services rather than the anticipated reimbursement. Please refer to the Billing Guidance section of this manual for more detailed Medicaid billing instructions.

## OFFICE/OUTPATIENT EXAMS DEFINITIONS

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

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

- **Established Patient** — An established patient is one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years.

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

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

## AMBULATORY CARE VISIT GUIDELINES

Ambulatory care is defined as all outpatient (OP) examinations, to include paid claims for the following types of examinations:

- Encounters
- Psychiatric Diagnostic Exam
- Physician Examinations
- Consultations
- Healthy Adult Physicals
- Maternal care, including antepartum and postpartum care
- Family Planning visits (service provided as part of Family Planning Program) or family planning
- EPSDT screenings
- Minimal exams performed without a physician's direct involvement for ongoing therapies, blood pressure checks, injections, etc., if billed using the appropriate CPT code
- Emergency department services

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

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

## EVALUATION AND MANAGEMENT SERVICES

Please refer to the CPT when multiple E&M services are provided on the same date of service (DOS).

### Convenient Care Clinics

Effective with dates of services on or after August 1, 2012, the SCDHHS will now allow Convenient Care Clinics (CCC) to enroll as a provider group for billing purposes. CCCs are in retail stores, supermarkets and pharmacies and may treat uncomplicated minor illnesses and provide preventative healthcare services. They are often referred to as retail clinics, retail-based clinics or walk-in medical clinics.

Episodic Care for adults and children is defined as a pattern of medical and nursing care in which services are provided to a person for a particular problem, without an ongoing established relationship between the patient and health care professionals. Examples of Episodic Care include, but are not limited to, allergies, bronchitis, ear infections, flu-like symptoms, mononucleosis, motion sickness, blisters, minor burns, minor cuts, sprains and strains. Episodic Care (i.e., sick visits) is covered for all ages and subject to the CCC's internal policies governing initial age for treatment.

#### Covered Services

EPSDT for this provider type is limited to children five years and older. For additional program, billing, and reimbursement policy information, please refer to EPSDT Standards in this section.

### Immunizations

Vaccinations are covered as indicated under Immunization in this section.

### Diabetes Patient Education

Diabetes Management services are medically necessary, comprehensive self-management and counseling services provided by programs enrolled by SCDHHS. Enrolled programs must adhere to the National Standards for Diabetes Self-Management Education and be recognized by the

American Diabetes Association, American Association of Diabetes Educators, Indian Health Services or be managed by a Certified Diabetes Educator. An eligible beneficiary must have a diabetes diagnosis and be referred by their PCP. For details on this service, please refer to the Enhanced Services Manual. Contact the PSC for a list of recognized programs in your area or information on how to become a provider of diabetes education.

### Preventive Services

Preventive services are defined as any routine service exam for adults or children when the procedures are performed in the absence of an illness or complaint(s). A well visit and a sick visit may be billed on the same DOS. The South Carolina Medicaid program requires that a complaint or illness be recorded before a service is compensable.

### Preventive Screening

Providers must follow the United States Preventive Services Task Force (USPSTF) grade A and B recommendations available on the USPSTF's website at A and B Recommendations | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org) when providing preventive screenings to full benefit Healthy Connections Medicaid members.

For preventive screenings for Family Planning Limited benefit members, please refer to the Family Planning section of this manual.

### Immunizations

Providers must follow the Advisory Committee on Immunization Practices (ACIP) recommendations on vaccines for both children and adults available at ACIP Vaccine Recommendations | CDC, when administering vaccines to full benefit Healthy Connections Medicaid Members.

For immunizations for Family Planning Limited benefit members, please refer to the Family Planning section of this manual.

All vaccines and vaccine administration are covered without cost-sharing.
https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations

### Family Planning Services

Family planning services are defined as preconception services that prevent or delay pregnancies and do not include abortion or abortion-related services.

Family Planning is a limited benefit program available to men and women who meet the appropriate federal poverty level percentage in order to be eligible. This program provides coverage for physical examinations, Family Planning services, Family Planning-related services, and some preventive

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.

Family Planning services do not require a referral or prior authorization for beneficiaries in Medicaid's managed care programs. All services rendered to dually eligible (Medicare and Medicaid) patients must be filed to Medicare first. Family Planning services that are non-covered services by Medicare are reimbursed by Medicaid. Providers may contact the PSC at 888-289-0709 or submit an online inquiry at Contact a Provider Representative | SCDHHS for billing procedures.

**Covered Services**

Family Planning services may be prescribed and rendered by physicians, hospitals, clinics, pharmacies, or other Medicaid providers recognized by state and federal laws and enrolled as a Medicaid provider. Services include family planning examinations, counseling services related to pregnancy prevention, contraceptives, laboratory services related to family planning, etc., and sterilizations (including vasectomies) accompanied by a completed Sterilization Consent Form (DHHS Form 687, located in the forms section of the provider portal).

Long-Acting Reversible Contraceptives (LARC) are covered under both the pharmacy benefit and under the medical benefit using the traditional "buy and bill" method. Any LARC billed to Medicaid through the pharmacy benefit will be shipped directly to the provider's office for insertion. Providers must only bill Medicaid for the insertion of the device when it is purchased through the pharmacy.

All Family Planning services must be billed using the appropriate CPT or Healthcare Common Procedure Coding System (HCPCS) code with an FP modifier and/or an appropriate diagnosis code.

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

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

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.

**Examinations/Visits**

Four types of visits are covered for beneficiaries enrolled in the Family Planning Program. These visits include biennial (once every two years) physical examinations, annual family planning E&M visits, periodic family planning visits and contraceptive counseling visits.

### Initial Family Planning Visit

New patients are not required to have a physical examination during an initial Family Planning visit in order to receive hormonal contraceptives or other family planning procedures as prescribed. A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years. This visit must be billed using the appropriate level of CPT E&M codes with an FP modifier.

The initial visit is the first visit and requires the establishment of the medical record, an establishment of baseline laboratory data, contraceptive and sexually transmitted disease prevention counseling, medically necessary lab tests, and an issuance of supplies or prescriptions. The initial Family Planning Physical Assessment is an integral part of the initial Family Planning visit.

The following services, at a minimum, must be provided during the initial visit:

- Medical history.
- Reproductive life plan.
- Sexual health assessment.
- Height, blood pressure and weight check.
- Documentation of any treatment and/or counseling including administration and/or issuance of contraceptive supplies.
- Counseling and education, as necessary, regarding pregnancy prevention and/or sexually transmitted diseases.

The following services, at a minimum, must be provided during the initial visit:

- Breast exam, >20 years of age for females
- Cervical Cytology, ≥21 years of age for females

Genital exam, to include inspection of skin, hair and perianal region, as well as palpation of inguinal nodes, scrotum and penis for males.

### Biennial Physical Examination

The Family Planning Program sponsors adult physical examinations under the following guidelines:

- Examinations are allowed once every two years per beneficiary.
- The examinations are preventive visits.
- There are separate codes for initial patient visits and established patient visits.
- A FP modifier must be used when billing these codes for Family Planning beneficiaries.
- Diagnosis code Z00.00 or Z00.01 must be used when billing these codes for Family Planning beneficiaries.
- The examinations can be performed by a NP, PA or physician.

  The adult physical examination for Family Planning beneficiaries is a preventive, comprehensive visit and must contain the following components, at a minimum:

  - A past family, social, and surgical history for a new patient or an interval history for an established patient
  - Height, weight and body mass index (BMI)
  - Blood pressure
  - A generalized physical overview of the following organ systems:
    - Abdomen
    - Heart
    - Back
    - Lungs
    - Breasts (female)

- Pelvic (female)
- Brief muscular
- Peripheral vascular
- Brief neurological
- Prostate (male)
- Brief skeletal
- Rectal
- Head, Eye, Ear, Nose and Throat (HEENT)
- Skin
- External genitalia

– Age, gender and risk appropriate preventive health screenings, according to the United States Preventive Services Task Force (USPSTF) Recommendations (Grade A and B with the addition of Grade C prostate cancer screening recommendation).

For more information on these recommendations, please visit https://www.uspreventiveservicestaskforce.org/.

### Screenings

Family Planning covers a limited amount of prevention screening. Please refer to the USPSTF recommendations listed in the chart below.

| DESCRIPTION | APPROPRIATE FOR THE FOLLOWING FAMILY PLANNING BENEFICIARIES | ALLOWABLE CODES | REQUIRED MODIFIER | PROVIDER TYPE REQUIREMENTS | NOTES |
|---|---|---|---|---|---|
| Age and Risk-Appropriate Screenings for the Following:<br>Alcohol Misuse<br>BRCA Screening Questions<br>Depression<br>Intimate Partner Violence<br>Obesity<br>Tobacco Use<br>Low-Intensity Counseling for the Following:<br>Healthy Diet<br>Skin Cancer Prevention | All adults | 96150<br>96151<br>96152 | FP | NP, PA or Physician | Must occur during physical exam |
| Cholesterol Abnormalities Screening | Men aged 35+<br>Men aged 20-35 if at increased risk for coronary heart disease<br>Women ages 20+ if at increased risk for coronary heart disease | 80061<br>82465<br>83718 | FP | NP, PA or Physician | Must occur during physical exam |
| Pre-Diabetes and Type 2 Diabetes Screening | Adults aged 35 to 70 years who have overweight or obesity | 82947<br>82950<br>82951<br>83036 | FP | NP, PA or Physician | Must occur during physical exam |

| DESCRIPTION | APPROPRIATE FOR THE FOLLOWING FAMILY PLANNING BENEFICIARIES | ALLOWABLE CODES | REQUIRED MODIFIER | PROVIDER TYPE REQUIREMENTS | NOTES |
|---|---|---|---|---|---|
| Hepatitis C Virus Infection Screening | All adults at high risk for virus infection<br>One-time screening for all adults born between 1945-1965 | 86803<br>86804 | FP | NP, PA or Physician | Must occur during physical exam |
| Breast Cancer Screening (Mammography) | Women aged 40-74 | 77067<br>77066 | FP | Physician/Provider/Qualified Practitioner | Can occur outside physical exam |
| Abdominal Aortic Aneurysm Screening | Men aged 65-75 who have ever smoked | 76706 | FP | Physician Only | Can occur outside physical exam |
| Colorectal Cancer Screening | Men and Women ages 45-75 | 45331 45378<br>82270 82274<br>88305 G0105 | FP | Physician Only | Can occur outside physical exam |
| Colorectal Cancer screening using<br>Multi-targeted stool DNA (MT-sDNA) test Cologuard | Men and Women ages 45-75 | 81528 | FP | Physician Order Only | Can occur outside physical exam. Allowed every three years for asymptomatic, low-average risk members, |

| DESCRIPTION | APPROPRIATE FOR THE FOLLOWING FAMILY PLANNING BENEFICIARIES | ALLOWABLE CODES | REQUIRED MODIFIER | PROVIDER TYPE REQUIREMENTS | NOTES |
|---|---|---|---|---|---|
| Lung Cancer Screening for Smokers | Adults ages 50- 80 who have a 20-pack-year smoking history and currently smoke or have quit within the past 15 years | 71250 | FP | Physician Only | Can occur outside physical exam |
| Prostate Cancer Screening | Men aged 55-69 | G0102 G0103 84153 | FP | Physician Only | Can occur outside physical exam |

The following screenings have age, sex, and/or patient history limitations:

- Breast Cancer Screens (mammography) are covered for women ages 40 to 74 years with a recommended frequency of one screening every 2 years.
- Abdominal Aortic Aneurysm (AAA) screens are limited to men who have had a smoking history and are between the ages of 65 and 75 years.
- Colorectal Cancer screens are covered for both men and women who are between the ages of 45 and 75 years.
  - The mt-sDNA test (Cologuard) is recommended every three years for asymptomatic, low-average risk members, aged 45 to 75 years who:
    - Have not had any colorectal screening in the past, or
    - Have had a negative colonoscopy at least seven years prior.
  - The mt-sDNA test is not recommended for high-risk individuals who:
    - Have a personal history of colorectal cancer and adenomas.
    - Have had a positive result from another colorectal cancer screening at any time.
    - Have been diagnosed with a condition associated with high risk for colorectal cancer such as IBD, chronic ulcerative colitis, or Crohn's disease; or have a family history of colorectal cancer, or certain hereditary syndromes.
- Lung Cancer screens cover both men and women between the ages of 50 and 80 years and meet one or more of the following criteria:
  - Beneficiary is a current smoker
  - Beneficiary has a 20-pack per year history
  - Beneficiary quit smoking within 15 years
- Prostate Cancer screens are covered for men between the ages of 55 and 69 years.

Family Planning Counseling must be offered to Family Planning beneficiaries during the physical examination.

Portions of the physical may be omitted if not medically applicable to the beneficiary's condition or if the beneficiary is not cooperative and resists specific system examinations (despite encouragement by the physician, NP or office staff). A note must be written in the record explaining why part of the exam was omitted.

**Note:** If a medical condition and/or problem is identified during the physical examination and the provider is unable to offer free or affordable care based on the individual's income, the provider must refer the beneficiary to a provider who can offer services to uninsured individuals (examples include FQHCs, RHCs, free clinics, etc.). Please refer to "Referral Instructions for Family Planning" in this section for important information about billing for beneficiary referrals.

The following lab procedures are included in the reimbursement for the physical examination:

- Hemoccult
- Urinalysis
- Blood Sugar
- Hemoglobin

**Note:** College physicals, direct observed therapy (DOT) physicals, and administrative physicals are not covered.

### Annual Family Planning Evaluation/Management Visits

The Family Planning Program sponsors annual Family Planning Evaluation/Management visits. The annual visit is the re-evaluation of an established patient requiring an update to the medical record, interim history, physical examination, appropriate diagnostic laboratory tests and/or procedures, Family Planning Counseling, and adjustment of contraceptive management as indicated. This visit must be billed using the appropriate level of CPT E&M with an FP modifier.

The following services, at a minimum, must be provided during the annual visit:

- Medical history
- Sexual health assessment
- Weight
- Blood pressure check

- Symptom appraisal, as needed
- Documentation of any treatment and/or counseling including administration and/or issuance of contraceptive supplies
- Counseling and education, as necessary, regarding pregnancy prevention and/or sexually transmitted diseases
- Breast exam, annually if >19 years of age; then every three years if 20–39 years of age
- Cervical Cytology:
  - Every three years if ≥21 years of age
  - Every five years if ≥30 years of age
- Genital exam, to include inspection of skin, hair and perianal region, as well as palpation of inguinal nodes, scrotum and penis
- Laboratory tests
- Issuance of birth control supplies or prescription

### Periodic Revisit

The Family Planning Program sponsors periodic revisits for beneficiaries, as needed. The periodic revisit is a follow-up of an established patient with a new or an existing family planning condition. These visits are available for multiple reasons such as change in contraceptive method due to problems with that method (e.g., breakthrough bleeding or the need for additional guidance) or issuance of birth control supplies. This visit must be billed using the appropriate level of E&M with an FP modifier.

For E&M, the following services, at a minimum, must be provided during the revisit:

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

The following services, at a minimum, must be provided during the periodic visit:

- Symptom appraisal, as needed
- Laboratory tests
- Issuance of birth control supplies or prescription

### Family Planning Counseling Visits

The Family Planning Program provides Family Planning Counseling Visits for beneficiaries. The Family Planning Counseling/Education visit is a separate and distinct service (Preventative Medicine Counseling and/or Risk Factor Reduction Intervention) with an FP modifier. Family Planning Counseling/Education is a face-to-face interaction to enhance a beneficiary's comprehension of, or compliance with, his or her family planning method of choice. These services are for the expressed purpose of providing education/counseling above and beyond the routine contraceptive counseling that are included in the clinic/office visits.

**Note:** This service may not be billed on the same day as another visit.

**Covered Contraceptive Supplies and Services**

The Family Planning Program provides coverage for contraceptive supplies (for example, birth control pills or male condoms) and contraceptive services such as an injection, intrauterine device (IUD), Essure®, or sterilization. When billing for contraceptive services and supplies, all claims must bill using a relevant Family Planning diagnosis code.

**Long-Acting Reversible Contraceptives (LARCs)**

LARCs are covered under both the pharmacy benefit and under the medical benefit using the traditional "buy and bill" method. Any LARC billed to Medicaid through the pharmacy benefit will be shipped directly to the provider's office for insertion. Providers must only bill Medicaid for the insertion of the device when it is purchased through the pharmacy.

**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 Screenings and Testing

The Family Planning Program provides coverage for sexually transmitted infections (STI) screenings including syphilis, chlamydia, gonorrhea, herpes, candidiasis, trichomoniasis and HIV, when performed at the time of the physical examination, initial or annual family planning visits. All diagnostic tests will require the FP modifier to be appended to the CPT/HCPCS codes. All claims must contain a relevant Family Planning diagnosis code.

### Immunization

The Family Planning Program provides coverage for the Human Papillomavirus (HPV) 9-valent vaccine for members between the ages of 19- 45 years in alignment with the Centers for Disease Control and Prevention (CDC) adult immunization schedule and the Advisory Committee on Immunization Practices (ACIP) vaccine recommendations and guidelines, ACIP Vaccine Recommendations and Schedules | CDC as follows:

- Routine HPV vaccination is recommended for everyone through age 26 years if not adequately vaccinated when younger. HPV vaccination is given as a series of either two or three doses, depending on age at initial vaccination.

- HPV vaccination for adults aged 27-45 is based on recommendations for shared clinical decision-making, which is individually based and informed by a decision process between the health care provider and the patient. Clinicians may consider discussing HPV vaccination with members aged 27-45 who are most likely to benefit from it.

### Covered Medication

If, during a physical examination or annual family planning E&M visit, any of six specific STIs are identified, antibiotic treatment will be allowed under the Family Planning Program. The six STIs are syphilis, chlamydia, gonorrhea, herpes, candidiasis and trichomoniasis. STI testing and treatment are only covered during the beneficiaries' physical examination or annual family planning visit.

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

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

**Department of Public Health**

SCDPH provides outreach and direct FP services as part of the waiver and will assist women in finding a PCP or clinic to provide Family Planning services. Participants in the FP program can call

toll-free +1 855 472 3432 for more information about covered services and health department locations. Also, SCDPH contracts with private physicians who will offer FP services to participants.

**Tobacco Cessation**

Tobacco use is the leading cause of preventable disease and premature death in South Carolina. SCDHHS provides comprehensive coverage for tobacco cessation treatment through pharmacotherapy and counseling for all full-benefit Medicaid beneficiaries. SCDHHS also partners with SCDPH to communicate about programs available to assist Medicaid beneficiaries with quitting tobacco use.

Providers are encouraged to screen beneficiaries for tobacco use during medical encounters and document nicotine dependence using the appropriate diagnosis codes.

### Medication

SCDHHS covers prescriptions for the following tobacco cessation and nicotine replacement therapy (NRT) products:

- Bupropion sustained release (SR) products for tobacco use (Zyban)
- Varenicline (Chantix) tablets
- Nicotine gum
- Nicotine lozenge
- Nicotine nasal spray
- Nicotine inhaler
- Nicotine patch

Tobacco cessation products are exempt from prior authorizationrequirements. There is no limit to the number of quit attempts in a calendar year. The following medically appropriate combination therapies are also covered:

- Long-term nicotine patch + other NRT product (gum or spray)
- Nicotine patch + nicotine inhaler
- Nicotine patch + Bupropion SR

General edits on day supply are based on product dosing in manufacturer package inserts. Prescribers are encouraged to reference the AAFP Pharmacologic Product Guide for Food and Drug Administration (FDA)-approved medications for smoking cessation for more information on product guidelines.

As with all other pharmaceuticals, SCDHHS reimburses only rebated products (brand or generic) for fee-for-service (FFS) beneficiaries. A beneficiary must provide a prescription to receive any medication, including over-the-counter (OTC) products. A dual-eligible member can receive OTC products through Medicaid coverage, but the individual's Medicare Part D prescription drug plan must cover prescriptions for legend (non-OTC) tobacco cessation products.

For further questions about this benefit, prescribers may contact the pharmacy benefit administrator. For contact information refer to the Provider Administrative and Billing Manual.

### Counseling

Tobacco cessation counseling in individual and group settings is covered when billed with the appropriate code. Reimbursement for counseling is limited to four sessions per quit attempt for up to two quit attempts annually. Tobacco cessation counseling may be billed on the same day as an office visit using an appropriate modifier.

SCDHHS policy requires that all tobacco cessation treatment must be ordered by a qualified practitioner defined as a physician, NP, CNM or PA. Medical documentation including time spent counseling the patient, treatment plan, and pharmacotherapy records must be maintained in the patient record.

### South Carolina Tobacco Quitline

One-on-one telephone counseling with web-based support are available to all South Carolinians without charge through the South Carolina Tobacco Quitline. Participants in the Quitline program are connected with a personal Quit Coach, who helps the participant develop a quit plan and uses cognitive behavioral coaching and motivational interviewing techniques to support the quit process. This evidence-based program has been clinically proven to help participants quit tobacco use, and tailored programs are available for Hispanic, Native American, pregnant and youth callers, and smokeless tobacco users, as well as participants who have chronic medical and mental health conditions.

SCDHHS strongly encourages prescribers and pharmacists to refer patients to the South Carolina Tobacco Quitline at 1-800-QUIT- NOW (1-800-784-8669). Services are available 24 hours a day, seven days a week. Additional information is available at https://www.dph.sc.gov/health-wellness/tobacco-prevention-control/tobacco-cessation.

## Telehealth Overview

The Centers for Medicare and Medicaid Services (CMS) defines telehealth as the use of electronic information and telecommunications technologies to extend care when a provider and a patient are not in the same place at the same time.

Services rendered via telehealth may be rendered synchronously or asynchronously using a telecommunication system (audio/video) that permits interactive communications between a provider and a patient. The telecommunication system must be Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant. SCDHHS only reimburses for services conducted synchronously, using both audio and video components unless otherwise specified.

Services rendered via telehealth are not an addition to Medicaid-covered services but a mode of delivery for certain covered services. Quality of health care must be maintained regardless of the mode of delivery.

## Telehealth Definitions:

*Asynchronous telehealth,* sometimes referred to as “store and forward” services, allows providers and patients to share clinical information without real-time, audio-video communication. Asynchronous telehealth is only reimbursable when used for interprofessional consultations.

*Synchronous telehealth* is real-time, audio-video communication that connects physicians and patients in different locations (referring site and consulting site).

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

The *consulting provider* is the provider who evaluates the beneficiary via telehealth upon the recommendation of the referring provider.

**Eligible Providers**

Providers who meet the Medicaid credentialing requirements and are currently enrolled with the South Carolina Medicaid program are eligible to bill for covered Medicaid services via telehealth in accordance with SCDHHS coverage policies and the provider’s scope of practice. Both the referring and the consulting providers must be enrolled in the South Carolina Medicaid program.

### Referring Sites

A referring site (also called the patient site) is the location of an eligible Medicaid beneficiary at the time of the telehealth session. Medicaid beneficiaries are eligible for services via telehealth only if they are presented from a referring site located in the SCMSA. Referring site presenters may be required to facilitate the delivery of this service. Referring site presenters must be a knowledgeable person on how the equipment works and able to provide clinical support if needed during a session.

Covered referring sites are:

- The office of a qualified practitioner defined as a physician, NP, CNM, PA, or LIP
- Hospital (inpatient and OP)
- RHCs
- FQHCs
- Community Mental Health Centers
- Public Schools
- Act 301 Behavioral Health Centers
- Patient home

### Consulting Sites

A consultant site (also called the distant site) is the site at which the provider is located at the time of the telehealth session. The provider performing the medical care must be enrolled in the South Carolina Medicaid program and provide services in accordance with the licensing board and their scope of practice.

Practitioners at the distant site qualified to furnish telehealth services are:

- Physicians
- NPs
- PAs
- Licensed Independent Practitioners (and associates)

- Physical, occupational, and speech therapists

### Covered Services

Services that are eligible for reimbursement include consultation, office visits, individual psychotherapy, pharmacologic management, and psychiatric diagnostic interview examinations and testing, delivered via a telecommunication system. Audio-only (telephonic) care is available for established patients only. A licensed physician, NP, PA, licensed psychologist, licensed professional counselor, licensed independent social worker, and licensed marriage and family counselor may provide telepsychiatry services.

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

Healthy Connections Medicaid allows the service to be delivered via telehealth when the service meets the following criteria:

- The beneficiary must be present and participating in the telehealth visit unless otherwise specified in the procedure code description.
- The referring provider must provide pertinent medical information and/or records to the consulting provider via a secure transmission.
- Interactive audio and video telecommunication must be used, permitting encrypted communication between the distant site physician or practitioner and the Medicaid beneficiary. The telecommunication service must be secure and adequate to protect the confidentiality and integrity of the telehealth information transmitted.
- The telehealth equipment and transmission speed and image resolution must be technically sufficient to support the service billed. Any staff involved in the telehealth visit must be trained in the use of the telehealth equipment and competent in its operation.
- A trained healthcare professional at the referring site (patient site presenter) is required to present the beneficiary to the provider at the consulting site and remain available as clinically appropriate (this condition is waived when the referring site is the patient home).
- If the beneficiary is a minor (under 18 years old), a parent and/or guardian must present the minor for telehealth service unless otherwise exempted by State or Federal law. The parent and/or guardian need not attend the telehealth session unless attendance is therapeutically appropriate.

- The beneficiary retains the right to withdraw from the telehealth visit at any time.
- All telehealth activities must comply with the requirements of HIPAA: Standards for Privacy of individually identifiable health information and all other applicable State and Federal Laws and regulations.
- The beneficiary has access to all transmitted medical information, except for live interactive video, as there is often no stored data in such encounters.
- The provider at the distant site must obtain prior approval for service when services require prior approval, based on service type or diagnosis.
- The medical care is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's need.
- The medical care can be safely furnished.
- No equally effective, more conservative, or less costly treatment is available statewide.

**Unusual Travel**

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

### Unlisted Services or Procedures

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

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

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

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

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

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

Following are examples of P/RSPCE:

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

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

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

### Missed Appointments

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

**Home Health Services — Physician Requirements**
Home health services are provided only by home health agencies that are certified by SCDPH and have contracted with SCDHHS. Coverage is dependent upon a physician's orders and payable only to a contracted home health agency.

**Plan of Care**
Covered home health services must be ordered by the beneficiary's attending physician or qualified healthcare practitioner, as part of a written plan of care, practicing within the scope of their license and in compliance with state laws, rules and regulations. The plan of care must specify the treatment, services, items or personnel needed by the patient and the expected outcome. The care must be appropriate to the home setting and to the patient's needs. For additional information, providers may contact the PSC at 888-289-0709 or submit an online inquiry at Contact a Provider Representative | SCDHHS.

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

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

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

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

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

The attending physician must submit signed and dated certification by the 60$^{th}$ day of the patient's stay at the SNF in order for the patient to remain certified.

**Injections**

### Coverage Guidelines

Injectable drugs are covered if the following criteria are met:

- They are of the type that cannot be self-administered. The usual method of administration and the form of the drug given to the patient are two factors in determining whether a drug should be considered self-administered. If a form of the drug given to the patient is usually self-injected (e.g., insulin), the drug is excluded from coverage unless administered to the patient in an emergency (e.g., diabetic coma).

- The medical record must substantiate medical necessity. When acceptable oral and parenteral preparations exist for necessary treatment, the oral preparation must be the route of administration. If parenteral administration is necessary, the record must document the reason for choosing this route.

- Use of a drug or biological must be safe and effective, and otherwise reasonable and necessary. Drugs or biologicals approved for marketing by the FDA are considered safe and effective for purposes of this requirement when used for indications specified on the labeling. Occasionally, FDA-approved drugs are used for indications other than those specified on the labeling. Provided the FDA has not specified such use as non-approved, coverage is determined considering the generally accepted medical practice in the community.

- Drugs and biologicals that have not received final marketing approval by the FDA are not covered unless CMS advises otherwise.

- The injection must be furnished and administered by a physician, or by auxiliary personnel employed by the physician and under his or her personal supervision.

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

### Orphan Drugs

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

**Unlisted Injections**

If an injection is not listed, the appropriate J code must be used. A description of the drug, the National Drug Code (NDC) number, and the dosage, along with the office record, flow record (if

possible), and an invoice indicating the cost of the drug, must all be attached to the claim to be considered for payment. Claims containing this code without the required documentation will be rejected. Additional documentation may be required if the unlisted injection is being submitted for reimbursement for the first time. When a claim is rejected, providers must submit a new claim and attach the required documentation for medical review.

When billing multiple unlisted injection codes on the same claim, the documentation must identify the specific unlisted code that is to be considered for reimbursement.

The appropriate procedure code is billed per injection for administration.

**Botox®, Dysport®, Myobloc®, and Xeomin®**

Botox®, Injection, OnabotulinumtoxinA

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

- Dysport®
- Dysport® is FDA-approved for cervical dystonia in adults
- Myobloc® injection, rimabotulinumtoxinb
- Myobloc® is FDA-approved for cervical dystonia in adults
- Xeomin® injection, incobotulinumtoxina
- Xeomin® is FDA-approved for cervical dystonia in adults and for blepharospasm in adults previously treated with onabotulinumtoxinA (Botox®)

The botulinum toxin products listed on the left share certain properties and some FDA-approved indications. However, these agents are not identical. They have differing therapeutic and adverse even profiles. Botulinum toxin products are not directly interchangeable with one another.

SCDHHS requires support documentation to be submitted with claims filed for Botox®, Dysport®, Xeomin® or Myobloc®. Medicaid will pay claims for Botox®, Dysport®, Xeomin® or Myobloc® only

when administered for FDA-approved indications. Therefore, medical records submitted with the claim must:

- Include the beneficiary's age
- Clearly delineate the symptom or circumstance that necessitates the administration of Botox®, Dysport®, Xeomin® or Myobloc®

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

All Botulinum toxin products must be preauthorized Prime Therapeutics Management LLC except for those being administered to patients who are dually eligible for Medicare and Medicaid (please refer to Utilization Review Services in this section for more information) Prime Therapeutics Management LLC will pre-authorize all Botulinum Toxin — Type A for Botox® and Type B (Myobloc®) when administered for FDA-approved indications.

### Xolair® (Omalizumab)

Xolair® is FDA-approved for patients 12 years of age or older under some circumstances (see below for more detail). Physician CMS-1500 claims must be billed using the appropriate HCPCS J code and must include the prior authorization number. Claims submitted without prior authorization number will be rejected. Providers must submit prior authorization requests to Prime Therapeutics Management LLC at r by calling (866) 254-1669

SCDHHS requires prior approval for Xolair® (Omalizumab), 150 mg powder/vial. Prior authorization requests must be telephoned or faxed, toll-free, to the pharmacy benefit administrator. For contact information, refer to the Provider Administrative and Billing Manual.

Authorizations will be based on the following criteria:

**FDA-Labeled Indications:**

- Approved for treatment of patients 12 years of age or older with moderate persistent or severe persistent asthma for at least one year, who have had positive skin test or in vitro reactivity to a perennial aeroallergen and whose symptoms are inadequately controlled with inhaled corticosteroids.
- Symptoms not adequately controlled with the following three treatments:
  - Patient must have tried or have a contraindication to inhaled corticosteroids.

- Patient must have tried or have a contraindication to long-acting Beta 2 agonists (Reference: National Heart, Lung, and Blood Institute (NHLBI) guidelines).
- Patient must have tried or have a contraindication to a leukotriene receptor antagonist.

**Length of Prior Authorization:**

- 6 months
- Provider must verify clinical improvement at each subsequent renewal, if approved.

**The Physician Requesting the Prior Approval Must be one of the following:**

- Allergist/Immunologist
- Pulmonologist

**Required Labs:**

- History of positive skin test or radioallergosorbent (RAST) test to a perennial aeroallergen.
- Pretreatment serum lgE level must be 30 to 700 IU/ml.
- Weight and height

**Preventive Care Services**

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

### Cancer Screening Services

Please refer to the current edition of the ICD-10 for the most appropriate diagnosis code. If a more appropriate code is not available, use diagnosis code Z00.8.

| SERVICE | PROCEDURE CODE | FREQUENCY LIMITATIONS | COMMENTS |
|---|---|---|---|
| Mammography | 77067 | Baseline (ages 35-39*).<br>1 per 2 years (ages 40-74). | Must be referred by a qualified licensed provider |

| SERVICE | PROCEDURE CODE | FREQUENCY LIMITATIONS | COMMENTS |
|---|---|---|---|
| Hemoccult Test | One of the following:<br>82270, 82271<br>or 82272 | • 1 per year age 50 and up for low-risk individuals (no risk factors known).<br>• Age 40 and up for high-risk individuals with personal history of polyps, ulcerative colitis, or colorectal cancer; family history of breast or gynecological cancer | The hemoccult code includes both the collection of the stool and interpretation of the test. |
| Sigmoidoscopy | G0104 | • 1 per 5 years age 50 and up for low-risk individuals (no risk factors known).<br>• Age 40 and up for high-risk individuals with personal history of polyps, ulcerative colitis, or colorectal cancer; family history of breast or gynecological cancer | Must be referred/order by a qualified licensed provider |
| Screening Colonoscopy | G0121<br>G0105 | • 1 per 10 years age 50 and up for low-risk individuals (no risk factors known).<br>• Age 40 and up for high-risk individuals with personal history of polyps, ulcerative colitis, or colorectal cancer; family history of breast or gynecological cancer | Must be referred/order by a qualified licensed provider |

| SERVICE | PROCEDURE CODE | FREQUENCY LIMITATIONS | COMMENTS |
|---|---|---|---|
| Multi-targeted stool DNA (mt-sDNA) test (Cologuard) | 81528 | • The mt-sDNA test is allowed every three years for asymptomatic, low-average risk individuals, aged 45 to 75 years who:<br>o Have not had any colorectal screening in the past, or<br>o Have had a negative colonoscopy at least seven years prior.<br><br>• The mt-sDNA test is not allowed for high-risk individuals who:<br>o Have a personal history of colorectal cancer or adenomas<br>o Have had a positive result from another colorectal screening at any time<br>o Have been diagnosed with Irritable Bowel Disease (IBD), chronic ulcerative colitis, or Crohn's disease; or have a family history of colorectal cancer, or certain hereditary syndromes. | Must be referred/order by a qualified licensed provider |

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

### Obesity Management/Intervention Program

This policy currently targets those obese individuals who do not meet the criteria for gastric bypass surgery or related services. Beneficiaries eligible for the Obesity Management Program are:

- Adults, age of 21 or older with a body mass index (BMI) of 30 or greater.
- Children, age 12 to 21 years with BMI greater than or equal to 95$^{th}$ percentile for age and sex.

Currently, this program will exclude the following categories of beneficiaries:

- Pregnant women

- Beneficiaries who have had or are scheduled to have bariatric surgery/gastric banding/gastric sleeve.
- Beneficiaries actively being treated with gastric bypass surgery/vertical-banded gastroplasty/ sleeve gastrectomy.

Obesity Management Program consists of:

- Screening for obesity in adults using measurement of BMI. The BMI is calculated by dividing the patient's weight in kilograms by square height in meters.
- Dietary (nutritional) assessment and intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high intensity interventions related to diet and exercise.
- Therapeutic treatment to support weight loss in conjunction with intensive lifestyle therapy. Providers must follow the SCDHHS Preferred Drug List (PDL) when prescribing therapeutic treatment.

**Provider Services**

A provider is defined as a physician, PA or NP meeting the licensure and educational requirements within the State of South Carolina.

During the patient's routine physical exam or office visit, the provider will assess the patient's need for an obesity intervention program.

All obesity visits must include the following components listed below:

- Assess: Ask about and assess behavioral health risks and factors affecting behavioral change goals/methods.
- Advise: Give clear, specific and personalized behavioral advice, including information about personal health, harms and benefits.
- Agree: Collaborate with the patient to select appropriate treatment goals and methods based on the patient's interest and willingness to change behavioral patterns and habits.
- Assist: Use behavioral change techniques (self-help and/or counseling) to aid the patient in achieving agreed-upon goals by acquiring the skills, confidence, and social, environmental supports for behavioral change, supplemented with adjunctive medical treatments when appropriate.
- Arrange: Schedule follow-up contacts to provide ongoing assistance and/or support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.

The provider must also emphasize the importance of exercise, developing a realistic exercise plan with goals. The obesity intervention plan must be documented in the patient's medical health record.

The provider will arrange for an individual nutritional assessment to be provided by a licensed and Medicaid-enrolled dietitian.

A follow-up exam must be completed by the provider to evaluate the progress the patient has made, reviewing compliance with the exercise and nutritional plan of the patient. Documentation of each service must include the patient's BMI, progress toward weight management goals, activities and compliance with the treatment plan. The provider must record the patient's BMI in the chart. Providers may bill for all medically necessary diagnostic testing.

**Dietitian Services**

The dietitian is responsible for reviewing the patient's habits, providing dietary education, reinforcing the importance of exercise, developing a nutritional plan and establishing goals. The dietitian must document the patient's progress, activities, and compliance with the nutritional and exercise plan. A written progress report must be submitted within 48 hours of the nutritional counseling visit to the ordering provider each time the patient is seen individually or in a group/class setting. The dietitian must maintain complete medical records of the patient's nutritional and exercise plan, and his or her compliance with the obesity treatment regimen.

**Additional Resources**

For additional resources, providers may visit the SCDPH's Nutrition, Physical Activity & Obesity Prevention webpage at Nutrition, Physical Activity, & Obesity Prevention | South Carolina Department of Public Health (sc.gov).

**Nutritional Counseling Services**

**Eligible members:** Nutritional counseling will be allowed for full benefit Medicaid beneficiaries with a diagnosis of one of the conditions listed in the criteria below.

**Eligible Providers**: Physicians, Physician Assistant, Nurse Practitioners, Dietitians, FQHC, RHC.

**Place of Service:** Dietary evaluation and counseling is allowed in hospital outpatient clinics; public agencies such as health departments, federally qualified health centers, and rural health clinics; private agencies; physician offices, residential facilities (billed by healthcare professionals).

**Clinical Criteria:** Nutritional counseling is allowed when there is a chronic, episodic, or acute condition for which nutrition therapy is a critical component of medical management, including any one of the following:

- Inappropriate growth or weight gain such as inadequate weight gain, inappropriate weight loss, underweight, obesity, inadequate linear growth, or short stature
- Nutritional anemia
- Eating or feeding disorders that result in a medical condition such as failure to thrive, anorexia nervosa, or bulimia nervosa
- Physical conditions that have an impact on growth and feeding, such as very low birth weight, necrotizing enterocolitis, cleft palate, cerebral palsy, and neural tube defects
- Chronic or prolonged infections that have a nutritional treatment component, such as HIV or hepatitis
- Genetic conditions that affect growth and feeding, such as Cystic Fibrosis, Prader-Willi Syndrome, or Down Syndrome
- Chronic medical conditions, such as cancer, chronic or congenital cardiac disease, hypertension, hyperlipidemia, gastrointestinal diseases, liver disease, pulmonary disease, malabsorption syndromes, renal disease, significant food allergies, and diseases of the immune system
- Metabolic disorders such as inborn errors of metabolism (phenylketonuria (PKU), galactosemia) and endocrine disorders such as diabetes
- Non-healing wounds due to chronic conditions
- Acute burns over significant body surface area
- Metabolic Syndrome
- Documented history of a relative of the first degree with cardiovascular disease or possessing factors that significantly increase the risk of cardiovascular disease, such as a sedentary lifestyle, elevated cholesterol, smoking, high blood pressure, and higher than ideal body weight
- Pregnant women when the pregnancy is threatened by chronic, episodic, or acute conditions for which nutrition therapy is a critical component of medical management and postpartum women who need follow-up for these conditions or who develop such conditions early in the postpartum period, including any one of the following:
  - Conditions that affect the length of gestation or the birth weight, where nutrition is an underlying cause, such as:
    - Severe anemia [Hemoglobin (Hgb) less than 10m/dl or Hematocrit (HCT) less than 30]
    - Preconceptionally underweight (less than 90% standard weight for height)
    - Inadequate weight gain during pregnancy.
    - Intrauterine growth retardation.
    - Very young maternal age (under the age of 16).
    - Multiple gestation; or
    - Substance use or abuse

- Metabolic disorders, such as diabetes, thyroid dysfunction, maternal PKU, or other inborn errors of metabolism.
- Chronic medical conditions, such as cancer, heart disease, hypertension, hyperlipidemia, inflammatory bowel disease, malabsorption syndromes, or renal disease.
- Auto-immune diseases of nutritional significance, such as systemic lupus erythematosus.
- Eating disorders, such as severe pica, anorexia nervosa, or bulimia nervosa.
- Obesity when the following criteria are met:
  - Body Mass Index (BMI) greater than 30 in same woman pre-pregnancy and postpartum.
  - BMI greater than 35 at 6 weeks of pregnancy; or
  - BMI greater than 30 at 12 weeks of pregnancy. or
- Documented history of a relative of the first degree with cardiovascular disease or possessing factors that significantly increase the risk of cardiovascular disease, such as a sedentary lifestyle, elevated cholesterol, smoking, high blood pressure, and higher than ideal body weight.

**Utilization Management:** Nutritional counseling services do not require prior authorization; however, a referral is necessary when services are performed by dietitians.

**Additional Services:** If the total 12 hours per fiscal year have been utilized and additional units of nutritional counseling are needed, the provider must submit documentation of medical necessity justifying the need for additional units to:

SCDHHS
Attention: Medical Director
PO Box 8206
Columbia, SC 29202

**Documentation to be maintained in the Patient Record:**
At minimum, a patient's record must include:

- Referral (when applicable)
- Review of medical management, an evaluation of medical and psychosocial history, and treatment plan as they impact nutrition interventions
- Assessment of living conditions related to nutrition evaluation such as possession of a working stove, refrigerator, and access to city water or tested well water
- Diagnostic nutritional assessment, consisting of:
  - Review and interpretation of pertinent laboratory and anthropometric data.

  - Analysis of dietary and nutrient intake.
  - Determination of nutrient–drug interactions, and
  - Assessment of feeding skills and methods.
- Development of an individualized nutrition care plan, consisting of:
  - Recommendations for nutrient and calorie modification.
  - Calculation of a therapeutic diet for disease states such as diabetes, renal disease, galactosemia, and
  - Referral to other health care providers.
- Counseling on nutritional or dietary management of nutrition-related medical conditions
- Consultation with the beneficiary's primary care provider
- Education on reading food labels.

### Pharmacist Services

Licensed pharmacists are allowed to provide evaluation and management services for new and established patients when delivering contraceptives or performing urine pregnancy tests to members of childbearing age enrolled in the Healthy Connections full benefit program or the Family Planning Limited benefit.

**Adult Physical Exams**

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

- A past history for a new patient or an interval history on an established patient.
- A generalized physical overview of the following organ systems:
  - Abdomen
  - Back
  - Breasts (female)
  - Brief Muscular
  - Brief Neurological
  - Brief Skeletal
  - External genitalia

  - Heart
  - HEENT
  - Lungs
  - Pelvic (Female)*
  - Peripheral Vascular
  - Prostate (Male)
  - Rectal
  - Skin

- Family Planning Counseling must be offered. An additional Family Planning code may be billed for this service when provided. Please refer to Obstetrics and Gynecology in this section of the manual for the description of codes.
- The following lab procedures are included in the reimbursement for the physical:
  - Blood Sugar
  - Hemoccult
  - Hemoglobin
  - Urinalysis

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

**Diabetes Patient Education**
Diabetes Management services are medically necessary, comprehensive self-management and counseling services provided by programs enrolled by SCDHHS. Enrolled programs must adhere to the National Standards for Diabetes Self-Management Education and be recognized by the American Diabetes Association, American Association of Diabetes Educators, Indian Health

Services, or be managed by a Certified Diabetes Educator. An eligible beneficiary must have a diabetes diagnosis and be referred by their PCP.

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

## Immunizations

### Immunizations for Children

The Vaccines for Children (VFC) Program is a federally funded program created by the Omnibus Budget Reconciliation Act of 1993 that provides vaccines at no cost to children who qualify. Children who are eligible for VFC are entitled to receive pediatric vaccines that are recommended by the Advisory Committee on Immunization Practices (ACIP). In South Carolina, the VFC Program is managed by the SCDPH.

Medicaid providers may obtain free vaccines from the SCDPH through the VFC Program. Vaccines are delivered free of charge to providers enrolled in the program. For additional information on the VFC Program or to enroll as a provider in the program, you may contact SCDPH at 803-898-0460 (local) or 1-800-27-SHOTS (1-800-277-4687, outside the Columbia area). You may also visit the SCDPH website at Vaccinations | South Carolina Department of Public Health (sc.gov).

**Note:** The Rabies vaccine is non-covered through the VFC for children as it is not considered routine. However, the Rabies vaccine is covered by Medicaid for children. Providers may bill the appropriate administration and vaccine code to receive reimbursement from Medicaid.

### Immunizations for Adults

Providers must follow the Advisory Committee on Immunization Practices (ACIP) recommendations on vaccines for adults with full Medicaid benefits available here.

## Pediatrics and Neonatology

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

### Newborn Care for the Sick Newborn

A sick child is defined as a newborn not considered a well-baby, but not sick enough to be considered a neonate or critically ill.

**High Risk Channeling Project (HRCP) Neonatal Risk Screening**
Please refer to best practice guidelines for Perinatal Care (replaces High Risk Channeling Project — HRCP) under “Obstetrics and Gynecology” in this section.

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

**Sudden Infant Death Syndrome (SIDS)**
SIDS is defined as the unexpected and sudden death of an apparently normal and healthy infant that occurs during sleep and with no physical or autopsy evidence of disease.

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

**Neonatology**

Pre-Discharge Home Visit

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

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

Routine Newborn Circumcision

Routine newborn circumcisions are covered services without prior approval.

**Forensic Medical Evaluations**
Medicaid covers forensic medical evaluations for beneficiaries up to age 21. The purpose of the forensic evaluation is to:

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

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

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

The South Carolina Healthy Connections Medicaid Program, in accordance with federal requirements, Section 1905(r) of the Social Security Act, has developed an EPSDT benefit for Medicaid-eligible children from birth to age 21.

### EPSDT Standards

- To provide early health assessments for the child who is Medicaid eligible so that potential diseases can be prevented.
- To periodically assess the child's health for normal growth and development.
- To screen the child through simple tests and procedures for conditions needing closer medical attention.
- To diagnose the nature and cause of conditions requiring attention, by synthesizing findings of the health history and physical examination.

- To treat abnormalities detected in their preliminary stages or make the appropriate referral whenever necessary.

### Services Covered under EPSDT

The EPSDT benefit in South Carolina provides comprehensive and preventive health services needed to diagnose and treat a child's health and developmental conditions as early as possible.

## Periodic Screening Services

EPSDT covers regular screening services (check-ups) for infants, children and adolescents. At a minimum, children will receive services which constitute evaluations of their physical and mental health; their growth and development; vision, hearing and dental health; and their nutritional and immunization status.

The SCDHHS has adopted the Bright Futures/AAP Recommendations for Pediatric Preventive Health Services that is comprised of a set of periodic screenings and procedures applicable at each stage of the child's life, also called the "Periodicity Schedule" available at Periodicity Schedule | EPSDT (scdhhs.gov).

The age-appropriate required periodic screenings and procedures during an EPSDT visit are as follows:

- Comprehensive Health and Physical Examination:
  - Includes history, measurements, unclothed age-appropriate physical examination.
- Sensory Screening:
  - includes vision and hearing.
- Developmental/Behavioral Health Screenings:
  - Includes a general screening as part of the EPSDT screening component.
- Procedures:
  - Includes laboratory tests and procedures.
- Appropriate Immunization:

  - If at the time of screening, it is determined that immunization is needed and appropriate to provide, then immunization treatment must be provided at that time. For an age-appropriate immunization schedule, the provider must reference the CDC at https://www.cdc.gov/vaccines/vpd/vaccines-age.html.

- Oral Health:
  - Includes oral screening at each visit and when applicable, fluoride varnish and fluoride supplementation.
- Health Education and Anticipatory Guidance:
  - Includes age-appropriate health education (including anticipatory guidance) at each screening.

For details of pediatric preventive health care screening services and their frequency, please refer to the Bright Futures/AAP Periodicity Schedule at https://msp.scdhhs.gov/epsdt/site-page/ periodicity-schedule.

**Note:** Additionally, the SCDHHS policy exceeds the frequency and coverage recommended by the AAP and providers are required to follow the South Carolina-specific information for the following areas:

- Immunization:
  - For an age-appropriate immunization schedule, the provider must reference the CDC at https://www.cdc.gov/vaccines/schedules/hcp/index.html.
  - Every visit should be an opportunity to update and complete a child's immunizations. If a child is unable to be immunized at the recommended time, the reason must be documented in the child's record.
- Developmental/Behavioral Health Assessments:
  - Follow-up developmental and behavioral health assessments are allowed as indicated by the general screening during a periodic or inter-periodic visit.
- Lead Screening:

  - Children enrolled in Medicaid must receive blood lead screening at ages 12 months and 24 months. Additionally, any child between ages 24 and 72 months with no record of a previous blood lead screening test must receive one. The completion of a risk assessment does not meet SCDHHS requirements.

  - In collecting blood samples for lead testing, providers are required to follow the specimen and collection guidelines developed by the SCDPH. These guidelines are available on the SCDPH Bureau of Laboratories webpage at Public Health Laboratory (PHL) | South Carolina Department of Public Health (sc.gov)

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

- Oral Health:

  - Oral screenings are performed during each EPSDT visit through the month of the beneficiary's 21st birthday. For details on physicians' oral health services, please refer to the SCDHHS Oral Health Section of the Periodicity Schedule at https://www.scdhhs.gov/resources/programs-and-initiatives/epsdt/providers/periodicity-schedule.

### Inter-periodic Screening Services

EPSDT also covers medically necessary "inter-periodic" screenings outside of the periodicity schedule when there is an indication of a medical need to diagnose an illness or condition that was not present at the regularly scheduled screening or to determine if there has been a change in a previously diagnosed illness or condition that requires additional services.

**Note:** All health-related problems that are identified during an EPSDT visit must include referral (when indicated) to the proper entity for further evaluation and treatment. Referrals may include such services and evaluations to determine the need for assistive technology if it is determined that these services are medically necessary, and that the child may benefit from them. These services must be medical in nature and not for educational purposes.

### Diagnostic Services

EPSDT covers diagnostic services when a screening indicates the need for further evaluation.

### Treatment Services

- State Plan Covered Services:
  - EPSDT covers necessary health care services for treatment of all physical and mental illnesses or conditions discovered by any screening and diagnostic procedure.
- Non-State Plan Covered Services — Medically Necessary Services:
  - Additional health care services are available under the federal Medicaid program if they are medically necessary to treat, correct or ameliorate illnesses and conditions discovered regardless of whether the service is covered by the South Carolina Medicaid State Plan. Medical necessity is determined by South Carolina Medicaid on a case-by-case basis. Arbitrary limitations on services are not allowed within the EPSDT benefit (e.g., one pair of eyeglasses or 10 PT visits per year). South Carolina Healthy Connections Medicaid will make the final determination as to which treatment it will cover among equally effective, available alternative treatments. All in-state resources must be exhausted prior to treatment outside of the State.

### Additional Tests/Procedures

- Sickle Cell Test — A screening test is administered when indicated by family, medical history or in the presence of anemia.
- Parasites Test — A test for parasites is administered when indicated by medical history, physical assessment or a positive result of a previous test.
- Tuberculin Skin Test — Mantoux test (with five tuberculin units [TUs] of purified protein derivative [PPD] administered intradermally) must be considered for all children at increased risk of exposure to individuals with tuberculosis (TB). Providers may want to check with local, State or regional TB control officials (public health department) for more specific information relating to the epidemiology of TB in their area.
- Topical Fluoride Varnish — South Carolina Healthy Connections children can receive topical fluoride varnish during sick or well-child visits from the eruption of their first tooth through the month of their 21$^{st}$ birthday. Children ages zero through six may receive a maximum of four applications per year, while children ages seven through 20 may receive one application per year.

- Developmental/Behavioral Health Assessments — Follow-up developmental and behavioral health assessments are allowed as indicated by the general screening during a periodic or interperiodic visit.

## Transportation Services

Transportation services, including Non-Emergency Medical Transportation (NEMT), are available for EPSDT-eligible beneficiaries. To schedule NEMT trips to a medical appointment for beneficiaries not residing in a nursing facility, contact the Transportation Broker at https://www.mymodivcare.com/members/sc. To schedule NEMT trips to a medical appointment for beneficiaries residing in a nursing facility, contact the nursing facility directly.

### Beneficiary Eligibility for EPSDT Services by Provider Location

Based on the qualified healthcare practitioner's location, EPSDT services can be rendered to the beneficiaries as follows:

- In the physician's office:
  - EPSDT services can be rendered for beneficiaries ages 0–20 (through the month of the 21st birthday).
- In CCCs:
  - EPSDT services can be rendered only for children ages 5–20 (through the month of the 21st birthday).

## Pharmacy Services

Please see the Pharmacy Services Provider Manual for specific information regarding Pharmacy Services.

## Durable Medical Equipment/Supply

Please see the Durable Medical Equipment (DME) Services Provider Manual for specific information regarding DME and Supply Services.

**Continuous Glucose Monitoring (CGM)**

Continuous glucose monitoring devices are covered for full benefit Healthy Connections Medicaid beneficiaries.

CGM is covered under the Pharmacy or DME State Plan benefits with prior authorization that meets the following criteria:

- CGM must be prescribed by one of the following qualified healthcare providers:
  - Primary care provider (a physician, physician assistant or advance practice registered nurse)
  - Obstetrician
  - Endocrinologist

- Eligible beneficiary must have one of the following clinical criteria:
  - Type 1 diabetes mellitus
  - Gestational diabetes
  - Type 2 diabetes with one of the following:
    - Any type of insulin dependency
    - Non-insulin-treated diabetes with recurrent moderate (Level 2) or at least one severe (Level 3) hypoglycemic event.

**SCDHHS covers evaluation and management services for members who are HIV-positive. To bill for these services, providers must use the P4 modifier in correlation to the appropriate E/M code. Additional Long-Term Living Services**

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

- Case management services
- Private duty nursing services
- Personal care aide services
- Modified and therapeutic-diet home-delivered meals
- Limited nutritional supplements
- Environmental modifications

- Attendant care
- Companion services
- Pest control services

**Incontinence Products**
For incontinence products policy and procedures, please refer to the Home Health Services Provider Manual located on the SCDHHS website at Provider Manual List | SCDHHS.

**CLTC Offices**
There are 11 areas and three satellite CLTC offices Statewide. Each office is staffed by service managers who are professional social workers and Registered Nurses. These service managers work with the person and/or the family to plan and coordinate the services the beneficiary may need.

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

For additional information, please contact the PSC at 888-289-0709, submit an online inquiry at Contact a Provider Representative | SCDHHS or write to:

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

| AREAS | COUNTIES SERVED | PHONE NUMBERS |
|---|---|---|
| Area 1 — Greenville | Greenville, Pickens | (864) 660-4131<br>(888) 535-8523 |
| Area 2 — Spartanburg | Cherokee, Spartanburg, Union | (864) 594-4964<br>(888) 551-3864 |
| Area 3 — Greenwood, IMS | Abbeville, Edgefield, Greenwood, Laurens, McCormick, Saluda | (864) 223-8622<br>(800) 628-3838 |
| Area 4 — Rock Hill | Chester, Lancaster, York | (803) 560-6457<br>(888) 286-2078 |

| AREAS | COUNTIES SERVED | PHONE NUMBERS |
|---|---|---|
| Area 5 — Columbia | Fairfield, Lexington, Newberry, Richland | (803) 764-8319<br>(888) 847-0908 |
| Area 6 — Orangeburg | Allendale, Bamberg, Calhoun, Orangeburg | (803) 536-0122<br>(888) 218-4915 |
| Area 7 — Sumter | Clarendon, Kershaw, Lee, Sumter | (803) 567-3110 |
| Area 8 — Florence | Chesterfield, Darlington, Dillon, Florence, Marlboro | (843 )667-8718<br>(888) 798-8995 |
| Area 9 — Conway | Georgetown, Horry, Marion, Williamsburg | (843) 279-2011<br>(888) 539-8796 |
| Area 10 — Charleston | Berkeley, Charleston, Dorchester | (843) 529-0142<br>(888) 805-4397 |
| Area 11 — Anderson, IMS | Anderson, Oconee | (864) 660-4100<br>(800) 713-8003 |
| Area 13 — Ridgeland | Beaufort, Colleton, Hampton, Jasper | (843) 726-5353<br>(800) 262-3329 |
| Area 14 — Aiken | Aiken, Barnwell | (803) 641-7680<br>(888) 364-3310 |
| Area 17 — Centralized Intake | Statewide | (888) 971-1637 |

**Pediatric HIV Clinics (PHC)**

Pediatric HIV Clinics deliver specialized, comprehensive, multi-disciplinary care to vulnerable beneficiaries at risk for or with HIV. Additional information on these clinics can be found in the Clinic Services manual.

### Alcohol and Drug Abuse Rehabilitation Services

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

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

**Initial Medical Assessment and Referral**

Face-to-face contact between physician and client to assess the patient status, provide diagnostic evaluation screening, and provide physician's referral for A&D rehabilitative services must be billed using the appropriate code. This includes the completion of the A&D Medical Assessment signed and dated by the physician. A sample copy of the form can be found in the Forms section of the provider portal. Additional forms are available upon request from your county substance use disorder program. This form will be placed in the client's file at the local substance use disorder authority site. A copy must be retained in the patient's file. The assessment form completion is included in the reimbursement fee.

**Local Substance Use Disorder Authorities Currently Enrolled in Medicaid**

The following chart includes an address and telephone number for all local substance use disorder authorities currently enrolled in Medicaid:

| COUNTY | PROGRAM NAME AND ADDRESS | PHONE NUMBER |
|---|---|---|
| | South Carolina Department of Alcohol and Drug Abuse (DAODAS) | |
| | 101 Executive Center Drive, Suite 215 | (803) 896-5555 |
| | Columbia, South Carolina 29210 | |
| | Cornerstone | |
| Abbeville | 112 Whitehall Street | (864) 366-9661 |
| | Abbeville, South Carolina 29620 | |
| | Aiken Center | |
| Aiken | 1105 Gregg Highway | (803) 649-1900 |
| | Aiken, South Carolina 29801 | |
| | New Life Center | |
| Allendale | 570 Memorial Avenue | (803) 584-4238 |
| | Allendale, South Carolina 29810 | |
| | Anderson/Oconee Behavioral Health Services | |

| COUNTY | PROGRAM NAME AND ADDRESS | PHONE NUMBER |
|---|---|---|
| Anderson | 226 McGee Road | (864) 260-4168 |
| | Anderson, South Carolina 29625 | |
| | Dawn Center (Tri-County Commission of A&D Abuse) | |
| Bamberg | 608 North Main Street | (803) 245-4360 |
| | Bamberg, South Carolina 29003 | |
| | Axis I Center of Barnwell | |
| Barnwell | 644 Jackson Street | (803) 541-1245 |
| | Barnwell, South Carolina 29812 | |
| | Beaufort County Department of Alcohol and Other Drug Services | |
| Beaufort | 1905 Duke Street | (843) 470-4545 |
| | Beaufort, South Carolina 29901 | |
| | Ernest E. Kennedy Center | |
| Berkeley | 306 Airport Drive | (843) 761-8272 |
| | Monks Corner, South Carolina 29461 | |
| | Dawn Center (Tri-County Commission of A&D Abuse) | |
| Calhoun | Herlong Extension Industrial Park | (803) 655-7963 |
| | St. Matthews, South Carolina 29135 | |
| | Charleston Center | |
| Charleston | 5 Charleston Center Drive | (843) 958-3300 |
| | Charleston, South Carolina 29401 | |
| | Cherokee County Commission of Alcohol and Other Drug Services | |
| Cherokee | 201 West Montgomery Street | (864) 487-2721 |
| | Gaffney, South Carolina 29341 | |
| | Hazel Pittman Center | |
| Chester | 130 Hudson Street | (803) 377-8111 |

| COUNTY | PROGRAM NAME AND ADDRESS | PHONE NUMBER |
|---|---|---|
| | Chester, South Carolina 29706 | |
| | Alpha Center | |
| Chesterfield | 1218 East Boulevard | (843) 623-7062 |
| | Chesterfield, South Carolina 29709 | |
| | Clarendon County Commission on ADA | |
| Clarendon | 14 North Church Street | (803) 435-2121 |
| | Manning, South Carolina 29102 | |
| | Colleton County Commission on ADA | |
| Colleton | 1439 Thunderbolt Drive | (843) 538-4343 |
| | Walterboro, South Carolina 29488 | |
| | Rubicon Inc. | |
| Darlington | 510 East Carolina Avenue | (843) 332-4156 |
| | Hartsville, South Carolina 29550 | |
| | Trinity Behavioral Care | |
| Dillon | 204 Martin Luther King Jr. Blvd. | (843) 774-6591 |
| | Dillon, South Carolina | |
| | Dorchester Alcohol & Drug Commission | |
| Dorchester | 500 North Main Street, Suite 4 | (843) 871-4790 |
| | Summerville, South Carolina 29483 | |
| | Cornerstone | |
| Edgefield | 400 Church Street, Room 112 | (803) 637-4050 |
| | Edgefield, South Carolina 29824 | |
| | Fairfield County Substance Abuse Commission | |
| Fairfield | 200 Calhoun Street | (803) 635-2335 |
| | Winnsboro, South Carolina | |
| | Circle Park Behavioral Health Services | |

| COUNTY | PROGRAM NAME AND ADDRESS | PHONE NUMBER |
|---|---|---|
| Florence | 601 Gregg Avenue | (843) 665-9349 |
| | Florence, South Carolina 29501 | |
| | Georgetown County ADA Commission | |
| Georgetown | 1423 Winyah Street<br>Georgetown, South Carolina 29440 | (843) 546-6081 |
| | The Phoenix Center | |
| Greenville | 1400 Cleveland Street | (864) 467-3739 |
| | Greenville, South Carolina 29607 | |
| | Cornerstone | |
| Greenwood | 1510 Spring Street | (864) 227-1001 |
| | Greenwood, South Carolina 29646 | |
| | New Life Center | |
| Hampton | 102 Ginn Altman Avenue, Suite C | (803) 943-2800 |
| | Hampton, South Carolina 29924 | |
| | Shoreline BHS | |
| Horry | 2404 Wise Road | (843) 365-8884 |
| | Conway, South Carolina 29526 | |
| | New Life Center | |
| Jasper | 113 East Wilson Street | (843) 726-5996 |
| | Ridgeland, South Carolina 29936 | |
| | Alpha Center | |
| Kershaw | 709 Mill Street | (803) 432-6902 |
| | Camden, South Carolina 29020 | |
| | Counseling Services of Lancaster | |
| Lancaster | 114 South Main Street | (803) 285-6911 |
| | Lancaster, South Carolina 29720 | |
| | Gateway Counseling Center | |

| COUNTY | PROGRAM NAME AND ADDRESS | PHONE NUMBER |
|---|---|---|
| Laurens | 219 Human Services Road | (864) 833-6500 |
| | Clinton, South Carolina 29325 | |
| | The Lee Center Family Counseling and Addiction Services | |
| Lee | 108 East Church Street | (803) 484-6025 |
| | Bishopville, South Carolina 29010 | |
| | Lexington/Richland Alcohol and Drug Abuse Council | |
| Lexington | 130 North Hospital Drive | (803) 733-1390 |
| | West Columbia, South Carolina 29169 | |
| | Trinity Behavioral Care | |
| Marion | 103 Court Street | (843) 423-8292 |
| | Marion, South Carolina 29571 | |
| | Trinity Behavioral Care | |
| Marlboro | 211 North Marlboro Street, 2nd Floor | (843) 479-5683 |
| | Bennettsville, South Carolina 29512 | |
| | Cornerstone | |
| McCormick | 504 North Mine Street | (864) 465-2631 |
| | McCormick, South Carolina 29835 | |
| | Westview Behavioral Health Services | |
| Newberry | 800 Main Street or 909 College Street | (803) 276-5690 |
| | Newberry, South Carolina 29108 | |
| | Anderson/Oconee Behavioral Health Services | |
| Oconee | 691 South Oak Street | (864) 882-7563 |
| | Seneca, South Carolina 29678 | |
| | Dawn Center (Tri-County Commission of Alcohol and Drug Abuse) | |
| Orangeburg | 910 Cook Road | (803) 536-4900 |

| COUNTY | PROGRAM NAME AND ADDRESS | PHONE NUMBER |
|---|---|---|
| | Orangeburg, South Carolina 29118 | |
| | Behavioral Health Services of Pickens County | |
| Pickens | 309 East Main Street | (864) 898-5800 |
| | Pickens, South Carolina 29671 | |
| | Lexington/Richland Alcohol and Drug Abuse Council | |
| Richland | 2711 Colonial Drive | (803) 726-9300 |
| | Columbia, South Carolina 29203 | |
| | Saluda Behavioral Health System | |
| Saluda | 204 Ramage Street | (864) 445-2968 |
| | Saluda, South Carolina 29138 | |
| | Spartanburg County Alcohol and Drug Abuse Commission | |
| Spartanburg | 187 West Broad Street, Suite 200 | (864) 582-7588 |
| | Spartanburg, South Carolina 29306 | |
| | Sumter County Commission on ADA | |
| Sumter | 115 North Harvin Street, 3rd Floor | (803) 775-6815 |
| | Sumter, South Carolina 29150 | |
| | Union county Commission on ADA | |
| Union | 201 South Herdon Street | (864) 429-1656 |
| | Union, South Carolina 29379 | |
| | Williamsburg Commission on ADA | |
| Williamsburg | 115 Short Street | (843) 354-9113 |
| | Kingstree, South Carolina 29556 | |
| | Keystone Substance Abuse Services | |
| York | 199 South Herlong Avenue | (803) 324-1800 |
| | Rock Hill, South Carolina 29732 | |

## Alcohol and Drug Testing Policy

SCDHHS covers the following presumptive and definitive drug testing classifications and will reimburse for a maximum of one screening per procedure code, per DOS, not to exceed 18 screenings per 12-month period. Providers must bill the most appropriate Healthcare Common Procedure Coding System (HCPCS) code for the service rendered.

Drug test(s), presumptive, any number of drug classes; any number of devices or procedures, (e.g., immunoassay) read by direct optical observation only (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per DOS.

Drug test(s), presumptive, any number of drug classes; any number of devices or procedures by instrumented chemistry analyzers utilizing immunoassay, enzyme assay, TOF, MALDI, LDTD, DESI, DART, GHPC, GC mass spectrometry), includes sample validation when performed, per DOS.

Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods [e.g., alcohol dehydrogenase]); qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 1–7 drug class(es), including metabolite(s) if performed.

Alcohol and Drug screeningtests must be ordered by a qualified practitioner operating within their scope of practice and as allowed by State Law. Qualified practitioners may authorize certain laboratory tests to be performed at defined intervals over a period of 60 days with one “standing order” only when used in connection with an extended course of treatment for substance abuse disorders. The ordering practitioner must document in the beneficiary’s clinical record the medical necessity for the testing and the results of each test. Qualified practitioners ordering unnecessary tests for which Medicaid is billed may be subject to civil penalties.

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

Laboratory standing orders must be in a written form, patient-specific, and include a duration that cannot exceed 60 days. In all instances, standing orders are rendered invalid after 60 days from the date the initial test was ordered. Existing standing orders must be reviewed regularly to ensure their continuing validity.

Standing orders must include the following information:

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

A&D screens for employment purposes or for a court-ordered A&D screen are not covered under the Medicaid program.

### Tobacco Cessation

Tobacco use is the leading cause of preventable disease and premature death in South Carolina. SCDHHS provides comprehensive coverage for tobacco cessation treatment through pharmacotherapy and counseling for all full-benefit Medicaid beneficiaries. SCDHHS also partners with SCDPH to communicate about programs available to assist Medicaid beneficiaries with quitting tobacco use.

Providers are encouraged to screen beneficiaries for tobacco use during medical encounters and document nicotine dependence using the appropriate diagnosis codes.

#### Medication

SCDHHS covers prescriptions for the following tobacco cessation and NRT products:

- Bupropion SR products for tobacco use (Zyban)
- Varenicline (Chantix) tablets
- Nicotine gum
- Nicotine lozenge

- Nicotine nasal spray
- Nicotine inhaler
- Nicotine patch

Tobacco cessation products are exempt from prior authorization, requirements. There is no limit to the number of quit attempts in a calendar year. The following medically appropriate combination therapies are also covered:

- Long-term nicotine patch + other NRT product (gum or spray)
- Nicotine patch + nicotine inhaler
- Nicotine patch + Bupropion SR

General edits on day supply are based on product dosing in manufacturer package inserts. Prescribers are encouraged to reference the AAFP Pharmacologic Product Guide for FDA-approved medications for smoking cessation for more information on product guidelines.

As with all other pharmaceuticals, SCDHHS reimburses only rebated products (brand or generic) for FFS beneficiaries. A beneficiary must provide a prescription to receive any medication, including OTC products. A dual-eligible member can receive OTC products through Medicaid coverage, but the individual's Medicare Part D prescription drug plan must cover prescriptions for legend (non-OTC) tobacco cessation products.

For further questions about this benefit, prescribers may contact the Magellan Medicaid Administration's Clinical Call Center at (866) 247-1181.

**Counseling**
SCDHHS policy requires that all tobacco cessation treatment must be ordered by a qualified practitioner defined as a physician, NP, CNM or PA. Medical documentation including time spent counseling the patient, treatment plan, and pharmacotherapy records must be maintained in the patient record.

**South Carolina Tobacco Quitline**
One-on-one telephone counseling with web-based support are available to all South Carolinians without charge through the South Carolina Tobacco Quitline. Participants in the Quitline program are connected with a personal Quit Coach, who helps the participant develop a quit plan and uses cognitive behavioral coaching and motivational interviewing techniques to support the quit process.

This evidence-based program has been clinically proven to help participants quit tobacco use, and tailored programs are available for Hispanic, Native American, pregnant and youth callers, and smokeless tobacco users, as well as participants who have chronic medical and mental health conditions.

SCDHHS strongly encourages prescribers and pharmacists to refer patients to the South Carolina Tobacco Quitline at 1-800-QUIT NOW (1-800-784-8669). Services are available 24 hours a day, seven days a week. Additional information is available at
Quitline Information for Healthcare Providers | South Carolina Department of Public Health (sc.gov)

## Hospice

Please see the Hospice Services Provider Manual for specific information regarding Hospice Services.

## Inpatient and Outpatient Hospital Services

### General Policy Guidelines

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

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

## 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 PPS | CMSHospital Outpatient PPS | CMS

### Levels of Service

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

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

**Hospital Visits**

### Initial Hospital Care

Please refer to the current CPT when multiple E&M services are prescribed on the same date as initial hospital care.

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

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

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

Initial hospital care codes are exempt from the surgical package. For instructions on surgical package billing, please refer to General Surgery Guidelines within this section of the manual.

### Subsequent Hospital Care

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

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

Subsequent hospital care codes will "multiply" and must be reported as one line item, with the number of visits indicated in the “units” column.

### Hospital Discharge

Hospital discharge is a covered service. This charge is acceptable only if **billed in lieu of a hospital visit code**. It may not be charged if a surgical procedure was performed, and the surgery

is considered a surgical package. Reimbursement is made for only one physician for each hospital discharge.

**Concurrent Care Guidelines**

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

### Concurrent Care Criteria

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

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

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

### Medical/Surgical

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

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

**Critical Care Services**

Follow current CPT guidelines indicating services are considered a part of critical care and not reimbursed separately. Up to four hours of critical care per day are allowed. Critical care must be billed per DOS. Critical care services are not included in the surgical package and may be billed separately.

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

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

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

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

**Prolonged Services**

Medicaid will reimburse for prolonged physician services 99417 and 99418 with direct (face-to-face) patient contact.

Documentation for these CPT codes must clearly indicate that the service provided was direct (face-to-face) contact between the physician and the patient beyond the usual time for the level of E&M code billed. These codes are billed in addition to the appropriate E&M code. Please refer to the CPT guidelines for coding these services.

Prolonged Physician Services without Direct (face-to-face) Patient Contact will remain non-covered.

**ER Services**

### Outside Attending Physician

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

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

### Hospital-Salaried or Hospital-Based ER Physicians

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

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

The physician's service must be charged using an appropriate CPT code. Procedures identifiable as a unique and separate service may be reported separately.

### Levels of Service

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

### Emergency Life Support

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

**Pediatric Inpatient Rehabilitation Services**

Professional services of a physician or a qualified healthcare professional delivered in a pediatric inpatient rehabilitation unit are covered when medically necessary and are reimbursed separately from the facility services. For details on medical necessity and clinical criteria for pediatric inpatient rehabilitation services, please refer to the Hospital Services Provider Manual.

**Transportation of Self-Administered Oxygen-Dependent Beneficiaries**

This 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 PI.

It is the responsibility of both the hospital and DME provider to coordinate and dispense oxygen to the Medicaid beneficiary who is currently admitted to the hospital or hospital ER in order 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 billed with a U1 modifier, and the dispensing DME provider will be reimbursed 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 EMS 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.

**Observation Unit**
Medicaid will sponsor the professional reimbursement for E&M services provided to patients requiring observation in a hospital. Please refer to the current CPT for coding guidelines. Observation codes must be billed with place of service 22.

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

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

One limited examination per 30 days is required for all Administrative Day patients. Additional visits may be allowed if medical justification is submitted.

## Obstetrics and Gynecology

### Healthy Mothers/Healthy Futures Obstetrical Program

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

#### HM/HF Checklist

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

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

### Best Practice Guidelines for Perinatal Care (Replaces HRCP)

South Carolina Medicaid remains committed to the concept(s) of risk-appropriate care and enhancing maternal and child health outcomes. Therefore, the following Medicaid Best Practice guidelines are recommended:

- Early and continuous risk screening must be provided for all pregnant women.
  - SCDHHS has adopted the American College of Obstetricians and Gynecologists (ACOG) recommendations for screening serologically for syphilis during each pregnancy with the following frequency:
    - At the first prenatal care visit,
    - Once during the third trimester,
    - On the delivery date, at birth
- Early entry into prenatal care must be encouraged.

- Care for all prenatal women must be delivered by the provider level and specialty best suited to the risk of the patient. (AAP, American College of Obstetricians and Gynecologists. Guidelines for Perinatal Care. 8th ed. Elk Grove Village (IL): AAP; Washington, DC: American College of Obstetricians and Gynecologists, 2017.)
- All infants must receive risk-appropriate care in a setting that is best suited to the level of risk presented at delivery. (AAP, American College of Obstetricians and Gynecologists. Guidelines for Perinatal Care. 8th ed. Elk Grove Village (IL): AAP; Washington, DC: American College of Obstetricians and Gynecologists, 2017.)
- Risk assessment of the infant must be performed prior to discharge from the hospital.
- Every Medicaid-eligible mother and infant must receive a Postpartum/Infant Home Visit.
- Effective communication/coordination regarding the perinatal plan of care between each provider is essential (i.e., the specialist physician must communicate pertinent information back to the community-level physician).
- A medical home must be established for the mother-infant unit after delivery to handle the long-term health care needs.
- P/RSPCE referrals must be made when medically indicated.

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

**Ultrasounds**

SCDHHS policy allows three obstetrical ultrasounds per pregnancy for OB/GYN providers. Ultrasounds in the first trimester are performed to establish viability, gestational age or to detect malformations. Two additional ultrasounds, performed during the second or third trimester, establishes more detailed anatomy and/or interval growth.

**Additional Services**

Fetal Biophysical Profile

Fetal biophysical profiles must also be medically justified. The medical record must reflect medical necessity.

### Amniocentesis

Amniocentesis is a covered service when medically necessary. Justification must be documented in the medical record. Please refer to Genetic, Molecular and Biomarker Testing section within this manual for coverage criteria. Reimbursement is the same in the office or hospital (do not use modifier26 for place of service 21 or 22).

### Ultrasound for Amniocentesis Guidance

When performed in the hospital, do not use modifier 26 since the code is for supervision and interpretation only.

### Non-Stress Test

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

### Tocolytic

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

### Lab Procedures

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

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

### Venipuncture

When performing a venipuncture, bill the service as collection of venous blood by venipuncture. No documentation is required to be sent with the claim. If more than one venipuncture is performed on the same DOS, the claim must be billed hard copy with documentation of the number of venipunctures attached.

### Non-Self-Injectable Drugs

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

### Enhanced Services for Pregnant Women Offered by SCDPH

In addition to traditional medical care, pregnant women often have nutritional, environmental, psychosocial, and educational needs that may influence pregnancy outcomes.

To address these needs, all Medicaid pregnant women are eligible for the following Family Support Services through SCDPH:

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

For information on referrals to authorized providers of these services, call the PSC at 888-289-0709 or submit an online inquiry at Contact a Provider Representative | SCDHHS.

**17 Alpha Hydroxyprogesterone Caproate (Makena® and 17P)**

Makena® and compounded hydroxyprogesterone caproate are covered without a prior authorization. SCDHHS currently covers the use of 17 alpha hydroxyprogesterone caproate (17-P) intramuscular injections to support the prevention of preterm births. The therapy is considered effective in reducing negative outcomes and improving the quality of care in pregnant women. Makena® and compounded 17-P will be covered on a weekly basis beginning at 16 weeks' gestation through 36 weeks' gestation when the patient presents with a history of spontaneous preterm delivery in a single pregnancy, before 37 weeks' gestation. All other risk factors for preterm delivery and for the use of hydroxyprogesterone caproate are considered investigational and not medically necessary.

**Perinatal Care**

### Emergency Room Visit

When the physician meets the maternal patient in the ER or labor and delivery unit for immediate medical attention, the appropriate level emergency department code must be billed.

### Observation Admission

When the physician meets the maternal patient at the ER or labor and delivery unit and admits the patient to the hospital for observation (less than 24 hours), the physician must bill the appropriate level hospital observation code with place of service 22.

### External Version

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

**Note:** No assistant is allowed for this procedure.

**Uncomplicated (Routine) Deliveries**

Both vaginal and Caesarean section (C-section) deliveries are considered surgical packages. The following are inclusive in the surgical packages:

- Pitocin induction
- Surgical or mechanical induction
- Fetal monitoring (internal or external)
- Amnioinfusion
- Episiotomy
- Laceration repair
- Suture removal
- Standby for delivery
- Subsequent routine hospital care

- Hospital discharge
- Any related E&M visits within 30 days following the delivery
- Routine follow-up care (one postpartum visit may be billed separately using code CPT 59430. Please refer to Postpartum Care under Obstetrics and Gynecology in this section of the manual).
- Insertion of cervical dilator (e.g., laminaria, prostaglandin) is considered included in the surgical package and may not be billed in addition to the CPT code for the delivery. This applies whether being placed the day of delivery, or several days prior to delivery, if placed by the delivering physician or physician within the same practicing group.

Providers are required to append the following modifiers and, in some cases, complete the ACOG Patient Safety Checklist or a comparable patient safety justification form, when scheduling an induction of labor or a planned C-section for deliveries less than 39 weeks' gestation. The provider is responsible for maintaining a copy of this documentation in their files and in the hospital record, which are subject to SCDHHS PI review.

Providers may append the following modifiers to all CPT codes when billing for vaginal deliveries and C-sections:

- GB — 39 weeks' gestation and or more:
  - For all deliveries at 39 weeks' gestation or more regardless of method (induction, C-section or spontaneous labor).
- CG — Less than 39 weeks' gestation:
  - For deliveries resulting from patients presenting in labor, or at risk of labor, and subsequently delivering before 39 weeks, or
  - For inductions or C-sections that meet the ACOG or BOI-approved medically necessary guidelines, the appropriate ACOG Patient Safety Checklist must be completed and maintained for documentation in the patient's file, or
  - For inductions or C-sections that do not meet the ACOG or BOI-approved medically necessary guidelines, the appropriate ACOG Patient Safety Checklist must be completed. In addition, the provider must obtain approval from the regional perinatal center's MFM physician and maintain this documentation in the patient's file.

**No Modifier — Elective Non-Medically Necessary Deliveries Less Than 39 Weeks Gestation**
For deliveries less than 39 weeks gestation that do not meet ACOG or approved BOI guidelines or are not approved by the designated regional perinatal center's MFM physician.

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

**Hospital Admission for Delivery**
The hospital admission codes are not allowed if the delivering physician or group has provided prenatal care to the beneficiary. The appropriate level admission code may be billed with drop-in vaginal and C-section deliveries only.

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

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

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

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

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

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

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

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

**Multiple Births**
Please refer to Multiple Births within the Billing Guidance section of this manual for the policy on billing for multiple babies.

**Pre-Term Deliveries**
Please refer to the “Abortion Guidelines” below for the policy on coding for a vaginal delivery or non-elective abortion.

**Postpartum Care**

Routine Postpartum Visit

The postpartum period is defined as the 12 months following childbirth. The postpartum visit includes an uncomplicated routine GYN examination of the mother following a vaginal or C-section delivery. Providers may only bill for one routine postpartum visit per delivery. Reimbursement for all other routine postpartum visits is included in payment for the delivery.

Family Planning Counseling or instruction may not be billed in addition to the postpartum code when Family Planning services are rendered and documented. Please refer to Family Planning in this section of the manual for the code description and more details.

Complication/Other Medical Attention During 30-Days Post Delivery

If E&M services unrelated to routine postpartum care are necessary during the 30 days’ post-delivery, bill these services using modifier 24. Documentation in the patient’s chart must substantiate that the visit was unrelated to the delivery.

**Note:** Wound infection is not considered routine postpartum care.

**Abortion Guidelines**

Non-Elective Abortions

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

Therapeutic Abortions

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

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

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

Questions may be directed to the PSC at (888) 289-0709 or providers may submit an online inquiry at Contact a Provider Representative | SCDHHS

**Licensed Midwives**

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

As Medicaid providers, licensed and certified midwives are required to maintain and disclose their records consistent with the Provider Administrative and Billing Manual. As allied health professionals, licensed midwives are required by State Law (SC Code Section 20-7-510) to report any signs of abuse or neglect to children that they may encounter in the office or home setting.

Additional enrollment and documentation requirements are specified below. For more information on Medicaid-sponsored midwifery services, please contact the PSC at (888) 289-0709 or submit an online inquiry at Contact a Provider Representative | SCDHHS.

### Requirements for Physician Back-up

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

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

**Birthing Centers**

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

### OB/Newborn Care with Technical Component (TC) Modifier

Medicaid will reimburse for an all-inclusive facility fee. The facility fee will include all technical services provided by the birthing center including, but not limited to, administration, nursing, drugs, surgical dressings, supplies and materials for anesthesia.

### Observation for Maternity/Labor

This service is billable for observation of maternity/labor. This code is billable only if the patient is at the birthing center laboring, but the labor does not progress, and the patient is sent home to return later or discharged to the hospital.

**Pulse Oximetry Policy**

SCDHHS accepts the SCDPH Pulse Oximetry Screening test on newborns to detect congenital heart defects. Pulse oximetry is a non-invasive test that estimates the percentage of hemoglobin in blood that is saturated with oxygen.

The “Emerson Rose Act” (Act), effective September 11, 2013, mandates SCDPH require each birthing facility it licenses to perform a pulse oximetry screening test, or other SCDPH approved screening to detect critical congenital heart defects, on every newborn in its care. A newborn may be exempt from the required screening if the parent of the newborn objects, in writing, for reasons pertaining to religious beliefs only.

In accordance with the Act, birthing facilities shall perform a pulse oximetry screening test, or other SCDPH-approved screening to detect critical congenital heart defects, on every newborn when the baby is 24 to 48 hours of age, or as late as possible if the baby is discharged from the hospital before reaching 24 hours of age. Pulse oximetry screening for newborns shall be performed in the manner designated by SCDPH guidelines located at Homepage | South Carolina Department of Public Health (sc.gov)The hospital reimbursement for newborns is an all-inclusive payment for services rendered during that hospital stay and thus includes the pulse oximetry screen.

- In compliance with SCDPH policy, licensed midwives and certified nurse midwives that deliver a newborn in a birthing center must also perform this test. In addition, SCDHHS requires the test to be performed when a newborn is delivered in place of service home. When billing SCDHHS for the screening
- Licensed midwives delivering in a birthing center or home must bill the appropriate code appended with the SB modifier.
- Certified nurse midwives or other clinician delivering in place of service birthing center or home must bill the appropriate code appended with a UD modifier, as defined by each state.

The birthing center is responsible for following the policy as outlined by SCDPH. Medicaid reimbursement for this procedure will be paid at the line level.

**Levonorgestrel-Releasing Intrauterine System (Mirena®) Coverage**
Medicaid will sponsor reimbursement for the Levonorgestrel-Releasing Intrauterine System (Mirena®). To bill for Mirena®, the provider may use the appropriate HCPCS J code. Please include the FP modifier on the claim form. Providers must continue to use the appropriate Family Planning diagnosis codes and CPT codes for the insertion and removal of the device.

**Etonogestrel Implant (Implanon®) Coverage**
Medicaid will sponsor reimbursement for the Etonogestrel Implant (Implanon®/Nexplanon®), a single-rod implantable contraceptive that is effective for up to three years. To bill for Implanon®/Nexplanon®, the provider may use the appropriate HCPCS J code. Please include the

FP modifier on the claim form. Providers must continue to use the appropriate Family Planning diagnosis codes and CPT codes for the insertion and removal of the device.

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

**Lupron Depot® (Leuprolide Acetate)**
Medicaid will sponsor reimbursement for Lupron Depot® injections. The provider must supply the drug.

**Pessary**
Medicaid will sponsor reimbursement for pessaries; the physician must provide the pessary.

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

**Depo-Provera for Other than Contraceptive Purposes**
An appropriate code is used to report Depo-Provera for other than contraceptive purposes. Dosage is 50 mg. Frequency is limited to 500 mg and must be billed in units of 50 mg.

**Family Planning Program**
See Family Planning within this section of the manual for more information.

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

Definitions (as stated in the Code of Federal Regulations 42 CFR 441.251)
Sterilization — Any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing.

Institutionalized Individual — An individual who is:

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

Mentally Incompetent Individual — Means an individual who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

All sections of the Sterilization Consent Form (DHHS Form 687) must be completed when submitted with the claim for payment. Each Sterilization Claim and Consent Form are reviewed for compliance with federal regulations (42 CFR 441.250–441.259 subpart F).

*****The sterilization consent form is codified in federal regulations as an Appendix to 42 CFR 441 Subpart F. Because the form is codified in federal regulation it never expires and must be used regardless of whether there is a current OMB date. For Medicaid purposes the form does not require an expiration date to be valid. This is the only form that can be used, and it may not be altered in any way. The lack of a current form is not a valid reason to deny a claim providing the form has not been altered and is compliant with regulations. *****

### Requirements

For Medicaid financial coverage of an elective sterilization for a male or female, the following requirements must be met:

- The Sterilization Consent Form must be signed at least 30 days prior to, but no more than 180 days prior to, the scheduled date of sterilization.
- The individual must be 21 years old at the time the consent form is signed.
- The individual cannot be institutionalized or mentally incompetent. If the physician questions the mental competency of the individual, he or she may contact the PSC at (888) 289-0709 or submit an online inquiry at Contact a Provider Representative | SCDHHS.
- The individual must voluntarily give consent. All questions must be answered and all topics in the consent form discussed. (A witness of the patient's choice may be present during the

consent interview.) The Family Planning Counseling or family planning education/instruction procedure code may be billed when this service is rendered and documented.

- A copy of the consent form must be given to the patient after Parts I, II, and III are completed.
- At least 30 days, but not more than 180 days, must have passed between the signing of the consent form and the date of the sterilization procedure. The date of the beneficiary's signature is not included in the 30 days (e.g., day one begins the day after the signature). No one can sign the form for the individual.

Exceptions to the 30-day waiting period are:

- Premature Delivery — The informed consent must have been signed at least 30 days prior to the expected date of delivery. In cases involving a C-section, the scheduled date of the C-section is considered the expected date of delivery. At least 72 hours must have elapsed since the informed consent was given.
- Emergency Abdominal Surgery — The emergency does not include the operation to sterilize the patient. At least 72 hours must have elapsed since the informed consent was given. An explanation must accompany the consent form.

**Note:** If the beneficiary is pregnant, premature delivery is the only exception to the 30-day waiting period.

Informed consent may not be obtained while the patient to be sterilized is:

- In labor or childbirth.
- Seeking or obtaining an abortion.
- Under the influence of alcohol or other substances which may affect the patient's judgment.

### Transcervical Fibroid Ablation

Treatment for symptomatic uterine fibroids via Transcervical Fibroid Ablation (TFA) may be performed without prior authorization when **ALL** the criteria below are met and documented in the patient's record:

- Patient is a Healthy Connections member with full benefits;
- Evidence of uterine fibroids between 3 cm - 10 cm is provided via ultrasound or other imaging;

- Patient has at least one of the following symptoms that is a direct result of the fibroid(s):
  - Menorrhagia or other abnormal uterine bleeding that interferes with daily activities or causes anemia.
  - Pelvic pain or pressure
  - Lower back pain affects activities of daily living.
  - Urinary symptoms related to bulk compression of the bladder.
  - Gastrointestinal symptoms related to bulk compression of the bowl (e.g., constipation, bloating)
  - Dyspareunia.

## Specialty Care Services

This section of the manual contains policies and guidelines for services that are primarily performed and billed by specialty physicians who treat specific body systems. However, all physicians are subject to all guidelines in this manual.

### Consultations

A consultation is a request for an opinion and/or advice only. A consultation may involve a complete or a single organ system examination, followed by a written report in the patient's medical record.

The attending physician makes the request and continues in the role of primary physician unless he releases the patient to the consultant. The request for a consultation must be documented in the patient's record. The date the attending physician turns the patient's care over to the consultant must be documented, and the initial physician ceases billing.

When the consultant assumes responsibility or management of a portion or all of the patient's condition, services are considered subsequent hospital visits, office visits or concurrent care.

A follow-up consultation involves the consultant's re-evaluation of a patient on whom he or she has previously rendered an opinion or advice. As in initial consultations, the consultant provides no patient management or treatment.

Coverage — Consultation may be covered when the following conditions are met:

- A consultation or follow-up consultation is requested from a physician whose specialty or sub-specialty is different from the attending physician, for the opinion and/or advice in the further evaluation or management of the patient.

- Multiple consultations for the same patient must be determined to be medically necessary. Each consultation must relate to a different diagnosis or document that unusual circumstances exist, such as severity of condition or complexity of care.

Initial Inpatient Consultation — Using the CPT guidelines for terminology and levels of service, one initial consultation is allowed per patient per admission.

Documentation must reflect the request for the follow-up consultation and indicate that the consulting physician has not assumed responsibility for any portion of the patient's care. The third follow-up visit and all subsequent visits during that hospitalization must be billed with subsequent hospital visit codes.

Office or Other OP Consultations — Use the CPT guidelines for terminology and levels of service.

**Interprofessional Consultation**
Interprofessional consultation is defined as a situation in which the patient's treating physician or other qualified health care practitioner (hereafter referred to as the treating practitioner) requests the opinion and/or treatment advice of a physician or other qualified health care practitioner with specific specialty expertise (hereafter referred to as the consulting practitioner) to assist the treating practitioner with the patient's care.

Interprofessional consultation is intended to expand access to specialty care and foster interdisciplinary input on patient care. It is not intended to be a replacement for direct specialty care when such care is clinically indicated.

Reimbursement of interprofessional consultation is permissible, even when the beneficiary is not present, as long as the consultation is for the direct benefit of the beneficiary. The consulting provider must be an enrolled Medicaid provider. Interprofessional consultation services may be provided via telehealth and reimbursed with the use of the appropriate modifier.

**Referral**
A referral is the transfer of the total or specific care of a patient from one physician to another and does not constitute a consultation. Use proper codes for initiation of treatment (i.e., office or hospital visit codes).

## Psychiatric and Counseling Services

Psychiatric services include E&M, psychotherapy, and other services to an individual, family, or group and are compensable when medically indicated and in compliance with Medicaid policies. In order to be covered under the Medicaid program, a service must be medically necessary. Medical necessity means the need for treatment services is necessary to diagnose or treat an illness.

Medicaid-eligible beneficiaries may receive psychiatric and psychotherapy services when there is a confirmed psychiatric diagnosis from the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) or the ICD. Any psychiatric services provided to a child less than three years of age must be carefully documented to show medical necessity.

Covered psychiatric and psychotherapy services include the following:

- Psychiatric diagnostic evaluation
- Environmental intervention for medical management
- Psychological testing
- Psychotherapy
- Family Psychotherapy with patient present
- Family Psychotherapy without patient present
- Group psychotherapy
- Psychotherapy for crisis
- Medical E&M

These services are provided to, or directed exclusively toward, the treatment of the Medicaid-eligible beneficiary for the purpose of ameliorating disabilities, improving the beneficiary's ability to function independently and restoring maximum functioning.

Please refer to Covered Services in this manual for appropriate codes for each covered service listed above and who is eligible to bill for these services.

**Referral to Allied Professionals**

The psychiatric diagnostic evaluation completed by the physician/NP (also referred to as the supervising clinician) shall result in a determination of the beneficiary's need for psychiatric services and/or psychotherapy services. The physician/NP must document all treatment services authorized to be provided to the beneficiary. If appropriate, the physician/NP may authorize services to be rendered by an allied professional. The physician/NP must:

- See each beneficiary initially unless the beneficiary was accepted as a referral from another physician.
- Authorize the treatment services to be provided by the allied professional.
- Participate in patient staffing with the allied professional to document progress summaries.

If the beneficiary is referred by a non-physician (e.g., DSS, school counselor, etc.), the referral source must be documented in the chart.

When scheduling is a problem or the beneficiary's condition requires immediate treatment, a maximum of two psychotherapy visits in 14 days will be allowed by an allied professional under supervision prior to an initial psychiatric diagnostic evaluation by the supervising clinician. The supervising clinician must then perform the initial psychiatric diagnostic evaluation before any further psychotherapy services can be provided.

In all cases, the supervising clinician must assume all professional liability for services rendered by staff under his or her supervision. In the event of a post-payment review, the supervising clinician who is reimbursed by Medicaid is responsible for all records. Credentials of allied professionals who provided services must be on file and will be part of the post-payment review. If the allied professional's credentials are not on file or do not meet the qualifications, the supervising clinician's payments will be subject to recoupment.

**Supervision**

Direct supervision in the physician's office, group practice or clinic setting means that the supervising clinician must be responsible for all services rendered and be accessible at all times during the diagnosis and treatment of the beneficiary.

Services provided under direct supervision are covered only if the following conditions are met:

- The allied professional must be a part-time, full-time, or contracted employee of the supervising clinician, physician group practice, or of the legal entity that employs the supervising clinician; or the allied professional must be an independent contractor engaged by the physician/NP through a written agreement.
- The supervising clinician cannot be employed by the allied professional.
- The supervising clinician must be accessible to the allied professional while services are being delivered and must meet with the allied professional at a minimum of every 90 days to review beneficiary progress.

- The service must be furnished in connection with a covered physician/NP service that was billed to SCDHHS; therefore, the beneficiary must be one who has been seen by the physician/NP.
- A psychiatric diagnostic evaluation must be performed by the supervising clinician.

The allied professional providing psychotherapy personally works with the beneficiary to develop the IPOC and the supervising clinician meets with the beneficiary periodically during treatment to monitor the service being delivered and to review the need for continued services. There must be subsequent services by the supervising clinician of a frequency that reflects his/her continued participation in the management of the course of treatment. The supervising clinician assumes professional responsibility and liability for all services provided by allied professionals.

The supervising clinician must spend as much time as necessary directly supervising the services to ensure that patients are receiving services in a safe and efficient manner in accordance with accepted standards of practice. The supervising clinician must meet with the allied professional and document the monitoring of performance, consultation, guidance and education at a minimum of every 90 days to ensure the delivery of medically necessary services.

A supervising clinician is limited to supervising no more than three allied professionals who meet the qualifications to render psychotherapy services. Prior to services being rendered by allied professionals, the names and credentials of the three allied professionals being supervised must be submitted to:

SCDHHS
Division of Behavioral Health
Post Office Box 8206
Columbia, SC 29202-8206
Fax: 803-255-8204

This information must be updated as necessary or at least every 12 months. To satisfy this requirement, complete and return a copy of the Allied Professional Supervision Form found in the Forms section of the provider portal. Additionally, the credentials of the allied professionals must be maintained on file at the office where services are being provided.

**Individualized Plan of Care (IPOC)**
If it is determined through the psychiatric diagnostic evaluation that a beneficiary needs psychotherapy services and a referral is made to an allied professional OR psychotherapy services will be provided by the physician/NP, an IPOC is required within 45 days of the date of the initial psychiatric diagnostic evaluation. The IPOC is an individualized, comprehensive treatment plan,

which is based on the assessment and is created in partnership with the beneficiary and/or legally responsible person, except in the case of an emergency. The IPOC is designed to improve and/or stabilize the beneficiary's condition and must encompass all treatment goals and objectives.

The following services are not required to be listed on the IPOC:

- Psychiatric diagnostic evaluation
- Psychotherapy for crisis
- Environmental intervention
- E&M
- Psychological testing

Services not outlined in the treatment plan, other than those listed above, are non-billable and subject to recoupment. The allied professional providing psychotherapy services under the supervision of a physician/NP may develop the IPOC, but the IPOC must be signed by both the allied professional and the supervising clinician when psychotherapy is being provided by an allied professional.

The IPOC provides the overall direction for the treatment of the beneficiary and must include the following elements:

- Individualized treatment goals developed in conjunction with the beneficiary and/or family.
- Specific interventions and strategies that will be used to meet goals.
- Outcomes that are anticipated to be achieved by provision of the service and projected date of achievement.
- A projected schedule for service delivery, including the expected frequency and duration of each treatment method.
- The beneficiary and/or legally responsible person must sign the IPOC indicating that they were involved in the planning process and were offered a copy of the IPOC. If the beneficiary does not sign the IPOC, the reason must be documented in the clinical record.
- The physician/NP's signature is required on the IPOC to confirm the diagnosis, medical necessity of the treatment, and the appropriateness of care.

The original IPOC supervising clinician's signature date stands as the date to be used for all subsequent progress summaries, reviews and reformulations. Each page of the IPOC must be signed, titled and signature dated by the supervising clinician. Services added or frequencies of services changed in an existing IPOC must be signed and dated by the supervising clinician. An updated copy must be provided to the beneficiary. The IPOC must be filed in the beneficiary's clinical record with any supporting clinical documentation.

**Progress Summary**

A progress summary is a periodic evaluation and review of the beneficiary's progress toward the treatment goals, the appropriateness of the services being provided, and the need for the beneficiary's continued participation in treatment. If psychotherapy services are being provided by an allied professional, the supervising clinician and allied professional must meet to review the beneficiary's participation in all services every 90 days with completion during the calendar month in which it is due. Reviews may be conducted more frequently if the nature of needed services changes or if there is a change in the beneficiary's condition or status as determined by the physician/NP.

Progress summaries shall be documented in detail in the beneficiary's record and include:

- The beneficiary's progress towards treatment goals.
- The appropriateness of the services provided and their frequency.
- The need for continued treatment.
- Recommendations for continued services.
- The signature and title of the supervising clinician and allied professional.

If it is determined during the progress summary that the IPOC needs to be modified, then an updated IPOC also must be developed.

**IPOC Reformulation**

The maximum duration of an IPOC is 12 months (365 days) from the date of the signature of the supervising clinician. The allied professional must evaluate with the beneficiary his/her progress in reference to each of the treatment goals and desired outcomes. Based on the progress of the beneficiary, the IPOC must be reformulated annually to include updated treatment goals and outcomes. The signature of the supervising clinician is required on the reformulated IPOC.

**Transition/Discharge**
The supervising clinician is responsible for determining the duration of treatment based on the individual needs of the beneficiary. The allied professional involved in the delivery of services to the beneficiary may gather and/or give information to assist with this process. Beneficiaries may be discharged from treatment when they meet one of the following criteria:

- Level of functioning has significantly improved with respect to goals outlined in treatment plan.
- All treatment goals have been achieved.
- Beneficiary has developed skills and resources needed to transition to a lower level of care.
- Beneficiary requests discharge (and is not imminently dangerous to self or others).
- Beneficiary requires a higher level of care (e.g., inpatient hospitalization or Psychiatric Residential Treatment Facility [PRTF]).

**Psychiatric Diagnostic Evaluation**
Psychiatric diagnostic evaluation is an integrated biopsychosocial assessment, including history, mental status and recommendations. The evaluation may include communication with family or other sources and review and ordering of diagnostic studies.

Psychiatric diagnostic evaluation with medical services is an integrated biopsychosocial and medical assessment, including history, mental status, other physical examination elements as indicated, and recommendations. The evaluation may include communication with family or other sources, prescription of medications, and review and ordering of laboratory or other diagnostic studies.

- Psychiatric diagnostic evaluation
- Psychiatric diagnostic evaluation with medical services

These procedures may be reported once every six months and not on the same day as an E&M service performed by the same individual for the same beneficiary.

**Eligible to bill:** Physician/Psychiatrist or Psychiatric NP

**Psychological Testing**
Psychological testing includes psycho-diagnostic assessment of emotionality, intellectual abilities, personality and psychopathology (e.g., MMPI, Rorschach, WAIS) per hour of the physician’s time, both face-to-face time administering tests to the beneficiary and time interpreting these test results and preparing the report.

- Psychological testing.
- Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour.
- Each additional hour is listed separately in addition to code for primary procedure.

These procedures are reimbursed per hour, not per test. Report time as face-to-face time with patient and the time spent interpreting and preparing the report. Only three hours are allowable per day with a maximum limit of 12 hours in one year.

**Eligible to bill:** Physician/Psychiatrist or Psychiatric NP

**Environmental Intervention for Medical Management**
Environmental intervention for medical management purposes on a psychiatric patient's behalf, including coordination of services. This code can be billed when the supervising clinician meets with an allied professional to coordinate services, discusses treatment issues, and review the treatment plan for a beneficiary and must be clearly documented in the progress summary and signed by the supervising clinician. This code cannot be billed each time the clinician signs the chart only. One progress summary is required every 90 days. Medicaid will reimburse only the supervising clinician for this service.

- Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.

This procedure is reimbursed in 30-minute increments (units), not to exceed an hour and a half per day. The supervising clinician, when coordinating services with allied professionals, may bill one unit of this code.

**Eligible to bill:** Physician/Psychiatrist or Psychiatric NP

**Psychotherapy**
Psychotherapy is the treatment of mental illness and behavioral disturbances in which the physician or other qualified healthcare professional, through definitive therapeutic communication, addresses the emotional disturbance, reverses or changes maladaptive patterns of behavior, and encourages personality growth and development. Psychotherapy times are for face-to-face services with beneficiary and/or family member. The beneficiary must be present for all or some of the service.

- Psychotherapy, 30 minutes

- Psychotherapy, 45 minutes
- Psychotherapy, 60 minutes

One session, regardless of time, is allowed per day within this range of procedures. If this service is being billed, an IPOC must have been completed for the beneficiary.

**Eligible to bill:** Physician/Psychiatrist, Psychiatric NP or LMSW — with HO Modifier

**Psychotherapy with Medical Evaluation and Management Services**
Some psychiatric patients receive a medical E&M service on the same day as a psychotherapy service by the same physician/NP. To report both E&M and psychotherapy, the two services must be significant and separately identifiable. Please refer to the current CPT for further instruction. These services are reported by using the following codes specific for psychotherapy when performed with E&M services as add-on codes to the E&M service:

- Psychotherapy, 30 minutes
- Psychotherapy, 45 minutes
- Psychotherapy, 60 minutes

One session, regardless of time, is allowed per day within this range of codes. If this service is being billed, an IPOC must have been completed for the beneficiary.

**Eligible to bill:** Physician/Psychiatrist or Psychiatric NP

**Collaborative Care Model**
The Collaborative Care Model (CoCM) is a systemic strategy for treating behavioral health conditions in primary care through integration of care coordination and psychiatric consultants. The model uses triangulated care by coordination of the Primary Care Provider (PCP), a behavioral health care manager (BHCM), a psychiatric consultant, and a registry tool to deliver direct and functional care to the patient. The CoCM Registry is typically separate from the patient's EMR and is used as a centralized location for those involved in this model to manage caseloads and track their patients' outcomes over time.

This program covers the following medically necessary services rendered to recipients under the CoCM:

1. The PCP provides primary care services, coordinates care, and helps the patient access a range of health care services.

2. The BHCM supports and implements treatment initiated by the PCP, such as medication monitoring.

3. The primary care team, in consultation with the psychiatric consultant, determines the course of treatment and sets measurable benchmarks that they expect the patient to reach in the next six (6) months, which is the average episode of care for CoCM.

CoCM services may be delivered face-to-face, by video, or phone. Services performed via telehealth must include the GT modifier on the claim.

**Collaborative Care Model Registry**
A required part of the CoCM workflow is the use of a registry to manage caseloads and track patient outcomes. Options include:

- A spreadsheet used alongside the EHR
- A caseload management application used alongside the EHR
- A customized registry build in an EHR.
- A pre-made caseload tracker, such as the AIMS Caseload Tracker made specifically for CoCM.

SCDHHS will not limit providers to one type of registry but will require that the registry meets at minimum all of the following:

- Track clinical outcomes across a population of focus
- Track patient engagement across a caseload
- Facilitate efficient, systematic psychiatric caseload review
- Monitor individual patient progress
- Facilitate treatment-to-target by summarizing a patient's progress in a measurement-based, understandable and actionable way
- Enable efficient psychiatric consultation and case review, allowing providers to easily prioritize patients who need evaluation for changes in treatment or who are new to the caseload
- Is Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant
- Follows all applicable State and Federal laws, rules, and regulations

**Provider Requirements**
Primary care provider-led teams of qualified professionals shall be eligible to receive reimbursement for CoCM services billed under the PCP. This team must consist of the following:

- Primary Care Practitioner (Physician, NP, PA, or Certified Nurse Midwife (CNM))

- Psychiatric consultant (which may be a psychiatric extender such as a nurse practitioner or physician assistant).
- Behavioral Health Care Manager (bachelor's level degree in a behavioral health field such as in social work or psychology or a clinician with behavioral health training, including nurses.)
    - The BHCM furnishes both face-to-face and non-face-to-face services under the general supervision of the treating provider. BHCMs do not have to be independently licensed or bill traditional psychotherapy codes, as the services they provide are directed and goal-oriented and standardized across the model for a variety of patients.

**Covered Population**

The goal of CoCM services is to extend the capabilities of primary care practices to identify and treat beneficiaries with low to moderate behavioral health needs. CoCM is a covered service for full benefit Healthy Connections Medicaid beneficiaries whose diagnosed behavioral health disorder requires systematic management, regular monitoring, and the provision of brief interventions to ameliorate their behavioral health symptoms. CoCM is intended for beneficiaries with common behavioral health conditions that require systematic follow-up due to their persistent nature, including but not limited to mild to moderate depression, anxiety, post-traumatic stress disorder (PTSD), and substance use disorders (SUD). These services are not intended to manage complex, severe, and/or persistent conditions which may require more specialized care. Prior authorization is not required for this service.

**Billing Guidance**

Claims for CoCM services must be billed under the primary care provider's name and provider number as the rendering provider. The PCP practice is responsible for arranging payment of the psychiatric care provider and the behavioral health care manager. Medicaid enrollment is not required for the BHCM or psychiatric consultant.

CoCM is billed monthly by the PCP. CoCM billable time includes time spent with the patient when the PCP, psychiatric consultant, and BHCM act as a multidisciplinary team to assist with a behavioral health concern. CoCM does not replace evaluation and management codes. Office visits for direct patient care will continue to be billed with evaluation and management codes or other appropriate codes, however, the time and activities during the office visit cannot be counted toward CoCM.

Collaborative Care Model (CoCM) codes can be billed in the same month as targeted case management (TCM) services. However, the time and activities used to meet the criteria for TCM cannot be counted toward CoCM.

CoCM providers can bill separately for face-to-face services they provide in conjunction with CoCM services as long as this time is not included in the calculation of the time spent in providing CoCM services.

The intention of CoCM is to manage behavioral health issues in a primary care setting, as appropriate. While beneficiaries participating in CoCM services may concurrently receive core behavioral health services (i.e., assessment, individual, group, and family therapy), if the beneficiary has more intensive needs, they shall be evaluated for appropriateness for ongoing enrollment in CoCM. Additionally, if the beneficiary has a comorbid behavioral health condition for which more intensive behavioral health services are required, this time shall not be captured within the context of CoCM billing. Billable time includes non-traditional work (e.g., calling a patient to check in on how they are doing and administering a screening measure by phone, liaising with the PCP, consulting the psychiatrist, communicating clinical care with other professionals, ect.).

An episode of care is defined as the period of time in which a patient is receiving treatment. If an episode of care extends beyond six months and goals are not achieved, SCDHHS recommends that the practice consider if more intensive or specialized treatment strategies might benefit the patient. If the patient returns to treatment after 6 months have elapsed, a new episode of care could be started, and the provider should begin treatment again by billing the initial CoCM code 99492 and measuring a new baseline PHQ-9 score or other validated measurement tool.

Service Components

To submit CoCM specific codes for Medicaid reimbursement, the following service elements must be provided:

- Outreach and engagement of patients;
- Initial assessment, including administration of validated scales (e.g., PHQ-9 or GAD-7) and resulting in a treatment plan;
- Entering patients into a registry for tracking patient follow-up and progress;
- Participation in weekly caseload review with psychiatric consultant and modifications to treatment, if recommended;
- Provision of brief interventions using evidence-based treatments such as behavioral activation, problem-solving treatment, and other focused treatment activities;
- Tracking patient follow-up and progress using validated rating scales;
- Ongoing collaboration and coordination with treating providers;
- Referrals to specialty services and social services as needed; and,
- Relapse prevention planning and preparation for discharge from active treatment.

Primary care practices that provide collaborative care services must bill for CoCM using Current Procedural Terminology (CPT) codes for Psychiatric Collaborative Care Management Services (**99492, 99493, 99494 and G2214**).

Table. Medicaid Collaborative Care Model Codes, Description and Frequency

| CPT Code | Description | Frequency |
|---|---|---|
| 99492 | First 70 minutes in the **first calendar month** of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treated physician.<br><br>Can be billed with 99494 as an add-on code if more time is required. | 1 per year |
| 99493 | First 60 minutes in a **subsequent** month for behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treated physician.<br><br>Can be billed with 99494 as an add-on code if more time is required. | 1 per month |
| 99494 | Each **additional** 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treated physician.<br><br>Add-on code, must be billed with either 99492 or 99493. | 4 per month |
| G2214 | **Initial or subsequent** psychiatric collaborative care management, **first 30 minutes** in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician.<br><br>Code billed when the patient's total billable minutes are less than what is required to bill 99493. Cannot be billed in same month as 99492, 99493, or 99494. | 1 per month |

**Family Psychotherapy**

Family psychotherapy is a face-to-face intervention with family members of the beneficiary with the purpose of treating the beneficiary's condition and improving the interaction between the beneficiary and family member(s) so that the beneficiary may be restored to their best possible functional level. Family Psychotherapy may be rendered with or without the beneficiary to family members of the

identified beneficiary if the identified beneficiary is the focus of the sessions. The identified beneficiary is the family member with the symptom that has brought the family into treatment. Only issues pertinent to the identified beneficiary may be addressed under this service.

- Family Psychotherapy including patient, 50 minutes
- Family Psychotherapy, 50 minutes

One session, regardless of time, is allowed per day within this range of codes. If this service is being billed, an IPOC must have been completed for the beneficiary.

**Eligible to bill:** Physician/Psychiatrist, Psychiatric NP or LMSW — with HO Modifier

**Group Psychotherapy**
Group psychotherapy is a face-to-face intervention with a group of beneficiaries who are addressing similar issues with the purpose of restoring the beneficiary to his/her best possible functional level. Therapy is conducted in small groups. The group must be a part of an active treatment plan and the goals of group therapy must match the overall treatment plan for the individual beneficiary. The focus of the therapy sessions must not be exclusively educational or supportive in nature. Groups must consist of one professional and no more than eight beneficiaries.

- Group Psychotherapy — other than of a multiple-family group.

This code is covered for eligible beneficiaries in a group, even when the whole group is not Medicaid eligible. Medicaid will reimburse a clinician for one group session per day per Medicaid-eligible beneficiary. If this service is being billed, an IPOC must have been completed for the beneficiary.

**Eligible to bill:** Physician/Psychiatrist, Psychiatric NP or LMSW — with HO Modifier

**Psychotherapy for Crisis**
Psychotherapy for Crisis is an urgent assessment and history of a crisis state, a mental status exam and a disposition. The treatment includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma. The presenting problem is typically life-threatening or complex and requires immediate attention to a beneficiary in high distress.

- Psychotherapy for Crisis — This procedure is used to report the first 30–74 minutes of psychotherapy for crisis on a given date. It must be used only once per date even if the time

spent by the physician or other qualified health care professional is not continuous on that date. The beneficiary must be present for all or some of the service.

- A separate code is used in conjunction with Psychotherapy for Crisis to report each additional 30 minutes of crisis for psychotherapy.

**Eligible to bill:** Physician/Psychiatrist, Psychiatric NP or LMSW — with HO Modifier

**Medical Evaluation and Management Services**
Some psychiatry services may be reported with Medical E&M services or other services when performed. E&M services may be reported for treatment of psychiatric conditions, rather than using Psychiatry Services codes, when appropriate. Please refer to the current CPT as E&M codes are classified by type of service, place of service and the patient's status.

**Eligible to bill:** Physician/Psychiatrist or Psychiatric NP

**Interactive Complexity**
Interactive complexity refers to specific communication factors that complicate the delivery of a psychiatric procedure. Please refer to the current CPT for complete definition. For billing purposes, this is an add-on code for interactive complexity to be reported in conjunction with codes for diagnostic psychiatric evaluation, psychotherapy, psychotherapy when performed with an E&M service and group psychotherapy.

**Eligible to bill:** Physician/Psychiatrist or Psychiatric NP

## Ophthalmology and Optometry Services

SCDHHS recognizes parity between ophthalmologists and optometrists as defined by State Law with respect to reimbursement. Services rendered by optometrists must comply with SC Optometry Practice Act.

Routine vision services are covered for beneficiaries from birth up to the last day of the month of their 21st birthday. Routine vision services for adult beneficiaries 21 years and older are non-covered services. Routine vision services are defined as services related to refractive care: routine eye exams, refractions, corrective lenses and glasses. Services related to disease of the eye are covered, for an example glaucoma, conjunctivitis and cataracts.

Providers are responsible for accurately billing a valid and appropriate procedure code the level of which reflects services rendered to Medicaid beneficiaries. Providers must use the appropriate place of services (POS) code as defined by the Centers for Medicare and Medicaid Services (CMS). For services rendered via a mobile optometry unit on-site of a Title I public school, providers must

enter the POS=03 on the claim form. For a complete listing of POS codes please visit the CMS website: Place of Service Code Set | CMS. Reimbursement for vision services delivered in Title I schools via mobile units is the same as services delivered in an office setting.
When reporting services provided in an office, home, SC Title I public schools, hospital, or an institutional facility that are not specific ophthalmology codes providers must utilize E&M codes listed in the AMA CPT manual. Providers are responsible for all National Correct Coding Initiative (NCCI) rules and regulations.

If an E&M code is used for treatment of a disease, it cannot be used in conjunction with a comprehensive exam code for treatment on the same DOS (as defined by NCCI). The provider must bill either the E&M code or the comprehensive exam code. Providers must refer to the CPT manual to determine which E&M code is the most appropriate. The patients' record must reflect the level of service performed and must be well documented in the patients' chart. All services billed are subject to a PI review. During post-payment reviews (audits), auditors will monitor these codes closely to ensure that the code reflects the service billed and best meets the description reflected in the documentation. The use of E&M codes will count toward the 12 maximum visits allowed for all patients over the age of 21, for the fiscal year. The fiscal year begins July 1 of every year and ends June 30 of every year.

### Part I — Vision Care Services

Vision care services are defined as those that are medically necessary for the diagnosis and treatment of conditions of the eye. Refractive care is defined as the exam and treatment of visual states such as, but not limited to, the correction of amblyopia, presbyopia and for all services that can be corrected by the provision of corrective lenses. Referrals from local DSS offices or staff, schools, and patient's actual complaints of visual acuity constitute justification to provide eye exams and other refractive services for children under the age of 21. Providers must note these referrals and complaints in the patient's medical records.

**Exam and Glasses for Birth to Age 21**
For the treatment of children under the age of 21, one complete comprehensive eye exam is covered within a 365-day period (12 consecutive months).

A complete set of glasses is provided every 365 days when medically necessary.

### Repair and Replacement
Eyeglasses must be repaired without additional reimbursement when the repair or replacement of eyeglass parts is required due to defects in quality of materials or workmanship. Reimbursement is available for repair or replacement of eyeglass parts in situations where the damage is the result of

causes other than defective materials or workmanship. Replacement parts must replicate the original prescription and frame style. Repairs to frames may be rendered as necessary.

Providers must use the appropriate procedure code for the repair or replacement of component parts of eyeglasses. When a component part of eyeglasses is replaced, the U8 modifier may be affixed to the appropriate procedure code for the component part that is being replaced. The reason for the repair or replacement of parts must be documented in the recipient's records.

### Replacement of a Complete Pair of Eyeglasses

Reimbursement is available for one complete pair of replacement eyeglasses that has been lost or destroyed within twelve consecutive months. The replacement for a complete pair of eyeglasses must replicate the original prescription and frames. The U9 modifier is affixed to the appropriate procedure codes identifying fitting of eyeglasses and materials when claiming replacement of a complete pair of eyeglasses that has been lost or destroyed. An explanation of the circumstances surrounding replacement of the complete pair of eyeglasses must be maintained in the enrollee's record.

If a beneficiary has surgery or prescriptive change with a minimum of one-half diopter (0.50) during 12 consecutive months, only replacement lenses (not frames) will be covered. Providers must document medical necessity in the patient's medical record.

Contact lenses are allowed when prescriptive glasses are medically unsuitable. Documentation must indicate the medical necessity for contact lenses over glasses.

**Guidelines for Lenses and Frames**

Fabrication of eyeglasses shall conform to the current American National Standards Institute prescription requirements, and all lenses, frames and frame parts must be guaranteed against defects in manufacture and assembly. The provider who receives reimbursement for dispensing the eyeglasses has the final responsibility for this guarantee.

When adjustments to eyeglasses are required, the adjustment must be made without additional reimbursement whenever the enrollee returns to the original dispenser.

If the enrollee selects frames or lenses that are not Medicaid reimbursable, the enrollee must be informed prior to the fabrication of the eyeglasses that he/she will be financially responsible. In such cases, Medicaid may not be billed for all or part of the cost of said frames or lenses.

## Lenses

All lenses for children under the age of 21 are to be first quality impact resistant lenses meeting FDA regulations, free of surface imperfections such as pits, scratches or grayness. The lenses shall not contain bubbles, striations or other surface abrasions.

## Special Types of Lenses

**Polycarbonate Lenses**

All lenses provided to beneficiaries up to the age of 21, must be polycarbonate lenses and billed with the appropriate HCPCS vision code; non-polycarbonate lenses are not covered by SCDHHS.

**High-Index Lenses**

A 10 diopters (10DS) or greater lens is reimbursable at acquisition cost that is documented by an itemized invoice when such cost is greater than the fee listed for the lens code in the fee schedule. The fee schedule can be found on the SCDHHS website: http://www.scdhhs.gov/.

**Frames**

Frames supplied are to be first quality frames. All frames must have eye size, bridge size, temple length and manufacturer's name or trademark imprinted on them.

If the enrollee returns to the original dispenser to obtain the service, future fittings must be made by that dispenser without additional reimbursement:

- Frame Complete
- Deluxe Frame

**Guidelines for Contact Lenses**

Daily wear contact lenses will be covered for beneficiaries under the age of 21, if medical necessity has been established and prescription glasses are not suitable for the beneficiary. Daily wear contact lenses will be supplied in monthly increments. Contact lens procedure codes are per lens and the correct number of units must be indicated in the “units” column of the claim form/electronic record.

Providers must file for payment using the examination date as the DOS. Use CPT procedure codes for the fitting and dispensing of contact lens. These codes include the contact lens fitting, all follow-up visits, solutions and supplies. This reimbursement does not include the initial eye examination.

### Special Requests

If the covered contacts do not meet the needs of the patient, providers can contact the PSC at 888-289 0709 or submit an online inquiry at Contact a Provider Representative | SCDHHS before dispensing the contacts. Special requests will require medical justification prior to dispensing. The PSC will forward all requests to the Division of Health and Medical Services, which will review the requests and contact the provider with a decision. Health and Medical Services are responsible for all reviews and exceptions.

**Covered Contact Lens Products**

The following covered contact lens products includes:

- Contact lens, PMMA, spherical, per lens
- Contact lens, PMMA, toric or prism ballast, per lens
- Contact lens, gas permeable, spherical, per lens
- Contact lens, gas permeable, toric, and prism ballast per lens, or a high plus or minus gas permeable post cataract, per lens
- Contact lens, hydrophilic, spherical, per lens
- Contact lens, hydrophilic, toric or prism ballast, per lens
- UV lens, per lens
- Contact lens, other type. (Providers must contact and send documentation via the PSC. The PSC will forward the documentation to the Division of Health and Medical Services.)

**Dispensing Codes for Contact Lenses and Glasses**

The following dispensing codes and fees for contacts and glasses may be used when applicable for the services to be rendered.

92310 — Prescription of optical and physical characteristics of the fitting of contact lenses, with medical supervision of adaptation; corneal lenses. The dispensing procedure is bilateral, and the fee listed is for both eyes.

92311 — Prescription of a corneal lens for aphakia. The dispensing procedure is unilateral, and the fee listed is for one eye.

92312 — Prescription of corneal lenses for aphakia. The dispensing procedure is bilateral, and the fee listed is for both eyes.

92313 — Prescription of a corneoscleral (large lens). The dispensing procedure is unilateral, and the fee listed is for one eye.

92340 — Fitting of spectacles, except for aphakia. This code must only be filed when the glasses are physically received at the physician's office for the dispensing of glasses. The DOS when filing this procedure must always be the date the eye exam was performed.

92370 — Repair and refitting of spectacles; except for aphakia.

**Optician**
Providers must show eligible recipients the complete selection of Medicaid-reimbursable frames and explain that Medicaid pays only for frames that falls within the reimbursement limit.

Providers must have a selection of nickel-free frames for beneficiaries that have allergies to nickel. Providers must have a selection of oversized frames or special needs frames for children readily available as an option in the frame selection. See guidance above under Guidelines for Lenses and Frames.

Providers must file for payment using the examination date as the DOS. Reimbursement for eyewear does not include the initial eye examination. All records and medical justification must be documented and located in the patient's charts for auditing purposes.

Prescription requests must be written in language common to all health care practitioners providing vision care in the United States. Criteria for the prescription requests include, but are not limited to, the following:

- Unaided visual acuity at distance and near must be 20/30 or less. Aided and unaided visual acuities must be stated in the patient's records.
- Corrective lenses must be at least plus or minus 0.50 sphere or more, or plus or minus 0.50 cylinder or more in each eye; or 0.75 in one eye.
- Vertical and horizontal prisms will be authorized if medically necessary. The prescription must be remedial and not training — by nature.
- Replacement of lenses requires medical justification. Self-Employed Optometrist

Reimbursement is provided for the following materials and services in accordance with the fee schedule:

- Complete optometric eye examination.
- Office-based E&M services, consultations, diagnostic examinations, and non-invasive procedures for the diagnosis and treatment of diseases of the eye and the prescribing of pharmaceutical agents authorized under State Law.
- Eyeglass lenses.
- Contact lenses.
- Repairs and refitting of eyeglasses.
- Fitting of eyeglasses.

**Retail Optical Establishments and Ophthalmic Dispensers**
Reimbursement is provided for the following materials and services in accordance with the fee schedule:

- Complete optometric eye examination (limited to retail optical establishments and ophthalmic dispensers who employ an optometrist).
- Office-based E&M services, consultations, diagnostic examinations and non-invasive procedures for the diagnosis and treatment of diseases of the eye and the prescribing of pharmaceutical agents authorized under State Law (limited to retail optical establishments and ophthalmic dispensers who employ and optometrist).
- Eyeglass lenses.
- Contact lenses.
- Repairs and refitting of eyeglasses.
- Fitting of eyeglasses.

The fee schedule for vision services is located on the SCDHHS website at http://www.scdhhs.gov/.

## Part II — Diagnostic Ophthalmology Services

Diagnostic services included in the CPT coding range 92018–92287 are compensable as separate procedures if performed as a distinct and individual service and not included in the ophthalmological or E&M exam, with the following restrictions:

### Covered Services

#### Refractions

The determination of the refractive state is allowed as a separate procedure in addition to the ophthalmology exam.

#### Ophthalmoscopy

Routine ophthalmoscopy (direct or indirect) is a part of general and specific ophthalmologic services, whenever indicated. It is not reported separately. Ophthalmoscopy, extended, with retinal drawing, as for retinal detachment, melanoma, with interpretation and report, may be billed in addition to an ophthalmological exam or an E&M services procedure code. If medically necessary, this code may be billed one time per eye per DOS.

#### Visual Field Examination

This exam is compensable when medically indicated as separate from the ophthalmological or E&M exam.

#### Vision Therapy

The following procedures are allowed for vision therapy services only:

- Unlisted neurological or neuromuscular diagnostic procedure (Support documentation of therapy service must be attached to the claim.)
- Developmental testing; limited (e.g., Developmental Screening Test II, Early Language Milestone Screen) with interpretation and report.
- Developmental testing: extended (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report.
- Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning, problem-solving and visual-spatial abilities), per hour of the psychologist’s or physician’s time, both face-to-face time with the patient and time interpreting test results and preparing the report.

**Note:** If an eye examination indicates a need for corrective lenses, the examining provider performing the comprehensive exam must complete the course of treatment. This includes the eye examination and written prescription (Rx) for ordering the glasses for the Medicaid beneficiary.

## Part III — Ocular Surgery

### Post-Operative Management of Cataract Surgery

South Carolina Medicaid allows optometrists to bill for post-operative management only for appropriate CPT procedure codes. These are global codes and cover both the surgical care and post-operative management.

For an optometrist to bill and be reimbursed for post-operative management, optometrists must bill the above-referenced codes using modifier 55 only. Ophthalmologists must bill the above-referenced codes with modifier 54, surgical care only. If the ophthalmologist does not bill using a modifier, the provider will be reimbursed for the entire global fee, which includes both surgical care and post-operative management.

**Ocular Prosthesis:** The prescription and fitting of ocular prostheses are covered for all eligible beneficiaries. The molding and manufacturing of the actual prosthesis is through our Agent, MUSC Maxillofacial Prosthodontic Clinic. Providers must contact MUSC Maxillofacial Prosthodontic Clinic at:

Phone Number: (843) 876-1001
Fax Number: (843) 876-1098

Providers are responsible for forwarding all medically necessary documentation to our Agent in order for services to be rendered.

**Intraocular Lenses:** Physicians who supply these lenses may bill using the codes listed below. The codes are for the supply of lenses and must be billed in addition to the surgical procedure.

- Anterior chamber angle fixation lens.
- Posterior chamber lens.

**Ptosis:** Lid correction procedures are covered only when there is documented medical necessity for the improvement of visual disabilities. Services must be preauthorized by the Quality Improvement Organization (QIO) contractor, for utilization review.

**Note:** Simple blepharoplasty is considered a cosmetic procedure and therefore, non-compensable.

**Keratoplasty:** Corneal transplants are compensable. Physician reimbursement includes only the surgery. Reimbursement to the hospital includes all technical services including donor preparation.

**Special Ophthalmological Services**
The following medical ophthalmology codes may be billed separately from an ophthalmology exam or an E&M services code. These codes may be billed one time per eye per DOS when medically necessary.

- Ophthalmoscopy, extended, with retinal drawing, as for retinal detachment, melanoma with interpretation and report; initial.
- Ophthalmoscopy extended; subsequent.
- Fluorescein angioscopy with interpretation and report.
- Fluorescein angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral.
- Indocyanine-green angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral.
- Ophthalmodynamometry.
- Electrooculography with interpretation and report.
- Electroretinography with interpretation and report.
- External ocular photography with interpretation and report for documentation of medical progress.
- Special anterior segment photography with interpretation and report; with specular endothelial microscopy and cell count.
- Special anterior photography with fluorescein angiography.

**Use of Modifiers with Procedure Codes**
If it is medically necessary to repeat an ophthalmology procedure on the same DOS and the procedure is bilateral (i.e., the procedure is for both eyes), then the total charge amount for both eyes must be listed on the first line and again on the line recording the repeated procedure.

For the claim to process, the modifier on the first line must be “00” (two zeros), and the modifier on the line recording the repeated procedure must be (76). This is the only time these two modifiers must be used. It is imperative that the medical record of this patient indicates and justifies the medical necessity of repeating this service on the same day. The use of two modifiers indicates that the procedure was done bilaterally on the first occurrence and again bilaterally on the second occurrence. Indicate a “1” in the “units" column for the number of units on each line.

When medically necessary to repeat the same procedure on the same DOS and the procedure is unilateral, then the total charge amount for one eye must be listed on the first line utilizing an RT, right side (used to identify procedures performed on the right side of the body) or LT modifier, left side (used to identify procedures performed on the left side of the body). The second line for the repeated procedure must be billed utilizing a 76 modifier. The medical record of the patient must indicate and justify the medical necessity for the repeat procedure.

**Reminder:** In all cases, the fee listed for all ophthalmological procedures is for both eyes, unless otherwise indicated.

The use of modifiers AP (determination of refractive state was not performed in the course of diagnostic ophthalmological examination) is not reimbursed by SCDHHS and will result in rejected claims.

The following modifiers must be used for replacement of parts:

U8 = Replacement of a part of frames

U9 = Replacement of a part

## Otorhinolaryngology (ENT)

### General ENT Services

Diagnostic or treatment procedures usually included in an ENT exam are reported as an integrated medical service and must not be reported separately.

Microsurgical Techniques are procedures that describe “microsurgical techniques requiring use of operating microscope.” It can be billed in addition to the primary surgical procedure if it is not an inclusive part of the surgical procedure and if the documentation supports the use of microsurgical techniques. It is not for visualization of the operative field alone but is intended to be employed when the surgical services are performed using the techniques of microsurgery.

If the use of the operating microscope is an inclusive component of a procedure, the use of the operating microscope cannot be unbundled.

**Endoscopic Procedures:** Please refer to guidelines for endoscopic procedures under General Surgery Guidelines in this section of the manual.

**Uvulopalatopharyngoplasty:** Documentation (admission history and physical and operative report) is required with claims submitted for this procedure. The record must substantiate medical necessity as well as clarify the procedures performed.

**Septoplasty, Turbinectomy:** These and any other nasal reconstructive surgeries are covered only when there is a loss or serious impairment of bodily function, usually as a result of trauma, and the surgery restores the disabled function. The office record must document the functional deficit or the need for prompt correction.

**Speech Therapy (ST) and Hearing Therapy Services**
Services rendered by ENT specialists or therapists supervised by a physician are compensable using the appropriate code in the CPT with the following restrictions:

- ST and Hearing Therapy: Non-compensable. Please refer to Specialized Speech and Hearing Services for Children Under 21 below regarding services for children.
- Vestibular Function Test without Recording: Non-compensable (included in visit code).
- Ear Protector Attenuation Measurements (ear plugs): non-compensable.
- Hearing Aids and Hearing Aid Accessories: Must be pre-authorized and obtained through the SCDPH. Services are limited to children under age 21. For prior approval, send request to:

  Division of Children's Rehabilitative Services
  Box 101106, Mills Complex
  Columbia, SC 29211
  (803) 898-0784

- Ear Molds: To report, physicians must use the following supplemental codes:
  - Ear mold, not disposable, any type.
  - Ear mold, disposable, any type.

  - Use modifiers RT (right side) and LT (left side) to indicate which ear.
  - These codes are allowed four times every 12 months per ear for children under age 21.

- Cochlear Implants and related services:
  - Beneficiaries under the age of 21 years with unilateral or bilateral hearing loss may receive medically necessary placement, replacement and maintenance of cochlear implants that delivered in accordance with clinical standards of medical and audiological practice.
  - Beneficiaries aged 21 years and older with unilateral or bilateral severe to profound sensorineural hearing loss may receive medically necessary placement, replacement and maintenance of cochlear implants that delivered in accordance with clinical standards of medical and audiological practice. Hearing aid trial is not required to qualify for the cochlear implantation.
  - Replacement of cochlear implants are allowed once in 5 years. Maintenance services are allowed as necessary.
  - Cochlear Device Implantation: Requires prior approval from QIO one of the following methods:

    QIO Customer Service: (855) 326-5219
    QIO Fax: (855) 300-0082

- Specialized Speech and Hearing Services for Children Under 21: Services are available through clinics certified by SCDPH and through individual speech-language pathologists/audiologists who are licensed by the South Carolina State Board of Examiners in Speech-Language Pathology and Audiology and enrolled with the South Carolina Medicaid program. Speech/language and audiology services rendered by these providers must be pre-authorized by SCDPH, South Carolina Department of Disabilities and Special Needs, or a school district.
- ENT specialists who provide these specialized services in their office or clinic may apply for certification. If certified by SCDPH, the physician must enroll as a speech and hearing clinic with South Carolina Medicaid in order to obtain payment for these services (for children under 21). For information on SCDPH certification requirements, you may write to:

  Department of Public Health
  Clinic Certification

2600 Bull Street
Columbia, SC 29201

### Cardiology

Physicians performing these services in their office may bill for the complete procedure code, which includes the tracing, interpretation and report. Those providers interpreting the recording only must use the code that stipulates interpretation and report only. The modifier 26 is not necessary when the code clearly defines the professional component only (interpretation and/or report).

For more detail regarding EKG interpretations, please refer to Radiology Reimbursement Limitations under Radiology and Nuclear Medicine in this section of the manual.

### Pulmonary Medicine

Oxygen therapy given in the office is compensable when medically indicated and clearly identifiable as a separate procedure. Documentation must be submitted with the claim.

Questions regarding oxygen therapy equipment for home use may be directed to the PSC at (888) 289-0709. Providers may also submit on online inquiry at Contact a Provider Representative | SCDHHS for additional information.

A separate code is used to report tracheostomy tube change in the office setting. This may be used in addition to the appropriate level office E&M visit codes.

Overnight sleep apnea study services must be billed using the appropriate code.

### Tuberculosis (TB) Policy

TB services cover treatment directly related to the care of TB which falls under the following categories:

- Prescribed medications
- Physician services
- OP hospital services
- Public health clinics
- Laboratory
- Radiology

- Case management

**Note:** This policy does not cover hospital stays, room and board or observation stays.

Treatment of a beneficiary with TB is most successful within a comprehensive framework that addresses both clinical and social issues of relevance to the beneficiary. It is essential that treatment be tailored and supervised based on each beneficiary's individual clinical and social needs (patient-centered care). SCDPH is ultimately responsible for ensuring that adequate, appropriate diagnostic and treatment services are available, and for monitoring the results of therapy.

**Initial TB Screening**
The initial TB screening will be covered when performed by a NP, PA or Registered Nurse employed by the SCDPH clinic. The initial screening includes, but is not limited to the following:

- Brief mental and physical assessment
- Exposure history
- Referral for laboratory testing and or radiology services
- Referral for social services
- Referral for other medical services
- Consultation with TB medical clinician

SCDPH will bill SCDHHS for an E&M code.

For beneficiaries that are not in the limited benefits category (Family Planning and/or TB only), SCDPH will provide a referral for the beneficiary to be seen by a physician if medically necessary and maintained in the beneficiary's medical health record. The physician must bill SCDHHS utilizing a new patient examination 99203 CPT code. The physician will be reimbursed for the initial consultation as long as the consultation is done within a 30-day period from the date of the initial TB screening service provided by SCDPH, or all initial and subsequent treatment will be denied. If SCDPH determines that it is medically necessary for the beneficiary to see a physician for subsequent visits, they are responsible for providing authorization, which must be maintained in the beneficiary's medical health records. All services are subject to audit by SCDHHS Division of Program Integrity.

**Subsequent Nursing Services**
Subsequent nursing services are covered services when performed by an NP, Registered Nurse, and Licensed Practical Nurse, in the SCDPH clinic or home setting. SCDPH must bill all medically necessary exams to SCDHHS utilizing the appropriate E&M code. The maximum number of visits allowed for a treatment cycle is 360 for a beneficiary with latent TB infection and 360 for a beneficiary with TB disease. Medical necessity must be maintained within the beneficiary's medical health records.

**Case Management**
All Case Management services will be patient-centered and will include an adherence plan that emphasizes DOT, in which a beneficiary is observed to ingest each dose of anti-TB medications, to maximize the likelihood of completion of therapy. Each beneficiary's management plan must be individualized to incorporate strategies that facilitate adherence to the treatment regimen. Such measures may include, for example, social service support, treatment incentives and enablers, housing assistance, referral for treatment of substance abuse, and coordination of the TB services with those of other providers.

SCDPH is responsible for providing all Case Management services. Case Management services include, but are not limited to:

- Medication monitoring
- Providing services in the patient's home
- Referring all medically necessary laboratory tests
- Referring all medically necessary radiology tests
- Referring patient to a physician for consultation when medically necessary

Case Management services are limited to 360 visits per year, one visit per day. Case Management services will be covered when performed by a NP, PA, Registered Nurse or Social Worker employed by the SCDPH clinic.

**Multidrug-Resistant Tuberculosis (MDR-TB) Treatment Protocol**
MDR-TB is a form of TB that is resistant to two or more of the primary drugs (isoniazid and rifampin) used for the treatment of TB. The MDR-TB patient treatment model may involve a step approach. First high-dose oral medications are used that may include drugs such as isoniazid, pyrazinamide

and ethambutol. Then treatment can move to injectable drugs, such as capreomycin, kanamycin and amikacin. Treatment length may be extended to manage the disease.

The use of this very intense treatment regimen also requires that the MDR-TB patient receive additional services. For these patients, the below additional procedure codes are covered. For all services providers must follow NCCI correct coding.

- Vision screens up to six times per year
- Labs
- Peripherally inserted central catheter (PICC) line insertion

**Pharmacotherapy**
All treatment medications will be provided by SCDPH for SCDPH patients who have been diagnosed with TB disease and/or latent TB infection regardless of enrollment status (FFS or TB -only eligible). All medications will be reimbursed via 340B pricing. SCDPH must submit the acquisition cost plus dispensing fee to SCDHHS. SCDHHS will then reimburse SCDPH for the TB medications submitted.

**Laboratory Tests**
All laboratory tests are subject to medical necessity guidelines and documentation must be maintained in the beneficiary's chart.

Laboratory tests must be billed with a "00" (two zeros) modifier. If the laboratory tests are referred to an outside laboratory, then SCDPH will provide authorization which will be maintained in the beneficiary's medical health records.

**Radiology Tests**
Radiology tests including interpretation of exams are covered if performed by a NP, PA or Physician:

All radiology procedures must be billed with the appropriate modifiers. See below for a list of modifiers and descriptions:

- Modifier 00 must be appended to the CPT code when the provider has rendered both the TC (the physical taking of an x-ray) and the professional component (interpretation of results).
- Modifier TC must be appended to the CPT code when the provider has only rendered the taking of the x-ray.

- Modifier 26 must be appended to the CPT code when the provider has rendered the interpretation only. Providers are required to write a report and sign, and date.

## Obstructive Sleep Apnea

Treatment of mild obstructive sleep apnea (OSA) is covered via use of eXciteOSA, a Food and Drug Administration (FDA) approved prescription medical device, under the Durable Medical Equipment benefit. The device will be allowed without prior authorization for full-benefit Healthy Connections Medicaid members ages 18 years or older. Eligible members must have a diagnosis of mild OSA, indicated by a sleep study, with a score of apnea-hypopnea index of more than 5 and less than 15. Medical providers must follow the FDA guidelines for use, indications and contraindications when prescribing the device.

The device has the following two units:

- Power Source and Control Unit
  One prescription per lifetime is allowed for the power source and control unit. During the first two years, repairs or replacement covered under the product manufacturer's warranty are not billable to SCDHHS. If the power source unit is damaged or lost after two years of usage or ownership, SCDHHS may allow a replacement power source unit with prior authorization. Providers must file the prior authorization request to the SCDHHS Quality Improvement Organization (QIO).
- Oral Appliance Unit
  The prescription for the oral appliance unit must be renewed annually. During the first two years, repairs or replacement covered under the product manufacturer's warranty are not billable to SCDHHS. If additional units of oral appliance are needed during a 12-month period, the provider must file a prior authorization request to the SCDHHS QIO justifying the need for the additional unit. Only one additional unit may be allowed.

To be eligible for reimbursement for eXciteOSA, Healthy Connections Medicaid-enrolled DME providers must maintain a copy of the Medicaid Certificate of Medical Necessity (MCMN) in the patient's record.

DME Providers must utilize the following procedure codes, criteria, and limitations when billing for the prescription of eXciteOSA:

| Code | Descriptor | Limitations and Billing |
|---|---|---|
| E0490 | Power source and control electronics unit for oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, controlled by hardware remote | Allowed one (1) power source & control unit per patient per lifetime. This is a capped rental device. Procedure code may be billed monthly for up to13 months<br>KH- DMEPOS item, initial claim, purchase of first month rental.<br>KI – DMEPOS item, the second or third month of the capped rental period.<br>KJ- DMEPOS item, month four to thirteen of the capped rental period. |
| E0491 | Oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, used in conjunction with the power source and control electronics unit, controlled by hardware remote, 90-day supply | Supply Purchase. Oral device allowed one (1) per day per patient and up to four (4) per 12 months.<br>No modifier is required. |

## Allergy and Immunotherapy

### Allergy Testing

Scratch testing is the gold standard for Allergy Testing and is a covered service. Allergy testing under anesthesia and RAST testing is not a covered service. Allergy testing for food allergies is not normally considered medically necessary. Therefore, if the provider is testing for food allergies, they must clearly state the medical necessity and supporting documentation in the beneficiary's medical record. All services are subject to audit through the SCDHHS Division of Program Integrity.

### Allergen Immunotherapy

Allergen Immunotherapy is performed by providing injections of pertinent allergens to the patient on a regular basis with the goal of reducing the signs and symptoms of an allergic reaction or prevention of future anaphylaxis. This is usually done with allergen dosages that gradually increase over a period of months.

Providers may bill for professional services for allergen immunotherapy not including provision of allergenic extracts. These codes are for professional services only and do not cover reimbursement for antigen extract or venom.

**Antigen and Preparation**
Refer to code information on the provider portal for information on covered services.

**Allergy Testing and Immunotherapy**

### Allergy Testing

The MPFSDB fee amounts for allergy testing services are established for single tests. Therefore, the number of tests must be shown on the claim.

**Example:** If a physician performs 25 percutaneous tests (scratch, puncture or prick) with allergenic extract, the physician must bill the appropriate code and specify 25 in the "units" field of form CMS-1500 (paper claims or electronic format). To compute payment, the Medicare carrier multiplies the payment for one test (i.e., the payment listed in the fee schedule) by the quantity listed in the "units" field.

### Allergy Immunotherapy

For services rendered on or after January 1, 1995, all antigen/allergy immunotherapy services are paid for under the Medicare physician fee schedule. Prior to that date, only the antigen injection services, were paid for under the fee schedule. Codes representing antigens and their preparation and single codes representing both the antigens and their injection were paid for under the Medicare reasonable charge system. A legislative change brought all of these services under the fee schedule at the beginning of 1995 and the following policies are effective as of January 1, 1995:

- Separate coding for injection-only codes and/or the codes representing antigens and their preparation must be used.
  - If both services are provided, both codes are billed.
  - This includes allergists who provide both services using treatment boards.
- Single-dose vials of antigen may be billed only if the physician providing the antigen is providing it to be injected by some other entity. Single-dose vials, which may be used only as a means of insuring proper dosage amounts for injections, are costlier than multiple-dose vials and therefore their payment rate is higher. Allergists who prepare antigens are assumed to be able to administer proper doses from the less costly multiple-dose vials. Thus, regardless of whether they use or bill for single or multiple-dose vials while they are billing for an injection service, they are paid at the multiple-dose vial rate.

- The fee schedule amounts for the antigen codes are for a single dose. When billing those codes, physicians are to specify the number of doses provided. When making payment, carriers multiply the fee schedule amount by the number of doses specified in the “units” field.

- If a patient's doses are adjusted, e.g., because of patient reaction, and the antigen provided is more or fewer doses than originally anticipated, the physician is to make no change in the number of doses for which he or she bills. The number of doses anticipated at the time of the antigen preparation is the number of doses to be billed. This is consistent with the notes on page 30 of the Spring 1994 issue of the AMA's CPT Assistant. Those notes indicate that the antigen codes mean that the physician is to identify the number of doses “prospectively planned to be provided”. The physician is to "identify the number of doses scheduled when the vial is provided". This means that in cases where the patient gets more doses than originally anticipated (because dose amounts were decreased during treatment) and in cases where the patient gets fewer doses (because dose amounts were increased), no change is to be made in the billing. In the first case, carriers are not to pay more because the number of doses provided in the original vial(s) increased. In the second case, carriers are not to seek recoupment (if carriers have already made payment) because the number of doses is less than originally planned. This is the case for both venom and non-venom antigen codes.

- Venom doses and catch-up billing — Venom doses are prepared in separate vials and not mixed — except in the case of the three-vespid mix (white and yellow hornets and yellow jackets). Separate codes must be used for venom combinations of 2, 3, 4 or 5 venoms. Some amount of each of the venoms must be provided. Questions arise when the administration of these venoms does not remain synchronized because of dosage adjustments due to patient reaction. For example, a physician prepares ten doses utilizing the four-venom code in two vials — one containing 10 doses of three vespid mix and another containing 10 doses of wasp venom. Because of dose adjustment, the three vespid mix doses last longer, i.e., they last for 15 doses. Consequently, questions arise regarding the amount of "replacement" wasp venom antigen that is prepared and how it is billed. Medicare pricing amounts have savings built into the use of the higher venom codes. Therefore, if a patient is in two-venom, three-venom, four-venom or five-venom therapy, the carrier objective is to pay at the highest venom level possible. This means that, to the greatest extent possible, the two-venom code is to be billed for a patient in two-venom therapy, the three-venom code is to be billed for a patient in three-venom therapy, the four-venom code is to be billed for a patient in four venom therapy, and five venom code is to be billed for a patient in five venom therapy. Thus, physicians are to be instructed that the venom antigen preparation, after dose adjustment, must be done in a manner that, as soon as possible, synchronizes the preparation back to the highest venom code possible. In the above example, the physician must prepare and bill for only five doses of "replacement" wasp venom

— billing five doses of the single venom code. This will permit the physician to get back to preparing the four venoms at one time and therefore billing the doses of the "cheaper" four venom code. Use of a code below the venom treatment number for the patient must occur only for the purpose of “catching up”.

- Preparation of vials of non-venom antigens. As in the case of venoms, some non-venom antigens cannot be mixed, i.e., they must be prepared in separate vials. An example of this is mold and pollen. Therefore, some patients will be injected at one time from one vial — containing in one mixture all of the appropriate antigens — while other patients will be injected at one time from more than one vial. In establishing the practice expense component for mixing a multi-dose vial of antigens, we observed that the most common practice was to prepare a 10-cc vial; we also observed that the most common use was to remove aliquots with a volume of 1 cc. Our PE computations were based on those facts. Therefore, a physician's removing 10 1-cc aliquot doses captures the entire PE component for the service.

  This does not mean that the physician must remove 1 cc aliquot doses from a multi-dose vial. It means that the practice expenses payable for the preparation of a 10-cc vial remain the same irrespective of the size or number of aliquots removed from the vial. Therefore, a physician may not bill this vial preparation code for more than 10 doses per vial; paying more than 10 doses per multi-dose vial would significantly overpay the practice expense component attributable to this service.

  **Note:** This code does not include the injection of antigen(s); injection of antigen(s) is separately billable.

  When a multi-dose vial contains less than 10-cc, physicians may bill Medicare for the number of 1-cc aliquots that may be removed from the vial. That is, a physician may bill Medicare up to a maximum of 10 doses per multi-dose vial but may bill Medicare for fewer than 10 doses per vial when there is less than 10-cc in the vial.

  If it is medically necessary, physicians may bill Medicare for preparation of more than one multi-dose vial.

  **Examples:**

  – If a 10-cc multi-dose vial is filled to 6-cc with antigen, the physician may bill Medicare for six doses since six 1-cc aliquots may be removed from the vial.

  - If a 5-cc multi-dose vial is filled completely, the physician may bill Medicare for five doses for this vial.

  - If a physician removes ½ cc aliquots from a 10-cc multi-dose vial for a total of 20 doses from one vial, he/she may only bill Medicare for 10 doses. Billing for more than 10 doses would mean that Medicare is overpaying for the practice expense of making the vial.

  - If a physician prepares two 10-cc multi-dose vials, he/she may bill Medicare for 20 doses. However, he/she may remove aliquots of any amount from those vials. For example, the physician may remove ½ aliquots from one vial, and 1-cc aliquots from the other vial, but may bill no more than a total of 20 doses.

  - If a physician prepares a 20-cc multi-dose vial, he/she may bill Medicare for 20 doses, since the practice expense is calculated based on the physician's removing 1-cc aliquots from a vial. If a physician removes 2-cc aliquots from this vial, thus getting only 10 doses, he/she may nonetheless bill Medicare for 20 doses because the PE for 20 doses reflects the actual practice expense of preparing the vial.

  - If a physician prepares a 5-cc multi-dose vial, he may bill Medicare for five doses, based on the way that the practice expense component is calculated. However, if the physician removes ten ½ cc aliquots from the vial, he/she may still bill only five doses because the practice expense of preparing the vial is the same, without regard to the number of additional doses that are removed from the vial.

- Allergy Shots and Visit Services on the Same Day:

  - Visits must not be billed with allergy injection services unless the visit represents another separately identifiable service.

    » For a physician to receive payment for a visit service provided on the same day that the physician also provides a service in the allergen immunotherapy series, the physician is to bill a modifier 25 with the visit code, indicating that the patient's condition required a significant, separately identifiable visit service above and beyond the allergen immunotherapy service provided.

- Reasonable Supply of Antigens:

- See CMS Manual System, Internet Only Manual, Medicare Benefits Policy Manual, CMS Pub. 100-02 Chapter 15, section 50.4.4, regarding the coverage of antigens, including what constitutes a reasonable supply of antigens.

- Providers must only bill Medicaid for a 90-day (three-month) supply of Antigens and/or Venoms for each Medicaid beneficiary. When the provider notices that the beneficiary is running low on antigens, he or she may arrange for more antigens to be made and delivered. Please note that these services cannot be overlapped and reimbursed.

### Dermatology

The acne diagnosis codes (L70.0 - L70.9, L73.0) are covered only when the patient is 18 years of age or younger (non-covered beginning on the 19th birthday), and the acne condition is infected, cystic or pustular.

The keloid scar diagnosis L91.0 is covered only in severe cases with pain, intractable itching, or interference with range of movement.

### Oncology and Hematology

If a physician or physician group leases space in a clinic or hospital, they may bill for the chemotherapy administration and drugs provided all the following criteria are met:

- They are using their own employees, equipment, supplies and drugs.
- The services are provided in the leased area of the hospital designated as an office.
- The patient is not a registered inpatient or OP of the hospital.

A physician's office within an institution must be confined to a separately identified part of the facility that is used solely as the physician's office and cannot be construed to extend throughout the entire institution. Services performed outside the "office" area will be subject to coverage rules applicable to services furnished outside the office setting.

A distinction must be made between the physician's office practice and the institution. For services to be covered, auxiliary medical staff must be office staff rather than institution staff, and the cost of supplies must represent an expense to the physician's office practice. The physician must directly supervise services performed by his or her employees outside the office area; the physician's presence in the facility would not be sufficient.

If services are provided in an inpatient, OP, or infusion center setting, the physician can only bill for the E&M service and/or prolonged care, critical care services when appropriate. Reimbursement for

chemotherapy administration, drugs, supplies, equipment and nursing are included in the hospital or infusion center's reimbursement.

## Gastroenterology

Diagnostic procedures listed are covered as separate procedures if medically necessary and justified.

Obesity is now recognized as a disease state. Policy is currently being written and will be published later.

The following services are non-covered by Medicaid:

- Supplemental fasting
- Intestinal bypass surgery
- Gastric balloon for treatment of obesity

The following procedures to treat obesity are covered based on InterQual criteria. QIO must preauthorize all claims for these services. Approval will be based on medical records that document established InterQual criteria.

### Panniculectomy

Panniculectomy is the surgical excision of the abdominal apron containing superficial fat in obese individuals. The Lipectomy and Abdominoplasty procedure codes can be covered by Medicaid if:

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

### Gastrostomy Button Device Feeding Tube Kit

This service will be covered for beneficiaries under the age of 21 when performed in the physician's office setting to cover the cost associated with purchasing the device.

## Physical Medicine and Therapy

PT, OT and/or ST may be rendered in an office, or OP setting. The licensed therapist performing these services must meet the state licensure regulations specified by the South Carolina Department of Labor, Licensing, and Regulation (SCLLR). Licensed therapists may bill directly and be reimbursed for services rendered following billing and benefit limitations as described in the Rehabilitative Therapy and Audiological Services Provider Manual.

At a minimum, PT services must improve or restore physical functioning as well as prevent injury, impairments, functional limitations and disability following disease, injury or loss of limb or body part.

OT 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.

Physicians/NPs are required to submit the applicable CPT codes as defined in the CPT reference manual for the specified therapy. Therapy procedures are defined in 15-minute sessions, SCDHHS will define 15 minutes as one unit.

For children under the age of 21, PT/OT/ST services are available through rehabilitation centers certified by SCDES, and through individual licensed practitioners. Policy guidelines are located in the Rehabilitative Therapy and Audiological Services Provider Manual on our website located at www.scdhhs.gov.

**Osteopathic Manipulative Treatment**

Osteopathic Manipulative Treatment (OMT) is allowed as a separate procedure when medically necessary, justified, and performed by a physician, or licensed physical therapist employed by the physician. These procedures must be reported using procedure codes 98925–98929.

## Chiropractic Services

SCDHHS provides Medicaid reimbursement for a limited array of chiropractic services provided to Medicaid beneficiaries. Coverage is limited to treatment by means of manual manipulation of the spine for the purpose of correcting a subluxation demonstrated on x-ray. For the purposes of this program, “subluxation” means an incomplete dislocation, off centering, misalignment, fixation, or abnormal spacing of the vertebrae anatomically that is demonstrable on a radiographic film (x-ray).

It is the provider’s responsibility to ensure that services provided are due to medical necessity and are documented in the patient’s medical charts, and that the beneficiary’s Medicaid eligibility is current before chiropractic services are provided.

The provider must check the beneficiary’s Medicaid card before rendering services. Providers must call the toll-free number (+1 888 549 0820) listed on the back of the Medicaid insurance card to verify eligibility every time the Medicaid beneficiary is seen for chiropractic services. Eligibility changes on the first of each month. If services are provided, and are later denied because eligibility

was not checked, Medicaid will not pay for the services and providers must not bill the patient for these services.

Eligible Medicaid beneficiaries, regardless of age, are allowed six chiropractic visits per year, commencing on July 1 of each year.

### Neurology

Neurological testing procedure codes include the TC, interpretation, and the physician's professional services. Physicians doing only the interpretation must use the 26 modifier with the appropriate procedure code. All procedures must be medically justified.

Nerve Conduction Studies are covered as medically necessary when performed with needle electromyography (EMG) studies to confirm the diagnosis. It is recommended by the American Association of Neuromuscular and Electrodiagnostic Medicine (AANEM) that the nerve conduction study and a needle EMG be performed together to ensure an accurate diagnosis. Neurological testing includes the TC, the interpretation, and the physician's professional services. Physicians performing only the interpretation must use the 26 modifier with the appropriate procedure code.

Nerve conduction studies must be billed using CPT guidelines indicating each nerve and all site(s) along the nerve, not each site. Codes that indicate "each nerve" will multiply for payment and must be submitted on one line with the number of tests (or hours) indicated in the “units” column on the claim form. Claims submitted with more than the allowed number of units will reject with Edit Code 713. Providers may submit a new claim with documentation for medical review. If justified, reimbursement may be made to the provider.

### Hyperbaric Oxygen Therapy

For purposes of coverage, HBO therapy is a modality in which the entire body is exposed to oxygen under increased atmospheric pressure.

#### Covered Conditions

Program reimbursement for HBO therapy will be limited to that which is administered in a chamber (including the one-man unit) for the following conditions:

- Acute carbon monoxide intoxication.
- Decompression illness.
- Gas embolism.
- Gas gangrene.

- Acute traumatic peripheral ischemia. (HBO therapy is a valuable adjunctive treatment to be used in combination with accepted standard therapeutic measures, when loss of function, limb or life is threatened.)
- Crush injuries and suturing of severed limbs. (As in the previous conditions, HBO therapy would be an adjunctive treatment employed when loss of function, limb or life is threatened.)
- Meleney ulcers. (The use of HBO in any other types of cutaneous ulcer is not covered.)
- Acute peripheral arterial insufficiency.
- Preparation and preservation of compromised skin grafts.
- Chronic refractory osteomyelitis that is unresponsive to conventional medical and surgical management.
- Osteoradionecrosis as an adjunct to conventional treatment.
- Cyanide poisoning.
- Actinomycosis, but only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment.
- Soft tissue radionecrosis.

### General Surgery Guidelines

Criteria outlined in this section are contingent upon demonstrated medical necessity. The medical record must substantiate the need for surgical services including information to support the medical justification. Compensable services include correcting conditions that meet any of the following criteria:

- Conditions that directly threaten the life of the beneficiary.
- Conditions that have the potential for causing irreparable physical damage.
- Conditions that can result in the loss or serious impairment of a bodily function.
- Conditions that can result in the impairment of normal physical growth and development.
- Conditions that result from trauma and must be promptly corrected (i.e., as soon as medically feasible).

When care is furnished outside of these conditions, documentation must be included in the medical record, or when designated, justification must be attached to the CMS-1500 claim form for payment. This includes the history and physical, operative report, discharge summary and pathology report.

If a claim is submitted that requires support documentation, and the required documentation is not attached to the claim form, the claim will be rejected. In this case, the documentation must be attached to a new claim for review.

**Note:** All unlisted procedure codes must have documentation attached to the claim form to ensure equitable pricing of the procedure.

To avoid delay in the processing of your claim, do not use an unlisted code when a descriptive code is available. All unlisted codes suspend for review and pricing.

If the reviewer finds a code comparable for the procedure, the unlisted code will be priced at the same rate as the descriptive code. The reviewer may also choose to notify the provider of the proper code to use for future reference.

**Surgical Supplies**
Please refer to Supplies under Additional Ambulatory Services in this section of the manual for more detail.

**Ambulatory Surgical Services**
Many surgical procedures ordinarily performed on an inpatient or OP basis consistent with sound medical practice can be performed in an Ambulatory Surgical Center (ASC) for less cost. South Carolina Medicaid recognizes these procedures as compensable if performed in an ASC and included on the ASC list of covered procedures.

Surgeons must utilize only those ASC facilities contracted with South Carolina Medicaid for their Medicaid patients. South Carolina Medicaid reimburses the ASC for the facility charges under strict guidelines. Each ASC contracted is provided with a list of covered procedures (which is subject to change from time to time).

**Note:** The surgeon must verify with the ASC that the elective procedure is covered under ASC guidelines.

**Assistant Surgeon**
All guidelines that apply to the primary surgeon also apply to the assistant surgeon. The CPT surgical procedure codes that allow an assistant surgeon's fee are listed on the provider portal.

**Note:** These allowances are subject to change and may be used as a reference only.

## Surgical Guidelines for Specific Systems

### Integumentary System

#### Lesion Removal

Excision/treatment of non-malignant dermal lesions and other dermal anomalies are not covered routinely. However, Medicaid will provide coverage of these anomalies if the therapy conforms with accepted treatment standards of the problem and meets one of the following conditions:

- The lesion is pre-cancerous or suspected to be cancerous by physical findings, appearance or changes in characteristics.
- The anomaly causes pain, irritation, or numbness that result in the functional impairment of bodily functions or normal growth and development.
- At least two alternative methods of treatment (i.e., steroid injection, compression, silicone gel treatment, etc.) have been attempted and found ineffective.
- The anomaly is responsible for the loss of a bodily function and the treatment restores the disabled function.

#### Keloid/Scar Conditions

Medicaid will provide coverage of excision and/or treatment of a Keloid scar and scar conditions and fibrosis of the skin if the therapy conforms to accepted standards of the problem and meets one of the following conditions:

- The scar causes functional impairment which interferes with daily living.
- The scar is symptomatic with a history of ulceration or inflammation that causes repeat office visits. At least two methods of treatment such as radiation (silicone gel treatment), compression, steroids and laser surgery have been tried and failed.
- There is a history of repeated infections with the scar.

#### Destruction Codes

Treatment must be medically indicated according to the criteria set forth in the guidelines previously stated. Certain procedures are considered cosmetic and, therefore, non-compensable.

#### Chemosurgery (Mohs Technique)

Procedures are compensable if medically justified and not performed for cosmetic purposes.

Mohs micrographic surgery is defined by the AMA's CPT as a technique for the removal of complex or ill-defined skin cancer with the histologic examination of 100% of the surgical margins. It requires a single physician to act in two integrated but separate and distinct capacities: surgeon and pathologist.

**Musculoskeletal System**

### Facial Reconstructive Codes

Certain facial reconstructive procedures are covered. The criteria are contingent upon medical necessity as outlined in the General Surgery guidelines. Justification includes result of severe trauma and/or congenital malformations; each claim must have support documentation attached. If there is no documentation, the claim will be rejected.

If the reconstructive process must be performed in stages, each claim must have documentation that includes all prior stages. A consultant for the specialty will review each claim and make a determination.

Under no circumstances is payment allowed for reconstructive surgery performed for cosmetic reasons alone.

### Fracture Repair (For Acute Care of an Injured Part)

All codes listed in the musculoskeletal section of the CPT are considered surgical packages with the exceptions of those listed in this manual.

The original application of a cast, splint, strapping, or traction device is included in the treatment of a fracture or dislocation and may not be billed separately.

### Grafts

Most bone, cartilage and fascia graft procedures include the obtaining of the graft by the operating surgeon. When the assistant surgeon obtains the graft for the operating surgeon, the additional service may be identified and reported separately.

### Casts

**Application**

The original application of a cast, splint, strapping or traction device is included in the treatment of a fracture or dislocation and may not be billed separately except for the application of a halo-type body cast, Risser jacket, turnbuckle jacket, body cast, or hip spica cast. Plaster or fiberglass can be billed additionally for cast supplies.

Plaster casts for rehabilitation are compensable using the appropriate CPT codes for the upper or lower extremity. Reimbursement includes the actual application of the cast. Supply codes may be billed in addition to the application.

Synthetic casts (fiberglass) are covered but may only be billed one time during the patient's course of treatment. A delayed or non-union replacement or the replacement of a patellar-tendon-bearing (PTB) cast is covered.

**Replacement**
The application of a cast, splint, strapping or traction device is reimbursable if it is a replacement, or subsequent replacement to the original cast, splint, strapping or traction device.

**Removal**
Codes for cast removals are reimbursable only if another physician applied the cast.

**Repair**
To report any repairs made to a cast, use the supplemental codes plaster cast supplies, or fiberglass cast supplies.

**Cast Codes**
Cast codes will reimburse in an OP setting when the physician applies the cast. If these codes are applied by a hospital technician, then no reimbursement to the physician will be allowed.

**Application or Strapping**
If cast application or strapping is provided as an initial service (e.g., casting of a sprained ankle or knee) in which no other procedure or treatment (e.g., surgical repair, reduction of a fracture or joint dislocation) is performed, or is expected to be performed by a physician rendering the initial care only, use the casting, strapping, and/or supply code in addition to an E&M code, as appropriate.

## Splints

**Plaster Splints**
Plaster splints are compensable using the appropriate CPT codes for the upper or lower extremity. The reimbursement includes the materials used as well as the actual application of the splint.

**Synthetic Splints**
Synthetic splints (fiberglass) are covered but may only be billed one time during the patient's course of treatment. Any replacement is non-covered and cannot be billed except a PTB, delayed, or non-union cast.

**Custom Splints**
Custom-made splints are recognized as a viable part in the patient's rehabilitative period of treatment. Reimbursement is allowed for these splints only when made by a licensed orthotist or occupational therapist. To report any repairs or adjustments made to a splint, use and appropriate supply code.

**Prefab Splints**
Prefabricated splints (Velcro closure) are non-compensable under the Physician Services program.

### Orthotic Supplies
Please refer to the heading “Durable Medical Equipment/Supply” in this section of the manual.

**Cardiovascular System**
### Vascular Injection Procedures
Listed services for injection procedures include necessary local anesthesia, introduction of needles or catheters, injection of contrast medium with or without automatic power injection, and/or necessary pre- and post-injection care specifically related to the injection procedure. For injection procedures in conjunction with cardiac catheterization, please refer to Cardiology under Specialty Care Services in this section of the manual.

Radiological vascular injections performed by a single physician are compensable separate from the radiology service. Catheters, drugs and contrast media are not included in the listed service for these injection procedures.

For insertion of a Swan-Ganz catheter not associated with cardiac catheterization, use an appropriate assistant surgeon code in lieu of a heart catheter code.

### Implantable Vascular Access Portal/Catheter
For port-a-cath maintenance, use the appropriate J codes, supply codes and office visit code when applicable. Do not use an unlisted CPT code for catheter maintenance.

**Digestive System (et al.)**
### Contralateral Inguinal Exploration
Medicaid will reimburse for a contralateral inguinal exploration when a unilateral herniorrhaphy has been performed on an infant (under five years of age). To report this service, use an appropriate assistant surgeon code along with the procedure code for herniorrhaphy and attach support documentation for medical review.

### Gastric Bypass

Please refer to Gastroenterology under Specialty Care Services in this section of the manual regarding treatment of obesity and bariatric surgical procedures.

**Urinary System**

Services listed in this section are covered when medically necessary, with the following restrictions:

- Endoscopic Procedures: Follow guidelines for endoscopic procedures under General Surgery Guidelines within this manual.
- Urodynamics: These procedures may be billed in addition to the appropriate surgical code (Cystourethroscopy); reimbursement includes equipment and supplies.
- When performed (and billed) on the same DOS as the surgery, these services are not considered surgical and will be reimbursed at 100% of the established rate. Documentation must include the urine measurement.
- Urinary Supplies: Please refer to the Durable Medical Equipment/Supply section of this manual.
- Lithotripsy: Percutaneous, extracorporeal shock wave, and cystourethroscope lithotripsy are covered services when medically necessary. The physician is reimbursed only for the professional service. If the procedure is performed bilaterally, bill on two lines adding no modifier to the first procedure, and a 50 modifier to the second (bilateral) procedure.

**Nervous System**

No special restrictions apply other than those defined in the general surgery and pain therapy guidelines.

### Spinal Procedures for Injection of Anesthetic Substance

These procedures are reimbursed for the initial placement of an indwelling catheter for anesthesia purposes. Subsequent injections of the anesthetic agent are not allowed under the injection code. For maintenance of an epidural, please refer to Anesthesia Services and Pain Management Services in this section of the manual for additional information.

### Implantable Infusion Pumps

An implantable infusion pump is covered when used to administer anti-spasmodic drugs intrathecally (e.g., Baclofen) to treat chronic intractable spasticity in patients who have proven unresponsive to less invasive medical therapy as determined by the following criteria:

- As indicated by at least a six-week trial, the patient cannot be maintained on non-invasive methods of spasm control.
- Prior to pump implantation, the patient must have responded favorably to a trial intrathecal dose of the anti-spasmodic drug.

Each claim will be reviewed for these criteria; claims submitted without documentation will be rejected.

Implantable infusion pumps are also covered for treatment of pain. Please refer to Pain Management Services in this section of the manual for additional information.

### Organ Transplantation

SCDHHS 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 of 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.

See the Utilization Management, Prior Approval section of this manual for more information regarding organ transplants.

## Anesthesia Services

Anesthesia services consist of services rendered by a physician, a CRNA, or anesthetist assistant (AA) other than the attending surgeon or his or her assistant and shall include the administration of spinal or rectal anesthesia, or a drug, or other anesthetic agent. The agent may be administered by injection or inhalation, except by local infiltration, the purpose and effect of which administration is the obtaining of muscular relaxation, loss of sensation or loss of consciousness. The reporting of anesthesia services is appropriate by or under the responsible supervision of a physician.

Use of the surgical procedure code for billing anesthesia services will result in a rejection. When multiple surgical procedures are performed during the same period of anesthesia, only the anesthesia procedure code for the major procedure may be billed and the total time must reflect coverage for all procedures. Base time associated with the procedure code will be automatically assigned from the procedure code billed.

There is no additional payment for anesthesia services rendered by the attending surgeon or assistant surgeon when performed on an inpatient or OP basis.

### Time Reporting

Anesthesia time involves the continuous, actual presence of the anesthesiologist or the medically directed CRNA/AA. It starts when the anesthesiologist begins to prepare the patient for anesthesia care in the operating room and ends when the anesthesiologist is no longer in continuous, actual attendance. See the Billing Guidance section of this manual for billing information.

## Pain Management Services

The complaint of pain remains the single greatest reason for seeking medical attention. Pain is defined as an unpleasant sensory and emotional experience associated with actual or potential tissue damage. The condition is considered chronic pain when it has been present continuously or intermittently for six months or more, or it has extended two to three months beyond the expected recovery time. It is of utmost importance that medical providers seek the source of the pain in addition to working to relieve and resolve the pain. Patient history must be reviewed to ensure all areas of treatment have been explored. Appropriate referrals for concurrent medical or psychological treatment must be made. This requires all physicians, not just pain specialists, to understand the pain symptoms and their underlying cause.

The primary objectives of pain management must be to accomplish the following:

- Eliminate the use of optional health care services for primary pain complaints.
- Increase physical activities and return the patient to productive activity.

- Increase the patient's ability to manage pain and related problems.
- Reduce the use and misuse of medication.
- Decrease the intensity of subjective or illusory pain.

The policies outlined in the remainder of the Pain Management Services section of this manual apply to physicians of all specialties.

**Evaluation and Management Visits**
SCDHHS will cover one office or inpatient consultation necessary for screening a beneficiary focusing on identifying the cause of the pain and developing a pain management plan. When the consultant assumes responsibility for a portion or all of the patient's condition, appropriate office visit or subsequent hospital care codes must be used after the initial consultation. Consultative services related to any direct or indirect patient care are included in the basic value of an anesthesia payment and cannot be billed separately.

E&M guidelines apply to office, inpatient and OP hospital care for pain management.

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

- Opioid drugs for intractable cancer pain.
- Treatment for acute iron poisoning or iron overload.
- Chemotherapy for liver cancer.
- Treatment for thromboembolic disease and/or pulmonary embolism.

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.

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

- Chemotherapy treatment of liver cancer.
- Delivery of anti-spasmodic drugs for severe spasticity.

- Treatment of chronic intractable pain.

### Chemotherapy for Liver Cancer

The implantable pump is covered for the treatment of liver cancer in patients in whom the metastases are limited to the liver, and where one of the following applies:

- The disease is unresponsive.
- The patient refuses surgical excision of the tumor.

### Anti-Spasmodic Drugs for Severe Spasticity

An implantable infusion pump is covered when used to administer antispasmodic drugs intrathecally (e.g., Baclofen) to treat chronic intractable spasticity in patients who have proven unresponsive to less invasive therapy when both of the following criteria are met:

- As indicated by at least a six-week trial, the patient cannot be maintained on non-invasive methods of spasm control such as oral anti-spasmodic drugs, because these methods either fail to adequately control the spasticity, or they produce intolerable side effects.
- Prior to pump implantation, the patient must have responded favorably to a trial intrathecal dose of anti-spasmodic drug.

### Treatment of Chronic Intractable Pain

An implantable pump is covered when used to administer opioid drugs (e.g., morphine) intrathecally or epidurally for the treatment of severe or chronic intractable pain in patients who have a life expectancy of at least three months, and who have proven unresponsive to less invasive medical therapy when ALL of the following criteria have been met:

- Coordination must be made with other attending physicians in order to identify and treat the cause of the pain, rather than symptoms, if possible.
- The patient's history must indicate that he or she would not respond adequately to non-invasive methods of pain control.
- A preliminary trial of intraspinal opioid drug administration must be undertaken with a temporary catheter to monitor acceptable pain relief, degree of side effects and patient acceptance.

Refilling and maintenance of the implantable pump will be allowed when administered by a physician.

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

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

## Pathology and Laboratory Services

In accordance with federal regulations (42 CFR 493.1809), all laboratory testing sites (except for physician's offices) are required to have an appropriate CLIA certificate. CLIA is a regulatory program administered by the CMS. For more detail, please refer to Clinical Laboratory Improvement Amendments within this section of the manual.

Pathology includes services rendered by attending physicians and pathologists. Hospital laboratories must reference the Hospital Services Provider Manual. Independent laboratories will be covered in this section.

Laboratory services/tests must be ordered by the attending physician, appropriate to the study of the patient (i.e., consistent with the diagnosis and treatment of the patient's condition and medically necessary for the appropriate care of the patient). Medicaid reimbursement will generally include obtaining the specimen, the performance of the test, supplies used in the performance of the test, and recording of the test(s). In addition, the reimbursement includes reporting of the test results.

The DOS for all billing must be the date the specimen was collected. For specimen collections that span more than a 24-month period, the DOS must be reported as the date the collection began. For laboratory tests that require a specimen from stored collections, the DOS must be defined as the date the specimen was obtained from archives. Procedures reimbursed in components will be identified later and separate allowable handling fees will be defined in this section.

### Attending Physician Services

The attending physician is responsible for the study of the patient, medical necessity, and appropriateness of procedures ordered. Physicians may not bill for lab tests performed outside their offices. Physicians may not bill a patient for lab services performed in the office that are normally covered by Medicaid when the service would have been paid if a Medicaid claim was submitted, provided the physician has accepted the patient's Medicaid benefits for the office visit or other procedure on the same date.

The performance of a test(s) prior to seeing the patient is a screening procedure and is not compensable. The only exceptions are pregnancy tests and prenatal lab work.

All laboratory tests must be ordered for the appropriate diagnosis and treatment of the patient's illness. Laboratory services requested or performed as general screening services are non-compensable, except for services rendered under the healthy adult physical as outlined in the Preventive Care Services section of this manual. General health panels are non-compensable; fertility tests are non-compensable. Routine paternity tests are non-covered, but medically necessary exceptions will be considered. Claims must be submitted with documentation justifying the service.

The chlamydia rapid test procedure code is used to report the chlamydia rapid test.

### Venipuncture

A separate handling charge for blood products drawn through venipuncture is allowed and compensable. To report a routine venipuncture, use the collection of venous blood by venipuncture procedure code. Finger/heel/ear stick for collection of specimen(s) will be included in the office visit or lab test reimbursement and may not be billed separately. Filing for only the collection of specimen(s) is permissible, but an office visit or lab test reimbursement charge cannot be filed for the same DOS. The physician or clinic provider may charge a separate venipuncture code if he or she provided the entire diagnostic lab service or only extracted the blood for referral to an outside lab.

### Catheterization

Urine specimens collected by all methods are not considered a separate compensable charge. The patient is also not liable for the charge since the collection fee is considered part of the lab test or office examination. The provider may charge for a separate catheterization regardless of whether the specimen was collected for a test in the office or for referral to an outside laboratory.

**Automated Chemistry Tests and Panels**

Clinical laboratory tests are covered under Medicaid if they are reasonable and necessary for the diagnosis or treatment of an illness or injury. A physician who orders a series of clinical lab tests must specify the actual tests to be performed. If a panel is requested, the professional judgment of the physician must dictate the medical necessity of the complete panel instead of an individual test. Likewise, individual tests ordered by a physician must indicate a medical reason for the individual test in lieu of a panel that is less expensive.

### Automated Multi-Channel Chemistry Tests

Refer the codes information on the provider portal for acceptable services. If three or more of the tests are performed on the same DOS, they will be grouped together and paid according to the number of tests performed. Duplicate payments and payments that are not consistent with Medicaid policy will be recouped at post-payment review.

### Pathology Panels

Please refer to the current CPT for guidelines on acceptable criteria for billing organ or disease-oriented panels.

**Clinical Pathology Services**

South Carolina Medicaid will recognize both a professional and TC for all pathology codes. Refer to the code information on the provider portal for pathology codes requiring a 26 modifier in a hospital setting.

**Professional Pathology Services**

### Anatomical

Medicaid recognizes the expertise of professional pathology services when charged separately for the interpretation of all anatomical and surgical tissues. Postmortem examinations are non-covered by Medicaid.

### Blood Smears, Bone Marrows and Blood Bank Services

The 26 modifier is not required when performed in a hospital setting.

Bone marrows, including smears, aspiration, staining, biopsy and interpretation, are compensable as separate professional services. Care must be taken when coding bone marrow interpretation procedures; the 26 modifier is not required.

Blood bank services are covered; no modifier is required when performed in a hospital setting.

**Cytopathology and Surgical Pathology**

These procedures include accession, handling and reporting. The handling and interpretation of surgical tissues must be charged separately if rendered by a pathologist in a hospital or office when only the professional interpretation is necessary, using a distinct physician provider number and a 26 modifier. Only an independent laboratory may charge for the total lab procedure when the laboratory has performed the total service (i.e., both technical and professional component related to the surgical tissue).

Some surgical pathology codes will multiply by units for payment. When filing a claim, list the appropriate CPT code for the DOS one time and the number of units in the “days/units” column and the total charges for the number of units billed.

**Pap Smears**
Medicaid reimburses a pathologist for a professional interpretation of a Pap smear. An attending physician must specifically order the appropriate cytopathology code with definite hormonal evaluation.

Medicaid covers Pap smears for dually eligible Medicare/Medicaid beneficiaries who have exceeded the Medicare frequency limit. When the Medicare denial is received, the charges must be billed using the CMS-1500 claim form. Please refer to Cancer Screening Services within this section of the manual for frequency limitations.

**Specimen Referrals**
The pathologist must use the appropriate procedure codes to designate review and report of referred material only. A separate procedure code is used for comprehensive consultation with review of medical records and specimens, with report, on referred material.

**Referral Out-of-State (OOS)**
Specimens must be referred to a South Carolina Medicaid-enrolled independent laboratory, pathologist or hospital. OOS referrals to non-enrolled providers are not compensable through the Medicaid program. Providers cannot bill Medicaid beneficiaries when Medicaid would have paid the lab service if appropriate billing and referral procedures had been followed.

## Genetic, Molecular and Biomarker Testing

Genetic, molecular or biomarker testing is used to identify changes or abnormalities in chromosomes, genes, or proteins to confirm or rule out suspected genetic conditions. A genetic test involves an analysis of human chromosomes, deoxyribonucleic acid (DNA), ribonucleic acid (RNA), or gene products to establish a diagnosis of a genetic condition.

### General Criteria

**Genetic testing must meet all of the following criteria**:

- The patient must be evaluated by a board-certified clinician with expertise in clinical genetics pertinent to their specialty prior to the test being ordered. If necessary, collaboration with a medical geneticist or certified genetic counselor is recommended. Providers qualified to order genetic, molecular or biomarker testing include but are not limited to: Neurologist, Developmental Pediatrician, Pediatric Pulmonologist, Obstetrician, Endocrinologist,

Cardiologist, Surgeon, and Psychiatrist (for specific tests a psychiatric physician extender {physician assistant or nurse practitioner} under the supervision of a board-certified psychiatrist, may be allowed).

- The patient and/or parents/legal guardians (if applicable) must be appropriately counseled about the testing by a qualified professional (same or similar to ordering provider) who is involved in the beneficiary's care. An American Board of Medical Genetics or American Board of Genetic Counseling certified genetic counselor may be used for counselling when determined appropriate by the treating provider.
- The test must be performed by a certified Clinical Laboratories Improvement Amendment (CLIA) laboratory.
- The test must be clinically valid and scientifically proven for the identification of the specific genetically linked disease or clinical condition, based on published peer-reviewed literature.
- Genetic testing meet all of the following clinical criteria:
  - The test is ordered for the diagnosis and treatment of at least one of the following:
    - Genetic abnormalities or syndromes
      i. Any congenital anomalies
      ii. Developmental delays
      iii. Intellectual disabilities
    - Neoplastic chromosome abnormalities or syndromes
    - Hereditary conditions
    - Drug metabolism.
    - Post transplant rejection

  - At least one of the following is met:
    - The beneficiary displays clinical features or is experiencing current signs and symptoms of a genetic condition, **or**
    - There is a documented, reasonable expectation that the beneficiary is at high-risk based on family history, personal history, ethnicity, **or**
    - The test yields result that can be used to develop a clinically meaningful approach or course of treatment, or to cease unnecessary treatments,

  - The results of the test allow providers to treat current symptoms affecting the beneficiary's health or manage progression of an established disease or alter recommended screening or monitoring.

**Note: Clinical criteria and limitations for specific tests are detailed within the policy of that test.**

## Non-Covered Services

**Genetic testing is not covered for any of the following:**

- The beneficiary does not meet the criteria listed in policy.
- The screening is for the general population.
- The test is repeated after a negative test result.
- The test is repeated when limited to once in a lifetime testing.
- The test is performed for genetic research (experimental or investigational) or clinically unproven.
- Reproductive decision-making.
- Male or female infertility.
- Noninvasive Prenatal Screening (NIPS) or Noninvasive Prenatal Testing (NIPT) following a Chorionic Villis Sampling (CVS) or amniocentesis test that was able to yield results.
- Paternity testing.
- Sex determination of the fetus.
- Direct-to-consumer tests.

## Clinical Criteria, Limitations, Frequencies and Billing Guidance

**Genome and Exome Analysis**

EpiSign Complete
EpiSign Complete – a proprietary test, is a genome-wide methylation assay designed to readily identify methylation defects due to triplet repeat expansions and imprinting disorders as well as robust, reproducible epigenetic signatures for over 90 conditions.

## Billing Guidance

- This test is allowed once per lifetime per patient.
- Eligible members are children under the age of 21 years.
- Service is allowed without prior authorization.
- Claim must include diagnosis code.

| PROCEDURE CODE | TEST | PRIOR AUTHORIZATION REQUIREMENTS | LIMITATIONS AND FREQUENCY |
|---|---|---|---|
| 0318U | Pediatrics (congenital epigenetic disorders), whole genome methylation | No | Allowed once per lifetime per patient for members under the age of 21 years |

| | | | |
|---|---|---|---|
| | analysis by microarray for 50 or more genes, blood | | |

**Whole Exome Sequencing (WES)**

Clinical Criteria

In addition to general criteria, service is considered medically necessary for the evaluation of unexplained congenital anomalies or neurodevelopmental disorders in children when one of the following is met:

- Clinical presentation does not fit a well-described syndrome for which single-gene or targeted panel testing (e.g., comparative genomic hybridization/chromosomal microarray analysis) is available.
- A genetic etiology is the most likely explanation for the phenotype or clinical scenario despite previous genetic testing, OR when previous genetic testing has failed to yield a diagnosis and the affected individual is faced with invasive procedures or testing as the next diagnostic step (e.g., muscle biopsy).
  - WES is more practical than the separate single gene tests or panels that would be recommended based on the differential diagnosis.
  - WES results may preclude the need for multiple and/or invasive procedures.
- No other causative circumstances (e.g. environmental exposures, injury, or infection) can explain the symptoms.
- WES results have a reasonable potential to directly impact patient management and clinical outcome for the individual tested.

WES is not covered for:

- Environmental exposures, injury, or infection that may reasonably explain the patient's constellation of symptoms.
- Prenatal screening for fetal diagnosis.
- Preimplantation testing of an embryo.
- Genetic carrier screening.
- Genetic disorders in all other situations.

Billing Guidance

- Allowed once per lifetime per patient.
- Eligible members are children under the age of 21 years.
- Service is allowed without prior authorization.
- Claim must include diagnosis code.

| PROCEDURE CODE | TEST | PRIOR AUTHORIZATION REQUIREMENTS | LIMITATIONS AND FREQUENCY |
|---|---|---|---|
| 81415 | Exome Sequence Analysis | No | Allowed once per lifetime per patient for members under the age of 21 years |

**Comparator Exome Sequence Analysis**

Billing Guidance

- Service is allowed without prior authorization.
- Claim must include diagnosis code.
- WES criteria must be met before the comparator test is performed.
- Allowed on the same day as WES.
- Reimbursement for testing one or both parents and /or sibling shall not exceed the rate paid for one unit of this test (CPT 81416).
- Allowed once per lifetime per patient.

| PROCEDURE CODE | TEST | PRIOR AUTHORIZATION REQUIREMENTS | LIMITATIONS AND FREQUENCY |
|---|---|---|---|
| 81416 | Exome, Sequence Analysis, Each Comparator Exome | No | Allowed once per lifetime per patient for members under the age of 21 years |

**Exome Reanalysis**

Clinical Criteria

Whole exome reanalysis of previously obtained uninformative WES is medically necessary when one of the following criteria is met:

- There has been an onset of additional symptoms that broadens the phenotype assessed during the original exome evaluation, OR
- There has been a birth or diagnosis of a similarly affected first-degree relative, expanding the clinical picture.
- Original exome testing did not identify an underlying explanation of patient's symptoms and at least 12 months have passed since the original test.

### Billing Guidance

- Allowed once per lifetime per patient when clinical criteria is met.
- Members under the age of 21 years.
- Service is allowed without prior authorization.
- Claim must include diagnosis code.

| PROCEDURE CODE | TEST | PRIOR AUTHORIZATION REQUIREMENTS | LIMITATIONS AND FREQUENCY |
|---|---|---|---|
| 81417 | Exome Re-evaluation of Previously Obtained Exome Sequence | No | Allowed once per lifetime per patient for members under the age of 21 years |

## Whole Genome Sequencing (WGS)

### Clinical Criteria

In addition to general criteria, service is considered medically necessary for children under 21 years of age, for the evaluation of unexplained congenital anomalies or neurodevelopmental disorders when one of the following criteria is met:

- A definitive diagnosis cannot be made based on standard clinical workup.
- The patient's phenotype does not clearly identify a specific disease with an established single gene or multi-gene panel, or the patient has phenotypic characteristics outside of, or in addition to, what has been established for the disease.
- Genetic etiology is the most likely explanation for the phenotype or clinical scenario despite previous genetic testing.
- When previous genetic testing has failed to yield a diagnosis, and the affected individual is faced with invasive procedures or testing as the next diagnostic step.
- No other causative circumstances (e.g., environmental exposures, injury, infection) can explain the symptoms.

### WGS is not allowed for:

- Environmental exposures, injury, or infection may reasonably explain the patient's constellation of symptoms.
- Prenatal screening for fetal diagnosis.
- Preimplantation testing of an embryo.
- Genetic carrier screening.

- Genetic disorders in all other situations.

Billing Guidance

- Allowed once per lifetime per patient.
- Eligible members are children under 21 years.
- Service is allowed without prior authorization.
- Claim must include diagnosis code.

| PROCEDURE CODE | TEST | PRIOR AUTHORIZATION REQUIREMENTS | LIMITATIONS AND FREQUENCY |
|---|---|---|---|
| 81425 | Genome Sequence Analysis | No | Allowed once per lifetime per patient for members under the age of 21 years |

**Comparator Genome Sequencing Analysis**

Billing Guidance

- Service is allowed without prior authorization.
- Claim must include diagnosis code.
- WGS criteria must be met before the comparator test is performed.
- Allowed on the same day as WGS.
- Reimbursement for testing one or both parents shall not exceed the rate paid for one unit of this test (CPT 81426).
- Allowed once per lifetime per patient.
- Members under the age of 21 years.

| PROCEDURE CODE | TEST | PRIOR AUTHORIZATION REQUIREMENTS | LIMITATIONS AND FREQUENCY |
|---|---|---|---|

| | | | |
|---|---|---|---|
| 81426 | Genome Sequence Analysis, Each Comparator Genome | No | Allowed once per lifetime per patient for members under the age of 21 years |

**Whole Genome Reanalysis**

Whole genome reanalysis of previously obtained uninformative whole genome sequence is medically necessary when one of the following criteria is met:

- There has been an onset of additional symptoms that broadens the phenotype assessed during the original exome evaluation.
- There has been a birth or diagnosis of a similarly affected first-degree relative, expanding the clinical picture.
- Original genome testing did not identify an underlying explanation of patient's symptoms and at least 12 months have passed since the original test.

Billing Guidance

- Allowed once per lifetime per patient when criteria is met.
- Members under the age of 21 years.
- Service is allowed without prior authorization.
- Claim must include diagnosis code.

| PROCEDURE CODE | TEST | PRIOR AUTHORIZATION REQUIREMENTS | LIMITATIONS AND FREQUENCY |
|---|---|---|---|
| 81427 | Genome Re-evaluation of Previously Obtained Genome Sequence | No | Allowed once per lifetime per patient for members under the age of 21 years |

**Aorta Genomic Sequencing**

This lab test analyzes a genetic sample (DNA) for a variant that may indicate any number of illnesses affecting the aorta. Aortic dysfunction or dilation (e.g., Marfan syndrome, Loeys-Dietz syndrome, Ehler-Danlos syndrome type IV, arterial tortuosity syndrome); duplication/deletion analysis panel, must include analyses for TGFBR1, TGFBR2, MYH11, and COL3A1.

This test is performed as an evaluation for hereditary conditions that fall under aortic dysfunction or dilation. It is a genomic sequencing procedure (GSP) that looks for changes in the order, number, organization, and irregular arrangements within the gene chain specific to the medical condition.

### Billing Guidance

| PROCEDURE CODE | TEST | PRIOR AUTHORIZATION REQUIREMENTS | LIMITATIONS AND FREQUENCY |
|---|---|---|---|
| 81410 | Aortic Dysfunction or Dilation Genomic Sequence Analysis Panel | No | Allowed once per lifetime per patient for eligible members with full benefit. |
| 81411 | Aortic Dysfunction or Dilation Duplication/Deletion Analysis Panel | No | Allowed once per lifetime per patient for eligible members with full benefit. |

## Drug Metabolism Genomic Sequence Analysis

### Clinical Criteria

- Tests must be ordered by a board-certified psychiatrist or by a psychiatric physician extender (physician assistant or psychiatric nurse practitioner) under the supervision of a board-certified psychiatrist, AND
- Patient must have one of the following mental health conditions: general anxiety disorder, major depressive disorder, obsessive-compulsive disorder, bipolar or schizophrenia; AND
- The Medicaid member must meet at least one of the following:
  - Has experienced a trial and failure of two previous psychoactive drugs for the mental health condition being treated, OR
  - Is currently taking more than two medications to treat the mental health condition.

### Billing Guidance

- Service requires prior authorization.
- Eligible members are those ages 18 years and older with full Medicaid benefit.

- Claim must include diagnosis code.

| PROCEDURE CODE | TEST | PRIOR AUTHORIZATION REQUIREMENTS | LIMITATIONS AND FREQUENCY |
|---|---|---|---|
| 81418 | Drug Metabolism (e.g., pharmacogenomics) Genomic Sequence Analysis Panel Duplication/Deletion Analysis | Yes | Allowed once per day for members 18 years old and older when clinical criteria are met. |

**Post-transplant Rejection Gene Expression Test (HeartCare and AlloSure Kidney)**

HeartCare consists of two gene expression tests, AlloSure Heart and AlloMap Heart. When performed in conjunction with each other, they can identify if the immune system is reacting poorly to the transplanted organ and the likelihood of rejection. AlloSure Kidney is a gene expression test that assesses the probability of acute rejection in kidney transplant recipients with clinical suspicion of rejection.

Billing Guidance

- Patient has received heart and/or kidney transplant in the past 2 years
- Claim must include diagnosis code
- Test is ordered as part of post-transplant standard of care protocol staring 6 months post-transplant
- Test is allowed for beneficiaries with full benefit
- Test is allowed without prior authorization following the frequencies listed below:

| PROCEDURE CODE | TEST | PRIOR AUTHORIZATION REQUIREMENTS | LIMITATIONS AND FREQUENCY |
|---|---|---|---|
| 81595 | AlloMap Heart | No | Allowed one per day in conjunction with 81479 for heart transplant; allowed 2 per 6 months for the first year and 3 per 12 months in the second year post-transplant. |

| | | | |
|---|---|---|---|
| 81479 | AlloSure Heart | No | Allowed one per day in conjunction with 81595 for heart transplant; allowed 2 per 6 months for the first year and 3 per 12 months in the second year post-transplant. |
| 81479 | AlloSure Kidney | No | Allowed one per day per kidney transplant; allowed 2 per 6 months for the first year and 3 per 12 months in the second year post-transplant. |

**Genetic Testing for Cancer**

Oncotype DX Breast Cancer Assay

The Oncotype DX Breast Cancer Assay is a genetic test used for gene expression profiling by real time RT-PCR of 21 genes, utilizing formalin-fixed paraffin embedded tissue.

### Clinical Criteria

Medicaid members must have the following findings and diagnosis:

- recently diagnosed with stage I, stage II, or stage III invasive breast cancer; and
- cancer is estrogen receptor-positive; and
- cancer is HER2-negative; and

cancer is lymph node-positive or lymph node-negative;

### Billing Guidance

- Allowed once per lifetime per patient.
- Providers with CLIA certification are eligible to bill for this service.
- Eligible members are adults aged 18 years and older with full benefit, including members enrolled in the Breast and Cervical Cancer Program (BCCP).
- No prior authorization is required.
- Claims must be filed with primary diagnosis of the conditions listed above.

| PROCEDURE CODE | TEST | PRIOR AUTHORIZATION REQUIREMENTS | LIMITATIONS AND FREQUENCY |
|---|---|---|---|
| 81519 | Oncology (Breast), mRNA, Gene Expression Profiling by Real-time RT-PCR of 21 Genes | No | Allowed once per lifetime per patient for members 18 years old and older when clinical criteria are met. |

1. *Breast Cancer Susceptibility Gene 1 and 2 (BRCA)*

Individuals who inherit a mutated copy of the BRCA1 or BRCA2 gene are predisposed to developing breast, ovarian, tubal, peritoneal, pancreatic and prostate cancers. In rare cases, duplications or deletions of one or more exons, or coding regions, can occur and are classified as BRCA large cell rearrangements.

Clinical Criteria
BRCA genetic testing is covered for eligible men and women, aged 18 years and older, who meet one or more of the medical necessity criteria, which are based on the current National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology — Genetic/Familial High-Risk Assessment: Breast and Ovarian. To review the current NCCN guidelines you may visit:

https://www.nccn.org/professionals/physician_gls/pdf/genetics_screening.pdf

Meeting one or more of the breast and ovarian cancer criteria warrants further personalized risk assessment, genetic counseling and oftentimes, genetic testing and management.

- Genetic counseling must be received before and after genetic testing. Pre- and post-genetic counseling are considered medically necessary and is a covered service in addition to genetic testing.
- Genetic testing to determine if an individual carries a mutated BRCA1 or BRCA2 gene is allowed once per lifetime per patient with prior authorization.
  - Exceptions will be made for more than once per lifetime when:
    - Member has previously been tested for BRCA1 and BRCA2 comprehensive sequencing gene mutation analysis testing and received negative results. Documentation of these results must be submitted with

the authorization request to the QIO for medically necessary BRCA large cell rearrangement gene mutation testing.
    - Results are not available, and every reasonable attempt has been made to obtain the results. Documentation of reasonable attempts to obtain results from the genetic testing physician or the testing laboratory must be submitted with the authorization request to the QIO.
    - Testing of an individual without a cancer diagnosis should only be considered when an appropriate affected family member is unavailable for testing.

- Risk-Reducing Treatment /Management
    - Based on the results of the BRCA test, beneficiaries may select a treatment that may reduce their chances of developing cancer. Medical necessity must be established for the selected risk reducing treatment option in accordance with the NCCN Guidelines for Genetic/Familial High-Risk Assessment: Breast and Ovarian. Beneficiaries may also elect not to pursue treatment options.
    - Treatments include:
        - Increased cancer screenings:
        - Risk-reducing agent: Risk-reducing agents may be covered for a beneficiary with a BRCA genetic mutation or compelling family history conferring a high risk for breast, ovarian, tubal, peritoneal, pancreatic or prostate cancers.
        - Risk-reducing surgery: Risk-reducing prophylactic mastectomy or oophorectomy may be covered for a beneficiary with a BRCA genetic mutation or a compelling family history conferring a high risk for breast or ovarian cancer.

### Prior Authorization

Prior authorization must be obtained from QIO prior to initial or subsequent BRCA testing.

- One or more of the NCCN Clinical Practice Guidelines in Oncology — Genetic/Familial High-Risk Assessment: Breast and Ovarian criteria must be met.
- A completed Hereditary Breast and Ovarian Cancer (HBOC) form, signed and dated by the referring provider. The provider's signature submitted on the HBOC is their attestation, to the best of their knowledge, that the information provided in the document is true, accurate and complete. The physician must indicate one of the following on the HBOC form:

- The request is for initial BRCA1 and BRCA2 testing.
- The request is for repeat BRCA1 and BRCA2 comprehensive sequencing testing for the beneficiary because initial results are negative, or are not available, and large cell rearrangement testing is necessary.

### Documentation Required

The following documentation must be maintained in the beneficiary's medical record:

- The HBOC Genetic Testing Prior Authorization Form.
- Pre-testing genetic counseling clinical notes, to include but not limited to the following:
  - Pre-test counseling date with the name and qualifications of the counseling professional.
  - The risks, benefits and limitations discussed with the beneficiary.
  - The beneficiary's consent to proceed with specific gene mutation testing to be performed as attested by the beneficiary's signature on the consent form.
- The beneficiary's BRCA test results.
- Post-testing genetic counseling clinical notes, to include, but not limited to, the following:
  - Post-test counseling date with the name and qualifications of the counseling professional.
  - The beneficiary's acknowledgment of the test results.

Billing Guidance:

- Allowed once per lifetime per patient, except when large cell rearrangement testing is necessary.
- Providers with CLIA certification are eligible to bill for this service.
- Eligible members are adults aged 18 years and older with full benefit.

| PROCEDURE CODE | TEST | PRIOR AUTHORIZATION REQUIREMENTS | LIMITATIONS AND FREQUENCY |
|---|---|---|---|
| 81162-81167;<br><br>81212; 81215;<br>81216; 81217; | BRCA1&2 GEN FULL SEQ DUP/DEL<br><br>BRCA1&2 GENE FULL SEQ ALYS | Yes | Allowed one per lifetime for members aged 18 years and older when clinical criteria are met. |
| | BRCA1&2 GEN FUL DUP/DEL ALYS | | |

| | | | |
|---|---|---|---|
| | BRCA1 GENE FULL SEQ ALYS<br><br>BRCA1 GENE FULL DUP/DEL ALYS<br><br>BRCA2 GENE FULL DUP/DEL ALYS<br><br>BRCA1&2 185&5385&6174 VRNT<br><br>BRCA1 GENE KNOWN FAMIL VRNT<br><br>BRCA2 GENE FULL SEQ ALYS<br><br>BRCA2 GENE KNOWN FAMIL VRNT | | |

2. *Colorectal Screening*

Multi-targeted stool DNA (MT-sDNA) test, also known as Cologuard®, in a covered preventive screening in alignment with the United States Preventive Services Task Force (USPSTF) recommendation for colorectal screening. This screening is allowed for full-benefit Healthy Connections Medicaid members and those enrolled in the Family Planning limited benefit.

### Clinical Criteria

- The MT-sDNA test is recommended every three years for asymptomatic, low-average risk members, aged 45 to 75 years who:
  - Have not had any colorectal screening in the past, or
  - Have had a negative colonoscopy at least seven years prior.

- The MT-sDNA test is not recommended for high-risk individuals who:
  - Have a personal history of colorectal cancer and adenomas;
  - Have had a positive result from another colorectal cancer screening at any time; or,

- Have been diagnosed with a condition associated with high risk for colorectal cancer such as inflammatory bowel disease, chronic ulcerative colitis, or Crohn's disease; or have a family history of colorectal cancer, or certain hereditary syndromes.

### Billing Guidance

| PROCEDURE CODE | TEST | PRIOR AUTHORIZATION REQUIREMENTS | LIMITATIONS AND FREQUENCY |
|---|---|---|---|
| 81528 | Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers and fecal hemoglobin, utilizing stool, algorithm | No | The MT-sDNA test is recommended every three years for asymptomatic, low-average risk members, aged 45 to 75 years who:<br>• Have not had any colorectal screening in the past, or<br>• Have had a negative colonoscopy at least seven years prior. |

**Genetic Testing for Hereditary Conditions**

1. Cystic Fibrosis

Cystic fibrosis is a genetic disorder that causes the body to make thick, sticky secretions that clog the lungs and other organs, such as the digestive system. Cystic fibrosis is a recessive disorder. People who are carriers of a defective cystic fibrosis gene do not show symptoms of the disease. Therefore, an abnormal gene must be inherited from both parents for the child to develop the disease. Carrier testing may provide an early indication as to whether a fetus might be a carrier or might have cystic fibrosis.

### Clinical Criteria

Diagnostic testing, carrier testing and prenatal testing is allowed once per lifetime per patient. No prior authorization is required.

- Diagnostic or Confirmatory Testing is allowed when the following are met:
  - Eligible Medicaid member must be under the age of 21 years, AND
  - Member has symptoms of cystic fibrosis, but diagnosis is in doubt (e.g., individuals with a negative sweat chloride test), OR
  - Cystic fibrosis is clinically suspected, sweat chloride values are normal or non-diagnostic, and documentation of Cystic Fibrosis Transmembrane Conductance Regulator (CFTR) mutation is needed to confirm a diagnosis, OR
  - Patient is an infant with meconium ileus or other symptoms indicative of cystic fibrosis who is too young to produce adequate amounts of sweat for a sweat chloride test, OR
  - Patient is an infant with an elevated Immunoreactive Trypsinogen (IRT) value on newborn screening.

- Carrier Testing is allowed when the following are met:
  - Eligible Medicaid member is an individual at a child-bearing age, AND
  - Parent with a positive family history of cystic fibrosis (e.g., member has a previously affected child with cystic fibrosis), OR
  - One or both parents with a 1st degree relative identified as a cystic fibrosis carrier, OR
  - Reproductive partners, of persons with cystic fibrosis, OR
  - One or both parents are in a population known to have a carrier rate that exceeds a threshold considered appropriate for testing for cystic fibrosis.

- Prenatal Testing is allowed when the following are met:
  - Eligible Medicaid member is pregnant, AND
  - Both parents are carriers, OR
  - One parent is a carrier, and the other parent has cystic fibrosis, OR
  - One parent is a carrier or has cystic fibrosis and genetic testing on the other parent is unavailable/unknown, OR
  - Prenatal diagnosis where ultrasound demonstrates fetal meconium ileus, echogenic bowel, or obstructed bowel.

**Note**: Complete analysis of the CFTR gene by DNA sequencing is not appropriate for routine carrier screening.

### CFTR Known Familial Mutation, Sequencing and Duplication/Deletion Analysis

- **CFTR Known Familial Mutation Analysis**
  This test is considered medically necessary for members who meet the following criteria:

  - No previous genetic testing for known CFTR family mutation(s); OR
  - Previous CFTR panel testing was not inclusive of known family mutation; AND
  - Family CFTR mutation(s) in known biologic relative; OR

- Either biological parent is known carrier of a CFTR mutation.

- **CFTR Sequencing**
  This test is considered medically necessary for members who meet the following criteria:
  - Previous CFTR Standard Panel was negative (no mutation found) or only one mutation was found; AND
  - Individuals with a negative or equivocal sweat chloride test; AND
  - Unexplained Chronic Obstructive Pulmonary Disease (COPD) or bronchiectasis with unexplained chronic or recurrent sinusitis and abnormal pulmonary function tests (PFTs); OR
  - Idiopathic chronic (acute recurrent) pancreatitis is present, OR
  - Infants with meconium ileus or other symptoms indicative of CF and are too young to produce adequate volumes of sweat for sweat chloride test, OR
  - Infants with an elevated IRT value on newborn screening and a negative 23 mutation panel; OR
  - An individual with a family history of CF with an unknown mutation; OR
  - An individual whose reproductive partner is a known CF carrier, has a diagnosis of CF, or has a diagnosis of Congenital Absence of the Vas Deferens (CAVD).

- **CFTR Deletion/Duplication Analysis**
  This test is considered medically necessary for members who meet the following criteria:

  - Previous CFTR Standard Panel was negative (no mutation found) or only one mutation was found; AND
  - No previous CFTR deletion/duplication testing; AND
  - No known familial mutation

*Billing Guidance*

| PROCEDURE CODE | TEST | PRIOR AUTHORIZATION REQUIREMENTS | LIMITATIONS AND FREQUENCY |
|---|---|---|---|
| 81221 | CFTR Known Familial Mutation Analysis | No | Allowed once per lifetime when clinical criteria are met. |
| 81222 | CFTR Deletion/Duplication Analysis | No | Allowed once per lifetime when clinical criteria are met. |

| | | | |
|---|---|---|---|
| 81223 | CFTR Sequencing | No | Allowed once per lifetime when clinical criteria are met. |
| 81443 | Primary Ciliary Dyskinesia & Cystic Fibrosis NGS Panel | No | Allowed once per lifetime per condition when clinical criteria are met. |

2. *Spinal Muscular Atrophy*

Spinal Muscular Atrophy (SMA) is a genetic neuromuscular disease characterized by muscle atrophy and weakness. The disease generally manifests early in life and is the leading genetic cause of death in infants and toddlers. SMA is caused by defects in the Survival Motor Neuron 1 (SMN1) gene that encodes the SMN protein. The SMN protein is critical to the health and survival of the nerve cells in the spinal cord responsible for muscle contraction (motor neurons).

*Clinical Criteria*

Diagnostic testing, carrier testing and prenatal testing is allowed once per lifetime per patient with prior authorization.

- Diagnostic or Confirmatory Testing is allowed when the following are met:
  - Eligible Medicaid member must be under the age of 21 years, AND
  - Member has symptoms of SMA, but diagnosis is in doubt.

- Carrier Testing is allowed when the following are met:
  - Eligible Medicaid member is an individual at a child-bearing age, AND
  - Parent with a positive family history of SMA (e.g., member has a previously affected child with SMA), OR
  - One or both parents with a 1st degree relative identified as a SMA carrier, OR
  - Reproductive partners, of persons with SMA, OR

- Prenatal Testing is allowed when the following are met:
  - Eligible Medicaid member is pregnant, AND
  - There is a personal or family history of SMA or other muscular dystrophy of unknown type in a 1st* or 2nd** degree relative of either parent
  - The father is a known carrier

Note: *1st degree relatives: parents, children, siblings.
**2nd degree relatives: grandparents, aunts, uncles, nieces, nephews, and grandchildren

Testing of a fetus by amniocentesis or chorionic villus sampling should be offered in the following circumstances:

- Following a positive SMA carrier test in the mother and the father; or,
- Following a positive SMA test in the mother where the father is not available for testing and suspicion of the disease is high.

Billing Guidance

| PROCEDURE CODE | TEST | PRIOR AUTHORIZATION REQUIREMENTS | LIMITATIONS AND FREQUENCY |
|---|---|---|---|
| 81329 | SMN1 gene analysis; dosage/deletion analysis, includes SMN2 | Yes | Once per lifetime per patient when clinical criteria are met. |
| 81336 | SMN1 gene analysis; full gene sequencing | Yes | Once per lifetime per patient when clinical criteria are met. |
| 81337 | SMN1 gene analysis; Known familial sequence variant | Yes | Once per lifetime per patient when clinical criteria are met. |

3. Myotonic Dystrophy (DM1)

Myotonic dystrophy is a genetic condition that causes progressive muscle weakness and wasting due to the inability to relax muscles at will. This muscle weakness and wasting impacts the entire body, including the eyes, brain, gastrointestinal system and heart.

DMPK gene analysis is performed on patients who have a range of symptoms associated with DM1 to achieve a diagnosis. A blood specimen is collected to evaluate the repeat expansions in the muscle protein kinase DMPK gene.

### Clinical Criteria

Diagnostic testing, carrier testing and prenatal testing is allowed once per lifetime per patient. No prior authorization is required.

- Diagnostic or Confirmatory Testing is allowed when the following are met:
  - Eligible Medicaid member must be under the age of 21 years, AND
  - Member has symptoms of DM1 (e.g., individuals with characteristic muscle weakness), but diagnosis is in doubt.

- Carrier Testing is allowed when the following are met:
  - Eligible Medicaid member is an individual at a child-bearing age, AND
  - Parent with a positive family history of DM1 (e.g., member has a previously affected child with DM1), OR
  - One or both parents with a 1st degree relative identified as a DM1 carrier, OR
  - Reproductive partners, of persons with DM1

- Prenatal Testing is allowed when the following are met:
  - Eligible Medicaid member is pregnant, AND
  - Both parents are carriers, OR
  - One parent is a carrier, and the other parent has DM1, OR
  - One parent is a carrier or has DM1 and genetic testing on the other parent is unavailable/unknown, OR
  - Prenatal diagnosis where ultrasound demonstrates excessive amniotic fluid, decreased fetal movement, or other potential indicators of congenital DM1.

### Billing Guidance

| PROCEDURE CODE | TEST | PRIOR AUTHORIZATION REQUIREMENTS | LIMITATIONS AND FREQUENCY |
|---|---|---|---|
| 81234 | DMPK gene analysis; evaluation to detect abnormal (expanded) alleles | No | Once per lifetime per patient when clinical criteria are met. |

4. Duchenne/Becker Muscular Dystrophy

Duchenne Muscular Dystrophy (DMD) and Becker Muscular Dystrophy (BMD) are rare X-linked neuromuscular diseases. DMD and BMD are inherited disorders of progressive muscular weakness that impact male individuals more than female due to the nature of X-linked recessive disorders. Deletion and duplication analysis is performed to detect abnormal alleles associated with DMD and BMD.

### General Criteria

Diagnostic testing, carrier testing and prenatal testing is allowed once per lifetime per patient. No prior authorization is required.

- Diagnostic or Confirmatory Testing is allowed when the following are met:
  - Eligible Medicaid member must be under the age of 21 years, AND
  - Member has symptoms of DMD/BMD (e.g., individuals with a high CK level), but diagnosis is in doubt.

- Carrier Testing is allowed when the following are met:
  - Eligible Medicaid member is a female at a child-bearing age, AND
  - Parent with a positive family history of DMD/BMD (e.g., member has a previously affected child with DMD/BMD), OR
  - One or both parents with a 1st-degree relative identified as a DMD/BMD carrier, OR
  - Reproductive partners, of persons with DMD/BMD

- Prenatal Testing is allowed when the following are met:
  - Eligible Medicaid member is pregnant, AND
  - Mother is a carrier, and the other parent has DMD/BMD,

| PROCEDURE CODE | TEST | PRIOR AUTHORIZATION REQUIREMENTS | LIMITATIONS AND FREQUENCY |
|---|---|---|---|
| 81161 | DMD deletion analysis, and duplication analysis | No | Once per lifetime per patient when clinical criteria are met. |

5. *Hereditary Hearing Loss*

### Clinical Criteria

SCDHHS will allow genetic testing for both syndromic and non-syndromic hereditary hearing loss for eligible Medicaid members. Examples of syndromic hearing loss include Usher Syndrome, Pendred Syndrome, and Wolfram Syndrome.

Usher Syndrome is a rare inherited condition that impacts vision, hearing and balance. USH is the most common genetic cause of combined deafness and blindness.

People with Pendred Syndrome usually have hearing loss in both ears (often at birth), and a goiter. Pendred Syndrome has considerable phenotypic variability, even within families so genetic testing is often used to help with early detection before thyroid symptoms arise during puberty.

Wolfram Syndrome is an inherited condition that typically includes childhood-onset insulin-dependent diabetes mellitus and progressive optic atrophy. People with Wolfram Syndrome may also develop diabetes insipidus, sensorineural hearing loss, and autonomic nervous system degeneration. These symptoms are a result of variants in the WFS1/WFS2 genes and people diagnosed with Wolfram Syndrome may vary in severity and number of symptoms.

### Clinical Criteria

Diagnostic testing, carrier testing and prenatal testing is allowed once per lifetime per patient. No prior authorization is required.

- Diagnostic or Confirmatory Testing is allowed when the following are met:
  - Eligible Medicaid member must be under the age of 21 years, AND
  - Member has symptoms of syndromic or non-syndromic hereditary hearing loss, but diagnosis is in doubt.

- Carrier Testing is allowed when the following are met:
  - Eligible Medicaid member is an individual at a child-bearing age, AND
  - Parent with a positive family history of hereditary hearing loss (e.g., member has a previously affected child with hearing loss), OR
  - One or both parents with a 1st degree relative identified as a carrier for hereditary hearing loss, OR
  - Reproductive partners, of persons with hereditary hearing loss

- Prenatal Testing is allowed when the following are met:
  - Eligible Medicaid member is pregnant, AND
  - Both parents are carriers, OR
  - One parent is a carrier, and the other parent has hereditary hearing loss, OR
  - One parent is a carrier or has hereditary hearing loss and genetic testing on the other parent is unavailable/unknown.

Billing Guidance

| PROCEDURE CODE | TEST | PRIOR AUTHORIZATION REQUIREMENTS | LIMITATIONS AND FREQUENCY |
|---|---|---|---|
| 81430 | Hearing Loss; Genomic Sequence Analysis Panel | No | Allowed once per lifetime per patient when clinical criteria are met. |
| 81431 | Hearing Loss Duplication/Deletion Analysis Panel | No | Allowed once per lifetime per patient when clinical criteria are met. |

**Other Genetic Testing**

1. *Maternal Cell Contamination Testing*

*Clinical Criteria*

The contamination of fetal samples with maternal cells can interfere in diagnostic prenatal testing, although the presence of maternal cells does not always cause diagnostic prenatal test errors.

The frequency of contamination varies considerably, due to differences in sampling protocol and the success of fetal cell culture. The degree of maternal cell contamination that affects a prenatal diagnostic test result varies by genetic test and is highly dependent on the technology used by the performing laboratory.

This test evaluates more than 80 polymorphic variants at 10 loci to detect the presence of maternal cells and estimate the percent contamination.

Billing Guidance:

- Test is allowed for eligible member who are pregnant, AND
- As an adjunct to prenatal diagnostic testing (amniocentesis or chorionic villus sampling)

| PROCEDURE CODE | TEST | PRIOR AUTHORIZATION REQUIREMENTS | LIMITATIONS AND FREQUENCY |
|---|---|---|---|

| | | | |
|---|---|---|---|
| 81265 | Comparative analysis using Short Tandem Repeat (STR) markers; patient and comparative specimen | No | Allowed for pregnant women, once per pregnancy. |

2. *X-Inactivation Testing*

This test is used to determine a patient's X-chromosome inactivation pattern (random or skewed), which can assist in the evaluation of suspicious or diagnostic findings that do not show expected segregation patterns.

Billing Guidance:

- Allowed once per lifetime per patient. Not allowed for prenatal testing.
- Eligible members are females with apparent signs of X-linked recessive disorders to determine skewing of X-inactivation.

| PROCEDURE CODE | TEST | PRIOR AUTHORIZATION REQUIREMENTS | LIMITATIONS AND FREQUENCY |
|---|---|---|---|
| 81204 | AR (androgen receptor) gene analysis; characterization of alleles | No | Allowed once per lifetime per patient. Not allowed for prenatal testing |

3. Chromosome Analysis

Clinical Criteria

Genetic centers are permitted to fragment chromosome charges into the “tissue culture for chromosome analysis” charge and the analysis charge. Chromosome testing must be medically necessary.
In addition, reimbursement may be allowed for the following expanded services: extended chromosome analysis, R-Bands, and Fragile X DNA analysis.

The following conditions may be used as indications of analysis:

- Intellectual disabilities

- Dysmorphic fractures
- Multiple congenital abnormalities
- Abnormal sexual development
- Abnormalities of growth
- Certain types of malignancies

## Billing Guidance

| PROCEDURE CODE | TEST | PRIOR AUTHORIZATION REQUIREMENTS | LIMITATIONS AND FREQUENCY |
|---|---|---|---|
| 88245-88269;<br><br>88280-88289; | CHROMOSOME ANALYSIS 20-25<br><br>CHROMOSOME ANALYSIS 50-100<br><br>CHROMOSOME ANALYSIS 100<br><br>CHROMOSOME ANALYSIS 5<br><br>CHROMOSOME ANALYSIS 15-20<br><br>CHROMOSOME ANALYSIS 45<br><br>CHROMOSOME ANALYSIS 20-25<br><br>CHROMOSOME ANALY AMNIO OR CHORIO 15 CELL<br><br>CHROSOME ANALYS SITU AMNIOTIC FLUID<br><br>CHROMOSOME KARYOTYPE STUDY<br><br>CHROMOSOME BANDING STUDY<br><br>CHROMOSOME COUNT ADDITIONAL | No | Allowed one test per lifetime per patient per condition. Allowed for members under the age of 21 years when clinical criteria are met. |

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|---|---|---|---|
| | CHROMOSOME STUDY ADDITIONAL | | |

4. Infant and Children Genetic testing

Clinical Criteria

- Lysosomal Enzyme Analysis for Developmental Regression (e.g., Tay-Sachs Disease)
  At least one of the following indications must be present:
  - Growth failure
  - Development regression or developmental delay
  - Clouding of corneas
  - Hepatosplenomegaly
  - Coarsening of facial features
  - Abnormalities of skeletal system

- Amino Acid Analysis for Infants and Children
  At least one of the following indications must be present:
  - Feeding abnormalities
  - Growth failure
  - Development failure
  - Seizures
  - Uncommon acidosis
  - Suspected metabolic disorder

- Organic Acid Analysis for Infants
  At least one of the following indications must be present:
  - Feeding abnormalities
  - Unexplained acidosis
  - Growth failure
  - Seizures
  - Suspected metabolic disorder

- Carbohydrate Analysis for Infants and Children
  One of the following indications must be present:
  - Cataracts
  - Hepatosplenomegaly
  - Jaundice
  - Growth failure
  - Acidosis

- Seizures
- Suspected metabolic disorder

- Other Tests for Infants and Children
  These tests include the following:
  - Metabolic screen
  - Alpha-fetoprotein
  - Sialic acid
  - Sulfate incorporation

Billing Guidance

| PROCEDURE CODE | TEST | PRIOR AUTHORIZATION REQUIREMENTS | LIMITATIONS AND FREQUENCY |
|---|---|---|---|
| 81400-84999*<br><br>*Specific procedure codes as listed on the fee schedule | Lysosomal Enzyme Analysis for Developmental Regression;<br><br>Amino Acid Analysis for Infants and Children;<br><br>Organic Acid Analysis for Infants;<br><br>Carbohydrate Analysis for Infants and Children;<br><br>Other Tests for Infants and Children<br><br>• Metabolic screen<br>• Alpha-fetoprotein<br>• Sialic acid<br>• Sulfate incorporation | No | Allowed for infants and children, one test per condition when clinical criteria are met. |

5. Amniocentesis

### Clinical Criteria

Screening (serum screening with or without nuchal translucency ultrasound or cell-free DNA screening) and diagnostic testing (CVS or amniocentesis) for chromosomal abnormalities after counseling the beneficiary when meeting the following criteria:

- Women over 35 years of age
- Previous child with chromosomal disorder
- Multiple spontaneous abortions
- Patients with neural tube defects
- Patients at risk for having children with X-linked disorder (i.e., hemophilia or Duchenne muscular dystrophy, or metabolic disorders such as Tay-Sachs disease).

### Billing Guidance

| PROCEDURE CODE | TEST | PRIOR AUTHORIZATION REQUIREMENTS | LIMITATIONS AND FREQUENCY |
|---|---|---|---|
| 82143 | Amniotic fluid scan (spectrophotometric) | No | Allowed for pregnant women over the age of 35 years, once per pregnancy when clinical criteria are met. |

6. Non-Invasive Prenatal Screening

### Clinical Criteria

SCDHHS covers Non-Invasive Prenatal Screening (NIPS) of pregnant women for the detection of:

- Fetal chromosomal aneuploidy genomic sequence analysis panel, circulating cell-free DNA in maternal blood, must include analysis of chromosomes 13, 18 and 21.
- Fetal chromosomal microdeletion(s) genomic sequence analysis, circulating cell-free fetal DNA in maternal blood. n
- Fetal aneuploidy (trisomy 21, 18 and 13) DNA sequence analysis of selected regions using maternal plasma, algorithm reported as a risk score for each trisomy.

NIPS is considered medically necessary for pregnant women meeting all of the following criteria:

- Underwent pretest counseling.

- A cell-free fetal DNA test has not been performed yet in this pregnancy.
- Current pregnancy is not a multiple gestation.
- Current pregnancy greater than or equal to ten weeks and less than 23 weeks at the time the blood will be drawn.

Billing Guidance

| PROCEDURE CODE | TEST | PRIOR AUTHORIZATION REQUIREMENTS | LIMITATIONS AND FREQUENCY |
|---|---|---|---|
| 81420; 81422; 81507 | Fetal Chromosomal Aneuploidy;<br><br>Fetal Chromosomal Microdeletions;<br><br>Fetal Aneuploidy/DNA Seq/Analy/Mat Plas | No | Allowed for pregnant women, once per pregnancy when clinical criteria are met. |

7. Other tests, not otherwise categorized.
Medicaid beneficiaries under the age of 21 years are eligible for medically necessary genetic testing for the following hereditary conditions:

| PROCEDURE CODE | TEST | PRIOR AUTHORIZATION REQUIREMENT | LIMITATIONS AND FREQUENCY |
|---|---|---|---|
| 81410 | Connective Tissue Disorders NGS Panel | No | Allowed once per lifetime per patient, per condition |

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|---|---|---|---|
| 81413 | Comprehensive Cardiac NGS Panel<br>Long QT Syndrome NGS Panel | No | Allowed once per lifetime per patient, per condition |
| 81414 | Cardiac ion channelopathies (del/dup) | No | Allowed once per lifetime per patient, per condition |
| 81419 | Epilepsy/Seizure NGS Panel | No | Allowed once per lifetime per patient, per condition |
| 81434 | Retinitis Pigmentosa NGS Panel | No | Allowed once per lifetime per patient, per condition |
| 81439 | Dilated & Arrhythmogenic Cardiomyopathy NGS Panel<br>Hypertrophic Cardiomyopathy NGS Panel | No | Allowed once per lifetime per patient, per condition |
| 81441 | Inherited Bone Marrow Failure | No | Allowed once per lifetime per patient, per condition |
| 81442 | RASopathy NGS Panel | No | Allowed once per lifetime per patient, per condition |
| 81443 | Bardet-Biedl Syndrome NGS Panel<br>Brugada Syndrome NGS Panel<br>Cholestasis NGS Panel<br>Coffin-Siris Syndrome NGS Panel<br>Comprehensive Pulmonary NGS Panel | No | Allowed one test per lifetime patient per condition |

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|---|---|---|---|
| | Cone-Rod Dystrophy NGS Panel<br><br>Congenital Contractures NGS Panel<br><br>Congenital Stationary Night Blindness (CSNB) NGS Panel<br><br>Early Infantile Epileptic Encephalopathy NGS Panel<br><br>Focused NGS - Panel (16-60 Genes)<br><br>Hereditary Spastic Paraplegia NGS Panel<br><br>Hermansky-Pudlak Syndrome & Pulmonary Fibrosis NGS Panel<br><br>Kallmann Syndrome & Hypogonadotropic Hypogonadism NGS Panel<br><br>Leber Congenital Amaurosis NGS Panel<br><br>Lysosomal Storage Disease NGS Panel<br><br>Macular Degeneration NGS Panel<br><br>Mitochondrial Depletion NGS Panel<br><br>Neuromuscular Disorders NGS Panel<br><br>Non-Immune Hydrops NGS Panel<br><br>Ocular Albinism & Hermansky-Pudlak Syndrome NGS Panel | | |

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|---|---|---|---|
| | Optic Atrophy & Early Glaucoma NGS Panel<br><br>Overgrowth/Macrocephaly NGS Panel<br><br>Primary Ciliary Dyskinesia & Cystic Fibrosis NGS Panel<br><br>Pulmonary Arterial Hypertension NGS Panel<br><br>Rett/Angelman Syndrome NGS Panel<br><br>Rhabdomyolysis & Metabolic Myopathies NGS Panel<br><br>Syndromic Autism NGS Panel<br><br>Vascular Malformation NGS Panel | | |
| 81448 | Charcot-Marie-Tooth Hereditary Neuropathy NGS Panel | | Allowed once per lifetime per patient, per condition |
| 81470 | X-Linked Intellectual Disability (XLID) NGS Panel | | Allowed once per lifetime per patient, per condition |
| 81479 | Central Hypoventilation Syndrome NGS Panel<br><br>Cornelia de Lange Syndrome NGS Panel<br><br>Craniosynostosis NGS Panel<br><br>Dyskeratosis Congenita NGS Panel | | Allowed once per lifetime per patient, per condition |

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| | Familial Hypercholesterolemia NGS Panel<br><br>Maturity-Onset Diabetes of the Young (MODY) NGS Panel<br><br>Mitochondrial DNA Variant Panel<br><br>Neuronal Ceroid Lipofuscinoses NGS Panel<br><br>Periodic Fever NGS Panel<br><br>Peroxisomal Biogenesis Disorders NGS Panel<br><br>Skeletal Dysplasia NGS Panel<br><br>Surfactant Dysfunction & Respiratory Distress in Premature Infants NGS Panel<br><br>Tuberous Sclerosis Complex (TSC) NGS Panel | | |

### Radiology and Nuclear Medicine

Radiology services are those services performed by a radiologist/physician in conjunction with an x-ray, ultrasound, Positron Emission Tomography (PET scan), computerized axial tomogram (CAT scan), or magnetic resonance imaging (MRI). Radiological services are covered only when such services are consistent with the diagnosis and treatment of an illness or injury. Screening procedures are not reimbursable unless outlined as covered items in this manual.

Effective March 1, 2014, SCDHHS will no longer prior authorize high-tech radiology services. All radiology services will be based on medical necessity and held to the American College of Radiology (ACR) standards. ACR standards can be found at http://www.acr.org.

This policy pertains to all FFS recipients and SCDHHS will no longer exclude anyone based on category or whether they have third-party liability primary coverage. Providers must continue to refer

members in an MCO to the appropriate MCO provider in order to determine if prior authorization applies to radiology services.

**Positron Emission Tomography (PET) Scans**

PET scan reimbursement will be limited to two scans in a 12-consecutive month period. PET scans will only be covered for the staging and restaging of cancer malignancies.

### Staging

- The stage of the cancer remains in doubt after completion of a standard diagnostic work-up, including conventional imaging such as CAT scan, MRI or ultrasound, or
- The use of a PET scan could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient, and
- Clinical management of the patient would differ depending on the stage of the cancer identified.

### Restaging

- Detecting residual disease.
- Detecting suspected recurrence or metastasis.
- Determining the extent of recurrence.
- Potentially replacing one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient.

PET scans will not be utilized for screening purposes and the use of PET scans to monitor tumor response during a planned course of treatment will not be covered. Restaging only occurs after a course of treatment is completed and 90 days has lapsed prior to the restaging PET scan. PET scans will be subject to retrospective review to include paid inpatient/OP hospital and physician claims. Documentation must be maintained in the beneficiary's medical records and must support medical necessity. SCDHHS will not cover any additional PET scans over the frequency limitation of two in a 12-consecutive month period.

**Diagnostic Radiology**

Medicaid requires that all facilities providing screening and diagnostic mammography services meet FDA regulations. Medicaid claims for mammography services will be reviewed to ensure FDA criteria are met. Medicaid will not reimburse for mammography services performed by providers who are not certified, and providers cannot bill the Medicaid beneficiaries for the denied Medicaid

services. An FDA certificate for screening mammography services must be in the provider enrollment file. Questions regarding enrollment may be directed at:

Medicaid Provider Enrollment
Post Office Box 8809
Columbia, SC 29202-8809
Phone: 888-289-0709

**Diagnostic Ultrasound**
Ultrasound procedures are recorded as complete, limited or repeat procedures. Full documentation must justify the use of the complete procedure code. A complete procedure is one that the provider furnished both the professional and TCs. Please refer to Obstetrics and Gynecology in this section of the manual for pregnancy-related guidelines.

**Radiology Oncology**
A preliminary evaluation/consultation of the patient is allowed prior to the decision to treat and must be identified by the appropriate E&M code. Once the therapist assumes responsibility for the treatment and care of the patient, a separate consultation or E&M code will not be covered.

Please refer to CPT reference manual for appropriate codes for the treatment planning, radiation physics, treatment delivery and treatment management of radiation oncology.

**Clinical Treatment Planning**
Please refer to the CPT reference manual for appropriate codes for the treatment and planning process. These services include test interpretation, tumor localization, treatment volume determination, time/dosage determination, treatment modality, number and size of ports and selection of treatment devices.

**Medical Radiation Physics**
Please refer to the CPT reference manual for appropriate codes for services by the physician and physicist involved in radiation physics, dosimetry calculation, construction of treatment devices and other special services.

**Radiation Treatment Delivery**
Radiation treatment codes reflect the technical portion of radiation therapy services. The codes will be found in your CPT reference manual and represent individual sessions of service delivery or daily services. Multiple treatment sessions on the same DOS are allowed as long as there is a distinct break in therapy services/individual session.

**Clinical Treatment Management**
Please refer to the CPT reference manual for appropriate codes. Clinical treatment management codes reflect the professional component of treatment on a weekly basis. These codes are used to describe the physician's weekly radiotherapy management services at all energy levels. A weekly unit is equal to five fractions or treatment sessions, regardless of whether the fraction or treatment sessions are furnished on consecutive days or without regard to the actual time period in which the services are provided.

**Hyperthermia**
Treatments include external and internal procedures. Hyperthermia is used only as an adjunct to radiation/chemotherapy. It may be initiated by microwave, ultrasound, low-energy radio-frequency conduction or by probes.

**Clinical Brachytherapy**
Please refer to your CPT reference manual for all codes. Services bundled within the procedure codes include hospital admission, daily visits, follow-up care, dilation, insertion and removal of applicators. They do not include preparation of the element calculation of dosage or loading of the element.

**Nuclear Medicine**
Please refer to the CPT reference manual for appropriate codes for services related to diagnostic and therapeutic nuclear medicine. The procedures may be performed and charged separately, or as part of a course of treatment. Radioimmunoassay tests are found in the Clinical Pathology section of the CPT reference manual.

**Contrasts and Radiopharmaceuticals**
For appropriate codes for billing contrasts and radiopharmaceuticals providers must refer to the HCPCS reference manual. Physicians must not bill for radiopharmaceuticals and/or contrasts that are provided by the hospital.

**Independent Imaging Centers and Mobile Imaging Units**
Independent Imaging Centers and Mobile Imaging Units: Medicaid will reimburse for services provided by a freestanding imaging centers, mobile ultrasound units, and mobile imaging units when the services are consistent with diagnosis, treatment, injury or covered preventative services as found in Family Planning.

Independent imaging centers, mobile ultrasound units and mobile imagining units can only be reimbursed for the technical portion of an x-ray or other imaging service. Separate reimbursement will be made to the physician for the professional interpretation of the radiology procedure. The

physician's name must be on the radiology report as the reading/interpreting physician. Reimbursement will be sent to the reading/interpreting physician or reading/interpreting physician group practice. The reading/interpreting physician must be enrolled with SCDHHS as an in-state provider. All OOS providers must go through the OOS approval process. OOS physicians must attach a copy of the approval letter to each CMS-1500 form submitted for reimbursement.

## Podiatry Services

Podiatry services are services necessary for the diagnosis and treatment of foot conditions. These services are limited to the specialized care of the foot as outlined under the laws of the State of South Carolina.

### Office Examinations

Level of service guidelines must be followed as described in the current CPT. Podiatric exams may be charged at all levels of services as medically necessary for new or established office E&M visits.

### Treatment of Subluxation of the Foot

Subluxation of the foot is defined as partial dislocation to displacement of joint surfaces, tendons, ligaments or muscles of the foot.

Reasonable and necessary diagnosis and treatment (except using orthopedic shoes or other supportive devices for the foot) of symptomatic conditions such as osteoarthritis, bursitis, tendonitis, etc., that result from or are associated with partial displacement of foot structures are covered services. Surgical correction of a subluxed foot structure that is either an integral part of the treatment of a foot injury, or that is undertaken to improve the function of the foot, or that is undertaken to alleviate an induced or associated symptomatic condition, is a covered service. The presentation of symptoms is clearly the paramount factor in coverage. Surgical and non-surgical treatments undertaken for the sole purpose of correcting the subluxed structure of the foot as an isolated entity are not covered.

### Treatment of Flat Foot

The term "flat foot" is defined as a condition in which one or more of the arches of the foot have flattened out. Services directed toward the care or correction of such a condition is not covered. However, the services or procedures required to make the initial diagnosis may be considered reasonable and necessary and are covered.

### Supportive Devices for the Feet

Orthopedic shoes and other supportive devices for the feet are not covered unless the shoe is an integral part of a leg brace.

**Prosthetic Shoe**
A prosthetic shoe (a device used when all or a substantial portion of the front part of the foot is missing) can be covered as a terminal device (i.e., a structural supplement replacing a totally or substantially absent foot). The beneficiary must be referred to a DME supplier for such devices.

**Excision of Nail**
When a procedure indicates a partial or total permanent nail removal, separate billing is not to be used for the medial and lateral borders of the same toe. The number of toes must be indicated if multiple toes are corrected at the same time.

**Plantar Warts**
Treatment for Verruca vulgaris and intractable plantar keratoma are covered services.

**Mycotic Nail**
Mycotic nail and other infections of the feet and toenails require professional services that are outside the scope of routine foot care and are covered services if the subsequent criteria are met. Treatment of a fungal (mycotic) infection of the toenail can be covered under the following circumstances:

- Clinical evidence of mycosis of the toenail.
- Medical documentation that the patient has either a limitation of ambulation requiring active treatment of the foot, or in the case of a non-ambulatory patient, a condition that is likely to result in significant medical complications in the absence of such treatment.

**Routine Foot Care**
Routine foot care includes the cutting or removal of corns or calluses, the trimming of nails, and other hygienic and preventative maintenance care.

Reimbursement for routine foot care is allowed under the medical conditions listed below when the patient is under the active care of a physician, licensed practitioner. It is essential that the patient has seen a physician for treatment and/or evaluation of the complicating disease process during the six months prior to the DOS. The allowable conditions are as follows:

- Diabetes mellitus
- Chronic thrombophlebitis
- Peripheral neuropathies involving the feet associated with:

  - Malnutrition and vitamin deficiency
  - Malnutrition (general, pellagra)
  - Alcoholism
  - Malabsorption (celiac disease, tropical sprue)
  - Pernicious anemia
  - Carcinoma
  - Diabetes mellitus
  - Drugs and toxins
  - MS
  - Uremia (chronic renal disease)

In evaluating whether the routine services can be reimbursed, a presumption of coverage is made where the evidence available discloses certain physical and/or clinical findings consistent with the diagnosis, and indicative of surface peripheral involvement.

The presumption of coverage is applied when a physician rendering the routine foot care has identified one Class A finding as noted below, two Class B findings, or one Class B and two Class C findings as follows:

***Class A Findings:***

- Non-traumatic amputation of the foot or an integral skeletal portion thereof

***Class B Findings:***

- Absent posterior tibial pulse
- Absent dorsalis pedis pulse
- A minimum of three trophic changes as follows:
  - Hair growth (decrease or absence)

- Nail changes (thickening)
- Pigmentary changes (discoloration)
- Skin texture (thin, shiny)
- Skin color (rubor or redness)

***Class C Findings:***

- Claudication
- Temperature changes (e.g., cold feet)
- Edema
- Paresthesia (abnormal spontaneous sensations in the feet)
- Burning

Additional services ordinarily considered routine may also be covered if they are performed as a necessary and integral part of otherwise covered services, such as diagnosis and treatment of diabetic ulcers, wounds and infections.

**Nursing Home Visits**
Podiatry care may be rendered to patients in nursing or rest home facilities, provided the service is medically necessary and meets the policies defined in this manual. Podiatry care must be requested by one of the following:

- The attending physician
- The patient
- The patient's family when the patient is incompetent
- Nursing service*
- Nursing service requests must be documented in the patient's chart. The podiatrist's records must indicate who made the request for services in this situation.

## NON-COVERED SERVICES

### Evaluation and Management Services

**Telehealth**

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

- Telephone conversations
- Email messages
- Video cell phone interactions
- Facsimile transmissions
- Services provided by allied health professionals

**Unusual Travel**

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

**EPSDT**

The following services are not covered under EPSDT:

- Experimental or investigational treatments (except qualifying clinical trials- for details refer to the Provider Administrative and Billing Manual).
- Services or items not generally accepted as effective and/or not within the normal course and duration of treatment.
- Services for caregiver or provider convenience.
- HCBS Waiver
- Services for which South Carolina Healthy Connections Medicaid has a waiver program are not considered to be State Plan benefits, and therefore, are not a benefit under EPSDT. For example, items such as respite, vehicle modifications and home modifications are not covered.
- Sports, camp or college physical examination.

## Obstetrics and Gynecology

### Infertility Procedures

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

### Gender Transition

Services and procedures related to gender transition are not covered.

### Family Planning

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

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

- Sterilization by hysterectomy.
- Abortions.
- Hospital charges incurred when a beneficiary enters an OP hospital/facility for sterilization purposes but then opts out of the procedure.
- Inpatient hospital services.
- Removal of an IUD due to a uterine or pelvic infection.
- Colposcopy and biopsy of cervix/vagina performed to identify and treat medical conditions.
- Diagnostic or screening mammograms.
- Treatment of medical complications (e.g., 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.
- Routine gynecological exams (diagnosis code Z01.411 or Z01.419) in which contraceptive management is not provided.

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

## Specialty Care Services

### Consultations Exclusions

Situations in which consultations generally are excluded from coverage are as follows:

- Physicians within the same specialty who are partners cannot be paid consultation fees for visits to the same patient unless one partner's sub-specialty is unique to a particular situation.
- Consultations required by hospital rules and regulations, or consultations between colleagues who exchange medical opinions as a matter of courtesy and normally without charge, are not covered.
- Anesthesia consultations are not covered on the same date as surgery or the day prior to surgery, if part of the pre-operative assessment.
- Follow-up consultations are not covered when the total or specific care of a patient is transferred from the attending physician to the consultant.

## Psychiatric and Counseling Services

The following services are non-compensable:

- Psychoanalysis
- Multiple-family group psychotherapy
- Narcosynthesis for psychiatric diagnostic and therapeutic purposes (e.g., sodium amobarbital [amytal] interview)
- Individual psycho-physiological therapy incorporating biofeedback training (20–30 minutes)
- Individual psycho-physiological therapy incorporating biofeedback training (45–50 minutes)
- Hypnotherapy

Psychotherapy services are non-covered in an inpatient setting when reimbursement of this service is included in the hospital reimbursement.

## Ophthalmology and Optometry Services

### Part I — Vision Care Services

The following services are non-covered under the Vision Care program:

- Routine eye exams for beneficiaries beginning on their 21st birthday and older.
- Refractions for beneficiaries beginning on their 21st birthday.
- Lenses and frames for beneficiaries beginning on their 21st birthday.
- Optometric hypnosis.
- Broken appointments.
- Special reports.
- Extended wear contact lenses, cosmetic lenses, tinted and/or colored contacts.
- Transitional and progressive lenses.

### Part II — Diagnostic Ophthalmology Services

**Glare Testing**

This is considered non-standardized and has not been proven effective in the diagnosis of visual disabilities. Therefore, no separate reimbursement is allowed for this procedure.

**Schirmer Test**

This is considered an integral part of the ophthalmological or E&M exam; separate reimbursement for this test is not allowed.

Orthotic or Pleoptic Training: Non-covered

Color Vision Examination: Non-covered

Dark Adaptation Examination: Non-covered

Radial Keratotomy: Non-covered

Vision Screenings: Non-covered for those individuals aged 21 or over

**Cardiology**

Vascular Studies

Thermography is non-covered.

**Dermatology**

Services provided for cosmetic reasons are non-covered.

**Physical Medicine and Therapy**

Biofeedback therapy may be utilized as a modality of treatment, but it is not reimbursable separately.

**Hyperbaric Oxygen Therapy**

No program payment may be made for HBO in the treatment of the following conditions:

- Cutaneous, decubitus and stasis ulcers
- Chronic peripheral vascular insufficiency
- Anaerobic septicemia and infection other than clostridial
- Skin burns (thermal)
- Senility
- Myocardial infarction
- Cardiogenic shock
- Sickle cell crisis
- Acute thermal and chemical pulmonary damage (i.e., smoke inhalation with pulmonary insufficiency)
- Acute or chronic cerebral vascular insufficiency
- Hepatic necrosis
- Aerobic septicemia
- Non-vascular causes of chronic brain syndrome (Pick's disease, Alzheimer's disease, Korsakoff's disease)

- Tetanus
- Systemic aerobic infection
- Organ transplantation
- Organ storage
- Pulmonary emphysema
- Exceptional blood loss anemia
- MS
- Arthritic disease
- Acute cerebral edema

### Topical Application of Oxygen

This method of administering oxygen does not meet the definition of HBO therapy as stated above. Also, its clinical efficacy has not been established. Therefore, no reimbursement is allowed for the topical application of oxygen.

**General Surgery Guidelines**

Certain surgical procedures are routinely not covered. These non-covered procedures typically fall into one of the following categories:

- Do not restore a bodily function.
- Are performed for cosmetic reasons.
- Have an alternative non-operative treatment.
- Frequently are performed for less than adequate diagnostic indications.
- Are not proven effective.
- Are experimental/investigational in nature.
- Are for the convenience of the patient.

No reimbursement will be made for subsequent procedures that do not add significantly to the complexity of the major surgery or are rendered incidentally and performed at the same time as the major surgery (e.g., incidental appendectomies, incidental scar excisions, puncture of ovarian cysts, simple lysis of adhesions, simple repair of hiatal hernias).

**Surgical Guidelines for Specific Systems**

Integumentary System

**Lesion Removal**

Medicaid will not provide coverage for excision/treatment of non-malignant dermal lesions and dermal anomalies under the following circumstances:

- The treatment is performed for cosmetic or emotional purposes.
- The therapy is experimental or investigational.

**Cosmetic Procedures**

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

Cosmetic otoplasty is not covered under normal circumstances. Payment will be considered for otoplasty procedures for children under 21, but only if there is documented evidence of psychological trauma because of their appearance. A psychiatric evaluation performed by a psychiatrist recommending treatment, plus pertinent medical documentation, must be attached to the claim. Lack of, or insufficient documentation will result in a rejected claim. All otoplastic procedures must be preauthorized by the QIO contractor.

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

**Male Genital System**

Routine newborn circumcisions are covered services for beneficiaries without tprior approval.

**Anesthesia Services**

The following CPT modifiers are non-covered:

P1 — A normal healthy patient

P2 — A patient with mild systemic disease

P3 — A patient with severe systemic disease

P4 — A patient with severe systemic disease that is a constant threat to life

P5 — A moribund patient who is not expected to survive without the operation

P6 — A declared brain-dead patient whose organs are being removed for donor purposes

These risk factor codes are non-covered.

**Pain Management Services**

There is no reimbursement to physicians or CRNAs for the set-up or subsequent daily management of patient-controlled analgesia pumps. Behavioral modification, PT, psychiatric services, and related services are also non-compensable as pain management or pain therapy services.

**Pathology and Laboratory Services**

Clinical Laboratory Improvement Amendments (CLIA)

The following codes are non-covered:

- Ovulation tests by visual color comparison methods for human luteinizing hormone.
- Fern test.
- Post-coital direct, qualitative examinations of vaginal or cervical mucous.

# 4
# UTILIZATION MANAGEMENT

## PRIOR AUTHORIZATION

### Pre- and Post-Payment Review

All Medicaid claims, including claims for surgery, are paid through an automated claims processing system. These claims are subject to pre-payment edits and may require documentation. If a pre-payment edit is received, providers must file a new claim and submit documentation to support medical necessity.

Post-payment reviews are conducted regarding utilization, appropriateness, medical necessity and other factors.

All claims and reimbursements are subject to post-payment monitoring and recoupment if review indicates a claim was paid inappropriately or incorrectly. Providers are required to maintain and disclose their records consistent with the Provider Administrative and Billing Manual.

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

### Utilization Review Services

SCDHHS contracts for utilization review services with the current QIO contractor.

The QIO review consists of:

- Pre-surgical justification for all hysterectomies.
- Select preauthorization review.
- Support documentation review.
- A retrospective review of a sample of paid inpatient/OP hospital claims.
- Select project studies as determined by SCDHHS.

Screening criteria may be obtained upon request from QIO. Any questions or concerns should be directed to QIO customer service at (855) 326-5219 or emailed to: atrezzoissues@Kepro.com. Please be advised that a beneficiary may not contact QIO directly.

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

SCDHHS reserves the right to review retrospectively any case that has received prior approval to assure accuracy and compliance with South Carolina Medicaid guidelines and federal requirements.

**Instructions for Obtaining Prior Approval**
The responsibility for obtaining pre-admission/pre-procedure review rests with the attending physician. The physician must submit all necessary documents, including the Request for Prior Approval Review Form, to QIO.

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

| | |
|---|---|
| QIO Customer Service: | 855-326-5219 |
| QIO Fax: | 855-300-0082 |
| Provider Issues Email: | atrezzoissues@Kepro.com |

Unless otherwise stated within SCDHHS policy or procedure, if the beneficiary has a primary coverage through Medicare or any other private health insurance, prior authorization by QIO is not required. The QIO reviewer will screen the medical information provided, using appropriate QIO or InterQual criteria for non-physician review.

If criteria are met, the procedure will be approved, and an authorization number assigned. Notification of the approval and authorization number will be given by written confirmation to the physician. Write this number in block 23 of the CMS-1500 claim form.

If criteria are not met, or a case is otherwise questioned, the QIO reviewer will refer the procedure request to a physician reviewer. If the physician reviewer cannot approve the admission/procedure based on the initial information provided, he or she will make a reasonable effort to contact the attending physician for additional supporting documentation of the need for the procedure.

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

Review personnel will assign an authorization number (if the procedure is approved), and a written copy of the authorization number will be sent to the physician.

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

QIO will verify all initial procedure denial decisions by issuing written notices to the attending physician.

The attending physician may request a reconsideration of the initial denial decision by submitting a written request outlining the rationale for recommending the procedure. Reconsideration may be requested whether the case was pre-procedure or post-procedure reviewed. The request must be in writing to QIO. If a case is denied upon reconsideration, the determination is final and binding upon all parties (CFA 473.38).

**Points of Emphasis for Prior Authorization**

QIO will accept medical review documentation via facsimile, telephone or via their website. Providers are responsible for verifying beneficiary eligibility prior to the prior authorization request being submitted and again prior to performing a service. Eligibility and managed care enrollment status may change during the time a request is submitted and approved and the actual date the procedure is performed.

A prior authorization request for beneficiaries enrolled in a MCO must be handled by the MCO. If you have any additional questions regarding the MCO you may contact the MCO's Provider Services department, or the Managed Care area at (803) 898-4614. Contact information for the MCOs is in the Managed Care Supplement.

Physician providers are responsible for providing the prior authorization number to any facility or medical provider who will submit a Medicaid claim.

The hysterectomy policy has changed.

**Quality Improvement Organization (QIO) Authorization**

SCDHHS will allow for the review and prior authorization of additional mental health visits (psychotherapy, family psychotherapy and group psychotherapy). The beneficiary's physician must request, in writing, prior authorization through SCDHHS to override the 12 allowable mental health visits. The prior authorization request must be submitted to the SCDHHS designated QIO by faxing the DHHS Mental Health Form (in the Forms section of the provider portal). The signature of the physician making the request must be on the form. The prior authorization request must include sufficient clinical information to determine the need for additional mental health visits. The physician

will be notified via QIO approval letter if the authorization request is approved, and prior authorizations will only be indicated for a six-month period.

All requests must be sent to the current QIO using one of the following methods:

Fax: 855-300-0082
Web portal: http://scdhhs.acentra.com

Other QIO contact information:

Customer Service: (855) 326-5219
Provider Issues Email: atrezzoissues@Kepro.com

When an emergency arises and there is insufficient time to obtain prior approval, the treating physician must prepare the required documentation and submit it for retrospective review. Claims requiring retrospective review are still subject to timely filing guidelines.

### Breast Cancer Susceptibility Gene 1 and 2 (BRCA)

Effective August 1, 2019, prior authorization must be obtained from QIO prior to initial or subsequent BRCA testing. One or more of the NCCN Clinical Practice Guidelines in Oncology — Genetic/Familial High-Risk Assessment: Breast and Ovarian criteria must be met.

A completed Hereditary Breast and Ovarian Cancer (HBOC) Genetic Testing Prior Authorization Request Form must be submitted to QIO. The form must be completed in its entirety, signed and dated by the referring provider. The provider's signature submitted on the HBOC is their attestation, to the best of their knowledge, that the information provided in the document is true, accurate and complete.

The physician must indicate one of the following on the HBOC form:

- The request is for initial BRCA1 and BRCA2 testing.
- The request is for repeat BRCA1 and BRCA2 comprehensive sequencing testing for the beneficiary because initial results are negative, or are not available, and large cell rearrangement testing is necessary.

### Hysterectomies

All hysterectomies must be preauthorized by QIO except for those being performed on patients that are dually eligible for Medicare and Medicaid. (Please refer to Utilization Review Services within this section of the manual for more information.) All prior approval requests for hysterectomies must be

in writing. The South Carolina Medicaid Surgical Justification Form and the Consent for Sterilization (DHHS 687) must be completed and submitted to QIO. The forms are available on the provider portal; both forms must be submitted at least 30 days prior to the scheduled surgery to QIO via facsimile at 855-300-0082.

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

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

Requests for prior authorizations must be submitted before the service is rendered. Exceptions to this policy include emergency, urgent case or retroactive eligibility. Emergency or urgent cases must also be submitted for approval before the claim is sent for processing.

Prior authorization, support documentation, quality assurance and quality care inquires must be submitted to QIO using one of the following methods:

QIO Customer Service: (855) 326-5219
QIO Fax: 855-300-0082
Provider Issues Email: atrezzoissues@Kepro.com

QIO urgent and emergent hysterectomy cases will be reviewed retrospectively. Please refer to Special Coverage Issues in this manual for additional Medicaid policies for hysterectomies. Cases that do not meet the QIO criteria will be referred for physician review. The physician will use clinical judgment to determine whether the proposed treatment was appropriate to the individual circumstances of the referred case. Pre-approved cases will not be subject to retrospective review by the QIO. However, SCDHHS reserves the right to review any paid claim and recoup payment when medical necessity requirements are not met. The patient and physician shall make the final decision as to whether to undergo surgery. Medicaid will not sponsor the hospital -related expenses associated with the surgery if the QIO physician consultant determines that the proposed surgery is not appropriate.

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 in which the physician determined that prior acknowledgement was not possible. In these

circumstances, a physician statement is required. The statement must indicate the cause of the sterility or the diagnosis and description of the nature of the emergency.

## Specialty Care Services

All services provided and billed are contingent upon medical necessity. SCDHHS reserves the right to request documentation to substantiate medical necessity at any time.

Certain procedures are always subject to medical review on a pre-payment basis. These procedures are listed in their respective specialty areas in this manual. If a claim is denied for reasons of "Not Medically Necessary", the provider may request a reconsideration. The request must be in writing and sent to the Division of Hospital Services at the following address:

SCDHHS
Division of Hospital Services
PO Box 8206
Columbia, SC 29202-8206

If the claim is denied a second time, the provider has the right to request an appeal within 30 days of the notice of denial. The request for an appeal must be in writing and sent to the Division of Appeals and Hearings at the following address:

SCDHHS
Division of Appeals and Hearings
PO Box 8206
Columbia, SC 29202-8206

If a hearing is necessary, a date will be arranged by the Division of Appeals and Hearings for the appellant and SCDHHS to formally review the claim(s).

Medicaid contracts with our QIO contractor, for utilization review services and pre-payment authorization of hysterectomies. Certain other procedures are subject to prior authorization through the Division of Hospital Services. For specific details, please refer to the Provider Administrative and Billing Manual.

## Psychiatric and Counseling Services

### Inpatient Admissions

SCDHHS will require prior authorization for all acute (general hospital) inpatient admissions. The Medicaid QIO, will perform the review and will accept prior authorization review requests via:

Fax: 855-300-0082
Web Portal: http://scdhhs.acentra.com

QIO nurse reviewers will screen the medical information provided using InterQual criteria. It is the responsibility of the attending physician to submit the Request for Prior Approval Review Form and all current medical documents that support the medical necessity of the admission to QIO. If criteria are met, the admission will be approved, and an authorization number assigned and faxed to the requesting provider.

For emergent or urgent admissions, providers must contact QIO for authorization within 24 hours of the date of the admission.

For admission to PRTF's or inpatient psychiatric hospitals for beneficiaries under age 21, please refer to the Psychiatric Hospital Services Provider Manual.

## Gastroenterology

### Panniculectomy

Prior authorization is needed and must be obtained by submitting documentation to QIO via fax, email or website; InterQual criteria apply.

## Physical and Medicine Therapy

Recipients aged 21 years and older who receive treatment services in one of the settings listed in the covered services section under Physical and Medicine Therapy within this manual must be pre-authorized by the QIO.

Medical documentation must be submitted to the QIO to justify the medical necessity for rehabilitative therapy services. Documentation includes, but not limited to, patient medical history, radiology, pharmacology records and letter of medical necessity which clearly indicates the medical justification for the service being requested. Any requests sent without medical documentation will be administratively denied. InterQual criteria will be used to make all determinations.

Patients with Medicare or any other payer are only required to obtain a prior authorization if Medicare or the primary carrier denied the service, or the service is considered not covered.

SCDHHS will require prior authorization for rehabilitative therapy treatment for children when the combined allowed 420 units have been met. The accumulative units will apply to any rehabilitative therapy treatment delivered to a patient either in a practice setting or in an OP hospital clinic.

Requests for therapy services for children that exceed the combined 420 units of rehabilitative therapy treatment services, must be submitted to QIO for authorization. The QIO will use InterQual's OP Rehabilitation criteria for medical necessity determinations. Requests for therapy services may be submitted by the PCP, NP, PA, physical, occupational or speech therapist. but must follow the guidelines outlined in the Rehabilitative Therapy and Audiological Services Provider Manual.

## Surgical Guidelines for Specific Systems

**Prior Authorization for Mammaplasty and Mastectomy and Reconstructive Procedures**

Reduction mammaplasty and gynecomastia, mastectomy procedures must be preauthorized by QIO using InterQual criteria. A Request for Prior Approval Form must be used when submitting a request for these services. A sample copy of the Request for Prior Approval Form can be found in the Forms section of the provider portal. The attending physician shall obtain prior authorization and submit all necessary documentation to QIO.

The following policies must be followed for reduction mammaplasty and gynecomastia:

- Prior authorization is required for all ages.
- Photographs must be submitted with all requests.
- Pathology/operative reports are no longer needed.
- QIO will conduct all reviews.
- Physicians are responsible for verifying beneficiary eligibility prior to the prior authorization request being submitted.
- Physicians are responsible for providing the prior authorization number to any facility or medical provider who will submit a Medicaid claim.

### Reduction Mammaplasty

Reduction mammaplasty for large, pendulous breasts on a female may be considered medically necessary when InterQual screening criteria are met. Prior authorization is required for all ages. A claim is reviewed for medical necessity and must be submitted with the preoperative assessment from the patient's record.

### Reconstructive Breast Surgery

Reimbursement is allowed for reconstructive breast surgery following a mastectomy performed for the removal of cancer or for prompt repair of accidental injury. Prior authorization and/or support

documentation must be obtained. QIO is responsible for prior authorization and support documentation requests; InterQual screening criteria applies.

Breast reconstruction done for cosmetic reasons is non-covered. Augmentation is non-covered under all circumstances. Payment is made for special bras through the DME program for women who have undergone any type of mastectomy.

### Gynecomastia

Although unilateral or bilateral mastectomy in a male is rarely indicated, this procedure may be allowed when medically necessary. Prior authorization must be obtained by the attending physician.

South Carolina Medicaid Request for Prior Approval Form and all necessary documentation must be sent to QIO; InterQual screening criteria applies.

### Male Gynecomastia

Repeat Male Gynecomastia may be considered when supporting documentation meets InterQual screening criteria.

**Male Genital System**

Circumcisions to be performed for beneficiaries older than 28 days with medical justification are allowed without prior approval,however, providers must maintain documentation of medical necessity in the patient's health records. Cosmetic reconstruction of the penis is non-compensable without medical justification. Prior approval must be granted by Medical Services Review before services are considered for payment.

Penile implants are non-covered unless prior approval is obtained. Reimbursement will not be allowed for penile prosthesis if the only reason is sexual dysfunction. The criteria for approval are based on medical necessity. Examples would be chronic depression as a result of sexual dysfunction or a paraplegic with decubitus problems who would benefit from better condom urine drainage.

The following support documentation is required:

- Summary of psychiatric care.
- The medical condition that surgery is expected to improve.
- History and physical.

As with cosmetic reconstruction, prior approval must be granted by the QIO contractor. A complete list of procedures requiring prior authorization is located on the provider portal.

Sterilization requirements are the same as for females. (Please refer to Elective Sterilization under Obstetrics and Gynecology within this section of the manual.)

### 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 of 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 for the services for members in the FFS program. The QIO will issue an authorization determination letter. The letter will also contain an authorization number that must be entered in the prior authorization field of all the UB-04 claim forms submitted for reimbursement.

Referral requests for organ transplants to both in-state and OOS centers must be submitted to QIO before services are rendered.

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

QIO Customer Service: (855) 326-5219
QIO Fax: 855-300-0082
Provider Issues Email: atrezzoissues@Kepro.com

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

- The description of the type of transplant needed.
- The patient's current medical status.
- The patient's course of treatment.
- The name of the center to which the patient is being referred.

Upon approval, QIO will issue an authorization number to the requesting physician 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 post 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.

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

### Kidney Transplantation

Medicaid will reimburse for kidney transplants. Professional services, including the nephrectomy and transplantation of the new organ, performed by a physician team, are reimbursed separately. Inclusive charges are compensable for the services rendered on behalf of the Medicaid-eligible beneficiary. Medicare coverage is primary, and Medicaid will only pay if Medicare benefits are either not available or have been denied.

A Medicare denial of benefits must accompany the claim, and the patient must be End Stage Renal Disease (ESRD) enrolled with Medicaid. (Please refer to “Nephrology and End Stage Renal Disease Services” under “Specialty Care Services” in this section of the manual.)

### Corneal Transplantation (Keratoplasty)

Corneal transplants are compensable. The reimbursement to the hospital includes all technical services, including donor testing and preparation.

Professional services are compensable using the appropriate CPT codes 65710-65755. All general surgery guidelines apply when billing for keratoplasty.

SCDHHS will cover the cost of the corneal tissue when a corneal transplant is performed in an ASC. The ASC will be reimbursed for the transplant surgical procedure and the corneal tissue must be submitted with the HCPCS procedure code V2785 (processing, preserving and transporting covered tissue). ASC providers must attach a copy of the invoice reflecting the cost of the tissue along with the claim to avoid delays in payment.

### Transportation for Medicaid Beneficiaries Requiring Transplants

Transportation arrangement for transplants is coordinated through the transportation broker. Once the authorization letter is received, the provider must notify the beneficiary that if transportation is needed, the beneficiary must contact the SCDHHS transportation broker in his or her region.

For information on the transportation program, you may call the PSC at (888) 289-0709, or submit an online inquiry at Contact a Provider Representative | SCDHHS

**Spinal Cord Neurostimulators**

Neurostimulator now require prior authorization by the QIO. Please refer to the provider portal for a complete list of procedures that require prior authorization. The implantation of spinal cord neurostimulators will be covered for the treatment of severe and chronic pain. Implantation of this device, related services and supplies, may be covered if InterQual criteria are met.

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

Procedure codes 63650, 63655, or 63685 may be used to bill for the implantation.

**Post-Payment Review**
Post-payment review of pain management services will be conducted regularly, at which time documentation of treatment and methods of resolving the source of the pain will be requested from the provider.

### Radiology and Nuclear Medicine

SCDHHS will include in post-payment reviews an assessment of providers' compliance with the following policies and payment rules. Post-payment reviews indicating unnecessary radiological procedures and interpretations, or non-covered or unallowable services will result in recoupment of any Medicaid payments.

- When both the ER physician and radiologist or cardiologist interpret an x-ray or EKG done in the ER, payment will be made for the interpretation and report that directly contributes to the diagnosis and treatment of the patient. The specialty of the physician rendering the service will not be the primary factor considered. The interpretation billed by the cardiologist or radiologist is payable if the interpretation is performed at the time of the diagnosis and treatment of the patient. Separate payment to the hospital medical staff is not made for interpretations performed solely for quality control and liability purposes under hospital policy.
- Reinterpretations, unordered images and second opinions are not reimbursable. Medical necessity must be documented for additional or repeat procedures for the same DOS (i.e., additional images were needed, patient in congestive heart failure, catheter placement, etc.).
- CPT procedures are compensable if ordered by an attending/ordering physician and deemed medically necessary for the diagnosis and treatment of the patient's condition.
- Routine chest x-rays without a diagnostic reason are not reimbursable.
- Radiological procedures performed as a screening mechanism, without a diagnostic reason for justification, are non-covered.
- Separate consultative procedures are non-covered. SCDHHS will also use post-payment review to determine adherence to correct coding to include:
  - Correct use of modifiers.

- Correct use of supervision and consultation codes when used in conjunction with a radiological procedure.
- Use of unlisted procedure code.
- All other service and coverage requirements listed in this section.

The incorrect use of modifiers or coding which results in an over-payment or improper payment to the provider will result in recovery of the over-payment and will result in a recovery action and/or sanction.

## OTHER SERVICE LIMITATIONS

### Medical Necessity

**Chiropractic Services**

Medicaid will only pay for services that are medically necessary. The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment. Additionally, the manipulative services rendered must have a direct therapeutic relationship to the patient's condition. Spinal axis aches, strains, sprains, nerve pains and functional mechanical disabilities of the spine are considered to provide therapeutic grounds for chiropractic manipulative treatment (CMT). Most other non-spinal diseases and pathological disorders (e.g., rheumatoid arthritis, muscular dystrophy, MS, pneumonia and emphysema) are not considered therapeutic grounds for CMT.

**Dermatology**

Visits and treatments for dermatological services must be medically necessary. The patient's record must clearly document the condition and medical necessity.

**EPSDT Services**

Providers must obtain a prior authorization for all medically necessary non-State Plan EPSDT services prior to service provision. Providers must submit documentation of medical necessity and any additional information that will assist in the determination of service coverage.

**Gastroenterology**

Bariatric Surgery

Bariatric surgery is a covered service for members who meet InterQual guidelines for medical necessity. Prior authorization is required for these procedures and must be requested from QIO.

**Radiology and Nuclear Medicine**

All radiology and diagnostic services must be medically necessary and directed to the diagnosis, maintenance, improvement, and treatment of illness and/or disability. All providers must use ACR best practice guidelines when determining the need for radiology services. The purpose of the guidelines is to improve the quality of services to patients and to promote the safe and effective use of diagnostic and therapeutic radiology. Therefore, the justification for any radiological treatment or service will align with best practice guidelines and must be documented in the patient medical record.

Medicaid requires that the attending/ordering physician must order all radiology services. The NPI of the attending ordering physician must be present on the claim in order for Medicaid to reimburse for services. The attending/ordering physician will be responsible for maintaining and/or providing access to the required documentation, regardless of whether the radiology procedures were provided in a hospital, OP facility, office, freestanding imaging center or mobile unit. As noted in the Documentation Standards below, this information may be recorded in the patient medical chart, nursing reports, radiology records, inpatient or OP medical information storage areas, or in the electronic health record. Services rendered in a hospital setting must be adequately documented, including the above-cited records by the physician, with corresponding records retained by the hospital.

### High-Tech Radiology

SCDHHS will review Medicaid reimbursements for high-cost diagnostic radiology procedures to determine medical necessity. Claims received with duplicated diagnosis and services ordered by multiple providers are not reimbursable and are not considered medically necessary. Physicians, when referring patients to specialists for consultations, must send their patients with copies of films and/or a portable device (thumb drive, CD).

### Standards for Documenting Medical Necessity and Provision of Services

Failure to maintain documentation that follows the above-referenced (ACR/Society of Interventional Radiology [SIR]) guidelines, as well as failure to comply with other payment rules established by the policies in this section, may result in a recovery action by SCDHHS and may result in provider sanctions.

The following standards are taken from the ACR and SIR practice guidelines (http://www.sirweb.org) for the Reporting and Archiving of Interventional Radiology Procedures revised in 2009. The guidelines must be followed when documenting medical necessity in the patient records. A medical record consists of a patient's medical information recorded in either written or electronic format. This information may be recorded in the patient medical chart, nursing reports, radiology records,

inpatient or OP medical information storage areas. The medical record must include, as appropriate, the following information:

- Documentation of pre-procedural inpatient and/or office consultation.
- Immediate pre-procedure note.
- Immediate post-procedure note.
- Final report.
- Documentation of post-procedure inpatient and/or office contact.

**Pre-Procedure Documentation**

The pre-procedural documentation provides a baseline record of patient status and documents the indication/justification for the procedure; it must be written in the chart before the procedure. Pre-procedural documentation, as appropriate, depending on the complexity and/or clinical urgency of the procedure, must include the following information:

- The plan for each procedure to be performed.
- Indication/justification for procedure and brief history.
- Findings of targeted physical examination.
- Relevant laboratory and other diagnostic findings.
- Risk stratification, such as the American Society of Anesthesiologists Physical Status Classification.
- Documentation of informed consent (consistent with state and federal laws) or, in the case of an emergency, that this was an emergency medical procedure.

**Immediate Post-Procedure Note**

Before a patient is transferred to the next level of care, an immediate post-procedure note, or a final report must be completed and available. The immediate post-procedure note must include, as appropriate:

- Diagnosis
- Procedure
- Physician
- Assistant
- Sedation
- Medications
- Findings
- Blood loss
- Specimen

It is not necessary for the listed items to be recorded in the order given above.

**Final Report**

A final report is required:

- To transmit procedural information to all members of the health care community who may participate in subsequent care of the patient.
- For legal purposes.
- For reimbursement.

Specific information to be included in this report depends on the procedure. The following elements are recommended, although all of them may not be applicable:

- Procedure
- Date
- Operator(s)
- Indication
- Method of anesthesia or sedation

- Procedure/technique: a technical description of the procedure. This information must include, as appropriate, access site (and attempted access sites), guidance modalities, catheters/guidewires/needles used, vessels or organs accessed technique, and hemostasis. Each major vessel catheterized for imaging or intervention must be noted specifically.
- For inserted medical devices, appropriate identifying information such as the product name, vendor and lot numbers.
- Medications, dosages, and route of administration, including any pre-medications and contrast agents.
- Estimated radiation dose (fluoroscopy time if no other measurement is available)
- Findings and results
- Complications
- Conclusion
- Post-procedure disposition

## Out-of-State (OOS) Services

### South Carolina Medicaid Service Area

All services must be rendered within the SCMSA. The SCMSA is defined as South Carolina and adjacent areas within 25 miles of its borders.

### Treatment Rendered Outside the South Carolina Medical Service Area

The term SCMSA refers to South Carolina and areas in North Carolina and Georgia within 25 miles of the South Carolina State border. Charlotte, Augusta and Savannah are considered within the service area. Medicare/Medicaid beneficiaries do not require prior approval from Medicaid for covered services from providers located within the SCMSA.

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

- Emergency medical services for beneficiaries traveling outside the SCMSA whose health would be endangered if care was postponed until their return to South Carolina. This includes all pregnancy-related services and delivery.

- When a SCMSA physician certifies that needed services are not available within the SCMSA and properly refers the beneficiary to an OOS provider.

### Prior Approval

In all but emergency situations, the referring physician must request approval prior to the OOS service. Referrals must be made to an OOS provider only when the procedure or service is not available within the SCMSA. All available resources must have been considered and indicated in the request to SCDHHS for the OOS referral. The referring physician is the one most aware of the client's medical history and needs and will best be able to justify the necessity for the OOS referral.

Prior to contacting SCDHHS, the referring physician must first contact any OOS provider who will render a service to the client and inform them of the client's medical status. The OOS provider must confirm, in writing, that he or she will enroll in the South Carolina Medicaid program and will accept Medicaid reimbursement as payment in full. The written confirmation must be submitted to SCDHHS along with the completed Referral Request Form for OOS services.

The referring physician must complete the Referral Request for OOS Services Form. A sample copy of the form can be found in the Forms section of the Provider Administrative and Billing Manual. The written requests for OOS referral must include the following information:

- Beneficiary's name and Medicaid number.
- DOS (state as "tentative" if unscheduled at the time of request).
- An explanation as to why you feel these services must be rendered OOS versus within the SCMSA.
- Name, address, telephone and fax number of the OOS providers(s) who will render the medical services. (For example, hospital and physicians(s) involved in that patient's medical treatment.)
- A copy of the beneficiary's medical records for the past year relating to the treatment of the condition.
- Any experimental and/or investigational services identified by the referring physicians that are sponsored under a research program or performed in only a few medical centers across the United States.

SCDHHS reserves the right to determine, based on medical advisement, that the needed medical services, or necessary supplementary resources, are more readily available in the other state. SCDHHS will reject referrals for the following reasons:

- All information required on the referral form is not provided with the requested attached documentation.
- The provider rendering the service(s) is not willing to enroll in South Carolina Medicaid and adhere to the enrollment criteria.
- The provider rendering the service(s) will not accept the South Carolina Medicaid reimbursement as payment in full.

To obtain approval for OOS referrals, the OOS coordinator can be reached by fax at 803-255-8255, or by mail at:

Medicaid Claims Receipt
PO Box 1412
Columbia, SC 29202-1412

The referring physician is responsible for communicating with the OOS provider coordinating services for the patient. Patients being referred OOS, as well as their escorts, can be provided transportation when necessary. Transportation and any other assistance are only provided when there are no other means available to the patient to meet the needs connected with OOS travel. Adequate advance notice, as well as prior approval, is mandatory in order to make the necessary travel arrangements. Providers may contact the PSC at (888) 289-0709 or submit an online inquiry at Contact a Provider Representative | SCDHHS: for additional information.

When a beneficiary is in one of the Medicaid MCOs, the requests for OOS services must be completed through the MCO. For assistance with authorizations for MCO-enrolled members, providers must contact the MCO's Provider Services department, or the Managed Care area at +1 803 898 4614. Contact information for the MCOs is in the Managed Care Supplement.

### Exceptions to Prior Approval

Medicaid will accept and review for medical necessity OOS claims from medical providers who did not seek any type of approval before filing their claim. However, experience has proven that these providers put themselves at an otherwise avoidable risk of non-payment or delayed payment due to the lack of knowledge of the South Carolina Medicaid claim filing policies and procedures.

### Foster Children Residing Out of the SCMSA

The DSS will be responsible for all Medicaid-eligible foster children when they reside OOS. The county case manager assigned to the case must assist with medical services. Prior approval is not

required for services rendered to foster children who live OOS; however, medical necessity remains a requirement. The OOS coordinator must be contacted for two reasons:

1. The coordinator must determine whether the medical services can be reimbursed through the Medicaid program or whether DSS will reimburse the medical provider.

2. If Medicaid can reimburse for the services, proper enrollment and billing information needs to be sent to the medical providers involved.

Providers must contact the PSC at 888-289-0709 or submit an online inquiry at Contact a Provider Representative | SCDHHS for additional information.

### Retroactive Eligibility

When retroactive eligibility for Medicaid is granted, the beneficiary is responsible for notifying the medical provider that retroactive eligibility has been granted.

For additional information regarding retroactive eligibility, please refer to the Provider Administrative and Billing Manual.

### Dually Eligible Beneficiaries

When a beneficiary has both Medicare and Medicaid coverage, Medicare is considered the primary payer. However, if the beneficiary does not have Part A benefits, medically necessary inpatient hospital services will require approval.

In order to verify eligibility on Medicare/Medicaid patients, contact the PSC at 888-289-0709 or submit an online inquiry at Contact a Provider Representative | SCDHHS.

### Ancillary and Other OOS Services

Other health care services are compensable under the South Carolina Medicaid OOS program. For OOS referral questions, please contact the PSC, submit an online inquiry, or write to SCDHHS for more information. For professional claims, providers must write to:

Medicaid Claims Receipt
PO Box 1412
Columbia, SC 29202-1412

For institutional claims, providers must write to:

Medicaid Claims Receipt
PO Box 1458
Columbia, SC 29202-1458

## Office/Outpatient Exams

### Laboratory Services

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

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

### X-Ray and EKG Services

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

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

## Convenient Care Clinics

### Preventative Services

The Medicaid program sponsors adult physical exams under the following guidelines:

- The exams are allowed once every two years per patient.
- The patient must be 21 years of age or older.

This exam may also be offered to patients with Medicare and Medicaid (dually eligible or qualified Medicare beneficiary).

- A past history for a new patient or an interval history on an established patient.
- A generalized physical overview of the following organ systems:
  - HEENT
  - Lungs

- Abdomen
- Skin
- Breasts (female)
- External genitalia
- Heart
- Back
- Pelvic (female)
- Prostate (male)
- Rectal
- Brief neurological
- Brief muscular
- Brief skeletal
- Peripheral vascular

Family Planning Counseling must be offered if the patient is female within childbearing years or for men. (An additional Family Planning code may be billed for this service when provided. Please refer to Obstetrics and Gynecology within this section of the manual for the description of codes.)

The following lab procedures are included in the reimbursement for a physical:

- Hemoccult
- Urinalysis
- Blood Sugar
- Hemoglobin

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

**Note:** College physicals, DOT physicals and administrative physicals are not covered services.

**Family Planning Services**
Not all Family Planning Services can be performed in all CCCs therefore, please review your licensure and requirements from the SCLLR authority and SCDES.

### Synagis® (Palivizumab) 90378

Medicaid covers the administration of Synagis® in accordance with the current ACIP recommendations and current clinical guidelines published by the American Academy of Pediatrics (AAP). The AAP guidelines can be found online on the AAP publications website (https://publications.aap.org) or through this link.

Prior approval is not required for up to six doses when given at least 30 days apart and meet the most current guidelines of the AAP for Synagis® administration. Any dose over the limit of six or administered outside the RSV season (as defined by the AAP) requires prior approval. If prior approval is needed, please submit requests to:

South Carolina Department of Health and Human Services

Attention: Medical Review/Synagis® Program
PO Box 8206
Columbia, SC 29202-8206

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

### Ultrasounds

Additional ultrasounds may be approved if supporting documentation is attached to the claim clearly indicating that the service provided is medically necessary. Examples of appropriate documentation include ultrasound reports and patient clinical records and history. If the documentation is insufficient or illegible, reimbursement for additional ultrasounds will be rejected. Claims for obstetrical ultrasounds that exceed the defined limits will be reviewed by QIO for medical necessity.

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

All ultrasound services that appear to fall outside of best practice guidelines are subject to post-payment review by the Division of Program Integrity. Multiple gestations billed with CPT add-on codes will be counted as one ultrasound if billed on the same claim with primary CPT codes.

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

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

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

## Hyperbaric Oxygen Therapy

### Reasonable Utilization Parameters

Reimbursement is allowed for HBO therapy when it is considered medically necessary. HBO therapy must not be a replacement for other standard, successful therapeutic measures. Depending on the response of the individual patient and the severity of the original problem, treatment may range from less than one week to several months' duration, with the average being two to four weeks. The medical necessity for use of HBO for more than two months, regardless of the condition of the patient, must be reviewed and documented before further reimbursement is requested.

## Preventive Services

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

The EPSDT program provides preventive health services to Medicaid-eligible children from birth to age 21 through periodic medical screenings. This includes the application of topical fluoride varnish in a primary care setting. An EPSDT screening is considered an encounter. A screening and an encounter code may not be billed on the same DOS. All EPSDT screenings must be billed using the

appropriate CPT codes (99381–99385 and 99391–99395). For additional program policy information, please refer to the EPSDT heading within this section of the manual.

The Medicaid program sponsors adult physical exams under the following guidelines:

- The exams are allowed once every two years per patient.
- The patient must be 21 years of age or older.

This encounter code may also be offered to dually eligible Medicare and Medicaid clients until Medicare covers physicals. If a patient has both Medicare and Medicaid coverage, bill Medicaid directly.

For additional program policy guidelines, please refer to Adult Physical Exams under Preventive Care Services in this section.

# 5
# REPORTING/DOCUMENTATION

## CO-SIGNATURES

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

- NP
- Certified Nurse-Midwife (CNM)
- Certified Nurse Specialist (CNS)
- PA

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

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

## EVALUATION AND MANAGEMENT SERVICES RECORDS AND DOCUMENTATION REQUIREMENTS

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

### Nursing Home/Rest Home Facility Services

Progress notes are required in the patient's record for all visits, including those performed to meet the requirements of continued long-term care. The medical record must justify and reflect the level

of service billed. Nursing home visits are subject to post-payment review under the same Medicaid guidelines as any other medical services.

## DOCUMENTATION OF THE TEACHING PHYSICIAN

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

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

## CONVENIENT CARE CLINICS

CCCs are required to send information regarding a service to the PCP by facsimile within 24 hours of the visit and maintain confirmation of receipt of the facsimile in the patient's file.

## TELEHEALTH

Documentation in the medical records must be maintained at the referring and consulting locations to substantiate the service provided. The request from a referring provider and the medical necessity for the service rendered via telehealth must be documented in the beneficiary's medical record. Documentation must indicate the services were rendered via telehealth. All applicable documentation requirements for services delivered face-to-face also apply to services rendered via telehealth. Examples may include but are not limited to the following based on provider specialty:

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

## OBSTETRICS AND GYNECOLOGY

### Licensed Midwife

The following documentation must be maintained for all services provided by a Licensed Midwife:

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

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

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

### Sterilization Consent Form

If the consent form is correctly completed and meets the federal regulations, the claim can be approved for payment. If the consent form does not meet the federal regulations, the claim will be rejected, and a letter sent to the physician explaining the rejection. If the consent form is not submitted with the claim, the claim will be rejected. If the line is rejected, a new claim must be submitted with the consent form. A sample copy of the consent form and instructions can be found in the Forms section of the Administrative and Billing Manual.

Listed below is an explanation 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 of the beneficiary's signature date.
  - Signature is not a correctable error.
  - Date is not a correctable error without detailed medical record documentation.
  - If the beneficiary signs with an "X", an explanation must accompany the consent form: Not a correctable error without detailed medical record documentation.
- A complete facility address: An address stamp is acceptable if legible.

**Physicians Statement**

- Beneficiary's name: Correctable Error.
- Date of the sterilization procedure (This date must match the DOS 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 physician's date must be dated the same as the sterilization date 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 Provider ID or NPI number (the same number that is in block 33 on the CMS-1500 claim form). Either the group or individual Medicaid Provider ID or NPI is acceptable.

## PSYCHIATRIC AND COUNSELING SERVICES

### Clinical Records

Providers must maintain a clinical record for each Medicaid eligible beneficiary receiving services that fully describes the extent of the treatment services provided. The clinical record must contain sufficient medical documentation to justify medical necessity for the level of service reimbursed and clearly specify the course of treatment. The absence of appropriate and complete records may result in recoupment of previous payments by SCDHHS. Each beneficiary's clinical record must contain the following documentation:

- Full demographic information, including beneficiary's full name, contact information, date of birth, race, gender and admission date.
- Consent forms, pertinent medical history, assessments and instructions to the beneficiary.

- All physician's orders, reports of treatments and medications, and other pertinent information necessary to monitor the beneficiary's progress.
- Reports of physical examinations, diagnostic and laboratory results and consultative findings.
- Documentation of communication regarding coordination of care activities.
- The beneficiary's name on each page generated by the provider.
- The beneficiary's Medicaid number on all clinical documentation and billing records.

### Clinical Service Notes

All psychiatric and psychotherapy services must be documented in a clinical service note (CSN) upon the delivery of services. The purpose of the CSN is to record the nature of the beneficiary's treatment, any changes in treatment, discharge, crisis interventions and any changes in medical, behavioral or psychiatric status. The CSN must include:

- DOS
- Name of the service provided
- Place of service
- Purpose of the contact (for psychotherapy notes, this must be tied back to the IPOC treatment goals)
- Description of treatment or interventions performed
- Effectiveness of the intervention(s) and the beneficiary's response or progress
- Duration of the service (start and end time for each service delivered)
- Signature, title, and signature date of the person responsible for the provision of services and supervising clinician, if appropriate

CSN's must be completed and placed in the clinical record within 10 business days from the date of rendering the service.

### Error Correction

Medical records are legal documents. Providers must be extremely cautious in making alterations to records. If errors are made, adhere to the following guidelines:

- Draw one line through the error and write “error”, “ER”, “Mistaken Entry”, or “ME” to the side of the error in parenthesis. Enter the correction, sign or initial and date it.
- Errors cannot be totally marked through, the information in error must remain legible.
- No correction fluid may be used.

### Late Entries

Late entries may be necessary at times to handle omissions in the documentation. Late entries must be rarely used and then only used to correct a genuine error of omission or to add new information that was not discovered until a later date. Whenever late entries are made, adhere to the following guidelines:

- Identify the new entry as “late entry”.
- Enter the current date and time.
- Identify or refer to the date and incident for which the late entry is written.
- If the late entry is used to document an omission, validate the source of additional information as much as possible.
- When using late entries, document as soon as possible.

## TUBERCULOSIS (TB) POLICY

### Documentation Requirements

All providers must keep documentation in the beneficiary’s medical record to justify medical necessity for the level of service reimbursed, including history, illness, physical findings, diagnosis, laboratory results, radiology results, and records on medications prescribed and delivered. Providers must follow NCCI and coding rules and practices. All services are subject to retrospective review by our Division of Program Integrity.

## BREAST CANCER SUSCEPTIBILITY GENE 1 AND 2 (BRCA)

The following documentation must be maintained in the beneficiary’s medical record:

- The HBOC Genetic Testing Prior Authorization Form.
- Pre-testing genetic counseling clinical notes, to include but not limited to the following:
  - Pre-test counseling date with the name and qualifications of the counseling professional.

  - The risks, benefits and limitations discussed with the beneficiary.
  - The beneficiary's consent to proceed with specific gene mutation testing to be performed as attested by the beneficiary's signature on the consent form.

- The beneficiary's BRCA test results.
- Post-testing genetic counseling clinical notes, to include, but not limited to, the following:
  - Post-test counseling date with the name and qualifications of the counseling professional.
  - The beneficiary's acknowledgment of the test results.

## CHIROPRACTIC SERVICES

As a condition of participation in the South Carolina Medicaid program, providers are required to maintain and allow appropriate access to clinical records that fully disclose the extent of services provided to the Medicaid patient. The maintenance of adequate records is regarded as essential for the delivery of appropriate services and quality medical care.

Providers must be aware that these records are key documents for post-payment review. In the absence of appropriately completed clinical records, previous payments may be recovered by SCDHHS. It is essential for the provider to conduct internal record reviews to ensure that services are medically necessary, and that service delivery, documentation, and billing comply with Medicaid policies and procedures.

### Clinical Records

Providers are required to maintain a clinical record on each Medicaid patient that includes documentation of all Medicaid-reimbursable services. This documentation must be sufficient to justify Medicaid participation. Clinical records must be current and consistently organized, meet documentation requirements, and provide a clear description of services rendered and progress toward treatment goals. Clinical records must be arranged logically, so that information may be easily reviewed, copied and audited.

Each Medicaid patient's clinical record must include, at a minimum, the following:

- A Release of Information Form signed by the patient authorizing the release of any medical information necessary to process Medicaid claims and requesting payment of government benefits on behalf of the patient.

- The initial written physician prescription (original or fax) and documentation of subsequent prescriptions required after every third visit.
- Patient history to include the following:
  - A general patient history, including review of systems.
  - Chief complaint/systems causing patient to seek chiropractic treatment.
  - Onset and duration of symptomatic problem, which may include quality and character of problem, intensity, frequency, location and radiation, onset, duration, aggravating or relieving factors, prior interventions and treatments, including medications and secondary complaints.
  - Family history (if indicated).
  - Past health history to include general health statement, prior illnesses, surgical history, prior injuries or traumas, past hospitalizations, medications, allergies, and pregnancies and outcomes.
- A physical examination report to include:
  - Evaluation of the musculoskeletal and nervous system.
  - Evaluation of the cardiovascular and gastrointestinal systems, and of the eye, ear, nose, and throat (both vascular and endocrine), if appropriate to symptoms causing patient to seek chiropractic treatment.
  - Analytical procedures used to determine vertebral subluxation (level and severity) and contraindications to treatment (e.g., inspection, palpation).
- Radiographic film (x-ray) and interpretation.
- A written report/assessment of the patient’s condition, including the precise area of subluxation.
- A treatment plan.
- CSNs.

### Treatment Plan

If an evaluation indicates that treatment is warranted, the chiropractor must develop and maintain a treatment plan that outlines short- and long-term goals, as well as the recommended scope, frequency and duration of treatment. The treatment plan must serve as a comprehensive plan of care by outlining the service delivery that will address the specific needs of the patient. The treatment plan must be individualized and must specify the problems to be addressed, goals and objectives of treatment, types of interventions to be utilized, planned frequency of service delivery, criteria for achievement, and estimated duration of treatment. The treatment plan must contain the signature and title of the chiropractor and the date signed.

The individualized treatment plan must be reviewed and updated according to the level of progress. If a determination is made during treatment that additional services are required, these services must be added to the treatment plan. When long-term treatment is required, a new treatment plan must be developed each year. If services are discontinued, the chiropractor must ensure that the reason for discontinuing treatment is indicated in the treatment plan.

### Clinical Service Notes

Chiropractic services must be documented by CSNs. A CSN is a written summary of each treatment session. The purpose of these notes is to record the nature of the patient's treatment by recording the service provided and summarizing the patient's participation in treatment.

CSNs must do the following:

- Furnish a pertinent clinical description of the activities that took place during the session, including an indication of the patient's response to treatment as related to stated goals and objectives.
- Reflect delivery of a specific billable service as identified in the patient's treatment plan.
- Document that the services rendered correspond to billing as to DOS, type of service rendered, and length of time-of-service delivery.

### Error Correction Procedures

The patient's clinical record is a legal document; therefore, extreme caution must be used when altering any part of this record. Appropriate error correction procedures must be followed when correcting an error in the patient's clinical record.

Errors in documentation must never be totally eradicated, and correction fluid must never be used. Draw one line through the error, enter the correction, and add signature (or initials) and date next to

the correction. If warranted, an explanation of the correction may be appropriate. In extreme circumstances, having the corrected notation witnessed may be appropriate.

### X-Rays

The documenting radiographic film (x-ray) must have been taken at a time reasonably proximate to the initiation of the course of treatment. Unless the chiropractor concludes that more specific X-ray evidence is warranted, an X-ray is considered reasonably proximate if it was taken no more than six months prior to the initiation of a course of chiropractic treatment. Neither an MRI nor CAT scan may be used instead of an X-ray to document subluxation.

The x-ray is required Medicaid documentation and must be maintained in the patient's medical record. X-ray films must have permanent identification of the patient's name, the date the film was taken, and the name of the facility where taken. Films must be marked right or left side. If the x-ray was taken elsewhere (e.g., doctor's office or other medical facility), the written report must be present in the patient's medical record.

## PAIN MANAGEMENT SERVICES

Patient records must indicate medical necessity and are subject to post-payment review. Documentation in the record must indicate the treatment process, which includes the service(s) to be provided, diagnostic procedures and treatment goals. Goals must be specific according to patient needs and the services to be rendered.

Progress summaries must be documented at a minimum of every three months. The summaries must address the patient's progress toward treatment goals, appropriateness of services rendered and recommendations for the continued need for services.

# 6
# BILLING GUIDANCE

## SERVICES OUTSIDE OF THE COUNTRY

Medicaid will not provide any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States.

## DIRECT PHYSICIAN SUPERVISION

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

## PHYSICIAN'S OFFICE WITHIN AN INSTITUTION

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

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

## PHYSICIAN ADMINISTERED DRUGS

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

Medicaid requires providers billing for physician-administered drugs in an office, a clinic, or other OP setting to report the NDC when using a drug-related HCPCS code. The HCPCS code must include the correct NDC 5-4-2 format (11 digits total) to receive reimbursement from Medicaid. The NDC must be used on all claim submissions (e.g., electronic, Web Tool and CMS-1500).

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

**Billing Unlisted/Not Otherwise Specified HCPCS Codes**

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

**NDC Not Found on the NDC to HCPCS Crosswalk**

For a drug-related HCPCS code to be reimbursable by SCDHHS, the manufacturer of the drug must participate in the Federal Drug Rebate program. To determine whether the pharmaceutical manufacturer participates in the rebate program, please visit the following website for the NDC/HCPCS crosswalk at https://www.cms.gov/medicare/payment/part-b-drugs/asp-pricing-files.

The first five digits of the NDC identify the manufacturer of the product. Prescribers must use the crosswalk and the criteria below to determine if the drug is reimbursable by SCDHHS:

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

Please refer to the Provider Administrative and Billing Manual for information and instructions for claims submission.

## TEACHING PHYSICIAN POLICY BILLING REQUIREMENTS

Services provided by residents under the direct supervision of a teaching physician are billable to Medicaid. For Medicaid billing purposes, direct supervision means that the teaching physician is

accessible, as defined in Subsection I, when the resident provides the services being billed. The teaching physician is responsible for all services rendered, fees charged, and reimbursements received. The services must be documented, as defined in Subsection II, in the patient's medical record. The supervising physician must sign the patient's medical record, indicating that he or she accepts responsibility for the services rendered.

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

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

- **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 while providing a service meeting the requirements set forth for teaching physician billing.

- **Teaching Physician:** A teaching physician is an individual who, while functioning under the authority and responsibility of a resident program director, involves resident and/or medical students in the care of his or her patients or supervises residents in the care of patients.

## FEE-FOR-TIME COMPENSATION ARRANGEMENTS

Physicians may retain a substitute physician to take over their professional practice for reasons such as pregnancy, illness, or continuing medical education. Physicians are able to bill and receive payment for services provided by the substitute physician and then pay the substitute physician under a fee-for-time compensation arrangement. The substitute physician serves as an independent contractor rather than an employee.

The following requirements must be met:

- The regular physician is unavailable to provide services.

- The substitute physician must meet the same licensing requirements as required by Medicaid; however, Medicaid enrollment is not required.

- The beneficiary has arranged or seeks to receive services from the regular physician.

- The regular physician pays the substitute physician for services provided.

- The substitute physician shall not provide services to beneficiaries over a continuous period of longer than 60 days subject to the following exception:

  - The regular physician is called to active duty in the Armed Forces.

- The regular physician indicates services were provided by a substitute physician under a fee-for-time compensation arrangement by entering HCPCS code modifier Q6 (service furnished under a fee-for-time compensation arrangement) after the procedure code.

If the only services a physician performs in connection with an operation are post-operative services furnished during the period covered by the global fee, these services do not need to be identified on the claim as services furnished by a substitute physician.

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

## EVALUATION AND MANAGEMENT SERVICES

### Convenient Care Clinics

CCCs must bill Medicaid using Place of Service Code 17 as defined by the AMA's CPT for a walk-in, retail health clinic. Covered services for this place of service are limited to Episodic Care and wellness/preventative services. Wellness/preventative services are covered for recipients five years and older.

### Family Planning Services Referral and Billing

Family Planning beneficiaries have Medicaid coverage for a limited set of medical services. Beneficiaries enrolled in Family Planning are covered for preventive physical examinations and preventive health screenings, but do not have full Medicaid coverage for follow-up visits, treatment or medication (apart from those specifically outlined in the benefit structure).

If a health condition or problem is identified during the physical examination or after the provider receives lab results from a preventive screening that was performed, the provider must refer the patient to a source of free or subsidized care. SCDHHS strongly encourages providers to connect uninsured Family Planning beneficiaries to sources of care such as FQHCs, RHCs, free clinics, subsidized hospital clinics, etc. Providers will be compensated for the administrative costs associated with making referrals for Family Planning beneficiaries.

For more information about where to refer Family Planning patients for follow-up care, please visit the South Carolina Primary Health Care Association website, https://www.scphca.org/ or contact the SCDHHS PSC at 888-289 0709.

### Instructions

Providers that refer uninsured Family Planning beneficiaries for follow-up care or treatment for a problem or condition identified during the physical examination or annual family planning visit can bill for this referral activity. Providers must use the procedural coding and modifiers listed below. These referral codes may only be used in instances when the follow-up care is not covered as a component of the Family Planning Program.

**Note:** At least one of the modifiers listed below is required when billing for referral codes.

**Note:** Providers must NOT use the FP modifier when billing for referral codes.

Providers that refer uninsured Family Planning patients for follow-up care or treatment for any health issue identified during or after (lab results) the physical examination or annual family planning visit may bill for this referral activity using one of the following referral codes:

- Same Day Referral or Telephone Referral: Utilized when a patient is referred to follow-up care immediately after the physical exam or family planning visit OR if lab results are received after the physical exam or family planning visit, and a) results can be explained to the patient by phone and b) referral to follow-up care can occur by phone.
- Different Day Referral (In-Person): Utilized when a patient is required to receive lab results in-person, on a different day than the physical exam or family planning visit occurs.

### Billing Instructions

- Providers may include Same Day Referral or Telephone Referral on the same claim form as the physical examination or annual family planning visit.
- Providers may bill for the Same Day Referral or Telephone Referral on a separate claim form. If submitting a separate claim form, diagnosis code Z00.00 or Z00.01 must be used.
- Providers must bill for the in-person, Face-to-Face Referral on a separate claim form. Diagnosis code Z00.00 or Z00.01 must be used.
- Providers must include at least one modifier and up to four modifiers from the list below when billing for both referral codes.

### Modifier Instructions

Providers must use the appropriate modifier from the list below. Up to four modifiers can be used for each referral code (e.g., if a patient is referred to follow-up care for more than one positive screening, include modifiers for all positive screenings):

- If referring a patient for a positive diabetes screen, use modifier P1.
- If referring a patient for a positive cardiovascular screen, use modifier P2.
- If referring a patient for any positive cancer screen, use modifier P3.
- If referring a patient for any mental or behavioral health screens, use modifier P4.
- If referring a patient for any other condition or problem, use modifier P5.

Referral Instructions for Family Planning Providers who **do** offer free or subsidized care to uninsured individuals (e.g., FQHCs, hybrid clinics, RHCs, subsidized hospital clinics, etc.).

Providers that offer free or subsidized care to uninsured individuals must schedule follow-up visits with Family Planning beneficiaries when a problem or condition is identified during or after the physical examination or family planning visit. This “self-referral” activity is captured in the encounter rate for the physical examination or family planning visit. However, for data collection and monitoring purposes, providers who fall into this category must include the referral code and appropriate modifiers listed above as a separate line on the Encounter Claim Form (these codes will bill to $0.00). The referral codes and accompanying modifiers will provide important data to SCDHHS regarding the utilization of follow-up care among the Family Planning population.

**Note:** Uninsured Family Planning patients will be responsible for any fees associated with follow-up visits. As Family Planning beneficiaries are considered uninsured for purposes of follow-up care, all visits must follow the provider’s established policies and procedures for treating uninsured patients.

### Referral Instructions for Family Planning Providers who refer patients for additional, preventive screenings

- If you are a provider that performs a physical examination for a Family Planning beneficiary and are unable to perform certain preventive health screenings (e.g., include mammography, colonoscopy, AAA screening, and lung cancer screening using computerized tomography), you must refer the patient to a provider who is able to perform these screenings.
- Providers are not allowed to submit a referral claim for this type of referral.

## Office/Outpatient Exams

### After Hour Services

Primary Care Providers (Pediatrician's, Family Practice, General Practice, Internal Medicine and OB/GYN) may bill the E&M code that best describes the level of service being rendered.

- Services provided in the office at times other than regularly scheduled office hours or days when the office is normally closed (i.e., holidays, Saturday or Sunday), in addition to basic service.
- Service provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service.

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

## Additional Ambulatory Services

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

### Laboratory Services

Diagnostic lab services are compensable as separate charges when the provider renders the service and CMS's CLIA certification standards are met. The appropriate lab service must be used.

### Special Services/Visits

#### Post-Operative Follow-up Visit

This service is non-compensable. Please refer to surgical package guidelines under General Surgery Guidelines within this section of the manual.

#### Emergency Office Services

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

## Supplies

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

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

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

**Minor Surgical Tray** — A minor surgical tray includes those trays necessary for suture removal, minor debridement, superficial foreign body removal, or incision and drainage of superficial abscess.

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

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

The following additional supplies are listed below:

- Lacrimal Puncture Plugs
- Indwelling Catheter
- Urinary Drainage Bag
- Urinary Leg Bag
- Major Surgical Tray (including anesthetic injection)
- Splint
- Cast Supplies (e.g., plaster)
- Special Casting Material (e.g., fiberglass)
- Spacer, bag or reservoir with/without mask
- Sestamibi
- Supply of Radiopharmaceutical (Technetium)
- Technetium Medronate (up to 30 mCi)
- Thallous Chloride
- Strontium

- Crutches, wooden, pair
- Paragard® IUD, cost
- Cervical Collar, flexible, foam
- Philadelphia Cervical Collar, semi-rigid
- Pavlik Harness
- Knee Immobilizer, canvas longitudinal
- Shoulder Immobilizer
- Figure 8 Mobilizer
- Acromioclavicular Brace
- Family Planning Condoms
- Contraceptive Supply, Spermicide (e.g., vaginal foam/cream, suppositories, contraceptive gel/sponge)
- Minor Surgical Tray
- Peak Flow Meter
- Ear Mold, not disposable, any type (use LT or RT modifier)
- Ear Mold, disposable, any type (use LT or RT modifier)
- Zithromax, oral, 1-gram, single dose
- Contact Lens, spherical, per lens
- Contact Lens, toric/prism ballast, per lens
- Contacts, gas permeable, spherical, per lens
- Contacts, gas permeable, toric/prism, per lens
- Contacts, hydrophilic, spherical, per lens
- Contacts, hydrophilic, toric/ballast, per lens
- Anterior Chamber Intraocular Lens
- Posterior Chamber Intraocular Lens
- Application of Long Arm Splint
- Application of Short Arm Splint, static
- Application of Short Arm Splint, dynamic
- Application of Finger Splint, static
- Application of Finger Splint, dynamic
- Application of Rigid Total Contact Cast
- Application of Long Leg Splint
- Application of Short Leg Splint
- Supplies and Materials
- Educational Supplies

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

## Telehealth Reimbursement

**Professional Services**

Reimbursement to the health professional delivering the medical service is the same as the current fee schedule amount for the service provided. Consulting site physicians and practitioners submit claims for telehealth or telepsychiatry services using the appropriate CPT code for the professional service along with the telehealth modifier GT, “via interactive audio and video telecommunications

system". By coding and billing the "GT" modifier with a covered procedure code, the consulting site practitioner certifies that the beneficiary was present at the referring site when the telehealth service was furnished via telehealth. The GT modifier is not required for the CPT codes 98012-98015.

| CODE | DESCRIPTION |
|---|---|
| 98012 | Established patient synchronous audio-only E/M visit, 10 minutes or more of medical discussion |
| 98013 | Established patient synchronous audio-only E/M visit, 20 minutes or more of medical discussion |
| 98014 | Established patient synchronous audio-only E/M visit, 30 minutes or more of medical discussion |
| 98015 | Established patient synchronous audio-only E/M visit, 40 minutes or more of medical discussion |
| 98016 | Brief communication technology-based virtual check-in |

Fee schedules are located on the SCDHHS website at http://www.scdhhs.gov.

**Originating Site Facility Fee**

The referring site, also known as the originating site, is only eligible to receive a facility fee for telehealth services. Claims must be submitted with an appropriate HCPCS code (telehealth originating site facility fee). If a provider from the referring site performs a separately identifiable service for the beneficiary on the same day as telehealth, documentation for both services must be clearly and separately identified in the beneficiary's medical record, and both services are eligible for full reimbursement.

**Hospital Providers**

Hospital providers are eligible to receive reimbursement for a facility fee for telehealth when operating as the referring site. Claims must be submitted with the appropriate telehealth revenue code. There is no separate reimbursement for telehealth services when performed during an inpatient stay, OP clinic or ER visit, or OP surgery, as these are all-inclusive payments.

## Injections

A list of injection codes is provided on the provider portal. Injection codes include the cost of the drug only, not the administration.

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

Office E&M visits and additional office services are allowed as separate reimbursement from injection codes. If the administration of the drug is the only reason for the visit, then only a minimal

established office E&M visit is allowed in addition to the administration code and the drug code. Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular includes the syringe and administration of the drug. Minimal office visits include the observation time if indicated.

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

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

Guidelines on allergen immunotherapy can be found under the heading “Allergen and Clinical Immunology” and those for chemotherapy under the heading “Oncology and Hematology” in this section of the manual. Immunization guidelines can be located under the heading “Preventive Care Services”.

### Synagis® (Palivizumab)

If a 50 mg vial of Synagis® is administered to an infant up to 2 years old, the appropriate revenue code must be billed in combination with the appropriate service.

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

In order to ensure consistency, reimbursement for Synagis® is limited to physicians, hospitals and infusion centers. To avoid possible duplicate reimbursement, SCDHHS will not reimburse pharmacy providers for Synagis®. Payment for Synagis® administration will be limited to six doses per RSV season.

### Physician-Administered Injectable Drug Reimbursement Methodology

The reimbursement for drugs within each tier is set as follows:

- Tier 1 contains certain generic and injectable drugs in classes with therapeutic alternatives and is priced at Maximum Allowable Cost/Least Cost Alternative.

- Tier 2 contains newer agents and higher-cost drugs and is priced at Average Sales Price (ASP) plus 6%.
- Tier 3 contains moderately priced agents and older drugs where there are often significant Average Wholesale Price (AWP)/ASP differences and is priced at ASP plus 10%.
- Tier 4 contains drugs where ASP pricing is not available and is priced at AWP minus 18%.

The SCDHHS will adjust the provider-administered injectable drug fee schedule quarterly so that reimbursement levels reflect changes in market prices for acquiring and administering drugs. Fee schedules are located on the SCDHHS website at http://www.scdhhs.gov.

### Cancer Screening Services

South Carolina will sponsor reimbursement for mammography for dually eligible Medicare/Medicaid beneficiaries according to the frequency limitations listed. Claims rejected by Medicare for having exceeded their frequency limitations must be filed with Medicaid on a CMS-1500 claim form with no Medicare information provided.

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

### Nutritional Counseling Services

The following billing instructions apply to FFS only. Providers who submit claims to a MCOs must refer to the provider contract with the appropriate MCO for billing instructions.

All providers and dietitians are required to bill the appropriate CPT codes with a primary diagnosis code.

All qualified providers and dietitians must follow the criteria and limitations described below:

- Total of twelve (12) hours of combined initial, re-assessment and group medical nutrition therapy per fiscal year per patient is allowed. Services must be provided as in-person or via telehealth, face-to-face encounter with the beneficiary and the beneficiary's parent or guardian (when applicable).
- Nutritional counseling services are allowed to be performed via telehealth. A telehealth encounter must be billed with GT modifier, and it counts towards the twelve (12) hours of combined medical nutrition therapy services provided to a patient per fiscal year.

| PROCEDURE CODE | DESCRIPTION | BENEFIT CRITERIA AND LIMITATIONS |
|---|---|---|
| **97802** | Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes. | Allowed up to four (4) units of 97802 per same provider, provider location or billing entity. Allowed to be performed via telehealth with GT modifier. These units count towards the 12 hours of combined medical nutrition therapy services per patient per fiscal year. Not allowed on the same date of service as 97803 or 97804 by the same provider, provider location or billing entity. |
| **97803** | Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes | Allowed up to twelve (12) units of 97803 per month, per patient, up to four (4) units per date of service/visit, with at least 7 calendar days between visits. Allowed to be performed via telehealth with GT modifier. These units count towards the 12 hours of combined medical nutrition therapy services per patient per fiscal year. Not allowed on the same date of service as 97802 or 97804 by the same provider, provider location or billing entity. |
| **97804** | Medical nutrition therapy; group (2 or more individual(s), each 30 minutes | Allowed one (1) 97804 per date of service. Up to 4 units per month per patient, with at least 7 calendar days between visits. Group size allowed is 2-8 patients. Allowed to be performed via telehealth with GT modifier. These units count towards the 12 hours of combined medical nutrition therapy services per patient per fiscal year. Not allowed on the same date of service as 97802 or |

| | | |
|---|---|---|
| | | 97803 by the same provider, provider location or billing entity. |

Total of 12 hours of combined initial, re-assessment and group nutritional counseling therapy per state fiscal year per patient is allowed. Services must be provided as in person, face-to-face encounter with the beneficiary and the beneficiary's parent or guardian (when applicable). A minimum of 6 hours of intensive nutritional counseling must occur prior to the member being eligible for the obesity management therapy.

All providers and dietitians are responsible for clearly documenting the patient's chart with all information referenced in this policy. All services provided by both providers and dietitians are subject to review by the Division of Program Integrity. Services not meeting the requirements reflected in this policy may be subject to recoupment by SCDHHS.

The provider can either schedule the patient for an independent visit or may bill the initial medical nutrition therapy visit on the same day as a routine physical exam or E&M service. If the provider chooses to bill for both services on the same day, the provider will need to append modifier 25 to the billed claim for the second E&M service.

**Pharmacist Services**
Licensed pharmacists are allowed to bill new and established patient E&M codes, contraceptive injection administration, and urine pregnancy tests to members of childbearing age, enrolled in the Healthy Connections full benefit program or Family Planning Limited benefit program. Services rendered by a pharmacist must be billed on a CMS 1500 claim form with FP modifier. The claim must indicate the pharmacist individual NPI as the rendering provider and the affiliated pharmacy NPI as the billing provider. There is no prior authorization required for these services. Reimbursement of pharmacist services is 80% of the Medicaid physician base rate.

**Adult Physical Exams**
Adult physical exams are covered under the following guidelines:

- The exams are allowed once every two years, per patient.
- The patient must be 21 years of age or older.

The following appropriate age and diagnosis code Z00.8 must be used when billing:

- Preventive visit, new, age 18–39

- Preventive visit, new, age 40–64
- Preventive visit, new, age 65+
- Preventive visit, established, 18–39
- Preventive visit, established, 40–64
- Preventive visit, established, 65+

## IMMUNIZATIONS

### Immunizations for Children

Providers may bill for the administration of vaccines that are obtained through the VFC Program and administered in the doctor's office. When billing for immunization services for children under the age of 19, both the administration code and the vaccine code for the administered vaccine must be listed on the claim to receive reimbursement for the vaccine administration only. For this code combination, only the administration code will be reimbursable.

### Immunizations for Adults

When billing for vaccines for beneficiaries 19 years of age and older, the provider must bill for both the vaccine and the immunization administration code. For vaccines billed under the pharmacy benefit, only the administration fee can be billed on the medical side. Claims submitted for dually eligible patients must first be submitted to Medicare. Covered codes may be found on the Physicians Injectable Drug Fee Schedule located at https://www.scdhhs.gov.

## PEDIATRICS AND NEONATOLOGY

### Routine Newborn Care Exam

This procedure is an all-inclusive code for any visits made during the first day of the newborn's birth.

### Routine Newborn Follow-up Care

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

### Newborn Discharged Early

This procedure must be used only to report the history and examination of a normal newborn who is assessed and discharged from the hospital on the day of delivery.

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

### Healthy Mothers/Healthy Futures Newborn Health Initiatives

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

- Mother and infant referral to the WIC program at the county health department (for supplemental food and nutritional counseling).
- Referral to the county health department to set up an infant home visit.

Referral to the county DSS for infant eligibility and an appointment for the first EPSDT well-baby examination.

### Newborn Care

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

- Routine newborn care exam in hospital or birthing center.
- Normal newborn care not in hospital or birthing room setting.
- Follow-up care in nursery for a healthy newborn.
- History and examination.
- Newborn resuscitation.
- Mother/newborn WIC referral.
- Standby for newborn care, limited to two units (e.g., C-section/high-risk delivery).
- E&M Initial comprehensive preventative medicine.
- E&M Periodic Comprehensive Preventative Medicine.

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

### Newborn Care for the Sick Newborn

Used to report the newborn care exam for a sick newborn. If the newborn becomes critically ill, please refer to Neonatology in this section of the manual for coding instructions.

### Follow-up Care for the Sick Newborn

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

### Sick Newborn Care Billing Notes

Sick childcare may not be billed under the newborn's mother's Medicaid number. Sick childcare must be billed under the newborn's Medicaid number.

### Sudden Infant Death Syndrome (SIDS)

Appropriate procedure codes must be used to bill for infants being tested for SIDS. They are allowed once and are all-inclusive.

### Neonatology

#### Hospital Care for Sick Newborns

Hospital care for newborns who do not meet the criteria for NICU codes must be billed using hospital care codes or critical care codes, if appropriate.

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

#### Newborns Stabilized for Transport

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

**Neonatal Intensive Unit Care Codes**

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

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

Additionally, physician standby service and newborn resuscitation are to be used when the physician is standing by for the C-section and newborn resuscitation is required.

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

Initial pediatric critical care, per day — This code reflects initial E&M of a critically ill infant or young child, 29 days up through 24 months of age. This code is allowed only once per day and includes 24 hours of care provided by the attending physician.

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

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

If the neonate is released home and subsequently readmitted to the hospital, NICU codes cannot be billed. You must bill hospital care codes or critical care codes.

Subsequent pediatric critical care, per day — This code reflects subsequent E&M of a critically ill infant or young child, 29 days up through 24 months of age. This code is allowed only once per day and includes 24 hours of care provided by the attending physician.

Initial NICU care, once per physician or group — This code reflects the admission of a critically ill neonate when the intensity of care meets the definition set forth in the CPT. This code is allowed only one time and includes 24 hours of care provided by the attending physician.

Subsequent NICU care, per day — This code reflects subsequent E&M of a critically ill neonate, 28 days of age or less. This code is allowed only once per day and includes 24 hours of care provided by the attending physician.

Subsequent NICU care, per day — This code reflects subsequent E&M of the recovering very low birth weight infant (present body weight less than 1,500 grams). This code is allowed only once per day and includes 24 hours of care provided by the attending physician.

Subsequent NICU care, per day — This code reflects subsequent E&M of the recovering low birth weight infant (present body weight 1,500-2,500 grams). This code is allowed only once per day and includes 24 hours of care provided by the attending physician.

**Additional Services**

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

- Tracheal Lavage*
- 99255 — SIDS evaluation
- Venipuncture, under age 3 years, femoral, jugular or sagittal sinus*
- Scalp vein*
- Other vein*
- Push transfusion, blood, 2 years or under*
- Exchange transfusion, blood; newborn

- Cut down arterial catheterization*
- Arterial catheterization for prolonged infusion therapy, (chemotherapy), cut down
- Catheterization, umbilical artery, newborn, for diagnosis or therapy*
- Physician Standby Service, requiring prolonged physician attendance, each 30 minutes (limited to two units)**
- Newborn Resuscitation

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

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

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

**Extracorporeal Membrane Oxygenation Support (ECMO)**
ECMO services are reimbursed by the following CPT codes:

- Insertion of cannula(s) for prolonged extracorporeal circulation for cardiopulmonary insufficiency.
- Prolonged extracorporeal circulation for cardiopulmonary insufficiency, each additional 24 hours.

Prolonged extracorporeal circulation for cardiopulmonary insufficiency will be paid for each additional 24 hours up to four days. However, starting with day five, progress notes must be sent attached to the claim for appropriate reimbursement.

The initial and subsequent NICU care codes may be billed in addition to the ECMO codes.

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

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

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

- NICU discharge home visit.

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

- Initial pediatric critical care, per day
- Subsequent pediatric critical care, per day
- Initial NICU care, once per physician or group
- Subsequent NICU care, per day
- Subsequent NICU care, per day, recovering very low birth weight (body weight less than 1,500 grams)
- Subsequent NICU care, per day, recovering low birth weight (body weight 1,500–2,500 grams)

### Forensic Medical Evaluations

All forensic evaluations must be medically necessary. Use the following HCPCS codes to bill for these services:

- Prolonged E&M service before and/or after direct (face-to-face) patient care (e.g., review of extensive records and test, communication with other professionals and/or the patient/family); first 30 minutes (list additional minutes separately) for other physician service(s) and/or inpatient or OP E&M service.

  **Note:** this service is used to report the accumulated duration of the time spent by a health care professional providing prolonged care, even if the time spent spans over more than one DOS. (The last DOS must be billed.)

  – Each additional 15 minutes (list separately); must be used in conjunction with this service.

- Medical team conference with interdisciplinary team of healthcare professionals, face-to-face with patient and/or family; 15 minutes or more participation by non-physician qualified healthcare professional.

  **Note:** A non-physician qualified health care professional includes, but is not limited to, NPs and PAs.

- Medical team conference with interdisciplinary team of healthcare professionals, without patient and/or family; 15 minutes or more participation by physician.

- Participation by non-physician qualified healthcare professional; 15 minutes or more.

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

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

Providers can bill for EPSDT services and immunizations on the CMS-1500 claim form using the appropriate CPT codes. Providers who are set up for electronic billing may bill using the electronic billing system when using these CPT codes. Providers using the CMS-1500 claim form must bill under the Medicaid provider numbers they currently use for billing on the claim form such as:

- Physicians must bill under their group or individual provider numbers.

- Clinics must bill under their clinic numbers.

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

#### Periodic and Inter-periodic Screening Services

- All EPSDT screenings must be billed using the appropriate CPT codes regardless of provider type or location.

- Prior authorizations are NOT required for Periodic or Inter-periodic screening services.

- Medicaid providers enrolled with SCDPH in the VAFAC program may bill an immunization administration fee.

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

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

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

Indicator N — No problems found during visit

**Medically Necessary Services**
Providers must bill using the appropriate diagnosis and treatment code for each procedure. Providers must obtain a prior authorization for all medically necessary non-State Plan EPSDT services; submitting documentation of medical necessity and any additional information will assist in this determination.

**Reimbursement for EPSDT Services**
**Note:** This policy applies only to the Physician's office and CCCs.

Well-care visits conducted via telehealth must be billed with the appropriate EPSDT code and a GT modifier. Providers rendering services to children 24 months or younger must follow the American Academy of Pediatrics (AAP) recommendations to deliver the visit in person whenever possible. A justification as to why the visit could not be performed in person must be documented in the patient's health record.

### EPSDT Periodic Screening

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

- Screening components can be fragmented and billed separately.
- The screening provider can bill an office visit on the same day a screening is billed.
- South Carolina Medicaid policy allows providers to bill an EPSDT well-child screening on the same day as a sick visit.
- If individual components of a screening are not performed, the reason must be appropriately documented. Reimbursement for the screening fee may be subject to recoupment if each age-appropriate component is not performed and not documented.

### EPSDT Inter-periodic Screening

Reimbursement for an inter-periodic screening is the same as a periodic screening. The following guidelines must be used when billing for inter-periodic screenings:

- The provider must indicate the diagnosis code of the condition to justify the medical necessity for performing an inter-periodic screening.
- The inter-periodic screening must include all the required screening components appropriate to the child's age.
- Individual screening components or follow-up treatment cannot be billed as an inter-periodic screening.

### Additional Services

Additional services performed during an EPSDT visit may be covered separately from the EPSDT visit utilizing the appropriate CPT code and billed at a frequency according to the periodicity schedule available at https://www.scdhhs.gov/resources/programs-and-initiatives/epsdt/providers/periodicity-schedule. The additional services include:

- Immunization Administration:
  - When billing for an immunization administration and an EPSDT examination code on the same day, the provider must use modifier XU when billing the immunization administrative code in order to receive additional reimbursement.
  - Providers may bill for the administration of vaccines that are obtained through the VFC Program and administered in the physician's office.
  - When billing for immunization services for children under the age of 19, both the administration code and the vaccine code for the administered vaccine must be listed on the claim to receive reimbursement for the vaccine administration only. For this code combination, only the administration code will be reimbursable.
- Topical Fluoride Varnish
- Laboratory Tests and Analysis:
  - Reimbursement for the lab analysis is not part of the EPSDT service rate.
  - Blood level assessments:

    - If the provider office sends the blood lead samples to an outside laboratory for analysis, the laboratory will bill Medicaid directly for the blood lead analysis.
    - If the provider office is using the ESA LeadCare Blood Lead Testing System to analyze the blood lead samples internally, then the office may bill Medicaid directly using.
  - Age Limited Screenings
  - Elective Tests
  - Developmental and Behavioral Assessments

EPSDT providers are allowed to bill for standardized developmental, mental, emotional, behavioral and psychosocial assessments utilizing standardized screening tools that are culturally sensitive and have a moderate to high sensitivity, specificity and validity level. A general screening is recommended with follow-up screening, as indicated. Documentation must include a copy of the completed screening tool and the score per instrument screening tool. Billing for screenings follow coding guidelines and NCCI edits.

- Childhood and Adolescent Developmental Levels:
  - This code is limited to a frequency of two times per day for beneficiaries up to 18 years of age. Examples of standardized screening instruments include, but are not limited to:
    - Ages and Stages Questionnaire, 3rd Edition (ASQ)
    - Parents Evaluation of Developmental Status (PEDS)
    - Modified Checklist of Autism in Toddlers (MCHAT)
- Emotional and/or Behavioral Health Assessment:
  - This code is limited to a frequency of two times per day for beneficiaries up to 18 years of age. Examples of standardized screening instruments include, but are not limited to:
    - Ages and Stages Questionnaire: Social-Emotional (ASQ: SE)
    - Pediatric Symptom Checklist (PSC) or Pediatric Symptom Checklist — Youth Report (PSC-Y)
    - Modified Patient Health Questionnaire (PHQ-9)

  - Screen for Child Anxiety Related Emotional Disorders (SCARED)
  - Vanderbilt Diagnostic Rating Scale (Vanderbilt)

- Patient Focused Health Risk Assessment (e.g., health hazard appraisal). This code is limited to a frequency of two times per day for beneficiaries through 18 years of age. Examples of standardized screening instruments include, but are not limited to:
  - Acute Concussion Evaluation (ACE)
  - CRAFFT Screening Interview
  - Guidelines for Adolescent Preventative Services (GAPS)
- Caregiver-Focused Health Risk Assessment (e.g., depression inventory) for the benefit of the patient. This code is limited to a frequency of two times per DOS. Examples of standardized screening instruments include, but are not limited to:
  - Edinburgh Maternal Depression Screen
  - Safe Environment for Every Kid (SEEK)

## TOBACCO CESSATION

### Counseling

Tobacco cessation counseling in individual and group settings is covered when billed with appropriate CPT codes. Reimbursement for counseling is limited to four sessions per quit attempt for up to two quit attempts annually. Tobacco cessation counseling may be billed on the same day as an office visit using a 25 modifier.

## OBSTETRICS AND GYNECOLOGY

### Screening Brief Intervention and Referral to Treatment Initiative

The following billing procedures must be utilized in order to receive payment for SBIRT services.

SCDHHS began coverage for SBIRT in 2011 to improve birth outcomes and the overall health of moms and babies. SCDHHS has partnered with stakeholders across the state to help identify and treat pregnant beneficiaries who may experience alcohol or other substance abuse issues, depression, tobacco use or domestic violence. SBIRT services (screening and, when applicable, a brief intervention) are reimbursable in addition to an E&M code for pregnant women and/or those who are in the 12-month postpartum period.

SCDHHS will continue to use the screening and intervention HCPCS codes. The HD modifier is required when the services rendered indicate a positive result and/or when a referral is completed.

Providers must use the appropriate HCPCS code and the HD modifier when an SBIRT screening result is positive. Additionally, providers must use the appropriate HCPCS code with the HD modifier when a referral to treatment is made in conjunction with the brief intervention. These changes in billing procedures apply for Healthy Connections Medicaid members enrolled in both the Medicaid FFS and Medicaid Managed Care program.

- Screening — once per fiscal year
- Brief Intervention — twice per fiscal year

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

When billing for SBIRT services using appropriate HCPCS codes, providers must bill using both their individual and group NPI numbers on the CMS-1500 form or an electronic claim.

### Pregnancy Visits

Providers have two options when choosing how to bill for an **initial pregnancy visit:**

- Providers may bill an initial visit for each pregnancy using the Current Procedural Terminology (CPT) evaluation and management (E/M) code. Under this option, a provider would bill for a new patient E/M code even if the Medicaid member is a patient of record at that practice. The claim must contain a pregnancy diagnosis code.

OR

- Providers may bill the appropriate E/M code that meets the CPT description for level of complexity when billing for initial or antepartum visits. The level of complexity must be documented in the patient's medical record. The claim must contain a pregnancy diagnosis code.

### 17 Alpha Hydroxyprogesterone Caproate (Makena® and 17P)

Providers must bill the HCPCS code for Injection, hydroxyprogesterone caproate, (Makena®), 10 mg and/or Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg and bill for the

appropriate number of units administered. Providers billing for compounded 17 alpha hydroxyprogesterone caproate will continue to bill the appropriate HCPCS code using the TH modifier (obstetrical treatment/services, prenatal or postpartum) in order to be reimbursed. When billing for Makena® or Compounded 17-P, the appropriate CPT code can be billed for administration of the drug, which must be given in the physician's office or clinic. The reimbursement for Makena® (injection, hydroxyprogesterone caproate (Makena®), 10 mg) and/or injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg is listed on our Other Physician's Fee Schedule at www.scdhhs.gov. When billing Medicaid, providers must include the NDC in field 24A of the CMS-1500 claim form and the number of units in field 24G.

All providers must keep documentation showing the medical necessity for either Makena® or 17-P in the patient's chart. All claims are subject to potential PI audits and, therefore, it is the provider's responsibility to maintain the patient's records.

### Multiple Births

For multiple births of more than two, the claim must be sent a hard copy with operative notes attached.

If the patient delivers multiple babies, all either vaginally or by C-section, the first birth must be billed with modifier GB (39 weeks or more) or CG (less than 39 weeks), and each consecutive birth must be billed using modifier 51.

Example: Delivery of triplets, all vaginally at 39 weeks:

(GB) Vaginal Delivery

(51) Vaginal Delivery

(51) Vaginal Delivery

If the patient delivers multiple babies, the first vaginally and one (or more) via C-section, the first birth must be billed with modifier GB (39 weeks or more) or CG (less than 39 weeks), and the following birth, via C-section, must be billed using modifier 79.

Example: Delivery of triplets, 1st birth vaginally, 2nd and 3rd via C-Section at 38 weeks:

(CG) Vaginal Delivery

(79) C-section Delivery

(51) C-section Delivery

For further questions regarding multiple births, please contact PSC at (888) 289-0709 or submit an online inquiry at Contact a Provider Representative | SCDHHS

## Abortion

When billing for any type of abortion, the procedures must be billed using the abortion procedure codes. There are separate codes for spontaneous, missed, and septic abortions, and hydatidiform mole, and for therapeutic abortion. The vaginal delivery code must not be used to report an abortion procedure.

The only exception to this rule is if the physician performs the delivery of the fetus and only when the gestation is questionable and there is a probability of survival. The medical record must contain documented evidence that the fetus was delivered by the physician. If the physician did not perform the delivery, but problems necessitated his or her presence, then the appropriate E&M codes must be used to report these services.

Diagnosis codes to be used only to report therapeutic abortions and diagnosis codes to be used to report spontaneous, inevitable and missed abortions. Please refer to the provider portal for ICD-10-CM diagnosis codes for these services. Abortions, which are reported with diagnosis and procedure codes for therapeutic abortion, must be accompanied by complete medical records which substantiate life endangerment to the mother or that the pregnancy is a result of rape or incest, and the signed abortion statement.

Please refer to the provider portal for diagnosis codes do not require documentation.

## Licensed Midwife

### Required Modifier for Licensed Midwives

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

### Initial OB Exam by the Licensed Midwife

## Pregnancy Visits

Providers have two options when choosing how to bill for an **initial pregnancy visit:**

- Providers may bill an initial visit for each pregnancy using the Current Procedural Terminology (CPT) evaluation and management (E/M) code. Under this option, a provider would bill for a new patient E/M code even if the Medicaid member is a patient of record at that practice. The claim must contain a pregnancy diagnosis code.

OR

- Providers may bill the appropriate E/M code that meets the CPT description for level of complexity when billing for initial or antepartum visits. The level of complexity must be documented in the patient's medical record. The claim must contain a pregnancy diagnosis code.

**Physician Back-up Coding**
Each of the two obstetrical examinations by the backup physician must be billed using the appropriate level of complexity E&M CPT procedure code.

**Delivery Supply Code**
An additional code has been developed to reimburse for supplies used for delivery in the home setting. This procedure code may be billed by the Licensed Midwife in addition to the vaginal delivery code.

**Newborn Care**
The newborn examination must be billed with this CPT code using the SB modifier.

### Newborn Metabolic Screening+

In compliance with SCDPH Newborn Screening regulations, if there is no attending physician, then the Licensed Midwife is responsible for the collection of specimens. Providers who collect specimens for the newborn metabolic screening in a birthing center or home birth setting must follow the guidance established in Section V of the Department of Public Health (DPH) Lab Services Guide (PHL) | South Carolina Department of Public Health for specimen submission and invoicing

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

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

- The individual was already sterile before the hysterectomy and the physician who performs the hysterectomy certified in writing that the individual was sterile at the time of the hysterectomy. The certification must state the cause of the sterility.

- The individual requires a hysterectomy because of a life-threatening emergency, and the physician who performs the hysterectomy certified in writing that the hysterectomy was performed under a life-threatening situation in which the physician determined prior acknowledgement was not possible. The certification must include a diagnosis and description of the nature of the emergency. If timing permits, prior approval may be requested, but appropriate and timely medical care must not be delayed obtaining approval.

### Ectopic Pregnancy

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

### Pelvic Exam

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

### Sterilization and Other Related Procedures

Under the following circumstances, bill the corresponding sterilization procedure codes:

**Essure® Sterilization Procedure**

Effective with dates of service prior to May 31, 2010, SCDHHS will reimburse for the Essure® Sterilization procedure only when certain criteria are met. This procedure is available to women who have risk factors that prevent a physician from performing a safe and effective laparoscopic tubal ligation. Reimbursement will be 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 the beneficiary’s life.)

The procedure will be covered when performed in an inpatient or OP hospital setting or in a physician's office. SCDHHS will reimburse the implantable device by utilizing the HCPCS code with the FP modifier, and the professional service will be reimbursed utilizing the CPT code with the FP modifier.

Hysterosalpingogram and Radiological Supervision and Interpretation may be billed as follow-up procedures 90 days after the sterilization. A Sterilization Consent form must be completed and submitted with the claim.

Federal guidelines for sterilization procedures will remain a requirement which includes completing and submitting a Sterilization Consent Form.

- 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.

When billing for a vaginal delivery as well as a tubal ligation performed on the same DOS, the tubal ligation must be billed using modifier 79 (unrelated procedure or service by the same physician or other qualified health care professional during the postoperative period) to ensure proper reimbursement.

Claims for sterilization services must always be billed hardcopy with a copy of the Sterilization Consent Form attached.

Salpingectomy and/or Oophorectomy — The operative report must be submitted with the claim. The medical record must reflect medical necessity for the procedure performed. Reimbursement using these codes is not allowed if performed as a sterilization procedure, unless a copy of the Sterilization Consent Form is attached.

Dilation and Curettage — When a D&C is performed at the same time as sterilization, medical necessity for the D&C must be clearly documented in the patient's operative report.

## PSYCHIATRIC AND COUNSELING SERVICES

### Additional Billable Codes

Additional codes may be billed by a physician specializing in psychiatric care.

### Pediatric Sub-Specialist Program

SCDHHS will reimburse an enhanced rate to certain pediatric sub-specialists that meet the enrollment requirements. Please refer to The Pediatric Sub-Specialist Program under Special Coverage Groups in this section of the manual for full eligibility criteria to participate in this program.

## NEPHROLOGY AND END STAGE RENAL DISEASE SERVICES

### Physician-related Dialysis Procedures

In-Center Dialysis — Medicaid reimburses the nephrologist or other supervising internist an all-inclusive monthly fee for the supervision of ESRD services. These services are defined as monthly supervision of medical care, dietetic services, social services and procedures directly related to the physician's role in the treatment of ESRD.

If billing for a complete month of treatment supervision, the monthly code must be used. The DOS must be the last date in the month and the "days" unit block must be a "one", indicating one full month of supervision.

The monthly ESRD code includes all services rendered to the patient for all days of the month. Office visits must not be billed in addition to the monthly supervision. Special procedures may be billed separately (e.g., shunt revision, cannula declotting).

If the patient is hospitalized, or for some reason did not have a full month of in-center treatments, the partial month procedure code must be used with the appropriate number of days of supervision in the days/unit column on the CMS-1500 claim form and the appropriate "to" and "from" dates of service.

Inpatient Dialysis — If an ESRD patient is hospitalized, the hospitalization may or may not be due to a renal-related condition. In either case, the patient must continue dialysis.

Inpatient dialysis usually requires more intense physician involvement for a prolonged period and/or multiple visits. Physicians will be reimbursed for inpatient dialysis services for either acute renal failure (ARF) or ESRD patients on a FFS basis. Guidelines are the same for inpatient dialysis whether the patient is ARF or ESRD.

Complications or hospitalization for reasons not related to dialysis or the treatment of dialysis may be charged separately. However, when dialysis codes are charged, hospital visits may not be charged for the same DOS.

Visits may be charged on alternate dialysis days when applicable. Special procedures (e.g., an EKG) may be charged when clearly justified as a service outside of the normal dialysis management.

For inpatient dialysis, services Medicaid will apply the same rules as it does for all reasonable charge determinations. The services must meet the following criteria:

- They must be covered physician services.
- They must be medically necessary.
- They must be personally furnished by the physician.
- They must be within the requirements under Part B Medicare.

Home Dialysis — Medicare is the primary sponsor for patients receiving home dialysis services and Medicaid, if available, is the secondary sponsor of coinsurance and deductibles. The Social Security Administration does not require a delayed period for home services, and Medicare will reimburse from the initial course of treatment.

In this case, Medicaid will not reimburse for home treatments during the first ninety days of services as primary sponsor but will pay coinsurance and deductibles.

In certain instances, where Medicaid is the primary sponsor, the physician supervising the home dialysis patient must adhere to policies for in-center supervision. Reimbursement will be per full month of supervision, or per day for partial months. The monthly supervision fee includes all the services outlined for the alternate method of reimbursement. A home training supervision fee is allowed for the first month of home dialysis in addition to the regular monthly fee for treatment supervision.

Dialysis Training — Dialysis training is a covered service for ESRD patients. The initial completed course and per training session may be billed for training services for any mode (self, peritoneal or hemodialysis). The initial course is allowed only once in a lifetime. Training services for self-dialysis performed after the initial course is completed (retraining) are compensable on a per day basis, and under the following Medicare guidelines:

- The patient changes from one mode of dialysis to another.
- The patient's home dialysis equipment changes.
- The patient's dialysis setting changes.
- The patient's dialysis partner changes.
- The patient's medical condition changes (the patient must continue to be an appropriate patient for self-dialysis).

Home support services (e.g., reviewing the patient's technique and instructing him or her in any corrections) are not compensable as training services. Support services are included in the monthly or partial month ESRD supervision fees.

## PART II — DIAGNOSTIC OPHTHALMOLOGY SERVICES

Diagnostic services included in the CPT coding range 92018-92287 are compensable as separate procedures if performed as a distinct and individual service and not included in the ophthalmological or E&M exam, with the following restrictions:

### Cardiology

**Cardiac Catheterization**

The cardiologist must bill for the catheterization that describes the procedure and technique utilized; fragmenting the codes is not allowed.

If medically indicated, intracardiac electrophysiological procedures may be billed in addition to the catheterization angiogram procedure.

Cardiac MRI of the heart procedure codes are used to report the physician’s attendance and participation in the MRI of the heart. When filing for this procedure, bill appropriate MRI code depending on level of service. Use modifier 26 when billing the professional component only. The technical portion will be reimbursed to the hospital under the revenue code for MRI. Medical necessity for both the MRI and heart catheter (if needed) must be documented in the beneficiary’s chart. The procedure may be performed in lieu of heart catheterization, when possible. The code will be allowed reimbursement only once per DOS, regardless of how many sessions or images are performed.

**Vascular Studies**
Reimbursement to a provider for services purchased from an outside supplier or lab is not allowed. Reimbursement is only allowed to the provider who performed the service and is enrolled with South Carolina Medicaid.

Independent physiology labs performing monitoring services must be enrolled for participation. The physician requesting the service may only bill for the interpretation of the study if performed.

**Oncology and Hematology**
Infusion start and stop time must be clearly documented. Start time does not include the E&M service or delivery of adjunctive therapy by a nurse or physician.

Chemotherapy administrations, push technique, are only for pushing a chemotherapy agent and are not to be billed when pushing pre-medications or providing other incidental services. Only one push technique code will be allowed per day. These codes cannot be billed when given in a hospital setting.

If routine maintenance (flushing with heparin and saline) of an access device is the only service rendered, and is rendered by the nurse, the office visit code is appropriate.

Therapeutic or diagnostic infusions codes may only be billed when a therapeutic or diagnostic agent other than chemotherapy must be infused over an extended period. Payment of these codes is considered bundled into the payment for chemotherapy infusion when administered simultaneously. Separate payment is allowed when these services are administered sequentially or as a separate procedure. These codes cannot be billed in a hospital setting or in addition to prolonged service codes.

Blood transfusions may be billed only when the physician or an employee of the physician performs the transfusion. It must be billed per unit of blood. If the transfusion requires prolonged physician attendance, then it is appropriate to charge for this service. The medical record must substantiate this service. If hospital personnel administer the blood transfusion, it is reimbursable only under the hospital allowable costs.

A listing of chemotherapy drug codes can be found on the provider portal. The codes include the cost of the drug only, not the administration. Chemotherapy agents provided by a hospital are

considered a technical cost and may not be charged by a physician. The hospital is reimbursed for all technical costs.

When a patient receives the entire regimen of chemotherapy in an office setting, including lab work, hydration, pre-medication and all chemotherapy agents, these procedures indicate an infusion or injection by the physician or an employee of the physician. The following are appropriate codes to bill:

- If the patient received chemotherapy over four hours in the office via IV infusion:
  - Chemotherapy administration, intravenous infusion technique; up to an hour, single or initial substance/drug
  - Each additional hour, one to eight hours
  - J Codes — Appropriate medication charges
- E&M services are allowed when a separate and identifiable medical necessity exists and is clearly documented in the patient's chart. The physician must not routinely bill an E&M service for every patient prior to chemotherapy administration. Only one E&M service is billable per patient per day.
- Prolonged services may be billed in addition to the E&M code when the physician's expertise is medically necessary in evaluating and managing the patient over a prolonged period and specific documentation describes the content and duration of the service.
- Critical care services may only be used in situations requiring constant physician attendance of an unstable or critically ill patient. These codes may only be used in situations significantly more complex than other chemotherapy situations.

**Inpatient and Outpatient Hospital Services**

Services or supplies administered by the hospital or hospital employees are considered a part of the overall hospital service and are reimbursable only under the hospital allowable costs. A physician who is either salaried or contracted by the hospital, and who performs services under contract or employment, may not bill for those services separately under his or her individual Medicaid provider number. The contracting hospital may claim these services under the professional fees allowable for the hospital under their hospital-based physician Medicaid number.

**Gastroenterology**

Gastrostomy Button Device Feeding Tube Kit

Claims must be processed on a CMS-1500 claim form and include a copy of the invoice and appropriate documentation supporting the medical necessity of the device.

**Physical Medicine and Therapy**

Osteopathic Manipulative Treatment

An E&M office code may be billed in addition to an OMT code if the E&M service performed is documented as a significant, separately identifiable service.

**Chiropractic Services**

Billing for CMT is limited to one procedure per visit and one visit per day, with a maximum of six visits during a state fiscal year (July 1–June 30), with no exceptions. Eligible Medicaid beneficiaries, regardless of age, will be allowed six chiropractic visits per state fiscal year providers must call the toll-free telephone number on the back of the Medicaid insurance card to verify a patient's current eligibility and number of visits used to date during the current state fiscal year. Visits not used in one year do not carry over to the next year.

**Note:** For dually eligible Medicaid and Medicare beneficiaries, Medicare is the primary payer. Bill all chiropractic services to Medicare first. Once a dually eligible beneficiary has exhausted his or her Medicare-allowed chiropractic services, Medicaid reimbursement for chiropractic services is no longer available.

Medicaid-reimbursable CMT services are limited to the following three services only:

- CMT; Spinal, 1 to 2 Regions
- CMT; Spinal, 3 to 4 Regions
- CMT; Spinal, 5 Regions

**Radiologic Examination (X-Ray)**

Billing for radiologic examination is limited to two x-rays per beneficiary per state fiscal year (July 1–June 30). Medicaid-reimbursable radiology services are limited to the following:

- Radiologic Examination; Spine, Entire, Survey Study; Anteroposterior and Lateral
- Radiologic Examination; Spine, Cervical; Anteroposterior and Lateral
- Radiologic Examination; Spine, Thoracic; Anteroposterior and Lateral
- Radiologic Examination; Spine, Thoracolumbar; Anteroposterior and Lateral
- Radiologic Examination; Spine, Lumbosacral; Anteroposterior and Lateral

## HYPERBARIC OXYGEN THERAPY

### Technical Component

All technical services must be billed on the UB-04 hospital claim form. Payment for OP hyperbaric therapy is allowed. Inpatient therapy cannot be billed separately as the fee is included in the hospital DRG or per diem rate.

### Professional Component

If a physician directly supervises the HBO therapy, procedure codes for HBO may be billed on the CMS-1500 claim form; no modifier is necessary. The professional component must be coded as one of the following:

- Initial Treatment — An initial treatment is compensable only once per course of treatment for a specific diagnosis. HBO initial treatment is not billed in units of time, but rather the first day of the initial therapy.

- Subsequent Care — All subsequent HBO therapy treatments must be coded as such. Subsequent therapy is defined as any length of therapy following the initial treatment on any given day. If two subsequent treatments are performed on the same DOS (at different times of the day), a second charge may be used with a 76 modifier. HBO therapy is not billed in units of time, but rather in episodes of treatment.

## GENERAL SURGERY GUIDELINES

### Hospital Acquired Conditions (HACs)

SCDHHS will make zero payments to providers for other provider preventable conditions which includes Never Events. The reporting requirements for Never Events include ASCs and practitioners. These providers will be required to report Never Events on the CMS-1500 claim form or the 837-P claim transaction. Avoidable errors that fall under this policy include:

- Wrong surgical or other invasive procedure performed on a patient.

- Surgery or other invasive procedure on the wrong body part.

- Surgical or other invasive procedure performed on the wrong patient.

Providers are required to follow the following procedures for reporting avoidable errors (Never Events):

Claims submitted using the CMS-1500 claim form or 837-P claim transaction, must include the appropriate modifier appended to all lines that relate to the erroneous surgery(s) or procedure(s) using one of the following applicable National Coverage Determination modifiers:

- PA — Surgery wrong body part
- PB — Surgery wrong patient
- PC — Wrong surgery on patient

The non-covered claim must also include one of the following ICD-10-CM diagnosis codes reported:

- Y65.51 — Performance of wrong procedure (operation) on correct patient
- Y65.52 — Performance of procedure (operation) on patient not scheduled for surgery
- Y65.53 — Performance of correct procedure (operation) on wrong side or body part

### Related Claims

Within 30 days of receiving a claim for a surgical error, SCDHHS shall begin to review beneficiary history for related claims as appropriate (both claims already received and processed and those received after the notification of the surgical error). Also, the PI Division or its designee will audit all claims for the recipient to determine if they relate to or have the potential to be related to the original Never Event claim. When the PI or designee identifies such claims, it will take appropriate action to deny such claims and to recover any overpayments on claims already processed.

Every 30 days for an 18-month period from the date of the surgical error, PI or its designee will continue to review recipient history for related claims and take appropriate action as necessary. Related services do not include performance of the correct procedure.

### General Provisions

Medicaid will not pay any claims for “provider-preventable conditions” for any member who is Medicare/Medicaid eligible.

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

Reductions in provider payments may be limited to the extent that the following apply:

- The identified PPC would otherwise result in an increase in payment.
- The SCDHHS can reasonably isolate for non-payment the portion of the payment directly related to treatment for and related to the PPC.

To review the complete Health Acquired Conditions policy, please visit: http://www.cms.gov/HospitalAcqCond.

### Exploratory Procedures

If a procedure is carried out through the laparotomy incision, the physician may choose to bill for either the laparotomy or the actual procedure performed during the surgery; most likely, it will be the code that reimburses the higher rate. In any case, South Carolina Medicaid will sponsor payment for either the procedure or the laparotomy, not both.

Under the same principle, when a surgical procedure is performed through an endoscope, the diagnostic endoscopy is inclusive in the reimbursement. The physician may be reimbursed for either the endoscopic procedure or the diagnostic endoscopy, not both.

When endoscopy procedures are performed in the office, small supplies and materials provided by the physician over and above those usually included with the office visit may be billed. A minor surgical tray may also be billed.

### Multiple Surgery Guidelines

Multiple surgeries include separate procedures performed through a single incision, or separate procedures performed through second and subsequent incisions or approaches. All surgical procedures for the same DOS must be filed on one claim form when possible.

#### Payment Guidelines

When multiple surgeries are performed at the same operative session, the procedure that reimburses the highest established rate will be considered the primary procedure and will be reimbursed at 100% of the established rate. All second and subsequent surgeries performed at the same operative setting will be reimbursed at 50% of the established rate. Procedure codes that are exempt from multiple procedure reduction as outlined by the AMA in the CPT Standard Edition are reimbursed at 100%.

A vaginal delivery and tubal ligation performed on the same DOS will not be affected by this policy. Both procedures are reimbursed at 100%, even when performed on the same day. Use modifier 79 on the tubal ligation claim to ensure correct reimbursement.

#### Modifiers

Listed services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance must be identified by the addition of the appropriate modifier code, which must be reported by adding a two-digit number (modifier) placed after the procedure number. Modifiers commonly used in surgery are listed in the surgery section of the CPT and on the provider

portal. Only the first modifier indicated will be used to process the claim — Medicaid will key only the first modifier indicated for each procedure.

**Billing**
Claims for surgery must be filed using the CPT code that most closely describes the surgical procedure that was performed. When this is not applicable, an unlisted procedure code may be used, and the appropriate documentation must be attached to the claim form for adequate reimbursement.

Claims for more than one surgical procedure performed at the same time by the same physician must be billed as follows:

- On a single claim form, unless more than six procedures are performed.

  **Note:** If more than one surgical procedure is billed for the same DOS on different claims, the second claim that processes may reject. To avoid this delay, file all surgical procedures for the same DOS on one claim form.

- Only for subsequent procedures which add significantly to the major surgery or are not incidental to the major surgery.

- Using the appropriate modifier (Medicaid will key the first modifier indicated for each procedure only).

- With charges listed separately for each procedure.

When identical procedures (not bilateral) are billed for the same day, the first must be billed without a modifier, and the second with modifier 51. If the same procedure is billed a third time, the claim must be filed hardcopy with supporting documentation.

Modifier 62 is used to indicate that the skills of two surgeons were required. Modifier 66 is used to indicate circumstances requiring a surgical team. These modifiers will ensure proper reimbursement for each provider involved.

Modifier 52 is used to describe reduced services. Modifier 53 is used to describe a discontinued procedure. Both modifiers will be reimbursed at 50% when billed with a surgical procedure.

**Separate Procedures Performed on the Same DOS**
When two separate surgical procedures are performed on the same DOS at different operative sessions, both procedures will be allowed 100% of the established rate.

To report, submit the second procedure with modifier78 or 79. This will ensure that both procedures will be paid at 100%. If not reported in this manner, the lower priced of the two procedures will be reimbursed at 50%. All surgical procedures performed on the same DOS must be filed on the same claim form whenever possible.

**Procedure Codes That Multiply**
Occasionally, the CPT defines certain procedure codes as "each", indicating the possibility of multiple procedures. When filing these types of codes, list the code one time for the DOS and bill the appropriate number of units in the “units” column of the claim form and the total charge for the number of units billed. If there is only one surgical procedure for the DOS and multiple units are billed, payment for codes that multiply will be 100% of the established rate for the first unit and 50% for each additional unit(s) filed. If a surgical procedure with a higher established rate is performed on the same DOS, the higher established rate will be allowed and the code(s) to multiply will pay 50% of the established rate per unit filed.

**Automatic Adjustments to Paid Surgical Procedures**
All surgical procedure codes for the same patient and same DOS must be filed on the same claim form. This ensures that the correct procedure will reimburse at 100% of the established rate. At times, however, surgical codes are filed on separate claim forms, causing incorrect payments and the need for adjustments.

Automatic adjustments work in the following manner: When a claim for a surgical procedure code is submitted, the system will review the paid claims history for that patient, DOS and provider. If there is no previously paid surgical code(s) on file for that DOS, the surgery will pay at 100% of the established rate. If, however, there is a previously paid surgery on file for that patient, DOS, and provider, the system will compare the previously paid surgery and the newly submitted surgical code. It will then determine which of the codes would correctly reimburse the provider at 100%. If the newly submitted surgical code would pay at 100%, the system will make an automatic adjustment against the previously paid surgical code by subtracting 50% of the previously paid procedure from the amount to be reimbursed for the newly submitted surgical code. Therefore, the newly submitted surgical code will be allowed at 100% although the payment may not reflect the full amount due because of the recoupment of 50% of the previously paid procedure.

When the system reviews paid claims history for a patient, DOS and provider, and finds that the previous surgical claim paid correctly at 100% and the second surgical claim would pay at 50% of the established rate, there will be no adjustment as the claim will pay correctly.

**Bilateral Surgery**
To report a bilateral procedure, bill the first procedure with no modifier, and the second procedure with a 50 modifier. Report on two lines instead of one. A bilateral procedure billed with only one line will result in underpayment. Codes with bilateral descriptions may not be billed with a 50 modifier.

Claims filed for an assistant surgeon performing a bilateral procedure must be filed hardcopy with documentation using the 80, 81 or 82 modifier on both lines of the procedure code that is bilaterally performed.

Bilateral procedures will be reimbursed at 100% for the first procedure, and 50% for the second procedure (same as multiple procedures). If the bilateral procedure is billed in conjunction with another procedure that is normally reimbursed at a higher rate than the bilateral procedure, then each of the bilateral procedures will be reimbursed at 50%.

**Billing Procedures**
Surgical endoscopic procedures **always include** the diagnostic endoscopy. Therefore, the diagnostic endoscopy code is not allowed in addition to the surgical endoscopy for the same anatomical site.

Under the same principle, when a surgical procedure is performed through an endoscope, the diagnostic endoscopy is inclusive in the reimbursement. The physician may be reimbursed for either the endoscopic procedure or the diagnostic endoscopy, not both.

Endoscopic procedures do not require a 26 modifier when performed in the inpatient or OP hospital setting.

When two endoscopic procedures are performed on the same DOS, the first procedure must be reported without a modifier, and the second procedure must be reported with modifier 51.

**Ambulatory Surgical Services**
To bill for the professional service, the surgeon must submit claims following the usual surgical guidelines, using place of service “24”.

**Surgical Package**
The surgical package includes post-operative care for 30 days following surgery. Post-operative services rendered and billed during this 30-day period will be rejected for an 854-edit code. Normal post-operative care is considered part of the surgical package and includes office examinations and all hospital follow-up visits, including discharge management. Hospital and office E&M visits are allowed up to and including the day of surgery.

ER services and critical care are not considered part of the surgical package. They may be billed in addition to the surgery performed. For guidelines on delivery admissions, please refer to Perinatal Care under Obstetrics and Gynecology within this section of the guide.

Surgical procedures that are billed within 30 days prior to a paid office or hospital visit will suspend for review. If applicable, the office or hospital visit(s) will be recouped, and the surgery claim will process for payment. The surgical procedure may be rejected with edit 855. In that case, providers must submit a new claim and indicate that the surgery to be paid, and the visits to be recouped.

**Ambulatory Surgical Services**
Complications or services rendered for a diagnostic reason unrelated to the surgery may be billed with a separate examination code if the primary diagnosis reflects a different reason for the service.

To report post-operative visits unrelated to surgery, submit the visit code(s) with modifier 24 or 25. The medical record must substantiate that a visit(s) was justified outside of the surgical package limitation.

Follow-up care in the office and/or hospital may be billed if the surgery is an exception to the surgical package.

**Assistant Surgeon**
When billing for the assistant surgeon's fee, the modifier 80, 81, or 82 must accompany all procedure codes filed. Assistant surgeons must be physicians. Medicaid will not reimburse non-physician surgery assistants.

If, due to unforeseen circumstances, the surgery did require an assistant, and an assistant surgeon is not allowed for the surgical procedure, Medicaid will review the claim for reimbursement. Providers may submit a new claim with documentation for medical review. The medical record must justify the special need for an assistant surgeon.

An assistant surgeon will be reimbursed at 20% of the total allowable fee per procedure.

An assistant surgeon must use the same CPT procedure codes as the primary operating surgeon. The assistant surgeon modifier is the only modifier required for each procedure billed. Medicaid will only key the first modifier indicated.

The claim for the assistant surgeon must be submitted with a different individual provider number (rendering physician) from the primary surgeon. The assistant surgeon must be enrolled with South Carolina Medicaid in order to receive reimbursement.

Claims filed for an assistant surgeon performing a bilateral procedure must be filed using the 80, 81 or 82 modifiers.

## SURGICAL GUIDELINES FOR SPECIFIC SYSTEMS

### Organ Transplant 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 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 for a Medicaid member in the FFS program:

#### FFS Members

- Corneal transplants and related services
  Medically necessary corneal transplants delivered to a FFS member 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 a FFS member 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.

## Integumentary System

### Lesion Removal

Supporting documentation is required for a claim submitted for a lesion and a dermal anomaly removal or revision with diagnosis codes L91.0 and L90.5. Medicaid will not cover treatment that is considered to be experimental, investigational (i.e., chemical peels, cryosurgery, dermabrasion, punch grafts, bleomycin, interferon and verapamil injections), or done for cosmetic or emotional purposes.

### Keloid/Scar Conditions

Claims for these treatments must be accompanied by documentation that supports the criteria as outlined above. Medicaid will not provide coverage for excision and/or treatment of non-malignant dermal lesions, dermal anomalies and Keloid/scar conditions under the following circumstances:

- The treatment is performed for cosmetic or emotional purposes.
- The therapy is experimental or investigational.

Examples include chemical peels, cryosurgery, dermabrasion and punch grafts.

### Skin Grafts

Providers must follow CPT guidelines when billing for skin grafts. Procedures are identified by size and location of the defect (beneficiary area) and the type of graft. Skin graft codes that pertain to subsequent (each additional square centimeter) areas must be billed in units.

# ANESTHESIA SERVICES

## Time Reporting

South Carolina Medicaid only accepts actual time when billing for anesthesia services. Report time in minutes, in the "units" field (Item 24G) of the CMS-1500 claim form.

**Example:**
Anesthesia Start Time — 1:15 p.m.
Anesthesia Stop Time – 2:45 p.m.
Total Anesthesia Time Billed in Minutes — 90 minutes

### Modifiers of Anesthesia Services

The following modifiers are acceptable when billing in conjunction with the appropriate anesthesia CPT procedure code based on medical direction involved in the procedure:

- AA – Anesthesia services performed personally by an anesthesiologist. The anesthesiologist must remain in constant attendance of the patient.
- QY — Medical direction of one CRNA by an anesthesiologist.
- QK — Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals.
- AD — Medical direction of more than four concurrent anesthesia procedures involving qualified individuals.
- QX – Anesthesia services performed by CRNA with medical direction by a physician (anesthesiologist).
- QZ- Anesthesia services performed by CRNA without medical direction by a physician (anesthesiologist).

If the complexity of a surgery or complications that develop during surgery require both the CRNA and the anesthesiologist to be involved completely and fully in a single anesthesia case, both providers may bill for their services. The complexity of service or complications must be clearly documented in the patient's records and submitted with the claim. The anesthesiologist must bill using the AA modifier, anesthesia services performed personally by anesthesiologist. The CRNA must bill using the QZ modifier. These claims must be filed hardcopy with documentation supporting the need for both professionals.

Routine scheduling of a CRNA/AA, resident or intern to assist an anesthesiologist in the care of a single patient does not justify medical necessity.

The monitored anesthesia care modifiers QS, G8 and G9 do not describe medical direction involved in the anesthesia procedure. The monitored anesthesia care modifiers describe the type of anesthesia care. These are secondary modifiers. It is important to use a modifier that describes the medical direction involved as the first modifier when using more than one; Medicaid only accepts one modifier.

## Procedures

### Intubation

Payment is allowed for intubation (31500) performed in the intensive care unit or ER by an anesthesiologist or CRNA. Intubation is considered a regular part of anesthesia services and may not be a fragmented charge when performed in conjunction with anesthesia services.

### Catheter Placement

Anesthesiologists are reimbursed for placement of central venous, subclavian, arterial or Swan-Ganz catheters in addition to anesthesia services. CRNA/AAs will not be reimbursed for these codes. Refer to the provider portal for a list of codes.

### Spine and Spinal Cord Puncture for Injection

Medicaid reimburses personally performing anesthesiologists and CRNAs for the following spine and spinal cord puncture codes. Either the anesthesiologist or CRNA may bill for the codes listed below without a modifier, but not both.

For placement of the continuous epidural catheter, an anesthesiologist or CRNA, personally performing or supervised, bills the appropriate code with the appropriate modifier. Please refer to the provider portal for a list of appropriate codes.

### Laboring Epidural

The continuous epidural codes for the vaginal delivery and a vaginal delivery becoming a C-section reimburses a flat rate regardless of the time involved. The anesthesiologist and CRNA must bill with the appropriate modifier indicating personally performed or as part of an anesthesia team.

When a vaginal delivery becomes a C-section and the catheter remains in place for the C-section, you must bill for the vaginal delivery and then use the add-on code. This is an add-on code and therefore must be billed in conjunction with the procedure code.

If the C-section is performed under general anesthesia, you may bill the time for the C-section only, in addition to the labor and delivery epidural.

For a scheduled C-section, an anesthesiologist or CRNA bills with payment based on time.

When a tubal is performed at a later surgical session and the same catheter remains in place and is re-dosed, it is not appropriate to bill general anesthesia based on time.

## Anesthesia Consultations

Consultative services rendered on behalf of any direct or indirect patient care are included in the basic value of the anesthesia payment and may not be charged separately. However, if an

anesthesiologist is requested to consult with another physician or hospital anesthetist or examines a patient to determine the appropriate anesthetic agent and does not furnish direct anesthesia services or assume direct supervision of the anesthesia service, then the anesthesiologist may bill a separate consultation code based on the appropriate level of service.

The anesthesiologist may bill a consultative code if the surgery is canceled. An anesthesiologist may not charge a consultative service in addition to any anesthesia service (either for supervision or direct care).

### Fragmented Charges

Services considered an integral part of anesthesia services, such as blood gases, venipuncture, oxygen capacity, blood transfusions, administration of medications, intubation in the operating room, etc., are non-compensable when billed separately.

## PAIN MANAGEMENT SERVICES

### Post-Operative Pain Management

Physicians billing for post-operative pain management must bill the single or continuous procedure code when the insertion of the epidural catheter is for purposes other than surgical anesthesia. These codes include an allowance for insertion of the needle or catheter into the epidural space, and an allowance for injecting the drug or medication through the portal. If a continuous epidural is used for surgical anesthesia and remains in for post-operative pain, an additional insertion cannot be billed for management of the post-operative pain. These procedures must be billed without a modifier for the initial insertion.

Daily management of the epidural analgesia must be billed on days after the day of insertion of the epidural catheter. Up to five days of post-operative pain management may be allowed without additional documentation to justify the extended service. Unless a separately identifiable service has been rendered on the same day, do not bill any other service, including an E&M code.

Modifier QZ or AA (anesthesia services performed personally by anesthesiologist) must be used with the appropriate service. Please refer to Anesthesia Services within this section of the manual for a description of these modifiers.

### Nerve Blocks

Physicians are reimbursed for injection of anesthetic agents for nerve blocks. Anesthesiologists bill for these services without a modifier. Use separate procedure codes for trigger point injections that may also be billed by the anesthesiologist with no modifier.

Injecting any substance through the needles, including small amounts of contrast to confirm the position of the needle, is considered an integral part of the procedure and is not reimbursed separately.

When destruction of the facet joint nerve is performed following the block, only the codes for the nerve destruction must be billed, since their allowance includes the nerve block procedure.

## PATHOLOGY AND LABORATORY SERVICES

In accordance with Title XIX of the Social Security Act, Medicaid reimbursement for laboratory fees cannot be higher than the Medicare fee schedule established for laboratory services. Fee schedules are located on the SCDHHS website at http://www.scdhhs.gov.

It is further mandated that only the actual provider of the service or the provider performing the test may charge and receive Medicaid reimbursement. Providers cannot bill Medicaid patients when Medicaid would have paid for the lab service if the appropriate billing procedures and referral procedures had been followed.

Services or supplies administered by the hospital or hospital employees are considered a part of the overall hospital service and are reimbursable only under the hospital allowable costs. A physician who is either salaried or contracted by the hospital, and who performs services under contract or employment, may not bill for those services separately under his or her individual Medicaid provider number. The contracting hospital may file for these services under the professional fees allowable for the hospital under their hospital-based physician's Medicaid number.

Professional component services constitute the professional interpretation and report and must be charged using modifier 26. Claims for professional pathology services indicating a hospital as the place of service will be rejected if submitted without modifier 26. Only anatomical, surgical, and the clinical pathology procedures listed earlier in this section are reimbursable with a 26 modifier.

TC services are those services usually performed by a hospital in the administration of a hospital lab. These services include payment for a lab technician, equipment and supplies. Only a hospital may bill for separate technical lab services.

Total lab procedures are a combination of both the professional and TCs. Usually, an independent laboratory or a private practicing physician performing his or her own lab services is the only provider eligible for a total lab reimbursement rate. Pathologists and laboratories may bill for beneficiaries that are in the Family Planning Eligibility category only, but a valid family planning diagnosis code must be present on the claim, along with the FP modifier.

### Automated Chemistry Tests and Panels

Providers billing for automated multi-channel chemistry tests may bill these tests individually as described in the CPT coding manual. The system will bundle specific tests and reimburse one rate based on the number of tests performed. Claims with less than three of these tests will pay each individual test based on the fee schedule. The list above identifies those codes, when billing three or more, that are bundled to pay one rate based on the number of tests. A provider may also bill for individual tests that are assigned to a panel. If the individual tests are included on the list, these tests will also bundle when three or more are filed on the same claim form and pay one rate based on the number of tests.

Fee schedules are located on the SCDHHS website at http://www.scdhhs.gov.

### Blood

Medicaid requires that the securing supplier of blood products bill those products or packed cells. If a hospital laboratory secures the packed cells and washes, then the hospital must charge for the blood. A physician, clinic or other non-securing provider may not bill for the blood. In addition to the products, the securing provider may only bill for additional type and cross matching, if appropriate, and the transfusion.

### Professional Pathology Services

A pathologist may charge for a clinical lab interpretation if requested by the attending physician and reported as a contribution to direct patient care. This diagnostic procedure must be charged for limited and comprehensive services, respectively.

Interpretation of clinical lab tests will not be reimbursed. Only charges for consultations on clinical lab tests may be recognized. A professional component modifier is not required (26). General consultation procedures are not compensable for professional clinical lab services.

### Independent Laboratories

Whenever an independent laboratory charges Medicaid with an unlisted procedure, support documentation is required. Since SCDHHS and most independent laboratories recognize the mutual benefits of automated claims processing, steps must be taken to insure timely and efficient claims submission.

When a laboratory initiates a new lab test(s) or a new combination, notification must be sent to the Pathology program manager. This preliminary process will quicken the assignment of a code and approval for Medicaid payment.

Independent laboratories must submit charges on a CMS-1500 claim form with the appropriate CPT or supplemental code. The place of service must be an "81" and the DOS when the test was performed must be indicated.

Independent labs may bill for beneficiaries who are in the Family Planning Eligibility category only. A valid family planning diagnosis and modifier must be present on the claim.

## Clinical Laboratory Improvement Amendments (CLIA)

### Claims Editing

Claims will be denied for lab services delivered by any lab site meeting one or more of the following descriptions:

- A lab that does not have CLIA certification.
- A lab that submits claims for services not covered by CLIA certificate.
- A lab that submits claims for services rendered outside the effective dates of the CLIA certificate.

Individual physicians who are members of a group must bill under the group number. The CLIA editing is based on the provider number in field 33 of the CMS-1500. For more detailed information, please refer to the Provider Administrative and Billing Manual.

### Lab Procedures

The following sections indicate the lab procedures allowed for each type of certification. Current CLIA information can be found on the Internet at http://www.cms.hhs.gov/clia/.

Labs issued a Certificate of Registration, Certificate of Accreditation or Partial Accreditation, or Certificate of Compliance are allowed to perform and bill for the following procedures:

- All pathology and lab procedures
- Plasma volume, radiopharmaceutical volume-dilution technique (separate procedure); single sampling
- Plasma volume, radiopharmaceutical volume-dilution technique (separate procedure); multiple areas
- Red cell volume determination (separate procedure); single sampling

- Red cell volume determination (separate procedure); multiple samplings
- Whole blood volume determination, including separate measurement of plasma volume and red cell volume (radiopharmaceutical volume-dilution technique)
- Red cell survival study
- Platelet survival study
- Vitamin B-12 absorption study (e.g., Schilling test); without intrinsic factor
- Vitamin B-12 absorption study (e.g., Schilling test); with intrinsic factor
- Vitamin B-12 absorption studies combined, with and without intrinsic factor
- Culture and sensitivity urine only

Labs issue a Certificate of Waiver limited to performing only the following procedures:

| PROCEDURE | PROCEDURE | PROCEDURE |
|---|---|---|
| Lipid panel | Urinalysis, by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketone, leukocytes, nitrite, pH, protein specific gravity, urobilinogen, any number of constituents; non-automated, without microscopy | Urinalysis, by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketone, leukocytes, nitrite, pH, protein specific gravity, urobilinogen, any number of constituents; automated, without microscopy |
| Bacteriuria screen, exp culture/dips | Urine pregnancy test, by visual color comparison methods | Albumin, urine, microalbumin, semiquantitative (e.g., reagent strip assay) |
| Amines, vaginal fluid, qualitative | Blood, occult; feces, one to three simultaneous determinations | Cholesterol, serum, total |
| Collagen cross links; any links | Creatinine; other source | Glucose; quantitative |
| Glucose: post glucose dose (includes glucose) | Glucose: tolerance test, three specimens (includes glucose) | Glucose; tolerance test, each additional beyond three specimens |

| PROCEDURE | PROCEDURE | PROCEDURE |
|---|---|---|
| Glucose, blood, by glucose monitoring device(s) cleared by the FDA specifically for home use | Glutathione Reductase RBC | Glycated protein |
| Gonadotropin; follicle stimulating hormone | Gonadotropin; luteinizing hormone | Hemoglobin; by copper sulfate method, non-automated |
| Hemoglobin; glycated | Immunoassay analyte not antibody, single step method | Lactate (Acetic acid) |
| Lipoprotein, direct measurement; high-density cholesterol (HDL cholesterol) | pH, body fluid, except blood | Transferase; alanine amino |
| Triglycerides | Gonadotropin chorionic qualitative | Unlisted chemistry procedure |
| Blood count; spun microhematocrit | Blood count; other than spun hematocrit | Blood count; hemoglobin |
| Prothrombin time | Sedimentation rate, erythrocyte; non-automated | Immunoassay for tumor antigen, qualitative or semiquantitative; (EG, bladder tumor antigen) |
| Heterophile antibodies; screening | Immunoassay for infectious agent antibody, qualitative or semiquantitative, single step method (e.g., reagent strip) | Antibody; borrelia burgdorferi (Lyme Disease) |
| Culture, bacterial; aerobic isolate, additional methods for definitive identification, each isolate | Infectious agent antigen detection by enzyme immunoassay technique qualitative or semiquantitative; multiple step method, not otherwise specified, each organism | Infectious agent antigen detection by immunoassay with direct optical observation; influenza |
| Streptococcus, screen, direct | Anaerobic isolate, additional methods required for definitive identification, each isolate | Aerobic isolate, additional methods required for definitive identification, each isolate |

Labs issued PPMP Certificates are allowed to perform the above listed procedures for Certificate of Waiver ***and*** the following procedures:

- Fecal Leukocyte examination
- Semen analysis
- Wet mount, including preparations of vaginal, cervical, or skin specimens
- All potassium hydroxide preparations
- Pinworm examinations
- Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents, non-automated, with microscopy
- Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrate, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy
- Urinalysis; microscopic only
- Urinalysis; two or three glass test
- Nasal smear for eosinophil

## RADIOLOGY AND NUCLEAR MEDICINE

### Positron Emission Tomography (PET) Scans

Providers billing for radiopharmaceutical diagnostic imaging agents utilizing a CMS-1500 claim form must select the appropriate HCPCS code. When billing for an unlisted radiopharmaceutical agent the provider must include a copy of the invoice with the CMS-1500 claim form for review.

### Clinical Treatment Management

If at the final billing of the treatment course, there are three or four fractions beyond a multiple of five, those three or four fractions are considered a week. If there are only one or two fractions beyond a multiple of five, reimbursement for the sessions will be considered as having been covered through prior payment.

When the patient receives a mixture of simple, intermediate, and/or complex services, bill the code that represents the majority of the fractions furnished during the five-fraction week.

### Independent Imaging Centers and Mobile Imaging Units

Mobile units may bill the following codes for set-up and transportation in addition to the x-ray or EKG when the patient would require special transportation. These codes must be billed without a modifier:

- Set up of portable X-ray equipment in a nursing facility, per radiological procedure (other than re-takes of the same procedure). Medicaid will not reimburse for re-takes.
- Round-trip transportation of portable X-ray equipment and personnel to nursing home, per trip to facility or location; one patient seen.
- Round-trip transportation of portable x-ray equipment and personnel to nursing home, per trip to facility or location; more than one patient seen, per patient.
- Round-trip transportation of portable EKG to facility or location; per patient.

Charges must be submitted on a CMS-1500 claim form with the following restrictions:

- All CPT procedure codes must be submitted with a TC modifier.
- Separate charges for injection of contrast mediums, radiopharmaceuticals or catheterizations are not covered.

### Modifiers and Components

**Radiology services are divided into the following defined components:**

- TC — Includes equipment, supplies and technician time and effort. Provider must bill using the TC modifier.
- Professional Component — Includes the physician's supervision, interpretation, and report, and when appropriate, the physician's administration of an injection or catheterization. Payment will be made to the physician or radiologist who performed the interpretation and written report at the time of the diagnosis and treatment. Provider must bill using modifier 26.
- Complete Procedure — Is the combination of both the technical and professional services. Provider must bill 00 modifier.

- Modifier 76 — The use of modifier 76 can only be used on medically necessary repeat radiology procedures performed on the same DOS and must include both the technical and professional components.

Providers must bill using the appropriate modifiers which are determined by the parameters of services rendered. Therefore, if a rendering provider is only submitting the TC of the procedure, use the TC modifier along with the procedure code performed. If the claim is submitted utilizing the UB format, the modifier TC will be assumed. No further payment will be made to any additional provider for the TC for this procedure.

If the rendering provider is submitting the professional component/interpretation of the radiological procedure, use modifier 26 along with the procedure code performed. No further payment will be made to any additional providers for the professional component of the procedure.