



**Select Health**  
of South Carolina, Inc.  
*An AmeriHealth Mercy Company*

South Carolina  
**Healthy** Connections

## **Summary of Changes for the Select Health Provider Manual**



## SUMMARY OF CHANGES FOR THE SELECT HEALTH PROVIDER MANUAL

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### 08/01/2011 effective date

- 22, 28 . . . . . ▲ Member co-payments (increased)
    - ▲ Clinic visits: \$3.30
    - ▲ Office visits\*: \$3.30
    - ▲ Home health: \$3.30
  
  - 59 . . . . . ▲ Changed the Select Health 17P authorization form for the Universal 17P authorization form
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### 06/01/2011 effective date

- 14 . . . . . ▲ ~~Eyeglasses or contacts (adults over 21), 2nd pair of eyeglasses for children~~
  
- 18-19 . . . . . ✗ ~~Practitioner Appeal of Utilization Management and Claims Decisions~~
  - ▲ A member or a practitioner/provider with member consent may submit an appeal of any service denied by Select Health based on a medical necessity/appropriateness determination
  - ▲ Practitioners/providers submitting appeals on the behalf of a member must file appeal within 90 calendar days (effective 02/01/11) of denial or action notification.
  - + (3rd paragraph) Member consent must coincide with action giving rise to appeal therefore the provider/practitioner cannot obtain written consent prior to service. We have developed a form for providers to use to obtain member consent. The form can be found on the Select Health website, [www.selecthealthofsc.com](http://www.selecthealthofsc.com) and is also Exhibit 21 in this manual.
  - ✗ (4th paragraph) Select Health requires written confirmation of verbal requests for appeal along with member written consent in order to complete the appeal review. Requests without this information will not be processed. ~~The form for providers to use to obtain consent can be found on the Select Health website, [www.selecthealthofsc.com/firstchoice](http://www.selecthealthofsc.com/firstchoice) and is also Exhibit 15 in this manual.~~
  - ✗ Select Health has one appeal level, ~~practitioners/providers~~ members who wish to appeal any decision made by Select Health's Appeals Committee will be referred to the South Carolina ~~Department of Health and Human Services~~ Division of Appeals and Hearings.
  - ✗ ~~Requests for second level appeals must be submitted in writing within 30 calendar days to the South Carolina Department of Health and Human Services Division of Appeals and Hearings at:~~  
 Division of Appeals and Hearings  
 PO Box 8206  
 Columbia, SC 29202
  - + The State Fair Hearing process must be requested by the member. After requesting State Fair Hearing, a member may give the provider/practitioner written consent to represent him/her at the State Fair Hearing. Members are provided instructions on accessing State Fair Hearing in written appeal determination letter.
  - ▲ Expedited Appeal
  - ▲ An expedited review is granted to a provider or member upon ~~phone~~ verbal or written request.
  
- 22 . . . . . ✗ ~~First Choice Member Information: \*\* Co-payments do not apply to First Choice members for office visits, outpatient services or DME services.\*\*~~
  - + Member Co-payments  
 Some adult members will need to pay a small amount (co-payment) for certain services:  
 Chiropractic: \$1.15; medical equipment: \$3.40; clinic visits: \$2.30; office visits\*: \$2.30; home health: \$2.30; outpatient hospital: \$3.40; inpatient hospital: \$25.00; prescription drugs: \$3.40  
 There will be no co-payment for children less than 19 years of age, pregnant women, individuals receiving emergency services or federally recognized Native Americans.

\*Includes: doctor, nurse practitioner, licensed midwife and optometrist.

+ Member Ambulatory Care Visits (ACVs)

Ambulatory care visits (ACVs) for adults 21 years of age and older have been reduced to match SC Medicaid benefits of 12 ACVs per fiscal year.

27 . . . . . X Outreach Services: ~~Members between the ages of 2 and 20 years are eligible to receive a \$10 gift card if they complete their EPSDT exam within 90 days of receiving their EPSDT Now Due letter. Newborns with six exams prior to 15 months of age are eligible to receive a \$50 gift card.~~

28 . . . . . + Ambulatory Care Visit (ACV) Limit: Ambulatory care visits (ACVs) for adults 21 years of age and older have been reduced to match SC Medicaid benefits of 12 ACVs per fiscal year.

+ Co-payments

Some adult members will need to pay a small amount (co-payment) for certain services:

Chiropractic: \$1.15; medical equipment: \$3.40; clinic visits: \$2.30; office visits: \$2.30; home health: \$2.30; outpatient hospital: \$3.40; inpatient hospital: \$25.00; prescription drugs: \$3.40

There will be no co-payment for children less than 19 years of age, pregnant women, individuals receiving emergency services or federally recognized Native Americans.

A Medicaid beneficiary may not be denied services if they are unable to pay the co-payment at the time the service is rendered, however this does not relieve the beneficiary of the responsibility for the co-payment. It is the provider's responsibility to collect the co-payment from the beneficiary to receive full reimbursement for a service.

30 . . . . . ▲ Co-payments: Members who are 19 years of age or older; are subject to a **\$3.40** co-payment per prescription.

43-44 . . . . . X ~~Vision Services: Eyeglasses and contacts for members over 21 years of age are a covered benefit requiring vision practitioners/providers to secure prior authorization from Select Health's Medical Affairs Department. Adult members are covered for one pair of eyeglasses every year (365 days from last dispensing) when it is medically necessary or every two years when the prescription has not changed.~~

+ Vision Services: Routine eye exams are included in the core benefits provided by First Choice ~~for all members regardless of age.~~ under the age of 21. Prior authorization is not required for participating practitioners/providers; non-participating practitioners/providers are required to obtain authorization. First Choice covers vision services for all members with a medical diagnosis regardless of age.

First Choice will cover a replacement pair of eyeglasses for members under the age of 21. The replacement pair of glasses will be provided by Robertson's Optical, the same vendor that the State uses for the initial pair. To assist our practitioners/providers with the administration of this benefit, Robertson's Optical will submit claims for eyeglasses directly to Select Health. The initial pair of glasses for these members will be covered by Medicaid Fee for Service. The following codes: V2500-V2599, 92070, 92310, 92311, 92312, 92313 and 92340 will also be billed to Medicaid Fee-for-Service for members under the age of 21.

45 . . . . . X Vision Care: Medicaid Fee-for-Service will cover eyeglasses and contacts for members under age 21 (codes V2020, V2500-V2599) and dispensing fees, codes: 92070, 92310-92313 and 92340. ~~for all members.~~

55 . . . . . + First Choice Prior Authorization Information (exhibits)

+ Eyeglasses, 2nd pair of eyeglasses for children; Robertson Optical Laboratories, Inc.; phone: 800-922-5525, fax: 800-223-0731; 411 Commerce Dr. NE, Columbia, SC 29223

+ under Pain Management: code 27096

+ under Plastic Surgery & cosmetic: codes 54300, 54304, 54360

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**05/01/2011 effective date**

17 . . . . . Mental Health Substance Abuse Under First Choice

X Medicaid will reimburse all other mental health/substance abuse services under Fee for Service.

X (All practitioners/providers) – two sessions per calendar year

- ~~✗~~ (Private Psychiatrist only) — two sessions per calendar year
- ~~✗~~ Note: A maximum of one assessment per member every six months.
- ~~✗~~ Medicaid will reimburse all other mental health/substance abuse services under Fee-for-Service.
- + First Choice will reimburse practitioners/providers providing the following services without authorization:
- + 90801 - Psychiatric diagnosis interview exam - one assessment per member every six months
- + 90802 - Interactive psychiatric interview (private psychiatrist only) - one assessment per member every six months
- + Notes: For these services, Nurse Practitioners are included as allowed provider types.
- + First Choice may authorize additional assessments at our discretion, based on medical necessity. This applies to adults and children.
- + In cases where the Department of Alcohol & Other Drug Abuse Services or the Department of Mental Health submit laboratory claims (under Provider Type —80 Independent Lab), First Choice is responsible for reimbursement.
- + Should a First Choice member receive outpatient services in an emergency room setting for which the primary diagnosis is behavioral health (class code C), the emergency room visit (both professional and facility fees) shall be paid by First Choice.
- + Medical services rendered to patients admitted with a psychiatric diagnosis are the responsibility of First Choice. We will be responsible for Medicaid covered inpatient Behavioral Health Services (DRGs 424-433 and 521-523). Professional charges with the exception of those identified as psychiatric (CPT 90804-90899) and all anesthesia services associated with behavioral health will also be covered by First Choice. Medical services (physician services that are not mental health treatment services) provided by a psychiatrist or child psychiatrist are also covered by First Choice.
- + First Choice will coordinate the referral of our members for services that are outside of the required core benefits and which will continue to be provided by enrolled Medicaid practitioners/providers. These services include, but are not limited to, Targeted Case Management services, intensive family treatment services, therapeutic day services for children, out-of-home therapeutic placement services for children, inpatient psychiatric hospital and residential treatment facility services.

42 . . . . . Mental Health and Alcohol and Other Drug Abuse Services

- ~~✗~~ ~~Select Health~~ provides for the following mental health and alcohol and other drug abuse medical assessment services:
- ~~✗~~ 90801 - Psychiatric diagnosis interview exam (~~all practitioners/providers~~) — ~~two sessions per calendar year~~
- ~~✗~~ 90802 - Interactive psychiatric interview (private psychiatrist only) — ~~two sessions per calendar year~~
- ~~✗~~ Note: A maximum of one assessment per member every six months.
- ▲ **First Choice** provides for the following mental health and alcohol and other drug abuse medical assessment services:
- ▲ 90801 - Psychiatric diagnosis interview exam - **one assessment per member every six months**
- ▲ 90802 - Interactive psychiatric interview (private psychiatrist only) — **one assessment per member every six months**
- + **First Choice** is also responsible for:
- + Department of Alcohol & Other Drug Abuse Services or the Department of Mental Health laboratory claims (submitted under Provider Type —80 Independent Lab)
- + Outpatient services in an emergency room setting for which the primary diagnosis is behavioral health (class code C), the emergency room visit (both professional and facility fees).
- + Inpatient Behavioral Health Services (DRGs 424-433 and 521-523).
- + Professional charges (with the exception of those identified as psychiatric CPT 90804-90899)
- + Anesthesia services associated with behavioral health
- + Medical services (physician services that are not mental health treatment services) provided by a

psychiatrist or child psychiatrist

44 . . . . . Mental Health for Fee-for-Service:

- ~~✗~~ Select Health will provide coordination of these services. Medicaid Fee-for-Service will cover hospital services, physician services and psychiatric services provided by the Department of Alcohol and Other Drug Abuse and the Department of Mental Health.
- ~~✗~~ For services billed by a psychiatrist, Medicaid Fee-for-Service will cover procedure codes: 90804-90899. For services billed by a medical doctor (including a psychiatrist) or para-professional Medicaid Fee-for-Service will cover procedure codes: 90804, 90806, 90847, 90853, 90882 and 99371.
- ~~✗~~ SCDHHS considers the following to be mental health and alcohol and other drug abuse treatment services: Hospital Services (UB-04 claims); Inpatient DRGs 424 through 433, 521 through 523; Outpatient: primary diagnosis has a class code of C Physician/Clinic (CMS 1500 claims); Services provided by the Department of Alcohol and Other Drug Abuse Services (DAODAS); Services provided by the Department of Mental Health (DMH); Psychiatric services as outlined in the Medicaid Physician Services Provider Manual, Section 2.

Mental Health and Alcohol/Drug Services

- ▲ Some mental health, alcohol and other drug abuse treatment services will be reimbursed by Medicaid fee-for-service. SCDHHS considers the following to be mental health, alcohol and other drug abuse treatment services:
  - ▲ Hospital Services (UB-04 claims) - Outpatient services not rendered in an emergency room setting with a primary diagnosis of behavioral health (class code of C)
  - ▲ Services provided by the Department of Alcohol and Other Drug Abuse Services (DAODAS)
  - ▲ Services provided by the Department of Mental Health (DMH)
  - ▲ Psychiatric services as outlined in the Physicians, Laboratories, and Other Medical Professionals Provider Manual, Section 2, Psychiatric and Counseling Services, except the assessment codes detailed in the Psychiatric Assessment and Psychiatric Emergency Services section (CPT 90804 – 90899).

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**04/19/2011 effective date**

- 33 . . . . . ▲ If you choose to issue a refund for the overpayment, mail the completed overpayment worksheet along with any refund checks to:
- Select Health of South Carolina, Inc.  
Cost Containment and TPL Department  
PO Box 7320  
London, KY 40742**

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**04/01/2011 effective date**

- 14 . . . . . + Circumcision, unless performed prior to delivery discharge
- 18 . . . . . ▲ Provider/Practitioner Disputes: The provider registers a dispute either verbally or in writing within 90 calendar days from original denial notification **or action.**
- 40 . . . . . + Circumcision: Newborn circumcision will be covered if done prior to the delivery discharge. Circumcisions performed after that point will only be covered if medically necessary.
- 42 . . . . . + Podiatry Services: Services are limited to specialized care of the foot for members with a diagnosis of diabetes. Podiatrists must include the appropriate diabetic diagnosis code on the claim to ensure payment.
- 43 . . . . . + Rehabilitative Therapies: Services are provided through private rehabilitation clinics/practitioners/providers up to 300 units or 75 hours per year (this limit applies to the rehabilitative services combined).
- 50 . . . . . ▲ Updated image of member ID card.

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**03/01/2011**

- 14 . . . . . Services that Require Prior Authorization
  - ▲ Durable medical equipment, DME (billed charges **\$500** and over...)
  - + PET Scans (after Pain management)
- 14-15 . . . . . Referral and Authorization for Specialists: updated authorization requirements according to new corporate –wide standards.
  - ✗ Family Support Services
  - ✗ Pelvic Laparoscopy
  - ✗ Pediatric Day Treatment
  - ✗ PT, OT, ST – evaluations & re-evaluations
  - ▲ Home Health – **authorization required after 1<sup>st</sup> 6 visits**
  - ▲ Home Infusions & Injections – **removed S codes**
  - ▲ Pain Management – **reduced required codes**
  - ▲ PET scans – **moved from requires notification to requires authorization**
  - ▲ Therapy Services – **authorization required after 1<sup>st</sup> 12 visits**
  - + Septoplasty 30520
  - + More Cosmetic codes
- 15 . . . . . ▲ Authorization For Ancillary Services: Request prior authorization number form First Choice Medical Services Department if DME item is **\$500** or over
  - ▲ Durable Medical Equipment: Any needs for durable medical equipment (DME) exceeding charges of **\$500**
- 55 . . . . . + Prior Authorization Information
  - + Circumcision, unless performed prior to delivery discharge
  - + Durable Medical Equipment, billed charges \$500 and over
  - + Home Healthcare requires authorization after the 6<sup>th</sup> visit
  - + Septoplasty 30520
  - + Therapy Service PT,OT,ST, requires authorization after the 12<sup>th</sup> visit
  - + More Cosmetic codes

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**02/01/2011 effective date**

- Cover . . . . . + Healthy Connections logo
- 17 . . . . . + Section on Provider Disputes
- 18 . . . . . Practitioner Appeal of Utilization Management and Claims Decisions
  - ▲ Practitioners/providers may appeal **with member consent** any service denied by **Select Health** based on a medical necessity/appropriateness determination.
  - ▲ Practitioners/providers must file appeals within **90 days calendar** (effective 02/01/11) of denial **or action** notification. Appeals must contain a written request, a contact person’s name, address for further correspondence, a copy of the claim or EOB, **member written consent to appeal**, complete medical record and a summary of any additional details or documentation applicable for review of the appeal. **Select Health requires written confirmation of verbal requests for appeal along with member written consent in order to complete the appeal review. Requests without this information will not be processed. We have developed a form for providers to use to obtain member consent. The form can be found on the Select Health website, www.selecthealthofsc.com and is also Exhibit 21 in this manual.**
  - ▲ Select Health’s Appeals Coordinator will send the appealing practitioner/provider **and member** written notification of the appeal determination within 5 calendar days of determination.

- 19 . . . . . ▲ Sickle Cell **Program**
- 22 . . . . . ▲ Eligibility Verification: Eligibility information is available **through the NaviNet web portal, [www.navinet.navimedix.com](http://www.navinet.navimedix.com)**, and other electronic verification systems.
- ✗ ~~Member Eligibility: A newborn child of a First Choice mother... Exceptions are made when a mother has notified the Department of Health and Human Services prior to the birth of her child that she desires not to have the child enrolled and when a child has been adopted and arrangements were made prior to the birth.~~
- 27 . . . . . + Member Grievances: Practitioners/providers may report a grievance, without requiring member consent, at any time by contacting Member Services.
- + Practitioners/providers will also receive a copy of both the grievance acknowledgement letter and grievance decision letter.
- 30 . . . . . + Pharmacy Services: NOTE: Experimental drugs, procedures or equipment not approved by Medicaid are excluded.
- 36 . . . . . ▲ EPSDT/Immunization Claims/Encounters
- For vaccine administration: **Effective February 15, 2011 for claims with date of service on or after January 1, 2011** for vaccine administration, **for members 19 and older**, you must use:
- ▲ 90470...
- ▲ 90460 – Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component (one unit per date of service)
- ▲ 90461 – Each additional vaccine/toxoid component (two units per date of service)
- ▲ PLEASE NOTE: CPT advises to bill the above codes based on the number of components. At this time, SCDHHS will continue to use these codes per administration of each vaccine/toxoid and not per component for the VAFAC program.
- ▲ The administration of VAFAC vaccines is limited to a maximum of three units per date of service regardless of the number of additional vaccines administered. CPT codes 90460 and 90461 are covered codes for recipients under 19 years of age.
- 37 . . . . . Claims for Newborn Care
- ✗ ~~unless the mother has notified South Carolina Department of Health and Human Services prior to the birth of her child of her desire not to have the child enrolled.~~
- ✗ Rural Health Center
- + Evaluation and Management services and lab charges should be billed on separate claim forms.
- 40 . . . . . + Audiological Services: 92568 2 every 12 months
- ✗ V5090 6 every 12 months
- ✗ V5275/RT 6 every 12 months
- ✗ V5275/LT 6 every 12 months
- ▲ Chiropractic Services: Select Health will cover authorized services up to 6 visits per state fiscal year.
- ▲ Emergency /Non-Emergency Medical Transportation: These trips may be routine or non-routine transports to a Medicaid-covered service.
- 41 . . . . . ▲ Home Health Services: ...include intermittent skilled nursing, home health aide, physical, occupational and speech therapy services up to 50 visits per year.
- + Maternity Care: Note: Select Health follows the American Medical Association (AMA) guidelines when considering initial obstetrical exams for existing patients. These guide-lines state that new patient E&M coding is not to be used for each initial OB exam for an existing patient. The initial OB exam should be billed at a higher level E&M code based on the level of complexity.

- 42 . . . . . ▲ Prescription Drugs: Where appropriate, medications are prescribed to cover a maximum of 31 days.
- 44 . . . . . ✗ Non-Emergency Medical Transportation: Coordinated with the ~~Department of Social Services~~ transportation broker in the member’s county of residence.
- 45 . . . . . + Exhibit Listing: Member Consent for Appeal form