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Introduction

Select Health of South Carolina is a managed care organization licensed by the Department of Insurance and contracted with the South Carolina Department of Health and Human Services. Headquartered in Charleston, S.C., Select Health is a mission-driven health care organization with 20 years of experience serving low-income and chronically ill populations.

Select Health is a wholly owned subsidiary of AmeriHealth Caritas. AmeriHealth Caritas is one of the nation’s leaders in health care solutions for the underserved and chronically ill, impacting the lives of nearly 5 million individuals nationwide.

First Choice is Select Health’s Medicaid health plan. First Choice provides expanded benefits and services to Medicaid-eligible families.

Our Vision
Leading America in health care solutions for the underserved and chronically ill.

Our Mission
We help people get care, stay well and build healthy communities.

Our Values
Our service is built on these values:
- Advocacy
- Care of the poor
- Compassion
- Competence
- Dignity
- Diversity
- Hospitality
- Stewardship

Practice and Facility Changes

Please provide practice, physician and/or facility changes to us in writing and on practice letterhead. Please give at least a 30-day notice prior to the change and allow up to 30 days for the change to be completed.

Having your correct information is vital for accurate directories, claims payment and credentialing.

Changes requiring written notification include (but may not be limited to):
- Practice opening and/or closing to new members
- Physician name changes
- Practice mergers resulting in name or tax identification number changes
- Health care professional/provider/facility NPI numbers
- Changes to or additional facility locations or telephone numbers
- Changes to tax identification numbers or payee information
- Changes in physician participation (doctors joining or leaving the practice with effective dates)

Medicaid Managed Care Overview

Select Health of South Carolina is a state-approved managed care organization (MCO) currently participating in the Healthy Connections Choices program. Healthy Connections Choices is a state program that helps Medicaid beneficiaries enroll in health plans to get Medicaid services. Through the coordination of services, managed care results in:
- Improved health status of members
- Increased access to primary and preventive care
- Increased access to appropriate, coordinated, quality health care services
- Improved health outcomes
- Improved overall cost effectiveness of the Medicaid program

Medicaid beneficiaries have a choice among models:
- Managed Care Organizations (MCOs): The MCO model is a fully capitated plan that provides a core benefit package similar to that provided under the current Medicaid program. These models usually
include enhanced benefits and services in addition to the core benefit package.

- **Traditional Medicaid Fee-for-Service:** The traditional Medicaid fee-for-service model is the traditional Medicaid program reimbursing by fee schedule.

Health care professionals/providers are strongly encouraged to check for MCO or traditional Medicaid fee-for-service enrollment prior to performing a service. If the beneficiary is enrolled in an MCO, the health care professional/provider must be enrolled with South Carolina Medicaid (SCDHHS) and contracted with the managed care company or may need to obtain prior authorization in order to be reimbursed.

## Quality Assurance and Performance Improvement Program

In accordance with Federal regulations 42 CFR §§ 438.240-438.242, Select Health of SC’s Quality Assurance and Performance Improvement (QAPI) program provides a framework for evaluating the delivery of health care and services provided to members. The purpose of the QAPI program is to provide a formal process to systematically monitor and objectively evaluate the quality, appropriateness, efficiency, effectiveness and safety of the care and service provided to Select Health members by providers. The QAPI program also oversees the development of performance improvement programs designed to improve the overall health and satisfaction of Select Health members and providers.

The QAPI program also provides oversight and guidance for the following:

- Determining practice guidelines and standards by which the program’s success will be measured.
- Complying with all applicable laws and regulatory requirements, including but not limited to applicable state and federal regulations and NCQA accreditation standards.
- Providing oversight of all delegated services.
- Ensuring that a qualified network of providers and practitioners is available to provide care and service to members through the credentialing/re-credentialing process.
- Conducting member and practitioner satisfaction surveys to identify opportunities for improvement.
- Reducing health care disparities by measuring, analyzing and re-designing of services and programs to meet the health care needs of our diverse membership.

Select Health develops goals and strategies considering applicable state and federal laws and regulations and other regulatory requirements, NCQA accreditation standards, evidence-based guidelines established by medical specialty boards and societies, public health goals and national medical criteria. Select Health also uses performance measures such as HEDIS®, CAHPS®, consumer and provider surveys, and available results of the External Quality Review Organization (EQRO), as part of the activities of the QAPI program.

### QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT COMMITTEE

The QAPIC oversees Select Health’s efforts to measure, manage and improve quality of care and services delivered to Select Health members, and evaluate the effectiveness of the QAPI program.

The QAPIC works closely with the plan’s medical directors and is comprised of a variety of health professions (e.g., pharmacy, physical therapy, nursing, etc.), participating network providers from a variety of medical disciplines (e.g., medicine, surgery, radiology, etc.) with emphasis on primary care—including obstetric and pediatric representation and representation from the plan’s management or Board of Directors.

Additional committees support the QAPI program and report into the QAPIC:

#### Quality Clinical Care Committee

The Quality Clinical Care Committee is responsible for the provision of clinical care services and outcomes such as utilization management, integrated care management, chronic care management and clinical appeals.

#### Quality of Service Committee

The Quality of Service Committee monitors performance and quality improvement activities related to Select Health services to assure that services are coordinated and effective; reviews, approves and monitors action plans created in response to identified variances.
Pharmacy and Therapeutics Committee
The Pharmacy and Therapeutics Committee monitors drug utilization patterns, formulary composition, pharmacy benefits management procedures and quality concerns.

Compliance Committee
The Compliance Committee is responsible for making sure that the plan is complying with the terms of its contract with SCDHHS and with all applicable federal and state laws and regulatory requirements.

Credentialing Committee
The Credentialing Committee reviews practitioner and provider applications, credentials and profiling data (as available) to determine appropriateness for participation in the Select Health network.

Administrative Appeal and Grievance Committee
The Administrative Appeal & Grievance Committee considers and resolves member grievances that the grievance coordinator is unable to resolve to the members’ satisfaction. The committee also reviews appeal and grievance trends to identify opportunities for health care professional/provider and/or member education.

Appeals Committee
The Appeals Committee reviews administrative utilization management denials and claim denials which required prior authorization

Provider Dispute Committee
The Provider Disputes Committee reviews disputes resulting from post-service claim denials, utilization management denials and claim denials with a clinical component.

Culturally and Linguistically Appropriate Service (CLAS) Committee
The CLAS Committee provides direction for Select Health activities that are relevant to the 15 national CLAS standards and to NCQA’s Multicultural Healthcare Standards to ensure that Select Health members are served in a way that is responsive to their cultural and linguistic needs.

Practitioner Involvement
We encourage provider participation in our quality-related programs. Providers who are interested in participating in one of our Quality Committees may contact Provider Network Operations at 1.800.741.6605 or their Provider Network Account Executive.

QAPI Activities
The QAPI program is designed to monitor and evaluate the quality of care and service provided to members. On-going QAPI activities include:

Performance Improvement Projects
Select Health develops and implements Performance Improvement Projects (PIPs) focusing on areas of concern or low performance, both clinical and service-related, identified through internal analysis and external recommendations.

Ensuring Appropriate Utilization of Resources
Select Health will perform baseline utilization measurements to calculate inpatient admission rates and length of stay, emergency room utilization rates and clinical guideline adherence for preventive health and chronic illness management services to identify those areas that fall outside the expected range to assess for over- or under-utilization.

Chronic Care Improvement Programs
Select Health Chronic Care Improvement Programs were selected to address the expected high-incidence conditions for which there are evidence-based protocols that have been shown to improve health outcomes.

Measuring Member and Provider Satisfaction
Select Health uses the standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to assess member satisfaction. Select Health also conducts provider satisfaction studies annually. Survey results, along with analysis and trends on dissatisfaction and member opt-outs are reported to the QAPIC for review and identification/prioritization of opportunities for improvement.

Participant and Provider Dissatisfaction
Dissatisfactions or complaints/grievances from members and providers are investigated, responded to and trended. Trends and the results of investigations are reported to the QAPIC, which coordinates initiatives to address identified opportunities for improvement.
MEMBER SAFETY PROGRAMS
The QAPI department is responsible for coordinating activities to promote member safety. Initiatives focus on promoting member knowledge about medications, home safety and hospital safety.

NCQA HEDIS® Reporting Measures
The Select Health Quality Improvement Department is responsible for the collection and reporting of the Healthcare Effectiveness Data and Information Set (HEDIS®) standardized performance measures that assess the quality of health care – much like a report card. These measures, adopted by NCQA in 1993 and used by over 90% of all health plans in United States, are reported annually and consist of the following categories:

- Effectiveness of Care
- Accessibility/Availability of Care
- Experience of Care
- Utilization (Use of Services)

Adherence to these HEDIS guidelines:
- Ensures health plans are offering quality preventive care and services.
- Provides a comparison to other plans.
- Identifies opportunities for quality improvement.
- Measures the plan’s progress from year to year.

Select Health appreciates provider cooperation with medical record reviews and participation in the provider survey as part of our HEDIS data collection processes.

All plan policies referenced throughout this Provider Manual are available for health care professional/provider review upon request.

Important Phone Numbers
For information related to prior authorizations, appeals, clinical questions, membership verification, integrated care management, claims questions, health management programs or to contact the medical director, call:

- Medical Management, toll free: 1.888.559.1010
- Medical Management, Charleston area: 843.764.1988
- Medical Management Fax, toll free: 1.888.824.7788
- Medical Management Fax, Charleston area: 843.863.1297
- Medical Management Right Fax: 1.866.368.4562
- Provider Claims Services: 1.800.575.0418
- Provider Services Right Fax: 1.855.316.0093
- Appeals: 1.866.615.5186
- Appeals Fax: 1.866.369.6046
- Physician’s Peer-to-Peer Hotline: 1.866.615.5188

For membership verification, member complaints, requests to transfer members and LSA interpretation services:
- Member Services, toll free: 1.888.276.2020
- Member Services, Charleston area: 843.764.1877
- Member Services Fax, Charleston area: 843.569.4875
- Member Services Fax, toll free: 1.800.575.0419

For health care professional/provider services and administration, call:
- Toll free: 1.800.741.6605
- Charleston area: 843.569.1759
- Fax, toll free: 1.800.316.0093
- For claims: 1.800.575.0418
- Website: www.selecthealthofsc.com

Select Health Credentialing Requirements
Select Health maintains criteria and processes to credential and re-credential health care professionals to include but not limited to; Medical Doctors (MD); Doctors Osteopathic Medicine (DO); Doctors of Podiatric Medicine (DPM); Doctors of Chiropractic (DC); Doctors of Optometry (OD); Doctors of Philosophy (PHD); Certified Nurse Midwives (CNM); Nurse Practitioners (NP); Audiologists, Occupational Therapists, Physical Therapists, Speech and Language Therapists, Physician Assistants, Registered Dieticians and Behavioral Health Care Professionals: to include Psychiatrists, Substance Abuse Specialists, Psychologists and Nurse Specialists, and Ancillary providers — organizational (e.g. hospitals, home health) and non-organizational (e.g. laboratories, radiology centers). The scope of the Credentialing Program includes all health care professionals and non-physician health care professionals who have an independent relationship with the organization.
and who see members outside the inpatient hospital setting or outside of ambulatory freestanding facilities. Health care professionals who have been credentialed through a plan delegate are not directly credentialed by Select Health. All health care professionals and ancillary providers are re-credentialed every three years.

All contracted providers must also enroll directly with SCDHHS. This requirement provides accuracy in MCO reporting and assists SCDHHS in monitoring and ensuring ongoing provider compliance. For more information, consult Section 1 of any of the SCDHHS provider manuals.

**Required Credentialing Documentation**

All health care professionals/providers must submit a signed/dated application. Applications must be filled out correctly, completely and be legible and contain the provider’s attestation of the application’s correctness and completeness. Select Health accepts the S.C. Uniform Managed Care Credentialing Application or applications submitted through CAQH (Council for Affordable Quality Healthcare). The health care professional’s application and attestation/release form must have a signature dated within 120 calendar days prior to Select Health’s Credentialing Committee decision date (CAQH applications must be in a current non-expired status). Original, faxed, photocopied and electronic signatures by the health care professional/provider are acceptable (stamped signatures are not accepted).

In addition, the health care professional/provider must submit supplementary information related to licensure, malpractice coverage and professional liability claims history, hospital admitting arrangements, work history and education. All attestation, disclosure, and malpractice questions that are answered affirmatively must include a detailed explanation. If the health care professional/provider answers no, to any of the questions and the verification source contradicts this, the health care professional/provider will be notified in writing within seven (7) business days and may be asked to provide additional information.

Select Health must confirm that the health care professional’s/provider’s license to practice in South Carolina is current, valid, in good standing and without restrictions or sanctions. The health care professional’s license is verified online through the South Carolina Department of Labor, Licensing and Regulation; [http://www.llr.state.sc.us/POL/Medical/](http://www.llr.state.sc.us/POL/Medical/). The verification page is printed and inserted in the credential file. All non-physician health care professional/provider licenses will be verified through query of the appropriate state agency.

Select Health additionally queries the following sources to review state sanctions, restrictions on licensure or limitations on scope of practice:

- National Practitioner Data Bank (NPDB)
- Office of the Inspector General (OIG)
- General Services Administration (GSA) System for Award Management (SAM)
- South Carolina Department of Health and Human Services (SCDHHS) SC Excluded Providers List.

If a health care professional/provider was licensed in more than one state in the last five year period, the credentialing staff will verify licensure history via either the NPDB query or from the appropriate state licensing board for all states in which the health care professional/provider has worked. If the health care professional/provider is found to be currently sanctioned or suspended due to Medicaid/Medicare fraud and abuse in any state where they have practiced, he/she will not be allowed to participate in the plan’s network.

Verification of health care professional’s license must be no more than 120 calendar days old at the time of the credentialing decision.

The application packet must include the following items:

- Current state license
- Current Federal Drug Enforcement Administration (DEA) certificate
- Current State Controlled Substance certificate
- Current malpractice coverage: minimum coverage amount of $200,000/$600,000 with an additional patient compensation fund rider, or a minimum coverage amount of $1,000,000/$3,000,000. Federal/state tort coverage may be accepted.
- Current CLIA (if applicable)
- Disclosure of Ownership and Control Interest Statement (SCDHHS Form 1514)
- Collaborative Agreement for Physician Assistants (PA’s)
• Nurse Protocol: All NP’s must provide a copy of their most recent signed written protocol between the nurse and the preceptor physician.

The following information is requested in order to complete the re-credentialing process:
• Application – SC Uniform Managed Care Health Care Professional Credentials Update Form, OR;
• CAQH Universal Provider Datasource – health care professional/provider CAQH reference number
• Credentialing attestation
• Office hours/Patient Loads Form/Service Addresses
• Claims Information Form (if applicable)
• Disclosure of Ownership and Control Interest Statement (SCDHHS Form 1514)
• Supporting Documents – state professional license, federal DEA certificate (if applicable), State Controlled Substance certificate (if applicable), Malpractice Face Sheet, CLIA (if applicable)

Preceptor Verification (Nurse Practitioners); Collaborative Agreement (Physician Assistants)

As with initial credentialing, all applications must be signed and dated within 120 calendar days prior to Select Health’s Credentialing Committee decision date. Additionally, all supporting documents must be current at the time of the decision date.

SITE VISIT

Select Health will conduct a pre-contractual on-site review of all OB/GYN’s and Primary Care Practitioners to assess safety, cleanliness, and medical record-keeping practices, confidentiality policy and procedures, appointment scheduling policy, and after-hours accessibility. If a practitioner has multiple office locations a site visit is conducted at each site. Pre-contractual site reviews are reviewed and approved by the Director or Manager of Network Development. The Credentials Department is notified by Network Management when the site visit has been completed and whether the site visit results are acceptable by plan standards.

Subsequent site visits are required for the following events; a practitioner opens an additional office site, moves an office site or leaves a group practice to open his/her own office. Select Health must conduct site visits for relocated offices prior to the re-credentialing of any practitioner.

An additional site visit will be completed when a complaint has been lodged against a specific practitioner for concerns regarding office site quality.

COLLABORATIVE AGREEMENTS (FOR PA’S)

1. All PA’s must provide a copy of their most recent signed written collaboration agreement between the PA and the preceptor physician
2. Primary physician preceptor must be a participating provider with the plan
3. Collaboration agreement must include the scope of the PA’s practice and delineate the preceptor arrangement with supervising physician(s)
4. Agreement must be signed by both the PA and preceptor physician(s)

NURSE PRACTITIONERS (NP’S) PROTOCOLS

All NP’s must provide a copy of their most recent signed written protocol between the nurse and the preceptor physician and must include;

1. This general information must be dated not to exceed 365 days:
   a. Name, address, and South Carolina license number of the nurse;
   b. Name, address, and South Carolina license number of the physician;
   c. Nature of practice and practice locations of the nurse and physician;
   d. Date the protocol was developed and dates the protocol was reviewed and amended;
   e. Description of how consultation with the physician is provided and provision for backup consultation in the physician’s absence;

2. This information for delegated medical acts:
   a. The medical conditions for which therapies may be initiated, continued, or modified;
   b. The treatments that may be initiated, continued, or modified;
   c. The drug therapies that may be prescribed;
   d. Situations that require direct evaluation by or referral to the physician.

Preceptor must be a contracted and credentialed medical doctor who is qualified to oversee the services provided by a Nurse Practitioner (NP) with Select Health, be within a forty-five (45) mile radius and have telephone contact with the NP.

Written protocols will be reviewed for completeness
and must be signed by a Preceptor. The Plan will not enroll NP’s who utilize a supervising physician who is not participating with the Plan. Written protocols must display a signature that is not greater than 365 calendar days from the date of Plan committee approval.

Select Health retains the right to audit the Nurse Practitioner protocol and any amendments to the protocol to ensure they have been reviewed annually by the South Carolina Department of Labor, Licensing and Regulation Board.

**Licensed Dietition (LD) Enrollment**

All licensed dietitians must meet the South Carolina licensure and educational requirements. LDs practicing within 25 miles of the South Carolina border in Georgia or North Carolina must meet the licensure and educational requirements of the State in which the LD practices. LDs must register with SCDHHS and Select Health.

**Ancillary Providers**

Select Health defines two categories for Ancillary Providers – Organizational & Non-Organizational.

**Organizational Providers** are: Hospitals, Home Health Agencies, Skilled Nursing Facilities, Residential and Free Standing Ambulatory Surgical Centers.

**Non-Organizational Providers** are: Laboratory Centers, Infusion Agencies, Radiology Centers, Audiology, Speech, Occupational & Physical Therapy Centers, Outpatient Behavioral Health, and Durable Medical Equipment Suppliers (DME).

The credentialing process will verify that the ancillary providers listed above are in good standing with state and federal regulatory bodies.

Ancillary providers, described above, are credentialed and re-credentialed every 36 months consistent with the South Carolina Department of Health Human Services (SCDHHS) contractual requirements and health plan accreditations standards. Re-credentialing process will ensure that organizational/non-organizational providers continue to remain in good standing with state and federal regulatory bodies and if applicable, accrediting bodies.

**Ancillary Providers – Organizational**

Hospitals must:

- Be surveyed and licensed by the South Carolina Department of Health and Environmental Control (SCDHEC) and provide a copy of a current unrestricted license.
- Provide a copy of accreditation certificate from the Joint Commission (formerly known as JCAHO), American Osteopathic Association (AOA), Det Norske Veritas (DNV) or Commission on Accreditation of Rehabilitation Facilities (CARF).
  - If not accredited, the hospital must be certified by CMS and must submit either a letter of certification from CMS acknowledging CMS compliance, or a copy of its most recent CMS Site Survey. The Certification date or last survey date cannot be older than 3 years at the time of approval.
- Have the minimum acceptable amount of professional liability insurance. Acceptable limits are $1M per occurrence/$3M aggregate or federal/state tort coverage may be accepted.
- Submit a Disclosure of Ownership and Control Interest Statement (SCDHHS Form 1514). Listed owners will be monitored for sanctions via the List of Excluded Individuals and Entities (LEIE) available on the Office of Inspector General’s (OIG) website, SAM and the South Carolina Excluded Provider List posted on the South Carolina Department of Health and Human Services (SCDHHS) website.
  - Submit a signed application and attestation of correctness of the information supplied.

Home Health Agencies, Skilled Nursing Facilities and Ambulatory Surgical Centers must submit the same documents as a hospital along with a copy of accreditation certificates from a nationally recognized accreditation body.

- For home health agencies: Joint Commission, Community Health Accreditation Program (CHAP) or Accreditation Commission for Health Care (ACHC).
  - If not accredited, the home health agency must be certified by CMS and must submit either a letter of certification from CMS acknowledging CMS compliance, or a copy of its most recent CMS Site Survey. The Certification date or last survey date cannot be older than 3 years at the time of approval.
- For skilled nursing facilities: Joint Commission, Accreditation Association for Ambulatory Health Care (AAAHC), or Commission on Accreditation of
Rehabilitation Facilities (CARF) (rehab only).
- If not accredited, the facility must be certified by CMS and must submit either a letter of certification from CMS acknowledging CMS compliance, or a copy of its most recent CMS Site Survey. The Certification date or last survey date cannot be older than 3 years at the time of approval.
- Ambulatory surgical facilities must submit a copy of accreditation by a recognized national accreditation body.
  - If not accredited, the facility must be certified by CMS and must submit either a letter of certification from CMS acknowledging CMS compliance, or a copy of its most recent CMS Site Survey. The Certification date or last survey date cannot be older than 3 years at the time of approval.

Behavioral Health Facilities – facilities providing mental health and substance abuse services, including inpatient, residential and ambulatory services (outpatient, partial hospitalization and intensive outpatient) must:
- Hold licensure from the appropriate licensing agency to perform one or all of the following services:
  - Substance abuse and/or behavioral/mental health outpatient
  - Substance abuse and/or behavioral/mental health inpatient
  - Substance abuse and/or behavioral/mental health residential treatment
  - Substance abuse and/or behavioral/mental health partial hospitalization
  - Substance abuse inpatient detoxification or rehab
- Submit current Joint Commission, CARF, or Council on Accreditation (COA)* accreditation certificate for inpatient and residential treatment.
- Have the minimum acceptable amount of professional liability insurance. Acceptable limits are $1M per occurrence/$3M aggregate or federal/state tort coverage may be accepted.
- Submit a signed application and attestation of correctness of the information supplied.
- Provide a Disclosure of Ownership and Control Interest Statement (SCDHHS Form 1514).

The plan will conduct:
- Medicare/Medicaid Sanction review via Office of the Inspector General (OIG) online.
- Medicare/Medicaid sanction review via the General Services Administration (GSA) System for Award Management (SAM).
- Medicare/Medicaid Sanction review via online South Carolina Department of Health and Human Services (SCDHHS) SC Excluded Providers List.
- Adverse Action review via the National Practitioner Data Bank (NPDB); *NPDB is inclusive of Health Integrity and Protection Data Bank (HIPDB) data.
- Medicare Opt Out status checked via the Palmetto GBA Medicare website.

Ancillary Providers – Non Organizational
Infusion Agencies must:
- Provide a business license, if applicable.
- Have a permit issued by the State Board of Pharmacy.
- Have the minimum acceptable amount of professional liability insurance. Acceptable limits are $1M per occurrence/$3M aggregate or federal/state tort coverage may be accepted.
- Submit a signed application and attestation of correctness of the information supplied.
- Provide a Disclosure of Ownership and Control Interest Statement (SCDHHS Form 1514).

Durable Medical Equipment Suppliers must:
- Provide a business or retail license, if applicable.
- Have a Medical Gas/Legend Device license issued by the State Board of Pharmacy, if compressed air is provided.
- Have the minimum acceptable amount of professional liability insurance. Acceptable limits are $1M per occurrence/$3M aggregate or federal/state tort coverage may be accepted.
- Submit a signed application and attestation of correctness of the information supplied.
- Provide a Disclosure of Ownership and Control Interest Statement (SCDHHS Form 1514).

Audiology, Speech, Occupational, & Physical Therapy Centers must:
- Provide a business license, if applicable.
- Provide a staff roster of all licensed personnel and
corresponding license numbers.
• Have the minimum acceptable amount of professional liability insurance. Acceptable limits are $1M per occurrence/$3M aggregate or federal/state tort coverage may be accepted.
• Submit a signed application and attestation of correctness of the information supplied.
• Provide a Disclosure of Ownership and Control Interest Statement (SCDHHS Form 1514).

Laboratories must:
• Be certified by CMS under the Clinical Laboratory Improvement Amendment (CLIA) (or hold a waiver certificate if applicable), and be accredited by the College of American Pathologists (CAP).
• Have the minimum acceptable amount of professional liability insurance. Acceptable limits are $1M per occurrence/$3M aggregate or federal/state tort coverage may be accepted.
• Submit a signed application and attestation of correctness of the information supplied.
• Provide a Disclosure of Ownership and Control Interest Statement (SCDHHS Form 1514).

Mail Order Pharmacies:
• The organization must provide a business license, if applicable.
• The organization must have a pharmacy permit issued by the State Board of Pharmacy.
  • If located outside of South Carolina, the organization must have a non-resident South Carolina Permit issued by the SC Board of Pharmacy.
• The agency must have the minimum acceptable amount of professional liability insurance. Acceptable limits are $1M per occurrence/$3M aggregate or federal/state tort coverage may be accepted for applicable entity types.
• Medicare/Medicaid Sanction review via OIG online.
• Medicare/Medicaid sanction review via the General Services Administration (GSA) System for Award Management (SAM)
• Medicare/Medicaid Sanction review via online South Carolina Department of Health & Human Services (SCDHHS) SC Excluded Providers List.
• Adverse Action review via the National Practitioner Data Bank (NPDB). *NPDB is inclusive of Health Integrity and Protection Data Bank (HIPDB) data.
• Signed application and attestation of correctness of the information supplied must be provided.
• Disclosure of Ownership and Control Interest Statement (SCDHHS Form 1514)

Radiology Centers must:
• Provide a business license, if applicable.
• Have X-ray equipment periodically, satisfactorily inspected for safety by SCDHEC (center to provide recent Safety Inspection Reports).
• Be certified by the US Department of Health and Human Services, Public Health Services, Food and Drug Administration (FDA) if providing screening and diagnostic mammography services.
• Have the minimum acceptable amount of professional insurance. Acceptable limits are $1M per occurrence/$3M aggregate or federal/state tort coverage may be accepted.
• Submit a signed application and attestation of correctness of the information supplied.
• Provide a Disclosure of Ownership and Control Interest Statement (SCDHHS Form 1514).

Non-accredited Organizational Providers
If an organizational provider applicant is non-accredited and the plan demonstrates a network need, a CMS site visit or state review can be submitted in lieu of the plan site visit. The site survey can be no older than three (3) years at the time of Committee decision. The CMS or state site review is submitted by the facility along with any violations/citations noted during the review. An action plan to address these deficiencies must accompany the site review that is submitted for consideration. The site review is reviewed by the Credentialing Committee to verify that it meets Select Health and South Carolina Department of Health and Human Services (SCDHHS) standards for credentialing. A compliance or certification letter indicating compliance with all requirements may be accepted in lieu of a full site survey.

Upon verification of all submitted documents and primary sites, all files will be forwarded to the Credentialing Committee for review and approval. Providers identified with sanctions or issues will be presented individually for committee consideration.

Providers and all entity owners listed on the Disclosure of Ownership and Control Interest Statement (SCDHHS Form 1514) will be reviewed for
sanctions/exclusions from participation with Medicare or Medicaid programs. Credentialing staff will query each owner listed on the 1514 form online via GSA, OIG and SAM exclusion databases and against the South Carolina Excluded Provider List (SC EPL) to determine if any Medicare/Medicaid sanctions/exclusions exist.

If a Medicaid/Medicare fraud and abuse related sanction exists for any list owner within the past 10 years, the provider contract and related credentialing will be terminated. The provider, appropriate business units and the Program Integrity Department at the South Carolina Department of Health and Human Services will be notified. If an agent or managing employee is found to be sanctioned during monthly monitoring, it will be reported to the Program Integrity Department at SCDHHS.

**Ongoing Monitoring Of Sanctions & Complaints**
Select Health of South Carolina will conduct routine and ongoing monitoring of sanctions and complaints against practitioners. The purpose of this ongoing monitoring is to identify quality and safety issues between re-credentialing cycles and act on any identified quality or safety issues expeditiously.

**Required Re-credentialing Documentation**
- Application – SC Uniform Managed Care Health Care Professional Credentials Update Form, OR;
- CAQH Universal Provider Datasource – health care professional/provider CAQH reference number
- Credentialing Attestation
- Office hours/Patient Loads Form/Service Addresses
- Claims Information Form (if applicable)
- Disclosure of Ownership and Control Interest Statement (SCDHHS Form 1514)
- Supporting Documents:
  - State professional license
  - Federal DEA certificate (if applicable)
  - State Controlled Substance Certificate (if applicable)
  - Malpractice Face Sheet
  - CLIA (if applicable)
  - Preceptor Verification (nurse practitioners only)
  - Nurse Protocols (nurse practitioners)
  - Collaborative Agreement (physician assistants)

All health care professionals involved in the re-credentialing cycle are sent a re-credentialing notification (letter, email, fax) approximately four months prior to the re-credentialing due date.

As with initial credentialing, all applications must be signed and dated within 120 calendar days of Select Health’s Credentialing Committee decision date. Additionally, all supporting documents must be current at the time of the decision date.

All documents needed for credentialing/re-credentialing can be found on the Select Health website, www.selecthealthofsc.com.

**Select Health Credentialing/Re-credentialing Actions**
Select Health will:
- Verify state license through appropriate licensing agency.
- Verify board certificate or residency training or medical education.
- Query National Practitioner Data Bank.
- Verify hospital privileges in good standing at a Select Health participating hospital.
- Review five years of work history.
- Review sanctions activity from Medicare/Medicaid.

**Delegated Credentialing Requirements**
The following functions are required by the plan when delegating credentialing activities to a health care professional/provider:
- Services must be performed in accordance with the plan’s requirements and plan’s appointed accrediting organization’s standards.
- Notification of any material change in the health care professional/provider’s performance of delegated functions must be submitted to the plan.
- Plan may conduct surveys of health care professional/provider as needed.
- Health care professional/provider agrees to submit periodic/annual file audits conducted by the plan regarding the performance of its delegated responsibilities.
- Health care professional/provider agrees to submit to periodic file audits conducted by the plan's appointed accrediting organization.
• Recourse and/or sanctions will apply if the health care professional/provider does not make corrections to identified problems within a specified period.

• Health care professional/provider must obtain the plan’s written approval prior to further delegation of organizational functions.

• Should the health care professional/provider further delegate organizational functions, those functions shall be subject to the terms of the written delegation agreement between the health care professional/provider and the plan and in accordance with the plan’s appointed accrediting organization’s standards.

Disclosure of Ownership and Control Interest Statement

Initial Applications:
SCDHHS Form 1514 must be completed in accordance with its instructions. Credentialing staff will query on each reported owner listed on the 1514 form online via OIG, SAM and South Carolina Excluded Providers List to determine if any Medicare/Medicaid sanctions/exclusions exist. If a sanction exists for any listed owner, the credentialing process will be terminated and the Credentialing department will notify the Select Health Network Management department and the Managed Care Department at the South Carolina Department of Health and Human Services (SCDHHS).

The Network Management department obtains updated Ownership Disclosure information from network providers annually, based on OD Form signature date, (NM 159.205 Ownership Disclosure).

Re-credentialing Applications:
If Form 1514 is obtained during re-credentialing, staff will query each owner listed on the OD form online via OIG, SAM and South Carolina Excluded Providers List to determine if any Medicare/Medicaid sanctions/exclusions exist. If a sanction exists for any listed owner, the entity will be denied re-credentialing and the provider’s contract with Select Health will be terminated. The termination will be reported to the Credentialing Committee, Network Management department and the SCDHHS Managed Care department.

Prohibition on Payments to Excluded/Sanctioned Persons
Pursuant to section 1128A of the Social Security Act and 42 CFR 1001.1901, Select Health may not make payment to any person or an affiliate of a person who is debarred, suspended or otherwise excluded from participating in the Medicare, Medicaid or other federal health care programs.

A sanctioned person is defined as any person or affiliate of a person who is:
• (i) debarred, suspended or excluded from participation in Medicare, Medicaid, the State Children’s Health Insurance Program (SCHIP) or any other federal health care program;
• (ii) convicted of a criminal offense related to the delivery of items or services under the Medicare or Medicaid program; or
• (iii) had any disciplinary action taken against any professional license or certification held in any state or U.S. territory, including disciplinary action, board consent order, suspension, revocation or voluntary surrender of a license or certification.

Upon request of Select Health, a health care professional/provider will be required to furnish a written certification to Select Health that it does not have a prohibited relationship with an individual or entity that is known or should be known to be a sanctioned person.

A health care professional/provider is required to immediately notify Select Health upon knowledge that any of its contractors, employees, directors, officers
or owners has become a sanctioned person, or is under any type of investigation, which may result in their becoming a sanctioned person. In the event that a health care professional/provider cannot provide reasonably satisfactory assurance to Select Health that a sanctioned person will not receive payment from Select Health under the health care professional/provider agreement, Select Health may immediately terminate the health care professional/provider agreement. Select Health reserves the right to recover all amounts paid by Select Health for items or services furnished by a sanctioned person.

**Credentialing – Health Care Professional/Provider Rights**

Health care professionals/providers have the right to:

- Review information obtained through primary source verification for credentialing purposes. This includes information from malpractice insurance carriers and state licensing boards. This does not include information collected from references, recommendations and other peer review protected information.
- Be notified if any credentialing information is received that varies substantially from application information submitted by the health care professional/provider: e.g., actions on license, malpractice claim history, suspension or termination of hospital privileges, or board-certification decisions with the exception of references, recommendations or other peer-review protected information.
- The health care professional/provider will have the right to correct erroneous information if the credentialing information received varies substantially from the information that was submitted on his/her application.
- Upon request, be informed of the status of their application – if application is current and complete, the applicant can be informed of the tentative date that his/her application will be presented to the Credentialing Committee for approval.

**Provider Network Credentialing Appeals Process**

In the event a health care professional/provider is denied ongoing network participation or recredentialing as a Select Health health care professional/provider by the health plan based on an administrative reason or for quality of care reasons, the health care professional/provider is offered a process to appeal the determination. The appeal process described below will be communicated via certified mail to the health care professional/provider within five business days of the Credentialing Committee’s determination. The certified letter defines the reason for the denial and the health care professional/provider appeal rights. The health care professional/provider is instructed to file for reconsideration by submitting a written appeal, submitting additional information, as appropriate, within 30 days of the denial notification.

- The health care professional/provider is given written notice stating that the health care professional/provider has been denied recredentialing as a Select Health health care professional/provider and setting forth the reasons for the denial. The notice also states that the health care professional/provider has 30 calendar days from the date of the notice to request a hearing before Select Health’s Quality Assessment and Performance Improvement (QAPI) Committee to appeal the denial and shall contain a summary of the rights described below. The request for a hearing must be in writing and must state the relief sought by the health care professional/provider submitting the request.
- The QAPI Committee will consist of at least three qualified individuals, one of whom must be a participating health care professional/provider who is not otherwise involved in network management and is a clinical peer of the health care professional/provider filing the appeal. A clinical peer of the appealing health care professional/provider will be added if not otherwise represented within the QAPI Committee. The clinical peer health care professional/provider selected must not have been otherwise involved in any previous review of the case appealed.
- If a timely request for a hearing is made, Select Health shall give the health care professional/provider a second written notice stating the place, time and date of the hearing;
- The hearing shall be held before Select Health QAPI Committee. At the hearing, the health care professional/provider shall have the right to:
  - Appear in person and present evidence relevant to their case and may choose to be represented by legal counsel or another person of his/her choice.
  - Submit a written statement to the QAPI Committee at the close of the hearing.
- Within five business days following the hearing, the health care professional/provider will receive a
written decision of the QAPI Committee regarding the appeal (including a statement of the basis for the decision).

• A health care professional's/provider's right to a hearing shall be forfeited if the health care professional/provider fails, without good cause, to appear at the hearing.

• If the decision by the QAPI Committee to uphold the proposed action, the health care professional/provider has the right to seek arbitration as outlined in their health care professional/provider contract pursuant to section 15-48-10 ET SEQ. of the South Carolina Code of Laws (The South Carolina Uniform Arbitration Act) as modified in their signed contract with Select Health of South Carolina.

• In the event the health care professional/provider is terminated or scope of practice is limited by the plan, (for quality of care reasons) notification will be made to the proper agency/agencies. The adverse action will also be reported to SCDHHS' Program Integrity department and the program manager in the Managed Care Division. The plan will provide required notification to the proper agencies once the health care professional/provider has exhausted all appeal levels or once time frames for initiating appeal process have expired.

### Termination

Either party may terminate the provider agreement at any time by providing written notice as outlined in your contract of its intention to terminate the agreement to the other party (or other time set forth in the provider agreement). The effective date of termination will be on the first of the month following the expiration of the notice period. Termination of the agreement for any reason, including without limitation to the insolvency of the plan, shall not release the provider from his or her obligations to serve members when continuation of a member’s treatment is medically necessary. For specific details related to provider and plan obligations following termination and required member notice, consult the relevant section of the provider contract.

### Specialist Termination

When a specialty group’s contract with Select Health is terminated, it is the responsibility of Select Health as well as the specialty group to notify First Choice members affected by the termination prior to the effective date. Members who will be affected by the termination are those members who are receiving an active course of treatment from any of the specialists within the group. The specialty group must also provide continuation of care through the lesser of the current treatment or up to 90 calendar days for members undergoing active treatment for a chronic or acute medical condition. Providers must provide continuation of care through the postpartum period for members in their second or third trimester of pregnancy.

### Health Care Professional/Provider’s Bill of Rights

Each Select Health health care professional/provider shall be assured of the following rights:

- A health care professional, acting within the lawful scope of practice, shall not be prohibited from advising or advocating on behalf of a member who is his/her patient, for the following:
  - The member’s health status, medical care or treatment options, including any alternative treatment that may be self-administered.
  - Any information the member needs in order to decide among all relevant treatment options.
  - The risks, benefits and consequences of treatment or non-treatment.
  - The member’s right to participate in decisions regarding his/her health care, including the right to refuse treatment and to express preferences about future treatment decisions.
  - To receive information on the grievance, appeal and fair hearing procedures.
  - To have access to Select Health’s policies and procedures covering the authorization of services.
  - To be notified of any decision by Select Health to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested.
  - To challenge, on behalf of the First Choice members, the denial of coverage of, or payment for medical assistance.
  - Select Health’s health care professional/provider selection policies and procedures do not discriminate against particular health care professionals/providers that serve high-risk populations or specialize in conditions that require costly...
treatment.
• To be free from discrimination for the participation, reimbursement or indemnification of any health care professional/provider who is acting within the scope of his/her license or certification under applicable state law, solely on the basis of that license or certification.

NOTE: The provider shall not be prohibited or otherwise restricted from advising a Medicaid MCO member about the health status of the Medicaid MCO member or medical care or treatment for the Medicaid MCO member’s condition or disease, regardless of whether benefits for such care or treatment are provided under the MCO contract, if provider is acting within the lawful scope of practice.

Fraud and Abuse
Select Health receives state and federal funding for payment of services provided to our First Choice members. In accepting claims payment from Select Health, health care professionals/providers are receiving state and federal program funds and are therefore subject to all applicable federal and/or state laws and regulations relating to this program. Violations of these laws and regulations may be considered fraud or abuse against the Medicaid program. As a provider you are responsible to know and abide by all applicable state and federal regulations.

Select Health is dedicated to eradicating fraud and abuse from its programs and cooperates in fraud and abuse investigations conducted by state and/or federal agencies, including the Attorney General’s Office, the Federal Bureau of Investigation, the Drug Enforcement Administration, the HHS Office of Inspector General, as well as local authorities.

Examples of fraudulent/abusive activities:
• Billing for services not rendered or not medically necessary
• Submitting false information to obtain authorization to furnish services or items to Medicaid recipients
• Prescribing items or referring services which are not medically necessary
• Misrepresenting the services rendered
• Submitting a claim for health care professional/provider services on behalf of an individual that is unlicensed or has been excluded from participation in the Medicare and Medicaid programs
• Retaining Medicaid funds that were improperly paid
• Billing Medicaid recipients for covered services
• Failure to perform services required under a capitated contractual arrangement

Fraud and Abuse Contact Information
To report or refer suspected cases of fraud and abuse contact:
• Select Health’s Fraud and Abuse Hotline: 1.866.833.9718
• Mail: Special Investigations Unit 200 Stevens Drive Mail Stop 13A Philadelphia, PA 19113
• Or Select Health Compliance Hotline (secure and confidential 24 hours a day, 7 days a week): 1.800.575.0417

Providers may also report suspected fraud, waste and abuse to:
• South Carolina’s Division of Program Integrity Fraud and Abuse Hotline: 1.888.364.3224
• Fax: 1.803.255.8224
• Email: fraudres@scdhhs.gov
• Mail: SC Fraud Hotline Division of Program Integrity 1801 Main Street Columbia, SC 29202-3210

The agency opens a preliminary investigation on all suspected fraud and abuse complaints. Upon suspicion of fraud, the case is referred to the State Attorney General’s Office.

False Claims Act
The federal False Claims Act (FCA) was originally enacted in 1863 by a Congress concerned that suppliers of goods to the Union Army during the Civil War were defrauding the Army. The essence of the FCA is that any person who knowingly submits false claims to the government is liable for a multiple of the government’s damages, plus a penalty for each false claim. The key features of the FCA are as follows:

• Violations of the FCA are subject to penalties:
  • Treble damages - means that an original claim of $5 would be tripled to damages of $15, or three times the amount of damages.
$5,500 to $11,000 per violation (this is in addition to the treble damages).

The FCA contains a qui tam, whistleblower or relators provision to encourage private individuals to report misconduct involving false claims.

Qui tam provisions permit private individuals to investigate and file suit on behalf of the federal government for specific claims.

Qui tam relators are protected under the FCA from retaliation.

Allows rewards between 15-25 percent of the proceeds of the action or settlement if the government intervenes, or 25-30 percent of the proceeds of the action or settlement if the government does not intervene.

In 2009, the Fraud Enforcement and Recovery Act (FERA) was signed into law, which amended the FCA by imposing FCA liability for failure to report and return Medicaid and Medicare overpayments. Specifically, FERA provides that an FCA violation occurs when an entity “knowingly conceals or knowingly and improperly avoids an obligation to pay or transmit money or property to the government.” Therefore, knowingly and improperly failing to return an overpayment could form the basis of a FCA action against a provider. Overpayments must be reported and returned within sixty (60) days of discovery.

Federal Anti-Kickback Statute (AKS): makes it improper for anyone to solicit, receive, offer or pay remuneration (monetary or otherwise) in exchange for referring patients to receive certain services that are paid for by the government.

South Carolina Fraud and Abuse statutes:

- The South Carolina Presenting False Claims for Payment Statute (see S.C. Code Ann. § 38-55-170);
- South Carolina Medicaid False Claims Statute (see S.C. Code Ann. § 43-7-60);
- South Carolina Medicaid False Application Statute (see S.C. § 43-7-70);
- South Carolina Insurance Fraud and Reporting Immunity Act (see S.C. Code Ann. § 38-55-510 et seq.);
- South Carolina Computer Crime Act (see S.C. Code Ann. § 6-16-10 et seq.); and
- South Carolina DHHS Administrative Sanctions Against Medicaid Providers Act (see S.C. Code of Regulations R. 126-400 et seq.).

South Carolina Criminal False Claims Statute: Provides that any person, who knowingly causes, assists with, solicits, or conspires to present a false claim to an insurer, health maintenance organization or to any person (including the state of South Carolina) providing benefits for health care in South Carolina is guilty of:

- A felony if the claim is $10,000 or greater
  - If convicted, the person MUST be imprisoned not more than 10 years or fined not more than $5,000, OR BOTH
- A felony if the claim is more than $2,000, but less than $10,000
  - If convicted, the person MUST be fined in the discretion of the court, or imprisoned not more than 5 years, OR BOTH
- A misdemeanor if amount of claim is $2,000 or less
  - If convicted, the person MUST be fined not more than $1,000, or imprisoned not more than 30 days, OR BOTH


South Carolina Medicaid False Claims Statute:

- Provides criminal, civil, and administrative penalties and sanctions related to health care providers who knowingly and willfully cause or fail to make a false statement in an application or request for benefit, payment, or reimbursement or in any report or certificate submitted to the Medicaid program.
- Provides that it is unlawful for a provider to knowingly and willfully conceal or fail to disclose any material fact which affects the provider’s initial or continued entitlement to reimbursement or the amount of payment under the Medicaid program.
- Each false claim or concealed fact constitutes a separate offense and is a misdemeanor.

(See S.C. Code Ann. § 43-7-60)

- The misdemeanor is punishable by:
  - Imprisonment for up to 3 years
  - A fine of not more than $1,000 per offense
- Attorney general may bring civil action to:
  - Recover treble damages and
  - Seek penalties of up to $2,000 per false claim
• State Agency administering Medicaid program may impose administrative sanctions against a Medicaid provider who has been determined to have abused the Medicaid Program

Culturally and Linguistically Appropriate Services (CLAS)
Select Health has adopted the national standards for Culturally and Linguistically Appropriate Services (CLAS) as issued by the U.S. Department of Health and Human Services’ Office of Minority Health. As a health plan focusing on the Medicaid population, we have an uncommon appreciation for the need to provide culturally and linguistically appropriate services for our members. As part of our commitment to diversity, Select Health has established comprehensive policies and procedures, including a written Cultural Competency Plan, to ensure that members are served in the way that is responsive to their cultural or language needs.

This commitment to diversity may require information from our health care professionals/providers as directed by Title VI of the Civil Rights Act of 1964 (65 Fed. Reg. 52762-52774, Aug. 30, 2000). At regular intervals, the Network Management staff will remind health care professionals/providers about the importance of cultural competence, effective communication with Limited English Proficiency (LEP) members and health care professionals/providers’ responsibility for implementing appropriate measures that would ensure that languages, environment or other sensory barriers that could exclude, deny, delay or prevent timely delivery of health care or social services be removed.

Advances in Medicine
When new medical treatment becomes available, Select Health follows the recommendations that are made by South Carolina’s Department of Health and Human Services (SCDHHS) to cover a new procedure or treatment. Prior to making a decision the doctors at SCDHHS review all clinical and scientific facts available with the risks and benefits for the new procedure. Select Health will refer requests for new medical treatment not routinely covered to SCDHHS for determination of Medicaid coverage.

Preferred Bariatric Surgery Centers
As part of the quality assurance process, a list of preferred bariatric surgery centers has been established. Our preferred bariatric centers share these characteristics:

• Excellent infrastructure
  • Hospital systems (medical and surgical specialties)
  • Program components (pre-and post-surgery)
• Extensive experience
  • Surgeon experience and training
  • Surgical team longevity and stability
• Superior quality
  • Volume
  • Outcome data
• Participation in the American College of Surgeons Center of Excellence program

Our preferred bariatric surgery centers include:
• Hillcrest Memorial Hospital
• Medical University of South Carolina
• Palmetto Health Baptist (Columbia)
• Lexington Medical Center
• Spartanburg Regional Medical Center
• Summerville Medical Center
• Conway Medical Center (sleeve gastrectomy and lapband surgery only)

Medical Management Department
Utilization Management Program
The Select Health Utilization Management (UM) program establishes a process for implementing and maintaining an effective, efficient utilization management system within the scope of the Quality Improvement Program. UM activities are designed to assist the health care professional/provider in the organization and delivery of appropriate healthcare resources to members over the course of the member’s illness within the structure of their benefit plan. The primary goal of all utilization management functions is to collaborate with health care professionals/providers, members and others involved in health care delivery, to provide quality, cost effective health care in the most appropriate
setting for the intensity of services required.

- UM staff is composed of licensed or registered nurses and triage technicians.
- Determinations of approval or denial of coverage for services is based on medical necessity, eligibility for outpatient and inpatient services and benefit guidelines.
- UM decision making is based only on the appropriateness of care and services and existence of coverage. Select Health does not reward health care professionals/providers or other individuals conducting utilization review for issuing denials of coverage or services. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

The UM program utilizes criteria based on sound clinical evidence to make determinations to approve or deny coverage of services. Select Health has approved the following criteria to evaluate requests for services:

- Licensed InterQual criteria
- South Carolina State Medicaid Healthcare Guidelines
- Select Health internally developed criteria and policies

The criteria used in making a UM determination can be provided upon request to Select Health participating practitioners, providers and/or members.

**Adverse Determinations**

In situations where available clinical information does not support medical necessity or appropriateness by criteria approved by Select Health, the request for services will be reviewed by Select Health’s medical director. During the review process, the medical director may elect to discuss or consult with an external board certified same specialty physician from an NCQA certified independent review organization. The medical director, utilizing the plan’s criteria, his/her medical expertise and external resources determines if the request for payment of services will be approved or denied.

All adverse determinations are communicated in writing to the member and requesting health care professional/provider. This communication provides clear reasons for denial and appeal process information. The requesting health care professional/provider may contact Select Health and request a copy of the criteria used in rendering the final determination. Additionally, plan medical directors are available to discuss medical necessity determinations with the requesting health care professional/provider. Health care professionals/providers may contact Medical Management to request a peer-to-peer discussion.

**Medical Record Review Standards**

It is the policy of Select Health to set standards for the maintenance and content of patient records to ensure complete and consistent documentation. Medical records are an important source of patient information vital to the assessment of quality medical care. These standards are based on the requirements of National Committee for Quality Assurance (NCQA) and the South Carolina Department of Health and Human Services (SCDHHS) and may be revised as needed to conform to new NCQA or SCDHHS requirements.

Compliance with these standards will be audited by periodic review and chart samplings of the participating primary care offices. Health care professionals/providers must achieve an average score of 90% or higher on the medical records review. Select Health will assist health care professionals/providers scoring less than 90 percent through corrective action plans and re-evaluation.

**Medical Record Documentation Standards**

Select Health has adopted the following medical record-keeping standards to ensure complete and consistent documentation of patient medical records which are vital to quality patient care. In order to assess compliance, Select Health monitors PCP sites for adherence annually.

In addition to the following medical record documentation standards, Select Health reviews the overall PCP office site to ensure the confidentiality of patient medical records by maintaining records in a secure area that is only accessible to health care professional/provider’s office staff.

1. The member’s medical record is kept in a separate file, all papers are fastened together and located in a secure confidential area.
2. Member record contains a page or form which includes the patient’s name, Medicaid ID number, date of birth, sex, address, phone number, employer and next of kin, sponsor or responsible
party.
3. The member record will show the date of the first patient exam made through, or by the MCO.
4. Medical record contains the following for each visit:
   a. Date
   b. Purpose of visit
   c. Diagnosis or medical impression
   d. Objective findings
   e. Assessment of patient's findings
   f. Plan of treatment, diagnostic tests, therapies and other prescribed regimens
   g. Medications
   h. Health education
   i. Signature and title or initials of each provider that documents in the medical record
   j. Services, dates of service, service site, and name of provider for services provided through the MCO.
5. The record is legible by someone other than the writer. A second surveyor examines any record judged to be illegible by one surveyor.
   a. Content of record is presented in a standard format that allows a reader other than the author to review without the use of a separate legend/key.
6. Each page in the record contains the patient's name or ID number.
7. All entries, including each office or telephone encounter is clearly dated and initialed or signed by the service provider or author.
   a. If more than one person documents in the medical record, there must be a record on file as what is represented by which initials.
   b. All entries and or updates to the record are dated.
   c. All entries are initialed or signed by the author. Electronic medical records indicate authors by initials or automated system generated names. This applies to health care professional/providers and members of their office staff who contribute to the records.
   d. When initials are used there is a designation of signatures and status maintained in the office.
   e. Documentation of medical encounters must be in the record within 72 hours or three business days of the occurrence.
8. Allergies and adverse reactions are prominently listed. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record as “NKA” or “None”.
   a. A record of allergies or the statement “no known allergies” or NKA should be clearly found at a standard place on the chart (e.g. on the cover of the chart, on the first page of the chart, on a medication list or the problem list). There should be an inquiry about allergies on the first visit.
9. Past medical history is listed, includes operations, treatment and therapy prescribed and any medications administered or dispensed. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses.
   a. Initial history and physical exam for new patients are recorded within 12 months of the patient first seeking care or within three visits, whichever comes first. If applicable, there is written evidence that the health care professional/provider advised the patient to return for a physical exam.
10. A current Problem List is in the chart, identifying health related conditions.
   a. Each patient record includes a Problem List, documenting any health related conditions or chronic conditions requiring ongoing monitoring and treatment. (N/A if patient has no chronic condition.)
11. Current medications are documented in the record and notes reflect that long-term medications are reviewed at least annually by the health care professional/provider and updated as needed.
   a. Information regarding current medication is readily apparent from review of the record.
   b. Changes to medication regimen are noted as they occur. When medications appear to remain unchanged, the record includes documentation of at least annual review by the health care professional/provider.
12. There is evidence that preventive screening and services are offered in accordance with Select Health practice guidelines.
   a. Each patient record includes documentation
that preventive services were ordered and performed, or that the health care professional/provider discussed preventive services with the patient and the patient chose to defer or refuse them. Health care professional/providers may document that a patient sought preventive services from another health care professional/provider (e.g. GYN).

13. Patient’s chief complaint or purpose for visit is clearly documented.
   a. A patient’s chief complaint or purpose for a visit as stated by the patient is recorded. The documentation supports that the patient’s perceived needs/expectations were addressed.
   b. Telephone encounters relevant to medical issues are documented in the medical record and reflect health care professional/provider review.

14. Clinical/physical assessment and/or objective findings are recorded.
   a. Clinical/Physical assessment and objective findings are documented and correspond to the patient’s chief complaint, purpose for seeking care and/or ongoing care for chronic illnesses.

15. Working diagnoses or medical impressions that logically follow from the clinical/physical examination are recorded.

16. Treatment plans, diagnostic tests, therapies, laboratory tests, medications and other prescribed regimes are clearly documented for each visit and follow previously documented diagnoses and medical impressions.

17. Plan of action/treatment are consistent with diagnosis.
   a. Rationale for treatment decisions appears medically appropriate and substantiated by documentation in the record.
   b. Laboratory tests are performed at appropriate intervals.

18. Follow-up instructions and time frame for follow-up or next visit are recorded as appropriate.
   a. Return to office in a specific amount of time is recorded at the time of visit, or as follow-up to consultation, laboratory or other diagnostic reports.
   b. Patient involvement in the coordination of care is demonstrated through patient education, follow up and return visits.

19. Relevant hospital discharge summaries are included with the medical record.
   a. If the patient has been hospitalized a discharge summary from the facility is included in the chart.
   b. The discharge summary should include the reason for admission, the treatment provided and the instructions given to the patient on discharge.
   c. The discharge summary should be initialed or signed by the health care professional/provider to indicate the health care professional/provider’s review.
   d. If the patient has not yet been discharged or only discharged within the previous two weeks, the review should indicate a N/A.

20. If a consultation is requested there is a note from the consultant in the record. Consult reports reflect health care professional/provider’s review with initials or signature.
   a. If a consult has been ordered by the health care professional/provider, a report from the consulting provider has been placed in the record.
   b. The report should be initialed or signed by the health care professional/provider to indicate the health care professional/provider’s review of the results of the consult or noted in the electronic medical record. If the request is less than three weeks old, reviewer should indicate a N/A.

21. Documentation of referrals and results from specialists.
   a. Each member record has documentation of referrals and results from each specialist.

22. Diagnostic and laboratory reports reflect health care professional/provider’s review with initials or signature.
   a. Results of all diagnostic and laboratory reports are documented in the medical record.
   b. Records demonstrate that the health care professional/provider reviews diagnostic and laboratory reports and makes treatment decisions based on report findings. Reports with the review are initialed and dated by the health care professional/providers or another
system ensuring health care professional/provider review is in place. Electronic medical records indicate health care professional/provider’s review by initials or automated system generated names.

23. For patients 12 years and older, there is appropriate notation concerning the use of cigarettes, alcohol, and substances.
   a. The health care professional/provider must have documentation in the record regarding smoking habits and history of alcohol use and substance abuse for patients 12 years of age and older.

24. Discussion of a living will or Advance Directives, as appropriate.
   a. A note regarding discussing a living will or other advance directives should be present in the medical record, if appropriate*

* Defined as patients who are terminally ill or those with a serious chronic illness. Terminally ill may be defined as advanced stages of cancer, Alzheimer’s Disease, severe stroke, heart disease, lung disease, renal failure, or other fatal illnesses, all of which have a very limited prognosis. A serious chronic condition causes suffering and/or disability every day that will worsen over time and eventually cause death.

25. Documentation in record of after-hour services to include: emergency care, after-hour encounters, follow-up.
   a. Health care professional/providers must document any after hour services and/or telephone encounters with the patient into the permanent record. Emergency encounters should also be documented either in the form of the hospital emergency room record or a signed and dated notation as to when the patient was seen in the ER, the diagnosis and any recommendation.

26. Signed and dated consent forms, if applicable.
   a. Practitioners must have on file signed and dated consent forms by members.

Medical Record Retention

Select Health health care professionals/providers are required to comply with all medical record retention statutes in accordance with state and federal law.

The South Carolina statute currently requires record retention for a period of 10 years for adults and 13 years for children after last documented visit.

All Select Health members’ medical records are to be maintained by physicians for a period not less than five years from the expiration date of the contract with Select Health, including any contract extensions and retained further if the records are under review or audit until the review or audit is complete. Said records are to be made available for fiscal audit, medical audit, medical review, utilization review and other periodic monitoring upon request of an authorized representative of South Carolina Department of Health and Human Services (SCDHHS). Prior approval for the disposition of records must be requested from SCDHHS.

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

Referral and Authorization for Specialists, Hospitals and Ancillary Health Care Professionals/Providers

Participating Specialty Care Health Care Professionals/Providers

Select Health encourages members to seek referral from their primary care provider (PCP) for specialty care when such care is necessary. Prior authorization from Select Health is not required for participating plan specialists for office visits. Some services offered at the participating specialist’s office may require prior authorization. Participating specialists are advised to contact Medical Management prior to delivering a service if in doubt. For coordination and continuity of care, the specialty care physician is strongly urged to communicate all findings and any needs for follow-up care back to the PCP via a consultation record.

Specialty Care Access Standards:

Specialty providers must adhere to the following access standards:

- Emergent visits immediately upon referral
- Urgent medical condition care appointments within forty-eight (48) hours of referral or notification of the Primary Care Physician.
• Scheduling of appointments for routine care (non-symptomatic) within four weeks and a maximum of twelve (12) weeks for unique specialists.

**Non-Participating Health Care Professionals/Providers**

PCPs and plan participating specialists may refer members to a non-participating plan specialist if there is not a participating specialist in a particular field. However, plan health care professionals/providers who want to refer members to any non-participating health care professional/provider must contact Select Health's Medical Management department for prior authorization.

**Services That Require Prior Authorization**

Prior authorization is required of certain services as indicated below. This is inclusive of secondary coverage.

- Advanced outpatient imaging – nuclear cardiology, CTA, CCTA, CT, MRI, MRA, MPI*
- Air ambulance (retrospectively reviewed)
- Behavioral health (psychological and neuropsychological testing; electroconvulsive therapy; environmental intervention; interpretation or explanation of results; unlisted psychiatric services and inpatient services)
- Capsule Endoscopy
- Cardiac rehabilitation
- Chiropractic (all services)
- Circumcision (unless prior to delivery discharge)
- Contact lenses, including dispensing fee
- DAODAS services (bundled services and some discrete services)
- Durable medical equipment, DME (billed charges $500 and over, total per item; includes prosthetics and orthotics)
- Durable medical equipment leases and rentals
- Enteral nutritional supplements and supplies
- Holter monitors (event recorder monitors)
- Home health care (required after first 6 visits)
- Home infusions (including injections $250 and greater; if medication is approved so is the administration)
- Hysterectomy (Hysterectomy Consent Form is required)
- Insulin pumps
- Inpatient admission (including back transfers)
- Magnetoencephalography (MEG)
- Non-participating health care professional/provider (all services including urgent care and office-based laboratory)
- Certain medications (infusions/injectibles chemotherapy, PO and IV, Vitraset, Synagis) – Refer to PDL
- Outpatient maternity/OB services
  - Obstetrical outpatient services, admissions, observations, diabetic education and abnormal newborn deliveries
  - Services rendered by specialists for obstetrical patients (i.e. maternal fetal medicine, endocrinologist, cardiologist, etc.)
- Outpatient Surgical Services
  - Ablation
  - Blepharoplasty
  - Chemodenervation
  - Cochlear implants (insertion and programming)
  - Gastric bypass
  - Vertical band gastroplasty
  - Implants
  - Mastectomy for gynecomastia
  - Mastopexy
  - Maxillofacial
  - Paniculectomy
  - Penile prosthesis
  - Plastic surgery/cosmetic dermatology
  - Reduction mammoplasty
  - Septoplasty (except submucous resection, with/without cartilage scoring)
- Pain management services (external infusion pumps, implantable infusion pumps, spinal cord neurostimulators, radiofrequency ablation and nerve blocks)
- PET scans (limited to 2 per year)
- Plastic surgery/cosmetic dermatology
- Therapy services: physical and occupational therapies (evaluation, re-evaluation and first 48 units do not require prior authorization, per discipline)
- Therapy, services: speech therapy
  - Private therapy: authorization required for all services after initial evaluation or re-evaluation.
  - Facility-based therapy: evaluation, re-evaluation and first 48 units do not require prior authorization.
• Transplants (complete corneal transplant services, pre-transplant services provided prior to 72 hours of actual transplant and post-transplant services)
• Therapeutic abortions (clinical documentation and abortion statement required)
• Thoracolumbosacral orthosis (TLSOs – back braces)
• Unlisted and Category III codes
• Unlisted/miscellaneous DME items (regardless of cost)
• Unlisted surgical procedures
• Wheelchair parts (manual and power)

* Advanced outpatient imaging – Authorizations administered by NIA (see Advanced Outpatient Imaging in the First Choice Covered Services section of this manual for more information).

When services requiring prior authorization are necessary for a member, the health care professional/provider should contact Select Health Medical Management toll free at 1.888.559.1010 or 843.764.1988 in Charleston.

A copy of the prior authorization grid may be obtained from the Exhibits section of this manual or from the Select Health website: www.selecthealthofsc.com.

Providers may not bill members for services which require prior authorization and the authorization was not obtained, resulting in denial of the claim. The provider is responsible for obtaining prior authorization.

This list shows the majority of services that require prior authorization but is not all inclusive. Providers should contact Medical Management when in doubt about prior authorization requirements.

Authorization is not a guarantee of payment; other limitations or requirements may apply.

Services That DO NOT Require Authorization
• Emergency ground transport – ALS, BLS
• Emergency room services
• In-network eyeglasses, including refraction and fitting fee
• In-network gynecological and specialty physician office visits
• Observation
• Sterilizations (Consent for Sterilization form is required)
• X-rays

Services That Require Notification
• Crisis intervention (behavioral health)
• Maternity observation
• Normal newborn deliveries

Clinical Guidelines
Select Health of South Carolina and the AmeriHealth Caritas Family of Companies (ACFC) have established a Clinical Policy Committee (CPC) to develop local and corporate medical guidelines. Guidelines developed by the CPC are incorporated into the workflow of the Utilization Management, Claims Payment and Network Operations departments for consistency in approach to issues addressed through the CPC.

Clinical guidelines are based upon guidelines from established industry sources such as Centers for Medicare and Medicaid (CMS), the Agency for Healthcare Research and Quality (AHRQ), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies and peer-reviewed professional literature. These clinical guidelines, along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state or plan specific definition of medically necessary, and the specific facts of the particular situation are considered by Select Health when making coverage determinations. In the event of conflict between clinical guidelines and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements will control.

Select Health clinical guidelines are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. Select Health clinical guidelines are reflective of evidence-based medicine at the time of review. As medical science evolves, Select Health will update its clinical guidelines as necessary. Select Health clinical guidelines are not guarantees of payment. Guidelines developed through the CPC are reviewed by local, plan-specific medical directors, presented to the Quality Clinical Care Committee (QCCC) and are voted upon by the Quality Assessment Performance and Improvement (QAPI) Committee. Once approved, guidelines will be placed
Ancillary Services

Ancillary health services are services provided to patients to aid in the diagnosis or treatment of an illness or injury. They may be either diagnostic or therapeutic in nature.

Examples of diagnostic ancillary health services include: laboratory services, radiology, magnetic resonance imaging (MRI), etc.

Examples of therapeutic ancillary health services include: durable medical equipment, home health-care, home infusion therapy, physical therapy, specialty pharmacy services, speech therapy, surgical centers, transplant services, etc.

Authorization for Ancillary Services

1. Identify the patient as First Choice member
2. Request prior authorization number from First Choice Medical Management department
3. Record the prior authorization number in your system so that it will appear in box 23 on CMS 1500.

Call Select Health at 1.888.559.1010 or 843.764.1988 (Charleston area) if you need assistance.

Children’s Rehabilitative Services and Baby Net

Children’s Rehabilitative Services (CRS) and Baby Net are Medicaid-sponsored programs for children with a chronic illness or disability. Children may be members of First Choice and CRS or Baby Net.

CRS is responsible for requesting prior authorization from Select Health’s Medical Management department for the following covered services:

- Orthotics
- Prosthetics
- DME items provided through CRS clinics
- Family Support Services

Durable Medical Equipment

Any needs for durable medical equipment (DME) exceeding charges of $500 are coordinated and authorized through Select Health’s Medical Affairs department. For plan members who are hospitalized, the Select Health Clinical Coordinator will coordinate these services with the requesting physician and discharge planner prior to discharge.

Home Health Care/Family Support Services

Home health care provided to homebound members requires prior authorization from the Select Health Medical Affairs department. The home health authorization includes physical, occupational and speech home visits; a separate authorization is not required for these services. Members are limited to 50 visits per fiscal year for home health care services. Home social work services received from Family Support Services (FSS) do not apply to the 50-visit limitation. Home health care services must be ordered by a physician as part of a written plan of care. The ordering health care professional/provider must review and sign the Select Health plan of care at least every 60 days. The objectives of the Select Health plan of care should be to improve the member’s level of health, relieve pain and to prevent regression of member’s stable condition. The Select Health plan of care should restrict such care to the minimum number of visits necessary to meet these objectives. The care must be appropriate to the home setting and to the patient’s needs. The Select Health plan of care should have documented goals, needs and care rendered, identifying the treatment to be rendered: services, supplies, items or personnel needed by the patient and expected outcome.

Select Health utilizes the FSS clinical indicators as the review tool for authorizing FSS services.

Home Infusion/Specialty Pharmacy

Contact Select Health’s Medical Affairs department to coordinate Home Infusion Therapy/Services.

Speech, Physical and Occupational Therapies

Select Health provides benefits for home-based and outpatient therapy services for members. Prior authorization from Select Health’s Medical Affairs department is required for therapy services. Members must be eligible for home-based services.
per established homebound criteria prior to receiving therapy services in a home setting.

Outpatient therapy services provided to First Choice members by a private rehabilitation therapy clinic/health care professional/provider are also a covered benefit for all members.

## Behavioral Health Under First Choice

The professional and outpatient facility charges associated with Medicaid covered behavioral health services are included in Select Health’s covered responsibilities. Select Health will reimburse health care professionals/providers for most outpatient behavioral health services without prior authorization. Outpatient services that will require prior authorization are:

- Psychological and neuropsychological testing: 96101, 96118
- Electroconvulsive therapy: 90870
- Environmental intervention: 90882
- Interpretation or explanation of results: 90887
- Unlisted psychiatric service or procedure: 90889

### Notes:

- For these services, nurse practitioners are included as allowed provider types.
- Behavioral Health providers must adhere to the following access standards for First Choice members:
  - Non-life threatening emergency care: within 6 hours
  - Urgent care: within 48 hours
  - Routine care: appointment within 10 business days

In cases where the Department of Alcohol and Other Drug Abuse Services or the Department of Mental Health submit laboratory claims (under Provider Type 80 Independent Lab), Select Health 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 Select Health.

Medical services rendered to patients admitted with a psychiatric diagnosis are the responsibility of Select Health. We will be responsible for Medicaid covered inpatient Behavioral Health Services (DRGs 424-433 and 521-523). Professional charges and all anesthesia services associated with behavioral health will also be covered by Select Health. Medical services (physician services that are not mental health treatment services) provided by a psychiatrist or child psychiatrist are also covered by Select Health.

There are specific forms that will need to be completed for the different behavioral health services. These forms are available in the Exhibits section of this manual, on the Select Health website at www.selecthealthofsc.com or by contacting the Behavioral Health department and requesting they fax the necessary forms. For questions regarding prior authorization requirements or to obtain authorization, contact Select Health Behavioral Health at 1.866.341.8765.

Select Health will continue to 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 health care professionals/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.

### PSYCHOTHERAPY SUPERVISION GUIDELINES

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.

These guidelines pertain to services delivered by Licensed Master Social Workers (LMSW) under the supervision and direction of a physician or NP.

Services rendered by Licensed Independent Counselor Interns (LPC/I), Licensed Marriage and Family Therapist Interns (LMFT/S) and Licensed Independent Social Work applicants under the supervision of a licensed psychologist, licensed professional counselor supervisors, marriage and family therapist supervisors and licensed independent social work-clinical practice supervisors must also adhere to these guidelines.

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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 or other supervising behavioral health clinician 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 Select Health; therefore, the beneficiary must have been seen by the physician/NP.

- A psychiatric diagnostic evaluation has to be performed by the supervising clinician. The allied professional providing psychotherapy personally works with the beneficiary to develop the Individualized Plan of Care (IPOC) and the supervising clinician meets with the beneficiary periodically during the course of 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:

Select Health of SC
Behavioral Health Department
P O Box 40849
Charleston, SC 29423

**LICENSED INDEPENDENT PRACTITIONERS (LIPs)**

The Behavioral Health benefit includes services rendered by licensed independent practitioners:

- Licensed Psychologist
- Licensed Psycho-Educational Specialists (LPES)
- Licensed Independent Social Worker-Clinical Practice (LISW-CP)
- Licensed Marriage and Family Therapists (LMFT)
- Licensed Professional Counselors (LPC).

**Emergency/Urgent Care Services**

Members are encouraged to utilize the closest emergency room in the event of a life-threatening illness/condition. In other cases, members are encouraged to contact their primary care provider or the Nurse Help Line prior to the use of an emergency room or urgent care facility.

Coverage of emergency room services is reimbursed at the appropriate level based upon claims examination. Prior authorization is not required.

**Hysterectomy**

Reimbursement for a hysterectomy is not allowed if the hysterectomy is performed solely for the purpose of rendering an individual permanently incapable of reproducing. Requests for coverage of hysterectomy procedures require prior authorization. The member’s medical records, Surgical Justification for Hysterectomy form and the federally mandated Consent for Sterilization form signed by the member are to be provided to Select Health’s Medical Affairs department prior to performing the procedure. The Consent for Sterilization form may be obtained from the Exhibits section of this manual or the Select Health website, www.selecthealthofsc.com.
There is a 30-calendar-day waiting period from the date the consent form is signed before the surgery is performed. InterQual criteria will be used for screening prior authorization requests.

For urgent and emergent hysterectomy cases (including oophorectomy), the 30-day wait is not required; however, the reason for the procedure must be provided by the physician. The claim will be reviewed retrospectively.

Non-elective, medically necessary hysterectomies must meet the following requirements:

1. The individual or her representative must be informed orally and in writing that the hysterectomy will render the individual permanently incapable of reproducing.
2. The individual or her representative must sign and date the Consent for Sterilization form prior to the hysterectomy.
3. The Consent for Sterilization form is not required if the individual was already sterile before the hysterectomy or if the individual required a hysterectomy because of a life threatening emergency situation in which the physician determined that prior acknowledgment was not possible. In these circumstances, a physician statement is required. The statement must indicate the cause of the sterility or the diagnosis and description of the nature of the emergency. **Please note: medical records may not be substituted for the physician statement.**
4. Hysterectomy shall not be covered if performed solely for the purpose of rendering an individual permanently incapable of reproducing.
5. Hysterectomy shall 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.

**Inpatient Admissions/Outpatient Admissions or Procedures**

Inpatient admissions and certain outpatient procedures must receive prior authorization from Select Health’s Medical Affairs department. The ordering provider or specialist should contact Medical Affairs prior to the scheduled admission/procedure to confirm eligibility and secure an authorization. It is recommended that hospitals call Medical Affairs when members are presenting for elective/outpatient services that require prior authorization to confirm authorization and/or member eligibility.

Medical Affairs staff will collect appropriate medical information to substantiate medical necessity for the requested service. Clinical protocols recommended by InterQual will be utilized in the evaluation of the received clinical information to determine the appropriateness of the requested services. Medical Affairs staff members may consult with the medical director as needed.

Authorization determinations are based upon medical necessity, member eligibility and benefit coverage. The turn-around times for this procedure are monitored and reported by Select Health on a regular basis. Decisions for prior authorization requests are made as expeditiously as the member’s health requires, not to exceed the following timeframes:

- Non-urgent preservice decisions are made within 14 calendar days of receiving the request.
- Urgent preservice decisions are made no later than three calendar days after the receipt of the request. (Urgent refers to any case where an expedited decision is necessary to preserve the life or health of the member or the member’s ability to attain, maintain or regain maximum function.)

If the request is approved, an authorization number with approval notification will be provided to the requesting health care professional/provider by telephone, fax or voice mail. Written approval of an authorization is provided only upon request.

All emergent/urgent inpatient admissions should be reported to Medical Affairs by the next business day following admission. The Medical Management department will evaluate the clinical information according to InterQual Criteria and either approve the case for admission and certify the number of inpatient days or refer the case to the medical director for review. Determinations for urgent inpatient reviews will be made within 24 hours or one (1) calendar day of receipt of the request. Concurrent review determinations will be made within 24–72 hours, depending on the expiration of the certified concurrent period.

**Administrative Days**

Select Health covers **administrative days** for Medicaid-eligible patients who no longer require acute hospital
care but are in need of nursing home placement that is not available at the time. Payment for administrative days will be made at a per diem rate that includes drugs and supplies. The per diem rate is recalculated each October. For more information on submitting administrative day claims, consult the Claims Filing Manual located on the Select Health website, www.selecthealthofsc.com.

### Sterilization

Sterilization procedures do not require prior authorization. However, claims must be submitted via hard-copy with the Consent for Sterilization form, which can be obtained from the Exhibits section of this manual or the Select Health website.

Sterilization claims and consent forms are reviewed for compliance with federal regulation (42 CFR 441.250 – 441.259). It is the physician’s responsibility to obtain the consent and submit this form.

Sterilization requirements:

1. Sterilization is defined as any medical procedure, treatment or operation done for the purpose of rendering an individual permanently incapable of reproducing.

2. The individual to be sterilized must give informed consent not less than 30 full calendar days (or not less than 72 hours in the case of premature delivery or emergency abdominal surgery) but not more than 180 calendar days before the date of the sterilization. A new consent form is required if 180 days have passed before the surgery is provided.

3. The consent for sterilization cannot be obtained while the patient is in the hospital for labor, childbirth, abortion or under the influence of alcohol or other substances that affect their state of awareness.

4. The individual to be sterilized must be at least 21 years old and mentally competent at the time consent is obtained.

5. The individual to be sterilized must not be institutionalized (i.e., not involuntarily confined or detained under a civil or criminal status in a correctional or rehabilitative facility or confined in a mental hospital or other facility for the care and treatment of mental illness, whether voluntarily or involuntarily committed).

6. The individual must give informed voluntary consent on the approved Consent for Sterilization form. 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.

7. The Consent for Sterilization form is not required if the individual was already sterile before the procedure or if the individual required sterilization because of a life threatening emergency situation in which the physician determined that prior acknowledgment was not possible. In these circumstances, a physician statement is required. The statement must indicate the cause of the sterility or the diagnosis and description of the nature of the emergency. **Please note: medical records may not be substituted for the physician statement.**

8. Although hospitals are not required to submit a sterilization consent form with their claim, payment will be recouped if no such documentation is present in Select Health’s records or if the documentation is inaccurate. Hospital providers will be notified in writing and given 30 days to submit the consent form before a recoupment is made.

### Telemedicine Services

First Choice covers telemedicine services for providers who are currently enrolled with the South Carolina Healthy Connections Medicaid program and bill for telemedicine and telepsychiatry when the service is within the scope of their practice. The communication system must be HIPAA compliant.

Covered services include consultation, office visits, individual psychotherapy, pharmacologic management and psychiatric diagnostic interview examinations and testing, delivered via a telecommunication system. Only a licensed physician and/or nurse practitioner may provide telepsychiatry services. For more information on submitting claims for telemedicine services, consult the Claims Filing Manual located on the Select Health website.

### Therapeutic and Non-elective
Abortion

Therapeutic Abortions

Therapeutic abortions and services associated with the abortion procedure are covered only when the physician has found, and certified in writing, that on the basis of his or her professional judgment, the pregnancy is a result of rape or incest or the women 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 women in danger of death unless an abortion is performed.

Therapeutic abortions must be documented with a completed Abortion Statement Form (see Exhibit section), which will satisfy federal and state regulations.

The following guidelines are to be used in reporting therapeutic abortions:

1. ONLY diagnosis codes in the 635 (ICD-9) or 004, 007 (ICD-10) range should be used to report therapeutic abortions.
2. Abortions that are reported with diagnosis and procedure codes for therapeutic abortions must be accompanied by complete medical records that substantiate life endangerment to the mother or that the pregnancy is the result of rape or incest and the signed abortion statement.
3. Therapeutic abortion is NOT considered family planning, and is covered only under certain circumstances.
4. 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.
5. Prior authorization is required, clinical documentation, a copy of the completed abortion statement and a copy of the police report, if applicable, must be submitted to Select Health’s Medical Affairs department prior to performing the procedure.

Non-elective Abortions

All non-elective abortions including spontaneous, missed, incomplete, septic, hydatidiform mole, etc., require only that the medical record show such a diagnosis. If unable to determine whether the patient was in the process of an abortion from the hospital records, Select Health will ask the hospital to obtain additional physician office or clinic notes and/or ultrasound reports. Medical procedures necessary to care for a patient with ectopic pregnancy are compensable services.

The following guidelines are to be used in reporting non-elective abortions:

1. Spontaneous, inevitable or missed abortions should be reported with the appropriate other diagnosis codes (e.g., 630 ICD-9; 0010, 0011 and 0019 ICD-10; 631.0 ICD-9; 00281 ICD-10; 632 ICD-9; 0021 ICD-10; 634.00 ICD-9; 0035 and 00387 ICD-10; 636.00 ICD-9; 0045 ICD-10 and 637.00 ICD-9; 0045 ICD-10. This list is not all inclusive; determination of the appropriate ICD-10 code should be based upon clinical interpretation).
2. Non-elective abortion procedure codes for outpatient hospital are 59812, 59820, 59821, 59830, 59870 and 59200. For inpatient hospital, ICD-9 CM surgical procedure codes are 68.0, 69.02, 69.52, 69.93 and 96.49. These codes will need to be converted to the appropriate ICD-10-PCS code based upon clinical interpretation in order to determine the most appropriate conversion code(s) for the specific situation. These procedure codes should be used for spontaneous, incomplete, inevitable, missed, septic, hydatidiform mole or other non-elective abortions with appropriate diagnosis code.

Billing Notes

1. Vaginal delivery codes should not be used to report an abortion procedure. The only exception to this rule is when the physician delivers the fetus, the gestation is questionable and there is probability of survival. The medical record must contain documented evidence that the fetus was delivered by the physician.
2. When billing for any type of abortion, the principal procedure code must be the abortion.
3. Legible medical records should be included with all abortions and should include admission history and physical, discharge summary, pathology report, operative report, physician progress notes, etc.
4. The following diagnosis codes do not require the submission of supporting documentation: 630 ICD-9; 0010, 0011 and 0019 ICD-10; 631.0 ICD-9; 00281 ICD-10; 632 ICD-9; 0021 ICD-10;
Well-Woman Exam

Prior authorization is not required for an annual well-woman exam when performed by a participating provider.

If you detect a health problem during a well-woman exam, do not change the coding from a well exam to a sick visit. When billing, use V72.3X 3X ICD-9; Z01411, Z01419 ICD-10 as the first diagnosis. The second diagnosis is determined by the detected problem. If the well-woman exam can be completed, bill the well exam E/M code with modifier 25 and list any additional services. Do NOT bill another office visit on the same date of service.

Health Care Professional/Provider Disputes

A health care professional/provider dispute is an escalated verbal or written expression of dissatisfaction by a health care professional/provider, not otherwise acting in the capacity of an authorized representative of a Select Health member, to dispute the denial of payment of a claim or regarding a decision that directly impacts the health care professional/provider. In the case of a contracted, in-network health care professional/provider, the provider dispute system addresses the plan’s policies, procedures or any aspect of the plan’s administrative functions. For a non-contracted out-of-network health care professional/provider, the provider dispute system addresses non-payment, denial or reduction of a covered service rendered out of network, including emergency care. Provider disputes are generally administrative in nature involving post-service denials or reductions, as well as claims issues.

Health care professionals/providers must register the dispute within 60 calendar days from the original adverse notification or action are subject to administrative denial. Disputes involving multiple claims with same or similar payment issues may be consolidated. All provider dispute determinations will be communicated to the health care professional/provider in writing, unless otherwise requested by the health care professional/provider.

Common examples of health care professional/provider disputes include:

- Unresolved claims issues such as incorrect claims processing (TPL, COB, eligibility, payment dispute, timely submission, claim editing).
- Plan process issues such as failure to notify health care professional/provider of policy changes, dissatisfaction with the Select Health’s prior authorization process/ timeliness, etc.
- Plan service issues such as failure to return a provider call, availability of Select Health’s Provider Network representatives, lack of provider orientation/education, etc.
- Contracting issues such as incorrect capitation or claims payments, incorrect information regarding the health care professional/provider data or demographic, etc.
- Member issues surrounding a member’s behavior, non-compliance, non-adherence to treatment plans, etc.

To register a dispute in writing, a written explanation of the issue and any supporting documentation should be sent to:

Select Health of South Carolina Provider Claims Disputes PO Box 7310 London, KY 40742-7310

Submission of a provider dispute to a Post Office Box other than the address listed above may result in delays in the resolution of your dispute. For accurate and timely resolution of disputes, providers should include the following information:

- Health care professional/provider’s name
- Health care professional/provider’s plan ID number
- Health care professional/provider’s NPI number
- A contact person’s name, phone number and address for further correspondence
- Description of dispute
• Number of claims involved (if applicable)
• A sample of the claim(s) (if applicable)
• A description of the claims issue (if applicable)
• Supporting documentation

To register a dispute verbally, health care professionals/providers may call the Provider Claim Service Unit (PCSU) at 1.800.575.0418 or your provider account executive. Disputes will be resolved within 30 calendar days from date of receipt by the appropriate department, unless a mutually agreed upon extension of 15 calendar days is required to obtain additional information. Any mutually agreed upon extension shall be made between the provider initiating the dispute and the provider dispute staff.

Note: Claims payment disputes are not appeals. Appeals are usually for pre-service issues. An appeal is a request for review of an action. An “action” could be the denial or limited authorization of a requested service, including the type or level of service; or reduction, suspension, or termination of a previously authorized service, etc. Providers generally do not have the right to an appeal except on behalf of the affected member, as described in the following section.

Select Health encourages providers to contact your provider Account Executive or the provider claim service unit (PCSU) at 1.800.575.0418 to address additional questions.

## Medical Review Determinations

### Denials

In cases that do not meet medical necessity criteria for approval, professional staff will refer the case to the Select Health medical director for a final review and determination. A member of Select Health’s staff will communicate the final determination to the requesting health care professional/provider, offering him/her the opportunity to supply additional information. The medical director may refer a case for peer review with a same- or similar-specialty physician external to the health plan prior to the final determination. Individuals who make decisions on grievances and appeals shall be individuals who were not involved in any previous level of review or decision making and who are not a subordinate of the individual who made the prior adverse determination.

### Appeal of Utilization Management Decisions

A member or a health care professional/provider acting on behalf of the member and with the member’s written consent may submit an appeal of an action or service denial by Select Health based on a medical necessity/appropriateness determination.

An appeal is a request for review of an action as “action” is defined in 42 C.F.R. § 438.400; “Action” means (1) the denial or limited authorization of a requested service, including the type or level of service; (2) the reduction, suspension, or termination of a previously authorized service; (3) the denial, in whole or in part, of payment for a service; (4) the failure to provide services in a timely manner, as
defined by SCDHHS; (5) the failure of the managed care organization (MCO) to act within the timeframes provided in 42 C.F.R. § 438.408(b) as further provided by SCDHHS in First Choice’s contract with SCDHHS; or (6) for a resident of a rural area with only one MCO, the denial of a Healthy Connections MCO member’s request to exercise his or her right, under 42 C.F.R. § 438.52(b)(2)(ii), to obtain services outside the MCO’s network.”

Appeals must be filed within 90 calendar days from the date of receipt of denial or action notification. Appeals must contain a written request, a contact person’s name, address for further correspondence, member’s written consent, complete medical record and a summary of any additional details or documentation applicable for review of the appeal. The member’s written consent for the provider to appeal on their behalf should be signed by the member. The written request for appeal and the member’s written consent can be combined in one document or the Patient Consent for Provider to File an Appeal form may be used (see the Exhibits section or go to the Select Health website at www.selecthealthofsc.com).

Written acknowledgement of appeal receipt will be sent within five business days to the health care professional/provider submitting a pre-service appeal on behalf of the member. The letter shall:
- Acknowledge the plan’s receipt of the request,
- Advise the health care professional/provider that their request on behalf of the member has been classified as an appeal and
- Set the timeframe for the review of the appeal.

Unless an expedited resolution is requested, a verbal request for an appeal must be followed up with a written, signed appeal.

Select Health ensures that the medical director, nurse or licensed behavioral health professional, psychiatrist or psychologist involved in the review and/or resolution of an appeal, or clinical determination is licensed in the state of South Carolina and has appropriate training and clinical expertise in treating the member’s condition or disease addressed in the appeal when deciding the following:
- Appeal of a denial based on lack of medical necessity
- Grievance of denial of expedited resolution of an appeal; or
- Grievance or appeal involving clinical issues.

Resolution of the appeal and notification of the appeal decision is made within 30 calendar days of receipt of the appeal request. Select Health’s Appeals Coordinator will send the appealing health care professional/provider and member written notification of the appeal decision.

**Extension of Grievance and Appeal Resolution Timeframes**
Select Health may extend the timeframes for Grievances, Standard Appeals, and Expedited Appeals resolution for up to fourteen (14) calendar days if the member requests the extension, or if Select Health shows (to the satisfaction of SCDHHS, upon its request) that there is need for additional information and how the delay is in the member’s interest. If Select Health extends the timeframe, written notice will be sent to the member of the reason for the delay if the extension was not requested by the member. A member or a member’s authorized representative can also request an extension.

Select Health has one appeal level; members or health care professional/providers acting on behalf of the member, with the member’s written consent, who wish to appeal any decision made by Select Health’s Appeals Committee or Medical Director will be referred to the South Carolina Department of Health and Human Services Division of Appeals and Hearings. A State Fair Hearing may be requested by the member or the health care professional/provider on behalf of the member after Select Health’s appeal process is exhausted.

The State Fair Hearing process must be requested by the member within 30 calendar days of the denial or action notification. Members are provided instructions on accessing a State Fair Hearing in the appeal determination letter.

After requesting a State Fair Hearing, a member may give the provider written consent to represent him/her at the State Fair Hearing. Healthcare professionals/providers do not have an inherent right to the State Fair Hearing but may represent the member upon written authorization of the member.

**Expedited Appeal**
A member or a health care professional/provider acting on behalf of a member may initiate an
expedited appeal. This process is initiated when a delay in decision-making or standard medical appeal process may seriously jeopardize the member’s life or health or ability to attain, maintain or regain maximum function. A request for an expedited review can be made by a provider or member upon either verbal or written request. If this process is initiated for a concurrent review determination, the service is continued without liability to the member until the member is notified of the decision. If Select Health denies a request to treat an appeal as “expedited,” the appeal will be transferred to the standard appeal process.

The expedited appeal will be resolved and notice of action determination sent to the member via certified mail with return receipt request and to the practitioner acting on the member’s behalf within 72 hours after receipt of the appeal.

**Integrated Health Care Management Program**

The overall goal of our Integrated Health Care Management Program is to improve the health and welfare of our members. The following specific objectives direct our activities:

- Improve the health outcome measures of our members (as reflected by HEDIS® scores).
- Improve the coordination of care for our members – to include more consistent use of primary care providers (PCPs) and more appropriate use of specialists.
- Facilitate more efficient use of resources – including the appropriate level of care (setting and intensity).
- Improve the access to health care for our members.
- Increase the empowerment of our members to embrace self-care behaviors.

Within Integrated Health Care Management, we have several programs, which allow us to meet the specific needs of our member population. Each program’s focus is to maintain and/or improve the targeted population’s health status through assessment, coordination of resources and promotion of self-management through education. **We welcome referrals from our health care professionals/providers. If you think any of your patients who have First Choice would benefit from our programs, please call us at 1.888.559.1010, ext 55251.**

**Complex Care Management**

This program targets our members with complex medical conditions. These members may have multiple co-morbidities or may have a single serious diagnosis like HIV or cancer. Our nurses work one-on-one with these patients to meet their care needs. The following are some of the interventions provided by our nurse case managers:

- Coordination of care: making sure the member is seeing their PCP, assisting with referrals to specialists and making sure the PCP is aware of other care the member is receiving (specialists, ER, etc.).
- Patient education: making sure the member understands the disease and treatment regimen.
- Self-Management: guidance that motivates the member toward compliance and self-management.

**Disease Management Programs**

We have several disease-specific management programs. Interventions range from one-on-one nurse interaction for high-risk members to periodic educational mailings for low-risk members. The goal of all of our disease-specific management programs is to improve the quality of life for the involved members. We strive to accomplish this goal by providing risk-appropriate case management and education services, with a special emphasis on promoting self-management.

- **Breathe Easy** – asthma management program for members of all ages with asthma. We especially promote member compliance with controller medications. Our program is based on current asthma practice guidelines from the National Heart Lung and Blood Institute, accessible by the link below: http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.htm
- **In Control** – diabetes management program for members of all ages – with the goal of preventing or reducing long-term complications. Our program is based on current diabetes practice guidelines from the American Diabetes Association, accessible by the link below: http://professional.diabetes.org/CPR_search.aspx
- **Heart First** – heart failure management program with an emphasis on self-management interventions such as daily weights and medication compliance. Our program is based on current heart failure guidelines from the American College of Cardiology Foundation/American Heart
• **Sickle Cell Program** – assisting our members with sickle cell disease to get the care they need to better manage this disease. Our program is based on current sickle cell disease practice guidelines from the National Heart Lung and Blood Institute, accessible by the link below: http://www.nhlbi.nih.gov/health/prof/blood/sickle/index.htm

**Emergency Room Outreach Program**
This program provides outreach to members who are frequent ER users, directing them to more appropriate sources of care, such as their PCP or Urgent Care Center. The program was designed to improve patient health outcomes while reducing utilization of costly emergency room services. The objectives of the program include the following:

- Reduce emergency room utilization and costs.
- Provide member education about appropriate emergency room use and promote self-management behaviors.
- Increase the rate of PCP utilization.
- Identify and address barriers to primary care for individual members.
- Identify members with ongoing chronic conditions and refer them to the appropriate care management program.

**Rapid Response/Episodic Care Program**
This program is designed to meet the short-term or episodic needs of our members, especially members with recent hospitalizations. This program serves those members who are generally healthy and do not need a long-term care management program but have had recent healthcare issues and need short-term follow-up by one of our nurses to make sure they get the services they need for a complete recovery. Examples of members in this program include the following:

- Member discharged from the hospital with short-term home IV therapy.
- Member with recent trauma requiring short-term physical or occupational therapy.
- Member with dehisced surgical wound requiring wound VAC therapy.

Our Rapid Response nurses make sure our members get the appropriate care in the appropriate setting – in a timely manner – sometimes preventing unnecessary readmissions.

**Maternal Child Management (Bright Start®) Program**
This program is designed to improve the health outcomes of our pregnant members and their babies.

**Prenatal Risk Assessment Form and Care Authorization**
Members may obtain prenatal care without a referral from their primary care provider. The OB provider is responsible for contacting Select Health to obtain an authorization for prenatal care. This prenatal care authorization covers all prenatal and postpartum services (exams, testing, etc) provided by the OB provider in the OB office setting. Fetal biophysical profiles, non-stress tests and amniocentesis are allowed when medically necessary. Three ultrasounds are allowed without authorization; four or more, while they still do not require authorization, will require a high risk diagnosis. This requirement applies to all OB providers, even Maternal Fetal Medicine.

- To obtain the prenatal care authorization, OB providers are asked to fax a completed Prenatal Risk Assessment Form (see Exhibit) to 1.866.533.5493.

A Prenatal Outreach representative will fax the provider an authorization number once the risk assessment information is received. Please call our prenatal outreach staff at 1.888.559.1010, ext. 55251 with any questions about this process.

Additional authorization is required for inpatient hospital care (including the delivery) and other services (including testing) provided outside of the OB provider’s office. OB providers may call Select Health’s Medical Affairs department to secure any additional authorizations for service at 1.888.559.1010.

**Alpha Hydroxprogesterone Caporate (Makena™ and 17P) Injection Authorizations**
Select Health authorizes the use of 17 Alpha Hydroxprogesterone Caporate (Makena™ and 17P) injections for women who meet the medical necessity criteria as outlined on the Universal 17-P authorization form (see Exhibit 15). Please fax the completed Alpha Hydroxprogesterone Caporate (Makena™ and 17P) Authorization Form to 1.866.533.5493. Call 1.888.559.1010, option #5, and ask for Bright Start
Prenatal Outreach and Care Management

Early identification of pregnant members and their prenatal risk factors play a significant part in the Bright Start program. The Prenatal Risk Assessment Form provides risk-screening information that routinely is obtained during the first prenatal visit. Based on this information, our pregnant members are stratified as either low-risk or high-risk. Low-risk members receive appropriate educational materials with contact numbers to call with any questions or concerns during their pregnancy. High-risk members are followed by a registered nurse for risk-appropriate education and care management.

Examples of education topics and services provided by our high-risk prenatal care managers include the following:

- Diabetes/Gestational diabetes
- HTN/Pre-eclampsia
- Preterm labor
- Assistance with community resources
- Screening for Alpha Hydroxprogesterone Caprate (Makena™ and 17P) injections

We support all of our pregnant members to make healthy choices and to be active participants in their prenatal care.

Pulse Oximetry Screening

Effective July 1, 2014, in accordance with the Emerson Rose Act, SCDHHS and SCDHEC regulations, Select Health requires pulse oximetry screening tests on newborns to detect congenital heart defects. Pulse oximetry is a noninvasive test that estimates the percentage of hemoglobin in blood that is saturated with oxygen.

The Emerson Rose Act became effective Sept. 11, 2013, mandating that DHEC require each birthing facility it licenses to perform a pulse oximetry screening test or other DHEC-approved screening to detect critical congenital heart defects on every newborn in its care.

The test is to be performed 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 DHEC guidelines located at http://www.scdhec.gov/health/docs/PS-R016-20130827.pdf. A newborn may be exempt from the required screening if the parent objects, in writing, for reasons pertaining to religious beliefs only.

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 DHEC 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 at home.

When billing for the screening:

- Licensed midwives delivering in a birthing center or at home must bill procedure code 99499 and append the “SB” modifier.
- Certified nurse midwives or other clinician delivering in a birthing center or at home must bill procedure code 99499 and append the “UD” modifier.
- The birthing center is responsible for following the policy as outlined by DHEC.

Birth Outcomes Initiative

As an advocate of healthy moms and healthy babies, First Choice has joined SCDHHS and its other partners in the Birth Outcomes Initiative (BOI). The BOI’s goal is to improve the health of moms and newborns in the Medicaid program. Launched in July 2011, the BOI is focused on achieving five key goals:

- Ending elective inductions for non-medically indicated deliveries prior to 39 weeks in an attempt to reduce the number of C-sections as well as NICU admissions.
- Reducing the average length of stay in neonatal intensive care units and pediatric intensive care units.
- Reducing health disparities among newborns.
- Making Alpha Hydroxprogesterone Caprate (Makena™ and 17P), a compound that helps prevent pre-term births, available to all at-risk pregnant women.
- Implementing a universal screening and referral tool for physicians. This tool will screen pregnant women for tobacco use, substance abuse,
depression and domestic violence.

**Centering Pregnancy**

A component of the Birth Outcomes Initiative (BOI), Centering Pregnancy is a multifaceted model of group care that integrates the three major components of care: health assessment, education, and support, into a unified program within a group setting. Women with similar gestational ages meet together, learning care skills, participating in a facilitated discussion, and developing a support network with other group members. Each Pregnancy group meets throughout pregnancy and early postpartum. The practitioner, within the group space, completes standard physical health assessments.

The Centering Healthcare Institute must have certified the centering program provider and an incentive will be paid for members who attend five or more visits with the certified provider. For more information on submitting centering pregnancy claims, consult the Claims Filing Manual located on the Select Health website at www.selecthealthofsc.com.

**Screening, Brief Intervention And Referral To Treatment**

Screening, Brief Intervention and Referral to Treatment (SBIRT) is another component of the SCDHHS' Birth Outcome Initiative (BOI), with the primary goal to improve birth outcomes and overall health of the moms and babies in South Carolina. It is state health agencies' screening and treatment program for pregnant Medicaid enrollees for the treatment of substance abuse.

Clinicians who provide these services will be reimbursed by Select Health for the screening and the referral to treatment. For specific billing instructions refer to the Claims Filing Manual located in the Provider Center on the Select Health website.

**NICU Program**

Bright Start® program nurses also follow our newborns who require NICU admission. While in the NICU, the nurses follow the newborn’s course of treatment to make sure they receive the appropriate care in the appropriate setting without unnecessary delays. The nurses also work with the parents or guardians of these babies, making sure they learn to take care of their special newborns upon discharge.

**Payment of Non-Participating Pediatric Providers**

There may be cases where a non-participating pediatrician provides services to a newborn due to institutional and/or business relationships. Examples include post-delivery treatment prior to discharge by a pediatrician who is under contract with a hospital, as well as in-office services rendered by non-contracted providers within the first 60 days following hospital discharge.

In the interest of continuity of care, Select Health will compensate these non-participating providers, at a minimum, the Medicaid fee-for-service rate on the date(s) of service until such time the infant can be served by a participating physician, or can be transferred to a health plan in which the pediatrician is enrolled. A Universal Newborn Prior Authorization (PA) form has been developed and implemented as a means of facilitating the PA process for services rendered in an office setting within 60 days following hospital discharge. This form is located on the Select Health website and in the Exhibits section of this manual.

If you have any members who would benefit from one of our programs, please call Integrated Health Care Management at 1.888.559.1010, ext. 55251.

**First Choice Member Information**

First Choice is Select Health’s managed health care plan for Medicaid members.

**MEMBER ACCESS GUIDELINES**

The following guidelines apply to scheduling procedures at all health care professionals/providers' offices:

- Routine visits are scheduled within four to six weeks.
- Urgent, non-emergency visits within 48 hours.
- Emergency visits immediately upon presentation at a service delivery site.

Waiting times should not exceed 45 minutes for scheduled appointments of a routine nature. Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures. Walk-in patients with urgent needs should be seen within 48 hours.

Physicians will assure that access to emergency medical care is available to members 24 hours a day, seven days a week. This may be accomplished...
via telephone coverage, instructing First Choice members on where to receive emergency and urgent health care.

Primary care practices will provide at least one primary care physician full time equivalent per 2,500 members (First Choice, Medicaid and commercial members).

Accessibility guidelines will be monitored in a number of ways:
- Site visits conducted at credentialing
- Member satisfaction surveys
- Member grievances and appeals
- Telephone accessibility surveys

Members are educated about the importance of keeping appointments. If you experience a problem with a particular member, please notify Member Services immediately at 1-888-276-2020. We will provide one-on-one counseling with the member. When a member misses two consecutive appointments, the member is sent a letter explaining that the third appointment missed may lead to their disenrollment from First Choice.

**ENROLLMENT**
- All member enrollments are without regard to health care status.
- Effective date of enrollment takes two to six weeks.
- Each member selects a primary care provider (PCP) upon enrollment.
- All members receive a copy of the First Choice Member Handbook containing comprehensive information, which includes:
  a. Member Rights and Responsibilities
  b. Terms and conditions of enrollment
  c. Description of covered services
  d. How to access “out-of-plan” emergency services
  e. Member grievance procedures
  f. Disenrollment rights and procedures
  g. Select Health’s Member Services toll-free number: 1-888-276-2020

A copy of the First Choice member handbook is included with each health care professional/provider manual at initial orientation. If you would like an updated copy, call Provider Services at 1.800.741.6605.

**ELIGIBILITY VERIFICATION**
Each member will have two identification cards.
- Healthy Connections ID cards are mailed to each head of household by the state.
- All health care professionals/providers should review the Healthy Connections ID card during each visit. Please see the sample Healthy Connections ID card in the Exhibits section of this manual.
- Each member receives a First Choice ID card within two weeks of the effective date of plan membership. This card notes PCP, PCP phone number and member ID. Please see the sample First Choice ID card in the Exhibits section of this manual.

Eligibility information is available through the NaviNet web portal, www.navinet.navimedix.com, and other electronic verification systems.

Membership may be verified by calling Select Health’s Member Services department.

First Choice members should present their Healthy Connections ID card at each visit.

In addition, PCPs should confirm member eligibility by checking the First Choice provider roster. This roster is routinely mailed to the practice location at the first and middle of each month.

**MEMBER ELIGIBILITY**
The following categories of Medicaid recipients are eligible for First Choice membership:
- TANF – Temporary Assistance for Needy Families
- SOBRA – Women who are eligible for Medicaid because of pregnancy
- SSI without Medicare – Social Security Income without Medicare

All other Medicaid categories are ineligible to join First Choice.

A newborn child of a First Choice mother is automatically enrolled for health care services in First Choice.

**MEMBER DISENROLLMENT**
A First Choice member’s coverage begins on the first day of the month and lasts for a period of 12 months...
contingent upon their continued Medicaid eligibility. Disenrollment may be requested by the member or SCDHHS or First Choice.

Members may request disenrollment once, without a specific reason, at any time during the 90 days following their initial enrollment or re-enrollment. After 90 days they must provide a specific reason to leave First Choice. The following are considered cause for a member to request disenrollment at any time:

- Member moves out of the First Choice service area;
- First Choice does not, because of moral or religious reasons, cover the service the member wants;
- The member needs related services to be performed at the same time and not all related services are available in the network; the PCP or another provider determines that receiving the services separately would put the member at unnecessary risk;
- Other reasons, including but not limited to, poor quality of care, lack of access to services covered under First Choice's contract with SCDHHS, or lack of access to providers experienced in dealing with the member's health care needs.

First Choice may be notified of an involuntary disenrollment by the SCDHHS due to any of the following reasons:

- Loss of Medicaid eligibility or Medicaid MCO program eligibility;
- Death of member;
- Member’s intentional submission of fraudulent information;
- Member becomes an inmate of a public institution;
- Member moves out of state;
- Member elects hospice;
- Member becomes institutionalized in a long term care facility/nursing home for more than 90 continuous days;
- Member elects home and community based waiver programs;
- First Choice determines that member has Medicare coverage;
- Member becomes age 65 or older
- Member’s behavior is disruptive, unruly, abusive, or uncooperative and prevents First Choice from providing services to member or other enrolled members;
- Member is placed out of home [i.e. intermediate care facility for the mentally retarded (ICF/MR), psychiatric residential treatment facility (PRTF)]
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Health care professionals/providers are requested to document non-medical problems such as the above on separate sheets in the medical record and to notify Member Services as soon as possible for assistance.

First Choice members may not be disenrolled for pre-existing medical conditions, change in health status or high utilization of services.

**Member Transfer**

First Choice members may change primary care providers (PCPs) by calling Member Services. The effective date of the change will be as follows:

- Through the 25th of the month, change is effective on the 1st of the next month.
- From the 26th-31st of the month, change is effective
on the 1st day of the month after next.

If it is determined that Select Health has inappropriately assigned a member to the wrong PCP, we will make the adjustment on a case-by-case basis.

The PCP may request a member be transferred to another practice for any of the following reasons:
- Repeated disregard of medical advice
- Repeated disregard of member responsibilities
- Personality conflicts between physician and/or staff with member

Again, health care professionals/providers are requested to document such problems as these and contact Member Services as soon as possible for assistance, and the transfer will take place on the first day of the following month. The transferring health care professional/provider must transfer copies of the member’s medical record to the new health care professional/provider.

**Member No Shows**

All First Choice “no shows” must be reported to Member Services. There are procedures in place to control the no show frequency of our members. In order to initiate these procedures, please contact Member Services at 1.888.276.2020 to report all no show appointments.

**Medicaid Hotline Number**

A hotline has been established by the South Carolina Department of Health and Human Services for immediate health care professional/provider and member access to report problems or ask questions. This number is 1.888.549.0820.

**Member Rights and Responsibilities**

Select Health provides members with both written and verbal information regarding their rights and responsibilities as members of First Choice. All members receive a member handbook upon enrollment that outlines their rights and responsibilities in writing, and they are distributed annually via the member newsletter. Member Services representatives also attempt to contact each member household to discuss plan benefits and member rights and responsibilities.

**Members’ and Potential Members’ Bill of Rights**

1. To be treated with respect and with due consideration for his or her dignity and privacy.
2. To participate in decisions regarding his or her healthcare, including the right to refuse treatment.
3. To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in the federal regulations on the use of restraints and seclusion.
4. To be able to request and receive a copy of his or her Medical Records, and request that they be amended or corrected.
5. To receive healthcare services that are accessible, are comparable in amount, duration and scope to those provided under Medicaid FFS and are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished.
6. To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition.
7. To receive all information including but not limited to Enrollment notices, informational materials, instructional materials, available treatment options, and alternatives in a manner and format that may be easily understood.
8. To receive assistance from both SCDHHS and the MCO in understanding the requirements and benefits of the MCO’s plan.
9. To receive oral interpretation services free of charge for all non-English languages, not just those identified as prevalent.
10. To be notified that oral interpretation is available and how to access those services.
11. As a potential member, to receive information about the basic features of managed care; which populations may or may not enroll in the program and the MCO’s responsibilities for coordination of care in a timely manner in order make an informed choice.
12. To receive information on the MCO’s services, to include, but not limited to:
   a. Benefits covered
   b. Procedures for obtaining benefits, including any authorization requirements
   c. Any cost sharing requirements
   d. Service area
e. Names, locations, telephone numbers of and non-English language spoken by current contracted providers, including at a minimum, primary care physicians, specialists, and hospitals.

f. Any restrictions on member’s freedom of choice among network Providers.

g. Providers not accepting new patients.

h. Benefits not offered by the MCO but available to members and how to obtain those benefits, including how transportation is provided.

13. To receive a complete description of disenrollment rights at least annually.

14. To receive notice of any significant changes in the benefits package at least thirty (30) days before the intended effective date of the change.

15. To receive information on the grievance, appeal and fair hearing procedures.

16. To receive detailed information on emergency and after-hours coverage, to include, but not limited to:

   a. What constitutes an emergency medical condition, emergency services, and post-stabilization services.

   b. That emergency services do not require prior authorization.

   c. The process and procedures for obtaining emergency services.

   d. The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract.

   e. Member’s right to use any hospital or other setting for emergency care.

   f. Post-Stabilization care services rules as detailed in 42 CFR §422.113(c).

17. To receive the MCO’s policy on referrals for specialty care and other benefits not provided by the member’s PCP.

18. To have his or her privacy protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.

19. To exercise these rights without adversely affecting the way the MCO, its providers or SCDHHS treat the members.

20. To have a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.

21. To voice grievances or appeals about First Choice or the care it provides.

22. To make recommendations regarding First Choice’s member rights and responsibilities.

**Member Responsibilities**

1. Establish you or your children with a primary care provider (PCP) within 30 days of entering the Plan.

2. Not to change your PCP without approval from First Choice.

3. Inform First Choice of any loss or theft of your ID card.

4. Present your ID card whenever using health care services.

5. Being familiar with First Choice procedures to the best of your ability.

6. If you have any questions or require additional information, contact the First Choice Member Services Department to have your questions clarified.

7. Access preventative services.

8. Treat your PCP(s) and their staff(s) with kindness and respect.

9. Provide your PCP(s) with accurate and complete medical information.

10. Follow the prescribed treatment of care recommended by the provider or letting the provider know the reasons the treatment cannot be followed as soon as possible.

11. Obtain a referral from your PCP(s) before you go to the hospital your PCP(s) recommended.

12. Go to the emergency room only for emergencies.

13. Call your PCP(s) as soon as you or a family member feels ill. Do not wait. If you feel you have a life-threatening emergency, go to your closest hospital.

14. Make every effort to keep any agreed upon appointment.

15. Notify First Choice if your or your child/children’s name, address or phone number changes.

16. Inform First Choice of any change in your legal status regarding your authority to make decisions.
on behalf of your child or children.

**Advance Directives**

**Living Will and Power of Attorney**
South Carolina and federal law give all competent adults, 18 years or older, the right to make their own healthcare decisions, including the right to decide what medical care or treatment to accept, reject or discontinue. If members do not want to receive certain types of treatment or wish to name someone to make healthcare decisions for them, they have the right to make these desires known to their doctor, hospital or other healthcare providers, and in general, have these rights respected. Members also have the right to be told about the nature of their illness in terms that they can understand, the general nature of the proposed treatments, the risks of failing to undergo these treatments and any alternative treatments or procedures that may be available to them.

State law mandates that the Lt. Governor’s Office on Aging provide information to the public about advance directives or living wills and healthcare powers of attorney. The South Carolina legislature has approved forms for both a living will and a healthcare power of attorney. The living will form that the legislature approved is called a Declaration of a Desire for a Natural Death. Members may be directed to get these forms from the local Area Agency on Aging or by contacting the Lieutenant Governor’s Office on Aging at 1.800.868.9095 or 803.734.9900.

Health care professionals/providers should discuss these options with their patients and have the discussion documented in the patient's medical record.

**Outreach Services**
The Quality Improvement and Member Services departments are responsible for the promotion of preventive health services for all members and prenatal services for pregnant members. It is our goal to identify members eligible for preventive services, notify these members and track and report utilization of services.

**EPSDT/Immunizations Outreach**
The objectives for EPSDT outreach include:
- Notify all members eligible for screening and immunizations.
- Follow up with members not receiving the recommended EPSDT service.
- Act as a resource to First Choice EPSDT providers.
- Improve plan EPSDT and Immunization utilization.
- Review submitted EPSDT records for identified risk factors, immunizations not up-to-date and identified referrals.

**Foreign Language Interpretation Services**
The Member Services department is available to assist with non-English-speaking members. To access this free service, please call the Member Services department toll free at 1.888.276.2020 or at 843.764.1877 in the Charleston area.

Please tell the Member Services representative the language that requires interpretation. If you are unsure of the language, tell the representative right away and a Language Services Associates (LSA) interpreter will be available within 60 seconds to assist.

After hours (after 9 p.m. Monday-Friday and after 6 p.m. Saturday and Sunday), call the Nurse Help Line at 1.800.304.5436, and they will assist with getting you connected to this service.

**Primary Care Providers**
The primary care provider (PCP) functions as a “gatekeeper” who arranges primary care, specialty and ancillary services to meet members’ health care needs. The PCP manages the medical care of the member by:
- Meeting primary care needs
- Promoting quality and continuity of care
- Arranging for appropriate referrals to in-network health care professionals/providers
- Coordinating the overall health care for plan members
- Conducting adult health screenings and/or EPSDT visits as needed

PCP specialties may include:
- General practice
- Family medicine
- Internal medicine
- Pediatrics
- Nurse practitioner
- Obstetrics/Gynecology
Affordable Care Act (ACA) Enhanced Physician Payments

The Affordable Care Act mandates that an enhanced payment be made for those physicians attesting to meeting criteria as a primary care physician for 2013 and 2014.

This enhanced payment will be made as a supplemental gross adjustment to the plan for all the Select Health providers meeting the enhanced payment criteria. Select Health will be provided a file of all eligible services and providers meeting the payment criteria and will reimburse providers based on the data provided by SCDHHS for this project on a quarterly basis.

Physicians working for a FQHC or RHC who render services outside of the respective clinics (inpatient and outpatient hospital) are also eligible for the enhanced payment. The FQHC or RHC physician must properly self attest to eligibility. Claims that would qualify for inclusion would be those that are filed by a FQHC utilizing the CBP provider number and the RHC utilizing the GP provider number.

The ACA does not provide continued funding for the enhanced reimbursement past 2014. If there are no changes to the ACA regulations between now and Jan. 1, 2015, the state will discontinue the enhanced reimbursement.

Patient-Centered Medical Home

A patient-centered medical home (PCMH) is a model of care that strengthens the clinician-patient relationship by replacing episodic care with coordinated care and a long-term healing relationship. Each patient has a relationship with a primary care clinician who leads a team that takes collective responsibility for patient care; providing for the patient’s health care needs and arranging for appropriate care with other qualified clinicians. This model of care is intended to result in more personalized, coordinated, effective and efficient care.

The South Carolina Department of Health and Human Services (SCDHHS) has established a quality incentive for achieving PCMH designation. Provider practices that have applied for NCQA accreditation or have achieved NCQA Level I, II or III will receive a quarterly incentive payment (per member per month – PMPM – for each Select Health member) assigned to the practice.

Certified providers will be paid based upon the level of certification as posted on the NCQA website. Providers who have not achieved certification but have begun the application process must forward a copy on NCQA letterhead acknowledging that the application is in process. Providers may fax the letter to 1.803.359.7177.

SCDHHS has also deemed that FQHCs who achieved or who had begun the process to achieve Joint Commission PCMH recognition by July 2012 are also eligible for the incentive. FQHCs with this designation will receive the PCMH level III incentive payment.

Member Assignment

A member roster is available on NaviNet on the first of each month. The roster lists assigned members’ names, addresses, Medicaid ID number and phone numbers. The health care professional/provider should contact new members indicated on the roster within 90 days of the member’s enrollment to schedule adult physicals or EPSDT exams. If a roster has not been received for the current month, please contact Select Health at 1.800.741.6605. Please review the sample roster included in the Exhibits section.

To verify membership in a PCP practice, always check the member roster and member ID card when a member arrives for a scheduled appointment or call Member Services at 1.888.276.2020.

Primary Care Access Standards:

The following are access standards that primary care providers must adhere to:

- Routine visits are to be scheduled within four weeks.
- Urgent, non-emergency visits within 48 hours.
- Emergency visits immediately upon presentation at a service delivery site.

Waiting times should not exceed 45 minutes for scheduled appointments of routine nature. Walk-in patients with urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures. Walk-in patients with non-urgent needs should be seen within 48 hours.

After-Hours Care

Primary care services must be accessible after hours to members when medical conditions require medical attention before the next day of scheduled office
Billing for After-Hours Care
Effective for dates of services on or after April 1, 2013, the South Carolina Department of Health and Human Services (SCDHHS) will cover CPT codes:

- 99050 – Service(s) 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
- 99051 - Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service

The above reference procedure codes are ONLY authorized for primary care providers (i.e. pediatricians, family practice, general practice, internal medicine, and obstetrics and gynecology). Providers will still be able to bill the evaluation and management code that best describes the level of service being rendered.

The intent of this change is to encourage the expansion of office hours to evenings, holidays, and weekends to reduce the need for Medicaid beneficiaries to seek services in the emergency room. Providers may only bill for the following holidays: New Year’s Day, 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 hospital setting, outpatient hospital setting or an urgent care facility (place of service codes 20, 21, 22 and 23). CPT code 99050 and 99051 are codes, which would be reported in addition to an associated evaluation and management service code. These claims will require correct coding based on CPT guidelines.

Use of Network Health Care Professionals/Providers
Select Health provides a complete network of specialist, hospital and ancillary health care professionals/providers. PCPs must refer to network health care professionals/providers. Please contact Select Health Integrated Health Care Management if the use of a non-network health care professional/provider is required.

Covered Benefits
First Choice members are entitled to all of the benefits provided under the South Carolina Medical Assistance Program.

Depending on the Member’s category of aid and age, benefit limits and co-payments may apply. Please refer to the Co-Payments list in the following section.

NOTE: A provider or member can ask Select Health to approve services above the inpatient hospitalization limits. An exception can be granted if a member has a serious chronic illness or other serious health condition and without the additional services their life and/or health would be in danger; would need more costly services if the exception is not granted; and/or would have to go into a nursing home or institution if the exception is not granted.

To request an exception on behalf of a member prior to the service, providers should call Utilization Management at 1.800.559.1010. To request an exception after the services have been rendered mail the request to:

Select Health of South Carolina
ATTN: Appeals Coordinator
PO Box 7324
London, KY 40743

Benefits include, but are not necessarily limited to, the following:

- Alcohol, drug and substance abuse treatment services through the Department of Alcohol and Other Drug Abuse Services (DAODAS)
- Ambulance transportation
- Ancillary medical services
- Audiological services
- Chiropractic services
- Communicable disease services
- Disease management
- Durable medical equipment
- Early and periodic screening, diagnosis and treatment (EPSDT)/well child
- Family planning services
- Hearing aids and hearing aid accessories
- Home health services
- Hysterectomies, sterilizations, abortions (according to federal and state regulations)
• Independent laboratory and x-ray services
• Inpatient hospital services
• Institutional long-term care facilities/nursing homes
• Maternity services
• Newborn hearing screenings
• Nutritional counseling
• Outpatient pediatric aids clinic services (OPAC)
• Outpatient services
• Physician services
• Prescription drugs
• Preventive and rehabilitative services for primary care enhancement (PSPCE/RSPCE)
• Psychiatric services
• Rehabilitative therapies
• Transplant and transplant-related services
• Vision care services

Services Not Covered
Some services are not covered by the South Carolina Medical Assistance Program and/or Select Health, including, but not necessarily limited to, the following:
• Services that are not medically necessary
• Services rendered by a health care professional/provider who does not participate with Select Health, except for:
  • Emergency Services
  • Services otherwise prior authorized by Select Health
• Cosmetic surgery, such as tummy tucks, nose jobs, face lifts and liposuction
• Experimental treatment and investigational procedures, services and/or drugs
• Home modifications (for example, chair lifts)
• Acupuncture
• Infertility services
• Paternity testing
• Any service offered and covered through another insurance program, such as Worker’s Compensation, TRICARE or other commercial insurance that has not been prior authorized by Select Health
• Motorized lifts for vehicles
• Services provided outside the United States
• Private duty (also known as shift care) skilled nursing and/or private duty home health aide services for members 21 years of age or older
• Services not considered a “medical service” under Title XIX of the Social Security Act

When in doubt about whether Select Health will pay for health care services, please contact the Provider Services Department at 1.800.575.0418.

Co-payments
Some adult members will need to pay a small amount (co-payment) for certain services:
• Ambulatory surgery center: $3.30 (services per day)
• Chiropractic: $1.15
• Clinic visits: $3.30
• Durable medical equipment and supplies*: $3.40
• Home health: $3.30
• Inpatient hospital: $25.00 (per admission)
• Outpatient hospital: $3.40 (non-emergent, per claim)
• Physician office visits: $3.30 (includes nurse practitioners, midwives, optometrists and physician assistants)
• Podiatrist: $1.15
• Prescription drugs: $3.40

*Note: Durable medical equipment that is under a rent to purchase payment plan will have the $3.40 co-payment split evenly among the 10-month rental payment schedule.

There will be no co-payment for children less than 19 years of age, pregnant women, and 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.
**Member Grievances**

Grievances are defined by 42 CFR 438.400 as any dissatisfaction expressed by the member, or a representative on behalf of a member, about any matter other than a proposed action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee’s rights.

Members or authorized representatives acting on behalf of the member may file grievances within (thirty) 30 calendar days of the occurrence by calling Member Services at 1.888.276.2020. Member Services will document the grievance and coordinate the response and/or resolution with the appropriate departments.

Health care professionals/providers acting on behalf of the member may report a grievance with member consent. The member and the health care professional/provider who reports a grievance on behalf of a member will receive a copy of both the grievance acknowledgement letter and grievance decision letter.

Examples of dissatisfaction include, but are not limited to, situations where a provider was rude, the member was dissatisfied with the wait time, etc. Select Health is required to investigate these types of grievances (complaints not related to the physical condition of the office) and respond to the member within five business days. An adverse final resolution regarding the member’s grievance does not provide the member with the right to a state fair hearing.

**Quality of Service Grievances**

The following grievances pertaining to quality of services are forwarded to Select Health’s Network Management Department for investigation and resolution:

**Office Environment**
- Office unsafe
- Environment dirty/unsanitary/offensive/inadequate
- Equipment unsanitary
- Physical accessibility, physical appearance
- Adequacy of waiting and examining room space
- Adequacy/Security of medical record keeping

**Access**
- Wait time too long
- After hours coverage not available
- Difficulty obtaining a referral
- Language barrier
- Provider sees commercial patients first
- Office Hours not posted

**Service from Provider/Office**
- Negative comments regarding race, gender, status, etc.
- Lack of concern and/or uncaring attitude
- Office staff is rude or inconsiderate

**Difficulty Obtaining an Appointment**
- Preventive/Routine
- Urgent
- Emergent
- After hours

The provider will be contacted via telephone for grievances related to:
- Access
- Service from provider/practitioner
- Difficulty in obtaining an appointment

A site visit will be conducted for grievances related to office environment.

The Provider Network Account Executive will work with the provider/practitioner or office manager on a planned resolution or follow up process that may include but is not limited to a review of contractual requirements, provider/practitioner education regarding plan policies, procedures and processes and/or a Corrective Action Plan (CAP) to assist in the resolution of the member’s grievance.

**Clinical Practice Guidelines**

Select Health has adopted clinical practice guidelines for use in guiding the treatment of First Choice Members, with the goal of reducing unnecessary variations in care. The Select Health clinical practice guidelines represent current professional standards, supported by scientific evidence and research. These guidelines are intended to inform, not replace the physician’s clinical judgment. The physician remains responsible for ultimately determining the applicable
treatment for each individual.

Select Health’s Clinical Practice Guidelines are available at www.selecthealthofsc.com/firstchoice/provider/guidelines/diseaseemgt/index.aspx or call your Provider Account Executive to request a copy.

In support of the above guidelines, Select Health has Disease Management and Care Management programs available to assist you in the education and management of your patient with chronic illnesses. For more information or to refer a First Choice member to Integrated Care Management services, call 1.866.899.5406 for the Rapid Response Outreach Team (RROT) or the Complex Care Management Program.

EPSDT and Adult Health Screenings

PCPs who provide care to members from birth through the month of the 21st birthday will provide EPSDT (Early and Periodic Screening, Diagnosis and Treatment) examinations and required immunizations. A baseline visit is recommended and encouraged for all new First Choice members. Further visits should be scheduled according to relevant guidelines as outlined in the Exhibits section or as needed.

Select Health does utilize the EPSDT periodicity schedule as a standard for delivering EPSDT services. However, properly completed EPSDT claims falling outside of the standard will be paid.

Delivery of clinical preventive services should not be limited only to visits for health maintenance but also should be provided as part of visits for other reasons such as acute and chronic care.

Select Health will reimburse for annual exams for adults using these codes:
- 99385 – Health Screen, age 18-39 (1 per year)
- 99386 – Health Screen, age 40-64 (1 per year)

Additional Adult Vaccines

Hepatitis Vaccine

The hepatitis vaccine is reimbursed when exposure and risk for the member are documented. For institutionalized patients, the vaccine is ordinarily included in the service provided by the institution and not billable as a separate service.

End-Stage Renal Disease (ESRD) patients under the supervision of a physician and undergoing in-center hemodialysis treatments or those on home dialysis are considered approved for hepatitis vaccine injections. The vaccine is not an exception for the dually eligible Medicare/Medicaid client; patients eligible for Medicare must use Medicare coverage before billing Medicaid for the coinsurance.

Meningococcal Vaccine

First Choice covers the meningococcal vaccine and the administration fee for beneficiaries over 19 years of age.
- 90733 – Meningococcal polysaccharide vaccine (any groups(s)), for subcutaneous use.
- 90734 – Meningococcal conjugates vaccine, serogroups A, C, Y, and W-135 (tetravalent), for intramuscular use. When billing for the adult meningococcal vaccine, the provider may also bill the vaccine administration code 96372.

Monovalent Vaccine

Reimbursement for a second and separate immunization for monovalent vaccine for A-Taiwan virus is covered but is based on the cost of Fluogen (J3490) with an administrative fee.

Pneumonia Vaccine

The pneumonia vaccine (code 90732) for patients (two years of age and older) diagnosed in one of the following high-risk categories is allowed:
- Cardiovascular disease
- Pulmonary dysfunction
- Immune deficiencies
- Sickle cell anemia
- End stage renal disease
- Patients over age of 65
- Diabetes mellitus

Rabies Vaccine and Immune Globulin
Rabies vaccine and Immune Globulin effective with dates of service on or after Sept. 1, 2009, SCDHEC will discontinue providing rabies vaccine and immune globulin to medical practices in South Carolina.

To accommodate medical practices needing rabies vaccine for First Choice-eligible beneficiaries, coverage of the rabies vaccine will be for post-exposure prophylaxis. The coverage will be provided as a medical benefit.

As a medical benefit, physicians would purchase the vaccine and immune globulin and then bill Select Health for the vaccine, the immune globulin and related office services, using appropriate codes. Established billing codes for the rabies vaccine are CPT codes 90675 and 90676 and for rabies immune globulin are CPT codes 90375 and 90376.

**Topical Fluoride Varnish**
The best practices of the American Academy of Pediatrics recommend that children from the eruption of their first tooth through the month of their thirteenth birthday should receive fluoride varnish application in their primary care provider’s (PCP’s) office during their EPSDT visit two times per year (once every six months).

PCPs are encouraged to focus their efforts on children through age five, who are at high risk for dental caries. This follows the recommendations of the American Academy of Pediatrics and the United States Preventive Services Task Force. Primary care staff applying fluoride varnish must successfully complete an approved training before billing for the service.

Effective for dates of service on or after July 1, 2015, trained staff in a primary care setting must begin billing Current Procedural Terminology (CPT) code 99188 on the CMS-1500 form when applying fluoride varnish. This code replaces the American Dental Association (ADA) code of D1206 when the service is provided in a primary care setting. D1206 will no longer be available for billing in a primary care setting after June 30, 2015. All program requirements and rates applicable to D1206 delivered in a primary care setting are also applicable to the 99188 code.

**Blood Lead Testing**
The screening blood lead test is required as part of the EPSDT service. The finger or heel stick collection of the blood lead sample is covered by the EPSDT rate. Therefore, no additional reimbursement is available. However, the lab analysis is covered as a separate service.

Reimbursement for the lab analysis is not part of the EPSDT service rate. If your office sends the blood lead samples to an outside laboratory for analysis, the laboratory should bill directly for the blood lead analysis using the CPT code 83655.

If your office is using the ESA LeadCare Blood Lead Testing System to analyze the blood lead samples internally, your office should bill us directly using CPT code 83655.

**Immunizations**
As of July 1, 2011, the VAFAC (Vaccine Assurance for All Children) program was transitioned to the Vaccines For Children (VFC) program. All health care professionals/providers including those currently enrolled in the former VAFAC program, must complete the enrollment process to be eligible to receive federally funded VFC vaccine.

Practices with multiple office locations must enroll each office as a separate South Carolina VFC program provider if that site will be offering immunization services using VFC vaccines.

The South Carolina Department of Health and Environmental Control (SCDHEC) is now offering the SC STATE Vaccine Program as a supplement to the VFC program. Health care professionals/providers must be enrolled in the VFC program as a prerequisite to enrollment in the STATE Vaccine Program. Health care professionals/providers may opt to participate in the VFC program only or both the VFC and STATE Vaccine programs.

Health care professionals/providers wishing to enroll in the VFC program and/or the SC STATE Vaccine Program may do so by visiting the Enrollment website at: http://www.scdhec.gov/health/disease/immunization/vfc-enrollment.asp.

Select Health reimburses for vaccine administration. For accuracy and program compliance SCDHHS requires that claims for vaccinations include the Current Procedural Terminology code (CPT) for the vaccine product that is administered, however only the administration code is reimbursable.
Synagis
Synagis is reimbursed on a fee-for-service basis. The administration fee is included in the reimbursement. Health care professionals/providers must call Select Health’s Medical Affairs department at 1.888.559.1010 for prior authorization before administering Synagis.

Payment for Synagis is based on the number of units billed. Determination of units is based upon a 50 mg dosage. If the member receives multiples of the 50 mg dosage, the health care professional/provider should list units per 50 mg dose, not to exceed four units per day. For example, if a member receives 150 mg, this would equal 3 units. Select Health will reimburse according to the rates established by the Department of Health and Human Services.

Health care professionals/providers must use the dosage that is appropriate for each child according to his/her weight. The administrative fee (procedure code 90722) is payable in addition to the drug.

Pharmacy Services
Pharmaceutical services provide First Choice members with needed pharmaceuticals as ordered through valid prescriptions from licensed prescribers for the purpose of saving lives in emergency situations or during short term illness, sustaining life in chronic or long term illness or limiting the need for hospitalization. Members have access to most national chains and many independent pharmacies.

- All members are covered for prescription and certain over-the-counter (OTC) drugs/items with a prescription written by a doctor.
- Medications are prescribed to cover a maximum 31-day supply.
- Pharmacy benefits are managed through our Pharmaceutical Benefits Manager (PBM), PerformRx.
- Direct pharmacy claims questions (technical online processing) to Argus at 1.800.522.7487.
- Prior authorization and other pharmacy services related questions should be directed to Select Health/AmeriHealth Caritas Pharmacy Services at 1.866.610.2773 or faxed to 1.866.610.2775.

Monthly Prescription Limits
First Choice members who are 21 years of age and older are limited to four prescriptions or refills per month with certain exceptions. Medications used to treat the following conditions are exempt from the four prescriptions limit:
- Acute sickle cell disease
- Behavioral health disorder
- Cancer
- Cardiac disease
- Diabetes
- End stage lung disease
- End stage renal disease
- HIV/Aids
- Hypertension
- Lupus
- Organ transplant

A maximum of seven (7) prescriptions per month are covered for the above conditions.

To request a prescription limit override for any other condition, the prescriber should contact Select Health/AmeriHealth Caritas Pharmacy Services at 1.866.610.2773 or fax to 1.866.610.2775.

90-Day Medication Supply
To improve medication adherence in four (4) key therapeutic treatment areas; asthma, hypertension, diabetes, and high cholesterol, Select Health implemented a 90-day medication supply program.

Certain generic medications to treat these conditions will be allowed to process for a 90-day supply. There is a listing of these medications available on the Select Health website at: http://selecthealthofsc.com/pdf/provider/pharmacy/90-day-supply.pdf

Pharmacists are encouraged to work with providers in order to obtain a 90-day prescription for those members that are on medications who qualify for a 90-day supply.

This program will benefit members by allowing them to obtain a three-month supply of medication at each pharmacy visit for only one (1) copayment (if applicable). Pharmacies will be given two dispensing fees for all 90-day prescriptions filled as part of this program.

Contact the Pharmacy Customer Services Department
if you have any questions or concerns about this initiative at 1.888.610.2773.

**Coverage of Generic Products**
Select Health does not cover brand name products for which there are “A” rated, therapeutically equivalent, less costly generics available unless prior authorization is secured. Prescribers who wish to prescribe brand name products must furnish documentation of generic treatment failure prior to dispensing. The treatment failure must be directly attributed to the patient’s use of a generic version of the brand name product.

Exceptions to the generic requirement include brand name products of: digoxin, warfarin, theophylline (controlled release), levothyroxine, pancrelipase, phenytoin, carbamazepine and continued treatment utilizing clozapine.

**Over-the-Counter Drugs**
All members are covered for certain over-the-counter (OTC) drugs with a prescription written by a doctor. For adult members, these prescriptions will apply toward the monthly limit. Products will be dispensed generically when available as outlined above. Many items may be ordered by the member through the personal health care items benefit by calling Member Services at 1.888.276.2020.

**Co-payments**
Members who are 19 years of age or older are subject to a $3.40 co-payment per prescription. The following members are exempt from the co-payment:
- 18 years of age or younger
- Pregnant and the medicine is related to pregnancy
- Live in a nursing home or group home
- Receiving hospice, emergency or family planning services
- Receiving home- and community-based waiver services

**Prior Authorization**
In a continuing effort to improve patient care and pharmaceutical utilization, Select Health, in conjunction with its PBM, PerformRx, has implemented a prior authorization (PA) program for the initial prescription of certain medications. Requests for PA medications should be directed to Select Health/AmeriHealth Caritas Pharmacy Services at 1.866.610.2773 or faxed to 1.866.610.2775.

To obtain the prior authorization request form, see the Exhibits section or go to the Select Health website at www.selecthealthofsc.com.

**Temporary Supply**
For drugs subject to prior authorization, Select Health will authorize the pharmacy to issue a five (5) day supply of medication. If Select Health cannot grant the authorization within five days, approval will be given for at least a thirty (30) day prescription. Select Health will not require the member’s involvement or participation in the resolution of a prescription authorization issue as a condition for continuing the prescription.

**Transition Supply**
Select Health will allow new members who are currently at the time of enrollment to Select Health receiving non-preferred or prior authorized medications to continue receiving those medications for up to sixty (60) calendar days to allow the prescriber time to request prior authorization.

**Preferred Drug List**
Select Health maintains a Preferred Drug List (PDL). The PDL represents therapeutic recommendations based on documented clinical efficacy, safety and cost-effectiveness. All non-preferred medications will require prior authorization. Select Health’s criteria require a trial and failure or intolerance of one to three preferred medications, depending on the class. Please visit our website for a complete list of preferred products.

Requests for prior authorization medications should be directed to Select Health/AmeriHealth Caritas Pharmacy Services at 1.866.610.2773 or faxed to 1.866.610.2775.

Providers may request the addition of a medication to the list. Requests must include the drug name, rationale for inclusion on the list, role in therapy, and medications that may be replaced by the addition. Please direct such requests to the Pharmacy and Therapeutics Committee at Select Health, PO Box 40849, Charleston, SC 29423.

**NOTE: Experimental drugs, procedures or equipment not approved by Medicaid are excluded from coverage.**

**Appeal of Prior Authorization Denials**
Prior authorization denials may be appealed. Please see the section entitled “Medical Review
Determinations” to review the appeal process.

Claim and Payments

Health care professional/provider tip: Always check member eligibility before rendering services and submitting claims to Select Health to ensure your patient is a First Choice member.

Claims Address

If you are unable to submit claims electronically, please mail all Select Health claims:

Select Health of South Carolina
Claims Processing Department
P.O. Box 7120
London, KY 40742

For questions regarding claims or bills, please call Claims at 1.800.575.0418.

Claim Format

Hospitals use the UB 04 claim form.

All other health care professionals/providers use the CMS 1500 claim form. (See “Claims Filing Manual” for an explanation of required fields and recent CMS-1500 and UB-04 additional required fields and billing guidelines for the mandated 5010 837 formats).

To ensure timely processing of claims, please make sure your claims provide the following information:

• Correct member name and Medicaid ID number.
• Ancillary or hospital should use the facility ID number assigned by Select Health in Box 51 (UB 04).
• Facility NPI number in Box 56 (UB 04).
• Prior authorization number Box 63 on the (UB 04), or Box 23 on the (CMS1500), if required.
• The attending health care professional/provider’s individual (not group) Select Health health care professional/provider ID number and NPI number Box 76 (UB 04).
• If there is a NPI number entered in box 56, enter the taxonomy code for the facility in Box 81 (UB 04).
• The treating health care professional/provider’s individual (not group) Select Health health care professional/provider ID number and NPI number (Box 24) on CMS 1500 form.
• The Payee Information in Box 33 with the “pay to” NPI number (this could be an individual or a group, box 33a on CMS 1500) and taxonomy code (box 33b on CMS 1500). Also there has to be a physical address listed here not a PO box.
• Use valid diagnosis, revenue and CPT codes. Some health care professionals/providers inadvertently submit invalid codes not recognized by Medicaid. If your contractual agreement with Select Health indicates health care professional/provider specific codes, please use the specific codes indicated in your agreement.
• Claims improperly or incorrectly submitted may be returned.

Inpatient Claims

All Patient Refined Diagnosis Related Groups (APR-DRG)

Select Health has moved to All Patient Refined Diagnosis Related Groups (APR-DRGs) method of paying for hospital inpatient services. With the implementation of the APR-DRG payment methodology, Select Health will require that hospital providers submit the birth weight on claims for newborns in order to insure that we are grouping to the correct DRG.

The birth weight should be reported through the use of value code “54” in fields 39-41 on the UB-04 paper claim form or Loop 2300, Segment HI in the electronic claim submission, 837I or by reporting ICD-9-CM diagnoses category 764 and codes 765.00 and 765.1 or ICD-10-CM diagnoses category P0500, P0700 or P0710. If the birth weight is not provided via value code 54 or through ICD-9-CM/ICD-10-CM diagnosis codes, APR DRG grouper will assume the patient’s weight is that of a normal newborn.


Provider Preventable Conditions Policy

The Centers for Medicare and Medicaid Services (CMS) requires Medicaid programs nationwide to demonstrate that they are not paying for provider preventable conditions (PPC).

Provider preventable conditions are clearly defined into two separate categories: health care acquired conditions (HCACs) and other provider preventable conditions (OPPCs) or never events.
HCACs include hospital acquired conditions (HACs). Other provider preventable conditions refer to OPPCs and never events (surgery on a wrong body part, wrong surgery on a patient, surgery on a wrong patient, etc.).

In accordance with amendments to the SCDHHS non-payment for provider preventable conditions policy, Select Health includes the following OPPCs and never events in its non-payment policy:

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

Never Events:
- Surgery on a wrong body part or site
- Wrong surgery on a patient
- Surgery on the wrong patient

Inpatient acute care hospitals, ambulatory surgery centers (ASCs), physicians and other practitioners are held accountable for never events. Inpatient acute care hospitals are also held accountable for HACs and OPPCs.

Select Health will not pay any claims for PPCs for members who are Medicaid/Medicare eligible.

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

Reductions in provider payment(s) may be limited to the extent that:
- The identified PPCs would otherwise result in an increase in payment(s)
- The portion of the payment directly related to the treatment for the PPC can be isolated

Non-payment of PPCs will not prevent access to services for First Choice members. First Choice members should never be billed for these events.

The CMS list of HACs, which is utilized by Select Health, can be found at [http://www.cms.gov/HospitalAcqCond](http://www.cms.gov/HospitalAcqCond). Although state Medicaid programs may expand this list of HACs in defining PPCs, SCDHHS has not elected to expand on the CMS list of HACs at this time.

**Present On Admission (POA) Reporting**

Under the Hospital-Acquired Conditions and Present on Admission Indicator Reporting (HAC & POA) system, Inpatient Prospective Payment System (IPPS) hospitals are required to submit POA information on diagnoses for inpatient discharges.

Hospitals are required to include a POA indicator for each discharge diagnosis. Hospitals will not receive additional payment where the selected condition was not present on admission. The APR-DRG software will look at the POA indicator to identify diagnoses that meet the definition of a HAC. The grouper software will then ignore the HAC and assign a DRG as if it were not present. During the cost settlement process, adjustments will be made so that hospital costs associated with HACs are not reimbursed.

For more details on submitting POA indicators, consult the “Claims Filing Manual” located on the Select Health website, [www.selecthealthofsc.com](http://www.selecthealthofsc.com).

**Primary Care Provider Encounter Data and Billing**

Primary care providers (PCPs) must report both capitated services and those services that are reimbursed on a fee-for-service basis on the CMS 1500 claim form. Regardless of payment mechanism, all PCP services must be reported to the above address.

**Fee-for-Service Payments**

Fee-for-service payments are mailed or transmitted electronically via electronic funds transfer (EFT) by First Choice to the health care professional/provider with access to a remittance advice that will detail claims being paid, pended and/or denied, along with accompanying reasons. Please review the sample remittance advice located in Exhibits section. The electronic remittance advice is available through NaviNet or Emdeon’s (the First Choice clearinghouse) payment manager.
**First Choice Payments – as Payment in Full**

In accordance with guidelines established by SCDHHS, once a health care professional/provider has accepted assignment of benefits for a First Choice member, the health care professional/provider must accept the amount paid by First Choice or paid by a third party (if equal to or greater than that allowed by First Choice and in accordance with any contractual agreement with the third party payor) as payment in full. The member or member’s representative may not be balance billed for any services provided.

**Capitation Payments and Reports**

Capitation checks are mailed or transmitted electronically by First Choice to primary care providers’ remittance addresses at the beginning of each month. The panel roster, which should be used for reconciling the capitation payment, is available on NaviNet each month. The panel roster is the official roster for the month. Capitation will be paid for members added mid-month on the following month’s capitation check via a “retro add.” Capitation will be recovered for members leaving the practice at mid-month on the following month’s capitation check via a “retro term.” Capitation paid or recovered with greater than one month’s retroactivity will appear as a manual adjustment.

**Claims Payment Policies/Guidelines**

First Choice has enhanced clinical editing processes to promote correct coding and to put into practice outpatient payment policies that are national in scope, simple to understand and that come from highly respectable sources, such as:

- CMS’ medical coding policies
- AMA CPT coding guidelines
- Local and Regional Medicare policies

First Choice’s payment policies focus on areas such as:

- National bundling edits including the Correct Coding Initiative (CCI)
- Modifier usage
- Global Surgery concept
- Add On code usage
- Age/Gender appropriateness
- CMS’ National Coverage Determinations
- OPPS bundled and packaged services concept

**Claims Adjustment/Reconsideration Requests**

If a health care professional/provider believes there was an error made during claims processing or if there is a discrepancy in the payment amount, he/she may submit a written request for reconsideration. The request should include a copy of the claim, the remittance advice showing the denial and any supporting documentation and should be mailed to:

**Select Health of South Carolina**

**Claims Processing Department**

P.O. Box 7120
London, KY 40742

Or the health care professional/provider may call the Provider Claims Service Unit (PCSU) at 1.800.575.0418. Our representatives can help you resolve the issue, reprocess a claim via the phone, or advise whether a corrected claim or a written appeal needs to be submitted.

**Corrected/Resubmitted Claims**

A corrected professional claim (CMS 1500) should only be submitted for claims on which there was an error made on the original claim but a payment was still issued. Claims that were completely denied and had no payment issued can be resubmitted via normal processing (electronic or paper) and do not need to have the words “corrected” or “resubmitted” on them.

For corrected claims that are submitted via hardcopy, the word “corrected” must be noted on the claim as appropriate (for example):

- Claims with missing or incorrect charges but payment was issued, should be submitted as “corrected claims.”
- Claims with incorrect coding but some lines paid and some did not, should be submitted as “corrected claims.”
- Claims originally denied for missing or invalid information, for inappropriate coding or DX missing 4th or 5th digit, and no payment was made, should be submitted for reconsideration as a new claim.
- Claims originally denied for additional information should be sent as a resubmitted claim. In addition to writing “resubmission” on the claim, the additional information should be attached.

Corrected and resubmitted claims are scanned during reprocessing. Please remember to use blue or black pen.
ink only, and refrain from using red ink and/or highlighting that could affect the legibility of the scanned claim.

Corrected/Resubmitted claims should also be sent to:
Select Health of South Carolina, Inc.
Claims Processing Department
P.O. Box 7120
London, KY 40742

Note: You also have the option of submitting corrected CMS 1500 claims electronically. See page 35, “Submitting Corrected Claims Electronically.”

**REFUNDS FOR CLAIMS OVERPAYMENTS OR ERRORS**
Select Health and SCDHHS encourage providers to conduct regular self-audits to ensure receipt of accurate payment(s) from the health plan. Medicaid program funds must be returned when identified as improperly paid or overpaid.

If a plan provider identifies improper payment or overpayment of claims from Select Health, the improperly paid or overpaid funds must be returned to Select Health within 60 days from the date of discovery of the overpayment. Providers may return improper or overpaid funds to the health plan by:

1. Completing page one of the “Provider Refund Claim Form” (available online at www.selecthealthofsc.com/provider/resources/forms).
2. Using page two of the form, as needed, to list multiple claims connected to the return payment.
3. Submitting the completed form and refund check by mail to the claims processing department:
   Select Health of South Carolina
   Attn: Claims Repayment Research Unit
   PO Box 7120
   London, KY 40742

If the plan provider would prefer the improper payment or overpayment be recouped from future claims payment, the provider should call the Provider Claims Service Center or send the completed Provider Refund Claim Form without a refund check to the address below:
   Cost Containment Department
   P.O. Box 7320
   London, KY 40742

If the improper payment or overpayment is related to a subrogation issue—slip and fall, worker’s compensation or motor vehicle accident (MVA)—send the completed subrogation overpayment worksheet or any related documentation to subrogation@amerihealthcaritas.com.

**THIRD PARTY LIABILITY**
Third Party liability is the legal responsibility of other available resources to pay claims before the plan pays for the care of an individual eligible for First Choice. Medicaid is always the payer of last resort.

Third party payers include: private health insurance, Medicare, employment-related health insurance, court-ordered health insurance from non-custodial parents, worker’s compensation, long-term care insurance, liability insurance, other state and federal programs and first party probate-estate recoveries.

First Choice is a Medicaid Managed Care program and the payer of last resort. Therefore, First Choice will consider the primary insurer’s payments when calculating payment due the health care professional/provider. As a First Choice health care professional/provider you have agreed to accept First Choice’s payment as payment in full. Members receiving Medicaid-covered services may not be balanced billed.

First Choice Health Plan coordinates benefits with primary insurers for covered services and will **pay the lesser of**:
- The difference between the primary carrier’s paid amount and First Choice’s allowable, or
- The deductible, co-pay, and coinsurance total (patient liability) from the primary insurer not to exceed First Choice’s allowed amount

It is expected that the primary payer’s contractual obligations are considered when seeking reimbursement for secondary payment.

Secondary claims may be submitted as hard copy or electronically with the other insurer’s explanation of benefits (EOB) and reason/denial codes attached in order to ensure proper consideration. For further details on submitting electronic secondary claims, consult the Claims Filing Manual, located on the Select Health website.

Certain services (e.g. Department of Health and Environmental Control (DHEC) under Title V) are not subject to the standard coordination of benefits. However, health care professionals/providers are
encouraged to make every effort to obtain other insurance coverage information from their patients because health care professionals/providers are an important source of third party information.

**Cost Avoidance/Third Party Liability (TPL/COB) Recovery**

Cost Avoidance refers to the practice of denying a claim based on knowledge of an existing health insurance policy which should cover the claim. Like Medicaid fee-for-service, First Choice is required by the federal government to adhere to the cost avoidance policy. Providers must report primary payments and denials to First Choice to avoid rejected claims.

A provider who has been paid by First Choice and subsequently receives reimbursement from a third party must repay First Choice the difference between the primary carrier’s contractual obligation and the patient liability.

First Choice reviews Third Party Liability (TPL/COB) information on a routine basis. Potentially overpaid claims are identified and providers will receive notification of our intent to recover overpayments if the aggregate total of claims recovery is greater than $250.

First Choice will send a letter to health care professionals/providers notifying them of any overpayment recovery and will include with the letter a list of claims affected by the recently received TPL information. This information should assist the health care professional/provider in reconciling claims. This letter will indicate a specific timeframe for the healthcare professionals/providers to either submit a check or to allow the recoupment process to initiate.

First Choice will seek recovery for claims within a nine month period after the first date of the overpayment, not to exceed the one year timely filing deadline. However, recovery may be conducted on overpayments beyond this timeframe if:

- There is evidence of fraud,
- The health care professional/provider has established a pattern of inappropriate billing, or
- A system error has been identified that supports said recovery.

**Resources Secondary to Medicaid**

Certain programs funded only by the state of South Carolina (i.e., without matching federal funds) should be billed secondary to Medicaid.

These resources are:
- BabyNet
- Best Chance Network
- Black Lung
- Commission for the Blind
- Community Health
- Crime Victims Compensation Fund
- CRS (Children’s Rehabilitative Services)
- Department of Corrections
- DHEC Cancer
- DHEC Family Planning
- DHEC Heart
- DHEC Hemophilia
- DHEC Maternal Child Health
- DHEC Migrant Health
- DHEC Sickle Cell
- DHEC TB
- Indian Health
- Other Indigent (hospital charity)
- Other Sponsor
- Ryan White Program
- State Aid Cancer Program
- Vaccine Injury Compensation
- Veterans Administration
- Vocational Rehabilitation Services

**Submitting Claims Electronically**

Electronic Data Interchange (EDI) allows faster, more efficient and cost-effective claim submission for providers. EDI, performed in accordance with nationally recognized standards, supports the health care industry’s efforts to reduce administrative costs.

The benefits of billing electronically include:

- Reduction of overhead and administrative costs.
- EDI eliminates the need for paper claim submission. It has also been proven to reduce claim re-work (adjustments).
- Receipt of clearinghouse reports makes it easier to track the status of claims.
- Faster transaction time for claims submitted electronically. An EDI claim averages about 24 to 48 hours from the time it is sent to the time it is received. This enables providers to easily track their claims.
• Validation of data elements on the claim form. By the time a claim is successfully received electronically, information needed for processing is present. This reduces the chance of data entry errors that occur when completing paper claim forms.

• Quicker claim completion. Claims that do not need additional investigation are generally processed quicker. Reports have shown that a large percentage of EDI claims are processed within 10 to 15 days of their receipt.

All the same requirements for paper claim filing apply to electronic claim filing.

• Health care professional/providers should contact their vendor and confirm that the vendor will transmit the claims to Emdeon, the Select Health claims clearinghouse.

• Health care professional/providers should confirm with vendor the accurate location of Select Health health care professional/provider ID number.

• Submit with Payor ID 23285.

• Health care professional/provider should check the claims status report after each submission for any rejections. If rejections are noted, correct and resubmit.

Questions regarding electronically submitted claims should be directed to Provider Claim Services at 1.800.575.0418. Here you may obtain information about submitting claims electronically to Select Health or information regarding claims that have already been submitted electronically to Select Health. If you would like assistance in resolving submission issues reflected on either the Acceptance or R059 Unprocessed Claims reports, contact the Emdeon Provider Support Line at 1.800.845.6592.

Submitting Corrected Claims Electronically

*A corrected claim is defined as a resubmission of a claim with a specific change that you have made, such as changes to CPT codes, diagnosis codes or billed amounts. It is not a request to review the processing of a claim.

For UB04 claims, corrections can be submitted electronically by just changing the bill type to 117 or 137.

For Professional claims (claims filed on a CMS 1500 claim form) your EDI vendor or clearinghouse will need to do the following:

• Use “6” for adjustment of prior claims or “7” for replacement of a prior claim utilizing bill type in loop 2300, CLM05-03 (837P)

• Include the original claim number in segment REF01=F8 and REF02=the 13 digit original claim number; no dashes or spaces

• Include the plan’s claim number in order to submit your claim with the 6 or 7

• Use this indicator for claims that were previously processed (approved or denied)

• Do not use this indicator for claims that contained errors and were not processed (rejected upfront)

• Do not submit corrected claims electronically and via paper at the same time

For more information, please contact the EDI Hotline at 1.877.234.4271 or edi.sh@kmhp.com. Providers using our NaviNet portal, (www.navinet.navimedix.com) can view their corrected claims faster than available with paper submission processing.

If you do not currently have the capability to submit claims electronically, but are interested in doing so, contact the Emdeon Provider Support Line at 1.800.845.6592, or any EDI software vendor you choose. Instructions for paper submissions are available under Corrected/Resubmitted claims.

835 Electronic Remittance Advice

Select Health/AmeriHealth Caritas has partnered with Emdeon and HDX as clearinghouses for the 835 electronic remittance advice transactions. Emdeon and HDX are leaders in processing transactions for vendors, health care professionals/providers and health plans in the HIPAA compliant standardized formats.

Health care professionals/providers may choose either clearinghouse from which to receive their 835 Electronic Remittance Advice. The health care professional/provider’s current EDI vendor should be contacted for additional information prior to contacting HDX or Emdeon.

HDX Contact Information:

1.610.219.3331
HDX Electronic Remittance Service
ERSPayers@HDX.com

Emdeon Contact Information:

1.800.845.6592
Health care professionals/providers should be prepared to supply the following information during the set-up phase:

- EDI vendor and submitter ID
- Group/facility name
- Contact name, phone number and e-mail address
- Address
- Tax ID
- Payee ID

A copy of the 835 Companion Guide is available on the Select Health website, under HIPAA information: www.selecthealthofsc.com.

Additional assistance may be obtained by contacting Provider Services at 1.800.741.6605.

### Electronic Funds Transfer (EFT)

Select Health and Emdeon Business Services have partnered to offer you direct deposit for your claims payment. Health care professionals/providers interested in receiving electronic payments through Emdeon may get additional information through the Emdeon website, www.Emdeon.com/epayment or by contacting Select Health Provider Services at 1.800.741.6605.

Emdeon ePayment can simplify the payment process by:

- Providing fast, easy secure payments
- Reducing paper
- Not requiring you to change your preferred banking partner
- Simplifying your bank connectivity when multiple banks are required
- Managing health care professional/provider enrollment and authentication
- Eliminating checks lost in the mail
- Enabling you to view multiple payers in one easy-to-use application

You will need the following information to enroll in the EFT Program:

- Your Select Health assigned Health care professional/provider ID number
- The Select Health Payor ID: 23285
- Bank name and address
- Bank account type
- Nine-digit routing/ABA number
- Full account number with leading zeros
- Primary account holder name
- Tax ID number of account holder
- Payee ID (on your current remittance advice)
- The last two Select Health remittances, including cover sheet and payment amounts

#### Emdeon Payment Manager

Once you begin receiving your payments electronically, your paper remittance advice will be discontinued after 90 days. However, you can always view and print your remittance advice online at Emdeon’s website using Payment Manager. For more information, visit: www.emdeon.com/ProviderSolutions/provider_services_era.php.

If you are interested in Electronic Remittance Advice (ERA), Emdeon’s customer service staff can assist you in signing up by calling Emdeon at 1.877.363.3666.

### Billing Requirements for Certain Services

#### EPSDT

The EPSDT program was initiated as a comprehensive and preventive child health program for Medicaid recipients. First Choice members under age 21 qualify for EPSDT program benefits, including regular health screenings, immunizations, treatment and follow-up care for problems diagnosed during screenings.

#### EPSDT Pediatric Screening Tools

Best practice indicates that standardized behavioral health pediatric screenings are recommended to be done during the Early Periodic Screening, Diagnosis and Treatment (EPSDT) visits or as dictated by clinical need. This recommendation is in alignment with the American Academy of Pediatrics (AAP) recommendations regarding screening and surveillance of family and social environment for risk factors and mental health screening of children and adolescents in primary care settings.

CPT code 96110 is used to report standardized screening to identify childhood and adolescent behavorial health problems.
developmental levels. A general screen is recommended with follow up screens as indicated. This code is limited to a frequency of two (2) times per date of service for children up to 18 years of age.

CPT code 96127 is used to report a standardized instrument to assess the patient’s emotional and/or behavioral health. A general screen is recommended with follow up screens as indicated. This code is limited to a frequency of four (4) times per date of service for children up to 18 years of age.

**Components of an EPSDT Exam**
- A comprehensive health and developmental history
- An assessment of physical and mental development
- A comprehensive unclothed physical examination
- Appropriate immunizations
- Health education, including anticipatory guidance
- Vision, hearing and dental screenings
- BMI percentile
- Lead screening by child’s second birthday

**Laboratory tests are not part of the screening package and may be billed and reimbursed as additional claim lines. However, screening components cannot be fragmented and billed separately.**

**EPSDT/Immunization Claims/Encounters**

EPSDT claims/encounters are submitted on the CMS1500 claim form utilizing the following standard applicable CPT codes:

**New Patients:**
- 99381 Preventive visit, 12 months or younger
- 99382 Preventive visit, age 1-4
- 99383 Preventive visit, age 5-11
- 99384 Preventive visit, age 12-17
- 99385 Preventive visit, age 18-21

**Established Patients:**
- 99391 Preventive visit, 12 months or younger
- 99392 Preventive visit, age 1-4
- 99393 Preventive visit, age 5-11
- 99394 Preventive visit, age 12-17
- 99395 Preventive visit, age 18-21

**For immunizations provided under the VFC program for members less than 19 years of age, you must use the following administration codes:**
- 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 VFC program.

**The administration of VFC vaccines is limited to a maximum of three units per date of service regardless of the number of additional vaccines administered.**

**Coding Considerations**
- Modifiers 01 and 02 are not required for EPSDT claim submission to First Choice.
- When billing for an immunization administration and an EPSDT examination code on the same day, the provider will need to append a 25 modifier to the immunization administrative code to receive reimbursement.
- Primary care physicians can bill for topical fluoride varnish treatments, CPT code 99188 as part of the EPSDT exam.
- Claims for VFC vaccine administration must include:
  - The appropriate vaccination product CPT code
  - The appropriate vaccination administration code with a 25 modifier
  - For this code combination, only the administration code will be reimbursable
  - When billing First Choice, Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) must also submit CPT codes for the vaccination products.
- When billing for vaccines that are not covered under the VFC program or for beneficiaries over the age of 18, the provider may bill for vaccine and the administration codes 90471, 90472 and/or 90473, 90474 intranasal or oral route and 96372.
- If you detect a health problem during a well visit,
do not change the coding from a well exam to a sick visit. When billing, use V20.2 ICD-9; Z00121, Z00129 ICD-10, as the first diagnosis. The second diagnosis is determined by the detected problem. If the EPSDT screening and immunizations can be completed, bill the EPSDT code with modifier 25 and list any additional services. Do NOT bill an office visit on the same date of service.

- Select Health will reimburse for sports physicals IF all the components of a well visit are completed and the claim is coded using DX V20.2 ICD-9; Z00121, Z00129 ICD-10; V70.0 ICD-9 Z0000, Z0001 ICD-10; V70.3 ICD-9; Z020-Z026, Z0282, Z0289 ICD-10; V70.5 ICD-9; Z021, Z023 ICD-10; V70.6 ICD-9; Z008 ICD-10; V70.8 ICD-9; Z0070, Z0071 ICD-10; or V70.9 ICD-9; Z008 ICD-10 and with EPSDT E/M codes. Do NOT bill another E/M code on the same date of service.

Unlisted Procedure Codes
Unlisted procedure codes are services performed by a physician that are not specifically defined in the CPT book. These codes:

- Require prior authorization.
- A special report including description of the nature, extent and need for the procedure is submitted to our Utilization Management team.
- A comparative CPT code should be included in the report to determine reimbursement.
- If the code is for a drug or equipment, the manufacturer’s invoice is required.

AS Modifier
Assistant Surgery Services (AS modifier) will no longer be accepted by Select Health. Health care professionals/providers must use the modifiers: 80, 81 or 82. CPT codes with the use of one of these modifiers will only be paid to MDs (not PAs or CNPs).

Claims for Newborn Care
A newborn child of a First Choice mother is automatically enrolled for health care services in First Choice.

The claim for baby must include the baby’s date of birth and Medicaid number as opposed to the mother’s date of birth. Newborns must be billed separately from the mother. If the baby has not been named, insert “Girl” or “Boy” in front of the mother’s last name as the baby’s first name. Verify that the appropriate last name is recorded for the mother and baby.

On claims for twins or other multiple births, indicate the birth order in the patient name field: for example, Baby Girl Smith A, Baby Girl Smith B, etc.

Rural Health Center/Federally Qualified Health Center Encounters
SCDHHS requires that Select Health submit encounter data to the state using standard ICD-9/ICD-10 and CPT coding. Select Health is not permitted to submit encounter data which consists of the Rural Health Center or Federally Qualified Health Center “T” code.

Claims received with the “T” code will be denied with instructions to refile using CPT codes.

Evaluation and Management services and lab charges should be billed on separate claim forms.

Family Planning Services
Family planning services should be billed using the appropriate CPT/HCPCS code with a FP modifier and an appropriate family planning diagnosis code. The family planning modifier (FP) is required on all claims with the exception of hospital claims.

Many medical procedures also have family planning implications. Medical procedures with family planning implications would not be billed with the FP modifier. Referrals are not required nor are co-pays applied to family planning services, including prescriptions. Family planning pharmaceuticals and devices are not counted toward the adult monthly prescription limit.

Echocardiography and Sleep Studies
Within physician specialties, there are certain services that may be rendered by physicians within that specialty. Other services would be considered to be outside of the scope of services for that specialty. Sleep studies and echocardiography are two of those services.

Specialties that will be allowed payment for sleep studies are Critical Care, Neurology, Otolaryngology, Pulmonary, Sleep Disorders and Neonatology. When billed by other physician specialties, the claim will deny with the reason “Not a Covered Service for Provider Specialty.”

Specialties that will be allowed payment for echocardiography are Anesthesiology, Cardiology, Cardiovascular Surgery and Radiology. When billed by other specialties, the claim will deny with the reason “Not a Covered Service For Provider Specialty.”
First Choice Covered Services
Advanced Outpatient Imaging Services
Select Health reimburses for advanced outpatient imaging services. The following services require prior authorization:

- Nuclear Cardiology
- Computed Tomography Angiography (CTA)
- Coronary Computed Tomography Angiography (CCTA)
- Computed Tomography (CT)
- Magnetic Resonance Angiography (MRA)
- Magnetic Resonance Imaging (MRI)
- Myocardial Perfusion Imaging (MPI)
- Positron Emission Tomography (PET)

Prior authorization of the above listed services will be administered by National Imaging Associates (NIA) through Select Health’s existing contractual relationships. A separate authorization number is required for each procedure ordered.

The following services do not require authorization through NIA:

- Inpatient advanced imaging services
- Observation setting advanced imaging services
- Emergency room imaging services

Select Health will continue to perform prior authorization for interventional radiology procedures (even those that utilize MR/CT technology).

The ordering physician* is responsible for obtaining a prior authorization for advanced imaging services. It is the responsibility of the rendering facility to ensure that prior authorization was obtained. Payment will be denied for procedures performed without a necessary authorization, and the member cannot be balance-billed for such procedures.

Prior authorization is obtained through NIA’s website at www.RadMD.com or by calling 1.800.424.4895.

Patient symptoms, past clinical history and prior treatment information will be required and should be available at the time of the contact.

Website Access
NIA’s website, www.RadMD.com is available 24 hours a day, seven days a week, except when maintenance is performed once every other week after business hours. To begin, you will need to obtain your own unique user name and password for each individual user in your office. Simply go to www.RadMD.com, click on the New User button and complete the application form.

- If requesting authorization through NIA’s website and your request is pended, you will receive a tracking number, and NIA will contact you to complete the process.
- The NIA website cannot be used for retrospective or expedited authorization requests. Those requests must be processed by calling 1.800.424.4895.

Telephone Access
Call center hours of operation are Monday through Friday, 8 a.m. to 8 p.m. Eastern Time. You can obtain a prior authorization by calling 1.800.424.4895.

Important Notes
- Authorizations are valid for 30 days from the date of the initial request.
- The NIA authorization number consists of eight or nine alpha/numeric characters. In some cases, you may receive an NIA tracking number (not the same as an authorization number), if your authorization request is not approved at the time of initial contact. You can use either number to track the status of the request on the RadMD website or via the Interactive Voice Response telephone system.
- For prior authorization complaints/appeals, please follow the instructions on your denial letter.
- NIA’s Clinical Guidelines can be found on NIA’s website, www.RadMD.com under Online Tools/Clinical Guidelines. NIA’s guidelines for the use of imaging examinations have been developed from practice experience, literature reviews, specialty criteria sets and empirical data.
- An authorization number is not a guarantee of payment. Coverage of the requested service is subject to all of the terms and conditions of the member’s benefit plan, including but not limited to member eligibility and benefit coverage at the time the services are provided.

*We ask the ordering physician to contact NIA to obtain the authorization because he/she is the best source for clinical information.
Audiological Services
Audiological Services involve testing and evaluation of hearing-impaired children less than 21 years of age who may or may not be improved with medication or surgical treatment.

Several audiology services are covered by Select Health under its contract with SCDHHS, up to the limits specified below:

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<th>Description</th>
<th>Limit</th>
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<td></td>
</tr>
<tr>
<td>92557</td>
<td>1 every 12 months</td>
<td></td>
</tr>
<tr>
<td>92557/52</td>
<td>6 every 12 months</td>
<td></td>
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<tr>
<td>92567</td>
<td>6 every 12 months</td>
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<td>92568</td>
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Behavioral Health Services
Select Health provides mental health and alcohol and other drug abuse coverage for members.

This benefit includes services rendered by licensed independent practitioners (psychologists, marriage and family counselors, professional counselors and independent social workers) as well as medical professionals (physicians, psychiatrists and nurse practitioners). Services include the professional, outpatient and inpatient charges associated with behavioral health services. For more detailed information, refer to the “Behavioral Health under First Choice” section of this manual.

Chiropractic Services
Chiropractic services are available to all recipients. Chiropractors specialize in the detection and correction of structural imbalance, distortion or subluxation in the human body. Select Health will cover authorized services up to 6 visits per state fiscal year.

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.

Communicable Disease
An array of communicable disease services are available to help control and prevent diseases such as tuberculosis (TB), syphilis and other sexually transmitted diseases (STDs) and HIV. Communicable disease services include examinations, assessments, diagnostic procedures, health education and counseling, treatment and contact tracing, according to the Centers for Disease Control standards. In addition, specialized outreach services are provided such as directly observed therapy for TB cases.

Eligible individuals should be encouraged to receive TB, STD and HIV/AIDS services through their primary care provider (PCP) or by appropriate referral to promote coordination of these services. However, individuals have the freedom to receive these services from any public health agency without restriction.

If the member receives these services through their PCP, First Choice will cover these services. If services are received through non-participating health care professionals/providers, Medicaid fee-for-service will cover these services.

Department of Alcohol and Other Drug Abuse Services
The provider network of the South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) and the services they provide are included as behavioral health services under Select Health covered responsibilities.

First Choice members receiving services from DAODAS providers will continue to receive those services with no disruption in treatment. The provider network of DAODAS will work directly with Select Health for needed authorizations to ensure continuity of care. Select Health will use the same medical necessity criteria currently in use by DAODAS. These criteria are available for review upon request. Providers can continue to refer members for these specialty services directly to the DAODAS provider network.

To learn more, visit the DAODAS website at www.
daodas.state.sc.us for a facility locator and information on alcohol and drug abuse services.

**Durable Medical Equipment**

Durable medical equipment includes medical products, surgical supplies and equipment such as wheelchairs, prosthetic and orthotic devices and hearing aid services when ordered by a physician as medically necessary in the treatment of a specific medical condition. Luxury and deluxe models are restricted if standard models would be appropriate. Repairs to medical equipment are covered if reasonable.

**Emergency, Non-Emergency Medical Transportation**

Medical necessity for ambulance transport is established when the recipient’s condition warrants the use of ambulance transportation and the use of any other method is not appropriate. These trips may be routine or non-routine transports to a Medicaid-covered service. Types of services include ambulance, non-emergency medical vehicles and air ambulances.

**Family Planning**

Family Planning services are pregnancy prevention services for males (vasectomies) and females of reproductive age (usually between the ages of 10 and 55 years). Effective Jan. 1, 2014, family planning services including office visits/exams, preventive contraceptive methods, prescriptions, lab work and counseling are covered by First Choice. Family planning waiver recipients are not eligible for First Choice. Members are encouraged to use participating providers but may choose any provider. Non-participating providers should notify Medical Affairs at 1.888.559.1010 when providing services to First Choice members. Refer to the Billing Requirements for Certain Services section *(page 58 of this manual)* for billing details.

As a result of this benefit coverage, the First Choice member ID cards have changed. Refer to the Exhibits section of this manual to see the new ID cards.

**Hearing Aids and Hearing Aid Accessories**

Select Health is responsible for providing the following for members under age 21:

- **L8615:** Headset/headpiece for use with cochlear implant device, replacement
- **L8619:** Cochlear implant, external speech processor and controller, integrated system, replacement
- **L8621 – L8624:** Cochlear implant batteries
- **V5030 – V5267:** Hearing aids and accessories
- **L9900:** Orthotic and prosthetic supply, accessory, and/or service component of another HCPCS L code

Providers should order hearing aid batteries through SCDHEC who will supply the batteries and submit a claim to Select Health. A battery request form is available in the Exhibit section of this manual and on the Select Health website.

**Home Health Services**

Home health services are health care services delivered in a person’s place of residence, excluding nursing homes and institutions and include intermittent skilled nursing, home health aide, physical, occupational and speech therapy services and physician-ordered supplies. There is a home health visit limitation of 50 visits per year. Home health services require prior authorization after the first 6 visits. One authorization will cover all services rendered (visit, therapies, supplies, etc.) on the date(s) authorized; a separate authorization is not required for each service.

**Independent Laboratory and Radiology Services**

Benefits cover laboratory and x-ray services ordered by a physician and provided by independent laboratories and free-standing x-ray facilities. An independent laboratory and/or x-ray facility is defined as a facility licensed by the appropriate state authority and not part of a hospital, clinic or physician office.

Providers should refer to participating laboratories and free-standing facilities. For First Choice members the preferred laboratory is LabCorp.

Select Health uses the South Carolina Medicaid Health care professional/provider list to determine if a health care professional/provider is an independent lab or a free-standing x-ray facility.

**Inpatient Hospital Services**

Inpatient hospital services are those items and services provided under the direction of a physician, furnished to a patient who is admitted to a general
acute care medical facility for institutional and professional services on a continuous basis and for which admission is expected to last for a period greater than 24 hours. Among other services, inpatient hospital services encompass a full range of medically necessary diagnostic, therapeutic care including surgical, medical, general nursing, radiological and rehabilitative services in emergency or non-emergency conditions. Additional inpatient hospital services would include room and board, miscellaneous hospital services, medical supplies and equipment.

**Long-Term Care Facilities**
The first **90** days of continuous confinement in a long-term care facility, nursing home, or hospital that provides swing bed or administrative days are covered by Select Health. This responsibility can be up to **120** continuous days of confinement or until the member can be disenrolled at the earliest effective date allowed by system edits, at which time payment for institutional long-term care services will be reimbursed fee-for-service by the Medicaid program.

**Maternity Care**
Maternity services include high levels of quality care for pregnant members. Maternity care service benefits include prenatal, delivery, postpartum services and nursery charges for a normal pregnancy or complications related to the pregnancy.

Note: Select Health follows the American Medical Association (AMA) guidelines when considering initial obstetrical exams for existing patients. These guidelines 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.

**Maternity Coordination of Benefits (COB) with Global Codes**
Select Health does not reimburse maternity claims based on global procedure codes (59400, 59510, 59610 or 59618). However, other insurance carriers may pay based on these global codes and providers may submit claims with the global EOB.

Providers should bill Select Health with the **appropriate delivery only procedure codes**. After reviewing the member’s maternity claims history, the difference between the Select Health maximum allowable for all routine maternity services and the amount paid by the primary carrier for the global maternity service will be paid; provided that this difference does not exceed the member’s liability (including copay, coinsurance/ deductible).

**Non-Payment For Early Elective Deliveries**
In accordance with the SCDHHS Birth Outcomes Initiative, effective for dates of service on or after Jan. 1, 2013, Select Health of South Carolina, no longer provides reimbursement to hospitals or physicians for elective inductions or non-medically indicated deliveries prior to 39 weeks. This is a result of an extensive effort to reduce non-medically necessary deliveries.

Physicians must continue to append the following modifiers to all surgical CPT codes when billing for vaginal deliveries and cesarean sections or their claims will be automatically denied:

- **GB** – 39 weeks gestation or more
  - For all deliveries at 39 weeks gestation or more regardless of method (induction, cesarean 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.
  - For inductions or cesarean sections that meet the ACOG guidelines, the appropriate ACOG Patient Safety Checklist must be completed and maintained for documentation in the patient’s file.
  - For inductions or cesarean sections that do not meet the ACOG guidelines, the appropriate ACOG Patient Safety Checklist must be completed. Additionally, the physician must obtain and document approval from the regional perinatal center’s maternal fetal medicine physician in the patient’s file and in the hospital record.

- **No Modifier** – claims that do not have the GB/CG modifiers indicated will be denied
  - For elective deliveries less than 39 weeks gestation that do not meet ACOG approved guidelines or are not approved by the designated regional perinatal center’s maternal fetal medicine physician.

**Nutritional Counseling Program**
Effective August 1, 2015, a nutritional counseling program was implemented for Select Health members
with a body mass index (BMI) of 30 and greater who are not seeking gastric bypass surgery or related services. The Nutritional Counseling program will exclude the following member categories:

- Dual eligible
- Pregnant women
- Those who have had bariatric surgery, gastric banding or other related procedures
- Beneficiaries receiving active treatment with Gastric Bypass Surgery/Vertical-Banded Gastroplasty
- Patients, for whom medication use has significantly contributed to the beneficiary’s obesity as determined by the treating physician. Examples of medications that may cause weight gain include but are not limited to:
  - Atypical antipsychotics (aripiprazone, olanzapine, quetiapine, risperidone, ziprasidone)
  - Long-term use of oral corticosteroids (prednisone, prednisolone)
  - Certain anticonvulsant medications (valproic acid, carbamazepine)
  - Tricyclic antidepressants (amitriptyline)

The nutritional counselling program consists of screening for obesity in adults using the patient’s BMI, dietary nutritional assessments, intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high intensity interventions on diet and exercise. Adult beneficiaries who are committed to losing weight through diet and exercise will be eligible for an initial screening, five additional face to face behavioral counseling visits/encounters with a physician, physician assistant, and/or a nurse practitioner, an initial dietitian visit for nutritional counseling, and five follow up visits. Obesity-management-related treatment for children will continue to be covered as a part of the Medicaid Early Periodic Screening Diagnosis and Testing (EPSDT) Program.

Dietitian Enrollment: Licensed Dietitians (LD) providing nutritional counseling services for obesity will be recognized as a provider type by SCDHHS and Select Health. In order for LDs to be reimbursed directly for services rendered they must enroll with both SCDHHS and Select Health. A LD must meet the South Carolina licensure and educational requirements. LDs practicing within 25 miles of the South Carolina border in Georgia or North Carolina must meet the licensure and educational requirements of the State in which the LD practices. All services must be rendered within the South Carolina Medicaid Service Area (SCMSA). SCMSA is defined as South Carolina and adjacent areas within 25 miles of its borders.

Hospitals employing LDs will be reimbursed for nutritional counseling services for obesity by enrolling them directly with SCDHHS and Select Health and linking the LDs to the hospital’s professional clinical groups. LDs may enroll utilizing the provider credentialing process outlined on the Select Health website at http://www.selecthealthofsc.com/provider/resources/credentialing.aspx.

Observation Services
Observation stays do not require prior authorization or notification unless the diagnosis at admission is maternity related.

Continued hospitalization past 24 hours (observation or inpatient admission) will require authorization submission at the level of care indicated by the treating physician. Medical determination will be based on admission documentation and physician evaluation for the time under observation care. This information along with the assessment and plan of the treating physician will guide medical necessity determination for continued hospitalization at the requested level of care.

For questions, please contact Medical Management at 1.888.559.1010.

Outpatient Services
Outpatient services are defined as those preventive diagnostic, therapeutic, rehabilitative, surgical and emergency services received by a patient for the treatment of a disease or injury at an outpatient/ambulatory care facility for a period of time generally not exceeding 24 hours. Enrolled First Choice members do not have any limitations on the number of outpatient visits they may receive in any given time.

Physician Services
Physician services include the full range of preventive care services, primary care medical services and physician specialty services. All services must be medically necessary and appropriate for the treatment of a specific diagnosis as needed for the
prevention, diagnostic, therapeutic care and treatment of the specific condition. Physician services are performed at the physician's office, patient's home, clinic or skilled nursing facility. Technical services performed in a physician's office are considered part of the professional services delivered in an ambulatory setting unless designated as a separate service.

**Podiatry Services**

Podiatry services are those services medically necessary for the diagnosis and treatment of foot conditions. Services are limited to specialized care of the foot for members with a diagnosis of diabetes. Podiatrists must include the appropriate diabetic diagnosis on the claim to obtain payment.

**Prescription Drugs**

Covered pharmaceutical services include most legend (prescription) and certain non-legend (over-the-counter) products. Select Health sponsors reimbursement for unlimited prescriptions or refills for First Choice members younger than 21 years old, and up to four prescriptions or refills per month for members 21 years and older. However, certain items are exempt from the monthly prescription limit. The exemptions to the monthly limit are as follows: insulin syringes; home parental therapies; aerosolized pentamidine; Imitrex, Betaseron, epinephrine and diabetic emergency kits and clozapine therapy. Where appropriate, medications are prescribed to cover a maximum of 31 days.

A $3.40 per prescription co-pay applies, with the exception of the following members:

- Children
- Federally recognized Native Americans
- 18 years of age or younger
- Pregnant
- Long-term care facility residents
- Receiving hospice, emergency, ESRD, infusion center or family planning services

Select Health does not cover brand name products for which there are “A” rated, therapeutically equivalent, less costly generics available unless prior authorization is secured.

Prior authorization is required for select pharmaceuticals. Please see the Select Health plan’s Preferred Drug List for a complete listing. Health care professionals/providers may contact Select Health/AmeriHealth Caritas Pharmacy Services for prior authorization at 1.866.610.2773 or fax to 1.866.610.2775. Health care professionals/providers may obtain the PDL and authorization forms from the Select Health website: www.selecthealthofsc.com.

**Rehabilitative Therapies**

Rehabilitative therapy services include speech pathology and physical and occupational therapies, and are a covered benefit for all members. Services are provided through private rehabilitation clinics/health care professionals/providers up to 420 units or 105 hours per year (this limit applies to all of the rehabilitative services combined).

For hospital providers billing therapy procedures, the revenue code and the applicable CPT procedure code for the specified therapy must be submitted. For therapy procedures defined in 15-minute sessions, each 15-minute session will equal 1 unit and sessions are limited to 4 units per date of service.

**Topical Fluoride Varnish**

The best practices of the American Academy of Pediatrics recommend that children from the eruption of their first tooth through the month of their thirteenth birthday should receive fluoride varnish application in their primary care physician’s office during their EPSDT visit two times per year (once every six months).

The primary care physician will bill procedure code 99188 to Select Health on the CMS 1500 claim form.

**Vision Care Services**

All vision services for members under the age of 21 will be covered by Select Health of South Carolina. Covered vision services for these members include:

- Routine vision exams, including refractions
- Initial and replacement eyeglasses*
- Contacts (when medically necessary)
- Fitting and dispensing fees

*Members will be able to receive one replacement pair of eyeglasses per State Fiscal Year. (The State Fiscal Year runs from July 1st to June 30th.)

Members age 21 and older may only receive vision services when those services are identified as being medically necessary and not routine care. This would include services related to diseases of the eye (e.g. glaucoma, conjunctivitis and cataracts).
First Choice members with diabetes, regardless of age, are eligible for dilated eye exams with refraction. Claims should always be submitted with the diabetic diagnosis primary and the applicable vision-related diagnosis code secondary, if there are findings during the exam. Vision providers will be reimbursed for the vision exam, including the refraction component for members with diabetes.

Prior authorization is not required for participating health care professionals/providers (except for contacts, including the dispensing fee). Non-participating health care professionals/providers are required to obtain authorization for all services.

Eyeglasses will be provided by Robertson Optical Laboratories, the exclusive vendor for Select Health. All vision providers will be required to display current Medicaid frames from Robertson Optical. The physician ordering the eyeglasses, not Robertson Optical, must ensure that the member’s eligibility is current prior to placing the order. To assist our health care professionals/providers with the administration of this benefit, Robertson Optical will submit claims for eyeglasses directly to Select Health.

Services Provided by Medicaid Fee-for-Service
Select Health primary care providers (PCPs) or Select Health care managers may identify services required for members that are outside of the benefits package available to First Choice members. Medicaid fee-for-service may cover these services, and the Select Health Medical Management staff may assist the health care professional/provider and member in contacting the appropriate agency to access these services.

The following is a summary list of Medicaid fee-for-service benefits that may be coordinated by Select Health and the Department of Health and Human Services:

- **Dental Services**: Routine dental services are available to those under 21 years of age. Emergency dental services are available to all members.
- **Developmental Evaluation Services**: defined as medically necessary comprehensive neurodevelopmental and psychological developmental, evaluation and treatment services for recipients between birth and age 21. Developmental Evaluation Services may be provided through the plan’s network health care professionals/providers, which may include but shall not be limited to one of the two tertiary level Developmental Evaluation Centers (DEC) located within the The University School of Medicine, USC in Columbia or the Medical University of South Carolina at Charleston.
- **Fluoride Varnish Applications**: The purpose of applying fluoride varnish during an EPSDT well-child visit is to increase access to preventive dental treatment in an effort to intercept and prevent early childhood caries in children at moderate to high risk for dental caries. If this service is rendered in the dentist’s office it is covered by Medicaid fee-for-service.
- **Gardasil Vaccine**: This is the only cervical cancer vaccine that helps protect against four types of human papillomavirus (HPV): 2 types that cause 70 percent of cervical cancer cases and 2 more types that cause 90 percent of genital warts cases. Gardasil is for girls, young women, boys and young men ages 9 to 26.
- **Home- and Community-Based Waiver Services**: Targets members with long-term care needs and provides recipients access to services that enable them to remain at home rather than in an institutional setting. Waivers currently exist for the following special needs populations:
  - Persons with HIV/AIDS
  - Persons who are elderly or disabled
  - Persons with mental retardation or related disabilities
  - Persons who are dependent upon mechanical ventilation
  - Persons with pervasive developmental disorders
  - Persons enrolled in the Medically Complex Children’s waiver
  - Persons who are head or spinal cord injured
  - Women at or below 185 percent of federal poverty level for Family Planning Services only
- **Long-Term Care/Nursing Home**: after the first 90 to 120 days.
- **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 reimburses the following mental health, alcohol and other drug abuse treatment services:
• Services provided or referred by targeted case management (e.g. Department of Mental Health [DMH])
• Services rendered at residential treatment facilities
• Intensive family treatment services
• Therapeutic day services for children
• Out-of-home therapeutic placement services for children
• Inpatient psychiatric hospital services at a DMH inpatient facility

**Non-Emergency Medical Transportation:**
Coordinated with the transportation broker in the member's county of residence.

**Organ Transplants:** Includes pre-transplant services (72 hours preadmission), the event (hospital admission through discharge) and post-transplant services up to 90 days from the date of discharge. For information concerning the referral for medical evaluation and transplant arrangements, please contact the following:

*Transplant Coordinator*

**MUHA (Medical University Hospital Authority)**

**843.792.2123**

The following are not considered to be standard transplant services and remain the responsibility of First Choice:

• Corneal transplants
• Pre-transplant services rendered prior to 72 hours preadmission
• Post-transplant follow-up services
• Post-transplant pharmaceutical services

**Pregnancy Prevention Services:** Medicaid Fee-for-Service will reimburse directly to enrolled Medicaid health care professionals/providers for these services. The following programs are available:

• **MAPPS Family Planning Services:** Medicaid Adolescent Pregnancy Prevention Services provides Medicaid-funded family planning services to at-risk youths. These services are provided in local South Carolina Department of Social Services offices, schools, office settings, homes and other approved settings.

**Targeted Case Management Services:** Consist of services that will assist an individual eligible under the state plan in gaining access to needed medical, social, educational and other services. A systematic referral process to health care professionals/providers for medical education, legal and rehabilitation services with documented follow up must be included. Case management services ensure that necessary services are available and accessed for each eligible patient.

Case management services are offered to alcohol and substance abuse individuals, children in foster care, chronically mentally ill adults, emotionally disturbed children, children in the juvenile justice system, sensory impaired individuals, individuals with mental retardation or a related disability, individuals with a head or spinal cord injury or a related disability and adults in need of protective services. Medicaid reimbursable Targeted Case Management programs available to recipients are administered by the following:

• **Department of Mental Health:** Services for mentally ill adults and children with serious emotional disturbances.

• **Department of Juvenile Justice:** Services for children from birth to age 21 who are within the juvenile justice system.

• **Department of Social Services (DSS):** Services to emotionally disturbed children 0-21 in the custody of DSS and placed in foster care and adults 18 and over in need of protective services.

• **Continuum of Care for Emotionally Disturbed Children:** Children from birth to age 21 who are severely emotionally disturbed.

• **Department of Disabilities and Special Needs:** Services to individuals with mental retardation, developmental disabilities and head and spinal cord injuries.

• **Home and Community-Based Waiver Services:** Services target persons with long-term care needs and provide beneficiaries access to services that enable them to remain at home rather than in an institutional setting. Waivers currently exist for the following special needs populations:
  • Persons with HIV/AIDS
  • Persons who are elderly or disabled
  • Persons with mental retardation or related disabilities
  • Persons who are dependent upon mechanical ventilation
  • Persons with pervasive developmental disorders
• Persons enrolled in the Medically Complex Children’s waiver
• Persons who are head- or spinal cord-injured
• South Carolina School for the Deaf and the Blind: Services to sensory impaired children from birth to age 6.
• Sickle Cell Foundations and Other Authorized Health care professionals/providers: Services to individuals with sickle cell disease and/or trait. Medical University of South Carolina provides services to individuals with this disease.
Exhibit Listing

1. Definitions
2. SC Healthy Connections ID Card
3. New First Choice ID Card
4. Chart, Periodic Health Examinations in Children
5. Chart, Periodic Health Examinations in Adults
6. Chart, Obstetrical Care
7. First Choice Prior Authorization Information
8. Prior Authorization Request Form: Medications
9. Behavioral Health Outpatient Treatment Form
10. Behavioral Health Testing Form
11. Behavioral Health Crisis Intervention Form
12. Pregnancy Risk Assessment Information
13. Universal Newborn Prior Authorization Form
14. SBIRT Screening Tool
15. Universal 17-P Authorization Form
16. Surgical Justification Review for Hysterectomy
17. Consent for Sterilization 1723
18. Request For Prior Authorization/General
19. Request For Prior Authorization/DME
20. Physician Certification of Incontinence 1681S
21. Request For Prior Authorization/PT/OT/ST/Chiro
22. Member Consent to Provider Form
23. Hearing Aid Battery Request Form
24. Provider Refund Claim Form
25. Sample WIC Referral Form
26. Sample Provider/Member Roster
27. Sample Select Health Remittance Advice
**DEFINITIONS**

**Action:** (1) the denial or limited authorization of a requested service, including the type or level of service; (2) the reduction, suspension, or termination of a previously authorized service; (3) the denial, in whole or in part, of payment for a service; (4) the failure to provide services in a timely manner, as defined by SCDHHS; (5) the failure of the managed care organization (MCO) to act within the time frames provided in 42 C.F.R.§ 438.408(b) as further provided by SCDHHS in Select Health’s contract with SCDHHS; or (6) for a resident of a rural area with only one MCO, the denial of a Healthy Connections MCO member’s request to exercise his or her right, under 42 C.F.R.§ 438.52(b)(2)(ii), to obtain services outside the MCO’s network.

**Appeal:** Request for review of a pre-service action.

**Claim Form:** A statement for covered services provided by hospital/health care professional/provider and which is on a form or in a format acceptable to plan (UB04 or CMS1500).

**Compensation:** Remuneration to the participating health care professional/provider for services rendered to plan members through fee for service, capitation and/or other services payment for the procedures as listed herein:

a. **Capitation payment** means monthly remuneration according to the participation agreement for services provided by the health care professional/provider and covered by the plan, but subject to plan member access, quality assurance and utilization criteria retroactive review by the plan.

b. **Other services payment** means remuneration paid by the plan for services listed in the provider participation agreement under attachment A or subsequently approved by the plan at a negotiated rate. Remuneration to be paid subject to receipt and processing of other services claim.

**Covered Services:** Those health services and benefits to which plan members are entitled and that the health care professional/provider has agreed to provide plans members as set forth in the provider participation agreement and in accordance with the Title XIX SC State Medicaid Plan.

**Dispute:** an escalated verbal or written expression of dissatisfaction by a health care professional/provider, not otherwise acting in the capacity of an authorized representative of a Select Health member, to dispute the denial of payment of a claim or regarding a decision that directly impacts the health care professional/provider.

**Medical Director:** A physician designated by plan to monitor and review covered services to members provided or requested by a healthcare health care professional/provider.

**Medically Necessary:** Those medical services or supplies as provided by a hospital, skilled nursing facility, physician or other medical health care professional/provider who are required to identify, treat or avoid an illness or injury to a member and which, as determined by plan’s participating physician, medical director or utilization review process, are:

a. consistent with the symptoms or diagnosis and treatment of the member’s condition, disease, ailment or injury;

b. appropriate with regard to standards of good medical practice;

c. not solely for the convenience of the member, his or her participating physician, hospital, or other healthcare health care professional/provider; and

d. the most appropriate supply or level of service that can be safely provided to the member. When specifically applied to a potential inpatient member, it further means that the member’s medical symptoms or condition require that the diagnosis or treatment cannot be safely provided to the member as an outpatient.

**Member:** A person for whom premium payment has been made to and received by plan.

**Non-Participating Health Care Professional/Provider:** Any healthcare health care professional/provider who has not contracted with Select Health to provide covered services to members.

**Participating Health Care Professional/Provider:** Hospitals, physicians, nurse-midwives, midwives, birth centers, home health agencies, dentists, nurses, optometrists, physician assistants, clinical psychologists, social workers, pharmacists, occupational
therapists, physical therapists and any other health-care health care professionals/providers who/which are licensed, practice under an institutional license or are certified to practice under other authority consistent with the laws of South Carolina and who/which have been approved by plan or with whom plan has contracted to provide professional or health services to members.

**Physician:** A doctor of medicine or osteopathy, podiatrist, chiropractor, psychologist or mental health professional duly licensed to practice in the state of South Carolina. The following physician designations are used within the context of participation with Select Health: participating physician, participating primary care physician and participating specialist physician.

a. **Participating Physician:** Either a participating primary care physician or participating referral specialist physician who has contracted with Select Health to provide professional services to members.

b. **Participating Primary Care Physician:** A participating physician who provides primary care services to members (e.g., general practitioner, family physician, general internist or pediatrician or such other physician specialty as may be designated by the health plan) and is responsible when medically indicated for referrals of members to participating specialist physicians, other participating health care professionals/providers and, if necessary, non-participating health care professionals/providers. Except as otherwise permitted by Select Health, each member shall select or have selected on his or her behalf a participating primary care physician.

c. **Participating Specialist Physician:** A participating physician who is responsible for providing specialist services upon referral by a participating primary care physician.

**Prior Authorization Number:** A number provided by the health plan that the health care professional/provider utilizes to receive payment for services rendered to a member.

**South Carolina Department of Health and Human Services (SCDHHS):** The state agency responsible for administering South Carolina’s Medicaid program.

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**SC HEALTHY CONNECTIONS CARD**

Request Insurance ID Card. Follow applicable instructions. You must verify eligibility on each visit through the IVRS system at 1.888.809.3040, online through Medifax or you may visit the Select Health website at www.selecthealthofsc.com. On the IVRS or Medifax, a message will indicate at the end of verification if this person is on a managed care plan. Various swipe machines are available for a fee to verify eligibility through a printout. The name of managed care plan will be noted at the end of the printout.

Cards with the previous design (left) are still in use and valid, too.

**NEW FIRST CHOICE MEMBER ID CARD**

Member’s name, Healthy Connections ID number, member’s preferred language, primary care provider (PCP), PCP’s phone number and effective date of enrollment are on the front of card. Health care professional/provider information, authorization and claim information are on the back of card.

Eligibility may also be verified through the NaviNet website at www.navinet.navimedix.com.

The old First Choice member ID card (with a gold background, pictured here) is not valid as of 1/1/2014.

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*CLICK HERE TO RETURN TO TABLE OF CONTENTS*
# Chart, Periodic Health Guidelines for Children

A baseline visit is recommended and encouraged for all new plan members. Further visits should be scheduled according to relevant guidelines outlined below or as needed. Delivery of clinical preventive services should not be limited only to visits for health maintenance, but also should be provided as part of visits for other reasons, such as acute and chronic care.

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<td>At age 16</td>
<td></td>
</tr>
<tr>
<td>Lead screening</td>
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<tr>
<td><strong>Procedures—patients at risk</strong></td>
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</tbody>
</table>
| Pap smear                         |       |            |         |          |          |          |          |          |            |           |           |           |         |        |        | Every three years, starting at age 21.
| Pelvic exam                       |       |            |         |          |          |          |          |          |            |           |           |           |         |        |        | Each year for all sexually active young women, or starting at age 21.
| Chlamydial infection screening    |       |            |         |          |          |          |          |          |            |           |           |           |         |        |        | Each year for all sexually active, non-pregnant young women from 16 to 24 years of age.
| Sickle cell screening             |       |            |         |          |          |          |          |          |            |           |           |           |         |        |        | Indicated by family or medical history or in the presence of anemia.
| Tuberculin testing                |       |            |         |          |          |          |          |          |            |           |           |           |         |        |        | Upon recognition of high-risk factors.
| Parasite testing                  |       |            |         |          |          |          |          |          |            |           |           |           |         |        |        | When indicated by medical history, physical exam or a positive result of previous test.
| **Preventive counseling and anticipatory guidance** |       |            |         |          |          |          |          |          |           |           |           |           |         |        |        |                |
| Nutrition—2 years and younger     |       |            |         |          |          |          |          |          |           |           |           |           |         |        |        | Encourage mothers to breast-feed for 6-12 months if possible. Encourage use of iron-rich food, formula and cereal. Counsel parents about vitamin supplements.
| Nutrition—2 years and older       |       |            |         |          |          |          |          |          |           |           |           |           |         |        |        | Counsel parents that children need a balanced diet that is low in fat and includes a variety of foods. Encourage parents and children to use sugar and salt only in moderation. Counsel parents and children about the importance of maintaining a healthy weight.
| Injury and violence prevention    |       |            |         |          |          |          |          |          |           |           |           |           |         |        |        | See age-appropriate counseling for injury prevention. Includes seat belt usage, bicycle helmet usage, installing smoke detectors, safe storage of firearms and monitoring hot water temperatures (<120 degrees) with infants.
| Dental health                     |       |            |         |          |          |          |          |          |           |           |           |           |         |        |        | Brush with fluoride toothpaste, floss daily and visit a dentist regularly. Children 6 months to 12 years using well water should take a fluoride supplement.
| Skin cancer                       |       |            |         |          |          |          |          |          |           |           |           |           |         |        |        | Avoid excess sun exposure, especially those at high risk (fair hair, light skin, easy to burn, freckles). Use sunscreen when in the sun.
| Parental concerns                 |       |            |         |          |          |          |          |          |           |           |           |           |         |        |        | Encourage parents to discuss any concerns regarding their child's health, safety and behavior.
| **Immunization schedules**        |       |            |         |          |          |          |          |          |           |           |           |           |         |        |        |                |

Approved: 7/03, 3/05, 3/07, 8/08, 3/09, 12/11, 5/12, 5/13, 5/14

### Chart, Periodic Health Guidelines for Adults

#### Adult Preventive Health Guidelines

<table>
<thead>
<tr>
<th>Age</th>
<th>Physical examination</th>
<th>Blood pressure</th>
<th>Body Mass Index (BMI)</th>
<th>Cholesterol</th>
<th>Pap smear</th>
<th>Pelvic exam</th>
<th>Chlamydial infection screening</th>
<th>Mammogram</th>
<th>Clinical breast exam</th>
<th>Self breast exam</th>
<th>Physician testicular exam</th>
<th>Prostate-specific antigen (PSA)</th>
<th>Self testicular exam</th>
<th>Skin exam</th>
<th>Tuberculin skin test</th>
<th>Routine lab (UA, CBC, blood chemistry, STD screening)</th>
<th>Fecal occult blood</th>
<th>Colposcopy</th>
<th>Preventive Counseling</th>
<th>Adult Immunizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 21-29</td>
<td>Every 2-3 years</td>
<td>Every year</td>
<td>Every 3 years</td>
<td>Every 3 years</td>
<td>Every 3 years</td>
<td>Ever year</td>
<td>All sexually active non-pregnant young women age 24 and younger.</td>
<td>Baseline at age 35-40 or as suggested by your doctor. Every year for high-risk women beginning at the age of 35.</td>
<td>Every year</td>
<td>Every year</td>
<td>Monthly</td>
<td>Every year</td>
<td>Every year</td>
<td>Monthly</td>
<td>Every 3 years</td>
<td>All high risk individuals</td>
<td>Yearly as appropriate</td>
<td>Yearly as appropriate</td>
<td>Yearly as appropriate</td>
<td>Yearly as appropriate</td>
</tr>
<tr>
<td>Age 30-39</td>
<td>Every 2-3 years</td>
<td>Every year</td>
<td>Every year</td>
<td>Every 3 years</td>
<td>Every year</td>
<td>Every year</td>
<td>All older non-pregnant women who are at increased risk.</td>
<td>Every 1-2 years or as suggested by your doctor.</td>
<td>Every year</td>
<td>Every year</td>
<td>Monthly</td>
<td>Every year</td>
<td>Every year</td>
<td>Monthly</td>
<td>Every 3 years</td>
<td>All high-risk individuals</td>
<td>Yearly as appropriate</td>
<td>Yearly as appropriate</td>
<td>Yearly as appropriate</td>
<td>Yearly as appropriate</td>
</tr>
<tr>
<td>Age 40-49</td>
<td>Every 2-3 years</td>
<td>Every year</td>
<td>Every year</td>
<td>Every 3 years</td>
<td>Every year</td>
<td>Every year</td>
<td>All older non-pregnant women who are at increased risk.</td>
<td>Every 1-2 years or as suggested by your doctor.</td>
<td>Every year</td>
<td>Every year</td>
<td>Monthly</td>
<td>Every year</td>
<td>Every year</td>
<td>Monthly</td>
<td>Every 3 years</td>
<td>All high-risk individuals</td>
<td>Yearly as appropriate</td>
<td>Yearly as appropriate</td>
<td>Yearly as appropriate</td>
<td>Yearly as appropriate</td>
</tr>
<tr>
<td>Age 50-59</td>
<td>Every 1-3 years</td>
<td>Every year</td>
<td>Every year</td>
<td>Every 3 years</td>
<td>Every year</td>
<td>Every year</td>
<td>All older non-pregnant women who are at increased risk.</td>
<td>Every 1-2 years or as suggested by your doctor.</td>
<td>Every year</td>
<td>Every year</td>
<td>Monthly</td>
<td>Every year</td>
<td>Every year</td>
<td>Monthly</td>
<td>Every 3 years</td>
<td>All high-risk individuals</td>
<td>Yearly as appropriate</td>
<td>Yearly as appropriate</td>
<td>Yearly as appropriate</td>
<td>Yearly as appropriate</td>
</tr>
</tbody>
</table>

- **Physical examination**: Every 2-3 years, consider age, sex and risk factors.
- **Blood pressure**: At least every 1-2 years.
- **Body Mass Index (BMI)**: Every year or as suggested by your doctor.
- **Cholesterol**: Every 4-5 years, patients with positive risk factors should be monitored more frequently.
- **Pap smear**: Every 3 years for cervical cytology screening or as suggested by your doctor.
- **Pelvic exam**: Every year, beginning at age 21 or earlier for all sexually active young women.
- **Chlamydial infection screening**: All sexually active non-pregnant young women age 24 and younger.
- **Mammogram**: Baseline at age 35-40 or as suggested by your doctor.
- **Clinical breast exam**: Every year.
- **Self breast exam**: Monthly.
- **Physician testicular exam**: Every year.
- **Prostate-specific antigen (PSA)**: Every year.
- **Skin exam**: Every 3 years.
- **Tuberculin skin test**: All high-risk individuals.
- **Routine lab (UA, CBC, blood chemistry, STD screening)**: Yearly as appropriate.
- **Fecal occult blood**: Yearly for patients with a family history of colorectal cancer.
- **Colonoscopy**: Every 5-10 years depending on family history and findings.
- **Preventive Counseling**:
  - **Tobacco cessation**: Hazards of tobacco use. Seek counseling to stop smoking and/or chewing tobacco.
  - **Alcohol/drug treatment**: Hazards of alcohol and/or drug use. Avoid excessive alcohol use and do not drive while under the influence of alcohol.
  - **Diet and exercise**: Limit fat and cholesterol, maintain caloric balance and emphasize grains, fruits, vegetables and adequate calcium intake for women.
  - **Injury prevention**: Lap and shoulder belts, smoke detectors, safe storage and removal of firearms and back injury prevention.
  - **Skin cancer**: Avoid excess sun exposure and use a sunscreen when in the sun.
  - **Dental health**: Regular visits to the dentist, floss and brush.
  - **Folic acid**: All women who are planning or capable of pregnancy should take a daily multivitamin containing the recommended amount of folic acid.
  - **Self-examination**: Breast, skin and testes.
  - **Depression**: Assessment and screening.
- **Adult Immunizations**: Refer to the CDC website for the recommended adult immunization schedule: [http://www.cdc.gov/vaccines/schedules/downloads/adult/adult-schedule.pdf](http://www.cdc.gov/vaccines/schedules/downloads/adult/adult-schedule.pdf)
Obstetrical Guidelines

Frequency of visits

The frequency of follow-up visits is determined by the individual needs of the woman and the assessment of her risks. Generally, a woman with an uncomplicated pregnancy is examined every 4 weeks for the first 32 weeks of gestation, every 2-3 weeks until 36 weeks of gestation and weekly from 37 weeks until delivery.

<table>
<thead>
<tr>
<th>Recommended intervals for routine tests and tests indicated as medically necessary for individual patients during pregnancy:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Time (in weeks)</strong></td>
</tr>
</tbody>
</table>
| Initial visit, as early as possible | ★ History and risk assessment; obtain obstetric database that contains information regarding the patient’s:  
- Last menstrual period  
- Current pregnancy and past obstetric outcomes  
- Medical and social history  
- Dietary assessment  
- Physical findings  
- Estimated date of delivery (EDD)  
- Laboratory tests (including HIV screening)  
- Risk assessment (SCDHHS Pregnancy Form 204[P])  
- Dating ultrasound  
- Hemoglobin or hematocrit measurement  
- Hemoglobin electrophoresis for African American, Asian or Hispanic patients  
- Urine culture  
- Blood group and Rh type determinations  
- Antibody screen  
- Rubella antibody titer measurement  
- Syphilis screen  
- Cervical cytology  
- Hepatitis B surface antigen  
- Testing for gonorrhea, chlamydia and HIV  
- Offer cystic fibrosis screening  
- Blood pressure management  
- Urinalysis for glucose/albumin  
- Weight measurement and cumulative weight gain  
- Fetal movement  
- Evaluation of edema  
- Measurement of fundal height  
- Evaluation of fetal heart tones and rate  |
| Subsequent prenatal visits | Amniocentesis, if indicated  
- Offer genetic counseling to patients above age 35 or carrying twins above age 33 or with abnormal aneuploidy screening  
- Chronic villus sampling, if indicated  
- Offer nuchal translucency screening (between 10–13 wks)  |
| 8–18 | Maternal serum alpha-fetoprotein after 1st trimester nuchal translucency  
- Offer quad screening (if 1st trimester screening was not performed)  |
| 16–18 | Anatomy screening  |
| 18–22 | Diabetes screening  
- Repeated hemoglobin or hematocrit measurement  |
| 24–28 | Prophylactic administration of Rh(D) immune globulin for Rh Neg patients  
- Fetal movement counting instruction |
| 32–36 | Testing for sexually transmitted disease for patients with STD in pregnancy or significant history  |
| 35–37 | Group B strep screening |
| Patient education and information (ongoing) | Counseling is an ongoing and continuous process throughout the prenatal period. These items should be addressed as early as possible during prenatal care and continually reassessed:  
- Signs and symptoms to be reported to the physician  
- Timing of subsequent visits  
- Educational programs (childbirth education)  
- Analgesia and anesthetic options  
- Balanced nutrition, ideal caloric intake and weight gain, vitamins, folic acid and calcium intake  
- Use of seatbelts  
- Home safety  
- Infant safety seats  
- Over-the-counter drug use  
- Personal safety: domestic violence, psychological stress  
- Exercise and daily activity  
- Hazards of smoking, alcohol and drug consumption  
- Breast feeding  
- Postpartum care  |
| Postpartum Care, 21–56 days following delivery | Weight  
- Blood pressure  
- Breasts  
- Abdomen  
- Pelvic examination  
- Patient concerns  
- Family spacing  
- Signs of depression  
- Pap smear, if indicated  |

Adopted: 9/98  
# Chart, First Choice Prior Authorization Information

## Prior Authorization Information 2015

### DOES NOT Require Prior Authorization

- Emergency ground transportation (ALS, BLS)
- Emergency department services
- Participating gynecological and specialty physician office visits
- X-rays

### Notification REQUIRED

- Normal newborn deliveries
- Maternity observation

### Services REQUIRING PRIOR AUTHORIZATION

#### Inpatient

- Inpatient services
- All inpatient hospital admissions, including medical, surgical and rehabilitation
- Behavioral health
- Non-participating providers
- Obstetrical outpatient services, admissions, observations, diabetic education and abnormal newborn deliveries
- Services rendered by specialists for obstetrical patients (i.e. maternal fetal medicine, endocrinologist, cardiologist, etc.)
- Medical detoxification
- Elective transfers for inpatient and/or outpatient services between acute care facilities
- Skilled nursing facility
- Long-Term care initial placement (for acute services if still enrolled with the plan)

#### Pain Management

- External infusion pumps, spinal cord, neurostimulators, implantable infusion pumps, radiofrequency ablation nerve blocks and spinal injections

#### Plastic Surgery

Surgical services that may be considered cosmetic, including:
- Blepharoplasty
- Mastectomy for gynecomaestia
- Mastoplexy
- Maxillofacial—all codes applicable
- Panniculectomy
- Penile prosthesis
- Plastic surgery/cosmetic dermatology
- Reduction mammoplasty
- Septoplasty (except submucous resection, with/without cartilage scoring)

#### Therapy and Related Services

- Speech therapy—authorization required for all visits after initial evaluation/re-evaluation (private therapy only)
- Speech therapy—after evaluation and 1st 12 visits (facility only)
- Occupational and physical therapy—after evaluation and 1st 12 visits for each modality (facility and private therapy)

#### Pharmacy and Medications

Contact PerformRx:
- Medications (insuffusions, injectable drugs, chemotherapy, PO and IV) with billed amount equal to or greater than $250
- Medications not listed on the South Carolina Medicaid Professional Services Fee Schedule are not covered by First Choice

#### Advanced Outpatient Imaging Services

- Nuclear Cardiology
- Computed Tomography Angiography (CTA)
- Coronary Computed Tomography Angiography (CCTA)
- Computed Tomography (CT)
- Magnetic Resonance Angiography (MRA)
- Magnetic Resonance Imaging (MRI)
- Myocardial Perfusion Imaging (MPI)
- Positron Emission Tomography (PET)

Contact National Imaging Associates (NIA):
- www.RadMD.com or call 1.800.424.4895.

### Durable Medical Equipment

- Items with billed charges equal to or greater than $500 (total for each DME item), including prosthetics and orthotics
- All DME leases or rentals
- All enteral nutritional supplements and supplies
- All wheelchair parts (manual and power)
- Insulin pumps
- Thoracolumbosacral orthosis (TLSOs - back braces)
- All unlisted or miscellaneous items regardless of cost

### Home-Based Services

- Home health care—after 6 visits
- Home assessment
- Home infusion services and injections (equal to and greater than $200)

---

**Select Health of South Carolina**

PO Box 40849, Charleston, SC 29423

*We help people get care, stay well and build healthy communities.*
# Form, Prior Authorization Request: Medications

**Healthy Connections**

## Prior Authorization Request Form: Medications

Please type or print neatly. Incomplete and illegible forms will delay processing.

### I. Provider Information

<table>
<thead>
<tr>
<th>Prescriber Name</th>
<th>NPI #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriber Specialty</td>
<td>Phone</td>
</tr>
<tr>
<td>Prescriber Address</td>
<td>Office Contact Name</td>
</tr>
<tr>
<td>Pharmacy Name</td>
<td>Pharmacy Phone</td>
</tr>
</tbody>
</table>

### II. Member Information

<table>
<thead>
<tr>
<th>Member Name</th>
<th>Today's Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Plan ID #</td>
<td>Date of Birth</td>
</tr>
<tr>
<td>Drug Allergies</td>
<td></td>
</tr>
</tbody>
</table>

Plan Fax Numbers:

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absolute Total Care</td>
<td>1.866.399.0925</td>
</tr>
<tr>
<td>Advicare</td>
<td>1.866.255.7569</td>
</tr>
<tr>
<td>BlueChoice HealthPlan Medicaid</td>
<td>1.866.807.6241</td>
</tr>
<tr>
<td>FFS Medicaid</td>
<td>1.888.603.7696</td>
</tr>
<tr>
<td>First Choice by Select Health</td>
<td>1.866.610.2775</td>
</tr>
<tr>
<td>Molina HealthCare of SC</td>
<td>1.855.571.3011</td>
</tr>
<tr>
<td>WellCare of SC</td>
<td>1.866.354.8709</td>
</tr>
</tbody>
</table>

### III. Drug Information (One Drug Per Request Form)

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Drug Strength</th>
<th>Dosage Form</th>
<th>Dosage Interval</th>
<th>Quantity per Day</th>
<th>Diagnosis Relevant to this request</th>
<th>ICD-9 Code</th>
<th>Expected Length of Therapy</th>
<th>Number of Refills</th>
</tr>
</thead>
</table>

### IV. Drug History for this Diagnosis

A. Is the prescription for a drug to be administered in the office or for the member to take at home?  
☐ office  ☐ home

B. Is the member currently treated on this drug?  
☐ Yes: how long? [go to item C]  ☐ No [skip items C and D; go to item E]

C. Is this request for continuation of a previous approval?  
☐ Yes [go to item D]  ☐ No [skip item D; go to item E]

D. Has strength, dosage or quantity required per day increased or decreased?  
☐ Yes [go to item E]  ☐ No [skip item E; indicate rationale in Section V and submit form]

E. Please indicate previous treatments and outcomes with other medications below.

<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>STRENGTH</th>
<th>DIRECTIONS</th>
<th>DATES OF THERAPY</th>
<th>REASON FOR FAILURE OR DISCONTINUATION</th>
</tr>
</thead>
</table>

### V. Rationale for Request and Pertinent Clinical Information (Attach Additional Sheets if More Space Is Needed)

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.

Prescriber/Authorized Representative Signature

Plan Fax Numbers:

<table>
<thead>
<tr>
<th>Plan Name</th>
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<tr>
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<td>1.866.354.8709</td>
</tr>
</tbody>
</table>

Rev: 09/02/2014
**Form, Behavioral Health Outpatient Treatment**

**Behavioral Health Outpatient Treatment**

When complete, please fax to 1.888.796.5521.

Please type or print clearly. Incomplete and illegible forms will delay processing.

---

**Participating Providers:** prior authorization is only required for the following services: ECT* (90870), Environmental Intervention (90887), Interpretation of Results (90887), Unlisted Psychiatric Service (90899) and Psychological Testing (separate form, 96101, 96118).

*ECT services must be prior authorized by telephonic review. Please call 1.866.341.8765.*

**Non-Participating Providers:** prior authorization and a non-contracted provider form (available on the Select Health website) are required for all services.

---

1. **Member Information**

   - Member name ____________________ Healthy Connections ID # ____________________ SSN ____________________ DOB ____________________
   - Member address ____________________ City, State Zip ____________________ Phone ____________________
   - Who referred member for treatment? ☐ Self/parent ☐ PCP ☐ School ☐ State agency ☐ Other
   - Name of referring agent ____________________ Phone ____________________

2. **Treating Provider Information**

   - Name ____________________ MD ☐ Lic. Psychologist ☐ LIP ☐ NPI # ____________________ ☐ PAR ☐ NON-PAR ☐ In Credentialing Process
   - Address ____________________ City, State Zip ____________________ Phone ____________________ Fax ____________________
   - Group name/Select Health ID # ____________________ Contact name ____________________
   - Treating provider signature ____________________

3. **Reason for Services**

   - Primary reason/complaint ____________________ Start date requested ____________________
   - Services requested: Service code(s) ____________________ Frequency ____________________

4. **DSM Diagnosis**

   - List all DSM diagnoses (behavioral and medical):
     - ____________________
     - ____________________
     - ____________________
     - ____________________

5. **Please answer the following questions**

   - a) Is the member currently participating in any school services? ☐ Yes ☐ No
   - b) Is the member’s family or supports involved in treatment? ☐ Yes ☐ No
   - c) Has the member been evaluated by a psychiatrist? ☐ Yes ☐ No
   - d) Is the member involved with SCDMH or DAODAS? ☐ Yes ☐ No
   - e) Is there coordination of care with other behavioral health providers? ☐ Yes ☐ No
   - f) Is there coordination of care with medical providers? ☐ Yes ☐ No

6. **Reason for Authorization of NON-PAR Providers** *(Utilization Management will contact provider directly before giving authorization)* ☐ N/A — provider is PAR

   - a) Specialty of provider to meet the needs of the member ____________________
   - b) Continuity of care concerns ____________________
   - c) Accessibility/availability of provider ____________________
   - d) Clinical rationale ____________________

7. **Medications**

   - Is member on prescribed medication(s)? ☐ Yes ☐ No Prescribing physician(s) name(s) ____________________
   - Is member compliant with medication(s)? ☐ Yes ☐ No Please list medications and dosages ____________________

8. **Treatment Plan**

   - *Please attach the current treatment plan.* Please include documentation related to progress on goals and any changes made as a result.

9. **Additional Comments**

   - ____________________
   - ____________________
   - ____________________

---

Select Health of South Carolina | PO Box 40849 | Charleston, SC 29423 | Phone 1.866.341.8765 | Fax 1.888.796.5521

Revised October 7, 2014
**FORM, BEHAVIORAL HEALTH TESTING**

**Neuropsychological Testing Request**

**Psychological Testing Request**

Please check one of the above. When complete, please fax to 1.888.796.5521. Please type or print clearly. Incomplete and illegible forms will delay processing.

1. **MEMBER INFORMATION**
   - Member name
   - First Choice ID#
   - SSN
   - DOB
   - Member address
   - City, State Zip
   - Phone
   - Who referred member for treatment?
     - Self/parent
     - PCP
     - School
     - State agency
     - Other

2. **TREATING PROVIDER INFORMATION**
   - Name (include credentials)
   - NPI #
   - Phone
   - Address
   - City, State Zip
   - Fax
   - Group name/ID number
   - Contact name
   - Treating provider signature

3. **TESTING REQUESTED:**
   - Neuropsychological: 96118 96119 96120
   - Psychological: 96101

4. **REFERRAL REASON AND FUNCTIONAL IMPAIRMENT**

5. **HOW WILL THE ANTICIPATED RESULTS AFFECT THE MEMBER’S TREATMENT PLAN?**

6. **DSM-IV MULTI-AXIAL DIAGNOSIS**
   - **Axis I**
   - **Axis II**
   - **Axis III**
   - **Axis IV**
   - **Axis V: GAF**

7. **CHECK CURRENT SYMPTOM(S) PROMPTING REQUEST FOR TESTING:**
   - Anxiety
   - Inattention
   - Withdrawal/poor social interaction
   - Psychosis/hallucinations
   - Hyperactivity
   - Unprovoked agitation/aggression
   - Mood instability
   - Depression
   - Poor academic performance
   - Bizarre behavior
   - Self-injurious behavior
   - Eating disorder symptoms
   - Behavior problems affecting life functions (e.g. school, home)
   - Other, please list

8. **CURRENT MEDICATIONS**
   - List with dosages or attach sheet

9. **CHECK ALL ASSESSMENTS TO DATE**
   - No assessment procedures performed to date
   - Structured interview
   - Clinical interview with patient
   - Direct observation of parent/child interaction
   - Interview with family
   - Brief inventories or rating scales
   - Assessment by mental health professional(s)
   - Medical evaluation
   - Consultation with patient’s physician
   - Consultation with school personnel or others
   - Review of records of previous treatment
   - Other, please list

10. **PLEASE ANSWER THE FOLLOWING. ATTACH ADDITIONAL PAGES/RECORDS IF NECESSARY.**
   - Patient medical and psychiatric history
   - Family medical and psychiatric history
   - Describe any neurological incidents or events and/or neuro-developmental concerns
   - History of psychological testing and results/findings

11. **DESCRIPTION OF TESTING REQUEST**

12. **AUTHORIZATION REQUEST**
   - Service code
   - Hours
   - Request start date
   - Service code
   - Hours
   - Request start date
   - Service code
   - Hours
   - Request start date
   - FOR SELECT HEALTH USE ONLY
   - Auth #
   - Date communicated to provider
   - Staff initials/name
   - Auth code
   - Units
   - Start date
   - End date
   - Auth code
   - Units
   - Start date
   - End date
   - Auth code
   - Units
   - Start date
   - End date
   - Auth code
   - Units
   - Start date
   - End date
   - Auth code
   - Units
   - Start date
   - End date

---

Select Health of South Carolina | PO Box 40849 | Charleston, SC 29423 | Phone 1.866.341.8765 | Fax 1.888.796.5521

Revised July 15, 2015
Crisis Intervention Authorization Request

When complete, please fax to 1.888.796.5521.

Please type or print clearly. Incomplete and illegible forms will delay processing.

1. MEMBER INFORMATION

Member name ___________________________ First Choice ID# ______________ SSN ______________ DOB ______________

Member address ___________________________ City, State Zip ______________ Phone ______________

Who referred member for treatment? ☐ Self/parent ☐ PCP ☐ School ☐ State agency ☐ Other ___________________________

2. TREATING PROVIDER INFORMATION

Name (include credentials) ___________________________ NPI # ______________ Phone ______________

Address ___________________________ City, State Zip ______________ Phone ______________

Contact person name ___________________________ Contact e-mail ___________________________ Contact phone ___________________________

3. SERVICE INFORMATION

Date of service ___________________________ Place of service: ☐ Home ☐ School ☐ Other ___________________________

Participants in the session: ___________________________

Summary of the crisis or symptoms: ___________________________

Outcome of the crisis session: ☐ Member stabilized and sent home with family/supports ☐ Member taken to emergency department for possible admission ☐ Other outcome ___________________________

Patient status at end of services/session: ___________________________

4. MEMBER ACKNOWLEDGEMENT

"By signing below, I am stating that I am actively getting crisis intervention services. I know that public money (federal, state and local) pays for these services. Claims, statements or papers that are false or hide facts on purpose are grounds for prosecution under law."

Member/Guardian signature ___________________________ Print name ___________________________ Date ______________

☐ Member/Guardian declined or unable to sign the encounter form

Provider signature ___________________________ Print name ___________________________ Date ______________

FOR SELECT HEALTH USE ONLY

Auth # ______________ Date communicated to provider ______________ Staff initials/name ___________________________

Auth code H2011HO ☐ Units ______________ Start date ______________ End date ______________

Auth code ______________ Units ______________ Start date ______________ End date ______________

Select Health of South Carolina | PO Box 40849 | Charleston, SC 29423 | Phone 1.866.341.8765 | Fax 1.888.796.5521

Revised July 15, 2015
Pregnancy Risk Assessment Information

Please fax this form to Select Health of South Carolina at 1.866.533.5493.
If you have questions, please call Bright Start at 1.888.559.1010.

Provider Information

Provider name ___________________________ Tax ID #: ___________________________
Address _____________________________________________________________
Phone ___________________________ Fax ___________________________

Member Information

Member Name ___________________________ Medicaid ID #: ___________________________
Address _____________________________________________________________
Date of birth ___________________________ Language preferred ___________________________
Email _____________________________________________________________
Phone ___________________________

Tobacco use Pre-Pregnancy 1st Trimester 2nd Trimester 3rd Trimester
Average number of cigarettes smoked per day.
If none enter 0; 1 pack = 20 cigarettes

Pregnancy Information & History

Date of first prenatal visit ___________________________ 17P Candidate □ Yes □ No
EDC _______ Gest. Age _______ Gravida _______ Para _______ Pre-term _______ Living _______

Abortions: Spontaneous: _______ Induced: _______ □ Three consecutive abortions

Last Pregnancy
Low birth weight < 2500 grams □ History of incompetent cervix □ Fetal death greater than 20 weeks □ STD history
Gestational diabetes □ Premature ROM □ Pre-eclampsia/Eclampsia □ Postpartum depression
Pre-term delivery (gest. age: _______ Classical incision previous C-section □ IUGR
Congenital anomaly: _______ Other (specify) _______

Current Pregnancy
Multiple gestation: □ Twins □ Triplets □ Other: _______ Pre-eclampsia □ Eclampsia
Premature labor □ Diabetes □ RH sensitization □ Renal disease
Placenta previa □ Heart disease □ Sickle cell disease □ Abnormal ultrasound
Premature rupture of membranes □ Hypertension □ Incompetent cervix □ Alcohol or drug problems
STD (sexually transmitted disease) □ Previous delivery within 1 year of EDC □ Late and/or inconsistent prenatal care
IUGR □ 2nd/3rd trimester bleeding □ Periodontal disease □ PIH
Seizure disorder □ Asthma □ HIV □ No current risk
Other (specify) _______

Active Mental Health Conditions
No mental health conditions □ Schizophrenia □ Bipolar □ Depression
Other (specify) _______

Social, Economic and Lifestyle Issues
No identified social, economic or lifestyle issues □ Eating disorder □ Intellectual impairment
Homelessness □ Opioid therapy □ Substance abuse (specify type) _______
Mental/physical/sexual abuse (current or hx. of) _______

Maternity Authorization # _____________
Covering dates of service _______ to _______.

Please call Bright Start or fax an updated form if the member has any changes in condition during pregnancy. This updated information can assist Bright Start with member outreach.
# Universal Newborn Prior Authorization Form - Pediatric Offices

Out-of-network pediatric providers must provide this information to obtain an authorization for services rendered in the office during the first 60 days after discharge. Authorization should be requested by close of the next business day. For questions, contact the plan at the associated phone number.

*Fax the COMPLETED form OR call the plan with the requested information.

### Patient Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s name (first, middle, last)</td>
<td>DOB</td>
</tr>
<tr>
<td>Home phone</td>
<td>Mobile phone</td>
</tr>
<tr>
<td>Mom’s name (first, middle, last)</td>
<td>Mom’s Medicaid number</td>
</tr>
</tbody>
</table>

### Secondary Coverage

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
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</thead>
<tbody>
<tr>
<td>Policy holder</td>
<td>DOB</td>
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</table>

### EPSDT and Immunization

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Quantity</th>
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</thead>
<tbody>
<tr>
<td>99381</td>
<td>EPSDT new</td>
<td>1 visit</td>
</tr>
<tr>
<td>99391</td>
<td>EPSDT established</td>
<td>2 visits</td>
</tr>
<tr>
<td>90471</td>
<td>Immunization administered</td>
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<tr>
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<td></td>
</tr>
<tr>
<td>90473</td>
<td>Immunization administered</td>
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</table>

### E/M Non-EPSDT

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<th>Description</th>
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<tbody>
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### Labs

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<tr>
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<tbody>
<tr>
<td>CPT</td>
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</table>

### Other

<table>
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<th>Description</th>
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<tr>
<td>34150</td>
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</table>

Please note that our review applies only to the authorization of medical necessity and benefit coverage. This authorization is not a guarantee of payment unless the member is eligible at the time the services are rendered.

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Universal Newborn Authorization Form 1.2014
**Form, SBIRT Screening Tool**

**INSTITUTE FOR HEALTH AND RECOVERY**

**SBIRT INTEGRATED SCREENING TOOL**

* Fax the COMPLETED form to the patient's plan and referral site and keep a copy in patient file

- □ Absolute Total Care
- □ BlueChoice HealthPlan Medicaid
- □ Molina
- □ SC DHHS (Fee-For-Service)
- □ Wellcare

Fax: 877-285-3226
Fax: 877-798-1028
Fax: 866-454-1028
Fax: 803-255-6247
Fax: 866-533-5493

**PATIENT INFORMATION**

- Patient’s last name: 
- First: Middle: Language: Race: Ethnicity: 
- Phone no: 
- Street address: 
- Medicaid recipient no:

**PROVIDER INFORMATION**

- Practice name: 
- Group NPI: 
- Individual NPI: 
- Screening provider’s name: 
- Phone no:

**PATIENT SCREENING INFORMATION**

**Parents**
- Did any of your parents have a problem with alcohol or drug use? **YES** **NO**

**Peers**
- Do any of your friends have a problem with alcohol or other drug use? **YES** **NO**

**Partner**
- Does your partner have a problem with alcohol or other drug use? **YES** **NO**

**Violence**
- Are you feeling at all unsafe in any way in your relationship with your current partner? **YES** **NO**

**Emotional Health**
- Over the last few weeks, has worry, anxiety, depression or sadness made it difficult for you to do your work, get along with people or take care of things at home? **YES** **NO**

**Past**
- In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications? **YES** **NO**

**Present**
- In the past month, have you drank any alcohol or used other drugs?
  1. How many **days per month** do you drink? 
  2. How many **drinks on any given day**? 
  3. How often did you have **4 or more drinks per day** in the last month? 
  4. In the past month have you taken any prescription drugs? 

**Smoking**
- Have you smoked any cigarettes in the past three months? **YES** **NO**

**Comments:**

**ADVICE FOR BRIEF INTERVENTION**

<table>
<thead>
<tr>
<th>Y</th>
<th>N</th>
<th>N/A</th>
</tr>
</thead>
</table>
- Did you state your medical concern? 
- Did you advise to abstain or reduce use? 
- Did you check patient’s reaction? 
- Did you refer for future assessment? 

**At Risk Drinking**

<table>
<thead>
<tr>
<th>Non-Pregnant</th>
<th>Pregnant/Planning Pregnancy</th>
<th>Any Use is Risky Drinking</th>
</tr>
</thead>
</table>
- 7+ **drinks/week** 
- 3+ **drinks/day**

**CONFIDENTIAL SBIRT REFERRAL INFORMATION**

- Patient referred to: 
  - □ DMH 
  - □ DAODAS 
  - □ DHEC QUIT LINE 
    Fax: 1-800-483-3114
  - □ Private provider (Name & NPI) 
  - □ Domestic violence 
    803-256-2900

- Date of referral appointment (DD/MM/YY): Date screened: 
  - □ Patient refused referral 
  - □ Referral not warranted 
  - □ Patient requested assistance

Women’s health can be affected by emotional problems, alcohol, tobacco, other drug use and domestic violence. Women’s health is also affected when those same problems are presented in people close to us. By “alcohol,” we mean beer, wine, wine coolers or liquor.
Universal 17-P Authorization Form

*Fax the COMPLETED form OR call the plan with the requested information.

☐ Absolute Total Care  ☐ BlueChoice HealthPlan  ☐ First Choice by Select Health  ☐ WellCare Health Plan, Inc.

P: 803-933-3689  F: 866-918-4451
P: 866-902-1689  F: 800-823-5520
P: 888-559-1010  F: 866-533-5493
P: 888-781-4371  F: 866-918-4451
P: 855-237-6178  F: 866-533-5493
P: 888-781-3616  F: 888-571-3011

Date of Request for Authorization _____________________________
Patient/Member Name _________________________________________________ DOB ___________________
First   Middle    Last
Address (Street, Apt.#) ________________________________________ City/State/Zip _____________________
Phone ______________________ Medicaid Number ____________________ MCO ID Number ______________

Pregnancy Information and History
G___ T ___ P ___ A ___ L ___ (Note: A= abortion (spontaneous and medically induced) EDC ________________
Last menstrual period _______ EDD __________ Current Gestational age __________ weeks
Bed Rest ☐Yes ☐No Experiencing Preterm Labor ☐Yes ☐No
(Home administration available if on bed rest)
Singleton Pregnancy ☐Multiple Pregnancy
At least 16 weeks gestation ☐Yes ☐No** Major Fetal or Uterine Anomaly ☐Yes ☐No
Patient has a history of prior spontaneous singleton preterm birth between 20-36.6 weeks ☐Yes ☐No
Delivery was due to preterm labor or PPROM even if it resulted in C-section ☐Yes ☐No
Delivery was not due to medical indication, e.g. preeclampsia, abruption, etc. ☐Yes ☐No
Medication Allergies _____________________________________________________ ☐No known drug allergies
Other Pertinent Clinical Information: ____________________________________________

Pharmacy Information
☐ Ship to patient’s home address  ☐ End Date of Service ______________
☐ Ship to provider’s address  ☐ End Date of Service ______________
Shipping Preference: ☐Regular Mail ☐Ground ☐Overnight
Ordering Physician’s Signature: ______________________________ Makena or 17-P Compound

Provider Information
Ordering Provider Name __________________________________________
Ordering Provider NPI __________________________ Tax ID __________________
Address ______________________________________ City/State/Zip ______________
Phone _______________________________ Fax ______________________________
Provider Type: ☐OB/GYN ☐Family Medicine ☐MFM/Perinatology ☐Other
Practice Name: __________________________________________ Practice NPI: __________________________
Contact Person: _________________________ Phone: _________________________ Fax: _________________________

FOR MCO USE ONLY:
☐ Approved ☐Denied Authorization # __________________ Number of Injections __________________
Date of Notification to Provider: __________________ Reviewer(s) name & title: __________________

Please note that our review applies only to the authorization of medical necessity and benefit coverage. This authorization is not a guarantee of payment unless the member is eligible at the time the services are rendered.

** Prescription may be written prior to 16 weeks, but the vial shipment may be withheld by the pharmacy until the 15th week.
FORM, SURGICAL JUSTIFICATION REVIEW FOR HYSTERECTOMY

SOUTH CAROLINA MEDICAID PROGRAM
SURGICAL JUSTIFICATION REVIEW FOR HYSTERECTOMY

THIS COMPLETED FORM AND A SIGNED “ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION” FORM MUST BE RECEIVED 30 DAYS PRIOR TO SCHEDULED SURGERY.

PATIENT
NAME ___________________________________________ MEDICAID # __________________
LAST            FIRST            MI
BIRTHDATE _______________________ GRAVITY _______________ PARITY ________________
MONTH/DAY/YEAR
PROCEDURE CODE: ___________________ DX CODE: ___________________
HOSPITAL ___________________________________ NAME __________________________________
NPI (IF AVAILABLE)
PLANNED ADMISSION DATE _______________ PLANNED SURGERY DATE ________________
TYPE OF HYSTERECTOMY PLANNED_____________________________________________________

GYNECOLOGICAL HISTORY/PHYSICAL EXAM RELATING TO PRINCIPAL DIAGNOSIS:
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
HCT ____   HGB ____   CHECK ONE: PREMENOPAUSAL _____  POSTMENOPAUSAL _____

CONSERVATIVE TREATMENT/MEDICATION WITH DATES:
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

PRIOR GYN SURGERY/DIAGNOSTIC PROCEDURES (INCLUDE COPIES OF ALL REPORTS):
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

OFFICE NOTES AND ALL SUPPORTING DOCUMENTATION (e.g., ULTRASOUND, OPERATIVE AND PATH REPORTS, ETC.) ARE REQUIRED FOR APPROVAL AND SHOULD BE ATTACHED TO THIS FORM.

ATTENDING PHYSICIAN’S NAME _______________________________________ LAST FIRST MI NPI
ADDRESS ________________________________________________________________________________
CONTACT PERSON _______________________________ TELEPHONE (_____) ___________________
FAX (_____) ___________________________
SIGNATURE _______________________________ DATE _______________________________
ATTENDING PHYSICIAN
APPROVALS ARE VALID FOR 180 DAYS FROM DATE OF ISSUE.

Revised: 06/01/12
CONSENT FOR STERILIZATION

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from

Doctor or Clinic

for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children, or father children.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected those alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as

Specify Type of Operation

and benefits associated with the operation are explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withdrawing of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on:

Date

I, hereby consent of my own free will to be sterilized by

Doctor or Clinic

by a method called

Specify Type of Operation

until 100 days from the date of my signature below. I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services, or Employees of programs or projects funded by the Department but only for determining Federal law violations.

I have received a copy of this form.

Signature

Date

Medicaid ID

You are required to supply the following information, but it is not required (Ethnicity and Race Designation) (please check)

Ethnicity:  

Not Hispanic or Latino  

American Indian or Alaska Native  

Asian  

Black or African American  

Native Hawaiian or Other Pacific Islander  

White

■ PHYSICIAN’S STATEMENT ■

Shortly before I performed a sterilization operation upon

Name of Individual

on

Date of Sterilization

I explained to him/her the nature of the sterilization operation

Specify Type of Operation

intended to be a final and irreversible procedure and the discomforts, risks, and benefits associated with it.

I informed the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

Signature

Date

■ INTERPRETER’S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read the consent form in language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

Interpreter’s Signature

Date

DHHS 1723 (08/2010)
## Request for Authorization
### General

### Member Information
- Last, first MI ___________________________ Today’s Date ____________
- Medicaid ID # ___________________________ DOB ____________

### Practice/Facility Information
- Practice/Facility name ___________________________ Practice/Facility ID# ___________________________
- Contact person ___________________________ Fax # ____________ Call back # ____________

### Procedure & Physician Information
- Procedure ___________________________ Code ____________
- Planned date of service ___________________________ Physician NPI # ___________________________
- Physician last name, first name, MI ___________________________
- Address, city, state zip ___________________________

### Notes
- ___________________________________________
- ___________________________________________
- ___________________________________________
- ___________________________________________
- ___________________________________________
- ___________________________________________
- ___________________________________________

FAX completed request form along with documentation supporting the medical necessity of the requested service(s) to 1.866.368.4562.

Providers will be notified of determination via phone.

Approvals are valid for 180 days from the date of issue.

---


Revised July 15, 2015
# DME Request for Authorization

## From

<table>
<thead>
<tr>
<th>From</th>
<th>Fax</th>
<th>Phone</th>
<th>Date</th>
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<tbody>
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## E-mail

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## Member Information

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<tbody>
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## Procedure Information

<table>
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<tr>
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<th>DME</th>
<th>Medical supplies</th>
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<tbody>
<tr>
<td>Diagnosis</td>
<td>Service start</td>
<td>Service end</td>
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<tr>
<td>ICD9 code</td>
<td>HCPCS code</td>
<td>Quantity</td>
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## Provider Information

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</table>

<table>
<thead>
<tr>
<th>Address, city, state zip</th>
<th>Contact person</th>
<th>Fax</th>
<th>Call back #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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## Practitioner Information

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**FAX request form with supporting clinical documentation to 1.866.368.4562.**

## Select Health Use Only

<table>
<thead>
<tr>
<th>Case number</th>
<th>Date</th>
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<th>Ext.</th>
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<tr>
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</tbody>
</table>
Form, Physician Certification of Incontinence 168IS

Physician Certification of Incontinence

Please type or print neatly. Incomplete and illegible forms will delay processing.

To

Physician name ____________________________
Address ____________________________
City, State Zip ____________________________

FROM ____________________________

Beneficiary's name ____________________________
Social Security Number ____________________________ DOB ____________________________

Please complete the areas below and return to the “From” address above. This beneficiary is requesting incontinence supplies (includes diapers/briefs/pull-ups, wipes and/or underpads) through the Medicaid Home Health benefit. In order to qualify, the beneficiary must have one of the following conditions. Please check any that apply. The form must be fully completed.

☐ incontinent of bladder
☐ incontinence of bowel

Certifications for waiver beneficiaries are effective for 1 year from the date the physician signs the initial certification.

Certifications for non-waiver beneficiaries are effective for the timeframe indicated below as certified by the physician signing the certification:

☐ 3 months
☐ 6 months
☐ 9 months
☐ 12 months

What is the diagnosis related to incontinence? ____________________________

Does this beneficiary use any appliances (e.g. catheter, ostomy) to prevent incontinence? ☐ Yes ☐ No

If so, please list: ____________________________

Comments ____________________________

Please indicate one of the following:

☐ Incontinence supplies are NOT medically necessary
☐ Incontinence supplies are MEDICALLY NECESSARY for this Medicaid beneficiary

Physician’s signature ____________________________ Date ____________________________

(Nurse Practitioner or Physician Assistant signatures are not acceptable)

Last updated on 10/03/14 - SHv168IS
# Form, Prior Authorization, PT/OT/ST/Chiro

## Request for Authorization

### From

<table>
<thead>
<tr>
<th>From</th>
<th>Fax</th>
<th>Phone</th>
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</tr>
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</thead>
<tbody>
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</tbody>
</table>

### Procedure Information

Please select **ONE** of the following:

- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Chiropractor

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Service start</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>CPT code</th>
<th>ICD9 code</th>
<th>№ units requested</th>
<th>Service end</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

### Provider Information

<table>
<thead>
<tr>
<th>Provider name: last, first MI</th>
<th>Provider ID #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address, city, state zip</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contact person</th>
<th>Fax</th>
<th>Call back #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Practitioner Information

<table>
<thead>
<tr>
<th>Practitioner name: last, first MI</th>
<th>State ID #</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address, city, state zip</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contact person</th>
<th>Fax</th>
<th>Call back #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**FAX request form with supporting clinical documentation to 1.866.368.4562.**

### Select Health Use Only

<table>
<thead>
<tr>
<th>Case number</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Given by</th>
<th>Ext.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Form, Member Consent to Provider

Member Consent for Provider to File an Appeal

Provider Information

Provider name ___________________________ NPI # ____________
Group name ____________________________ Phone __________________
Address, city, state zip ________________________

Description of action that may be appealed:

Member Information and Consent

I agree to allow the provider listed above to file an appeal for me with First Choice. This will be an appeal of the action taken by First Choice that is described above. I have read this consent or have had it read to me and it has been explained to my satisfaction. I understand the information in the consent form and give my consent to this provider to file an appeal for me.

Member name (print) ___________________________ Date of birth ____________ Member ID # ____________
Address ____________________________ Phone __________________
Member signature ___________________________ Date* ____________

*Consent cannot be dated before the date(s) of the service(s) in question.

Consent from a Designated Representative

☐ The member listed above is unable to sign this consent form because of the reason(s) listed below. I am authorized to consent on behalf of the member and I hereby give my consent:

Representative name (print) ___________________________ Relationship to member ____________________________
Representative signature ___________________________ Date ____________
Witness name ___________________________ Signature ____________ Date ____________
**Children with Special Health Care Needs (CRS)**

**Hearing Aid Battery Request**

Please type or print neatly. Incomplete and illegible forms will delay processing.

### PATIENT INFORMATION

<table>
<thead>
<tr>
<th>Patient name: Last</th>
<th>First</th>
<th>MI (required)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>CRS #</th>
<th>Date of birth</th>
<th>SSN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicaid # (if eligible)</th>
<th>Authorization # if new aids ordered (required)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home address</th>
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<tbody>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>South Carolina</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### HEARING AID INFORMATION

How many hearing aids does the patient use?  

- [ ] 1  
- [ ] 2  

<table>
<thead>
<tr>
<th>Manufacturer</th>
<th>Model Number</th>
<th>Serial Number</th>
<th>Battery Size</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HEARING AID 1</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>HEARING AID 2</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Submitted by ___________________________  
Date submitted ________________

Submit this form to cooperhh@dhec.sc.gov.

[Click to send.]

### FOR CENTRAL OFFICE USE ONLY

Date batteries sent to patient ___________________________

Last updated on 11/15/13
Provider Refund Claim Form

In an effort to reduce the administrative burden on our providers, we have streamlined our refund process. Please complete this Provider Refund Claim Form in its entirety. The information provided on this form will enable us to credit your account in a timely manner. If your refund contains more than one claim, please complete the attached form or attach your own file. Thank you for your cooperation.

All checks should be made payable to Select Health of South Carolina. The refund and form should be mailed to:

Attn: Claims Repayment Research Unit
P.O. Box 7120
London, KY 40742

Provider Information:

Date: ____________________________

Provider Name: ____________________________

NPI: ____________________________

Provider Address: ____________________________

Office Contact: ____________________________

Phone Number: ____________________________

Member Information:

<table>
<thead>
<tr>
<th>Member Name</th>
<th>ID Number</th>
<th>Date of Service</th>
<th>Claim Number</th>
<th>Refund Amount</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
<td></td>
<td>$</td>
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</tbody>
</table>

Please print the refund check note the one copy, print out the attached form (page 2) or attach your own file.

Type of Refund:

☐ Medical Overpayment  ☐ Capitation

☐ Other:

Reason for Refund:

☐ Other Insurance (Attach Primary SOA)  ☐ Subrogation

☐ Duplicate payment  ☐ Claim was processed under the incorrect provider

☐ Incorrect provider/caghetti check  ☐ Not our check

☐ Billing error  ☐ Contract change/fee schedule update

☐ Eligibility  ☐ Recovery project (Please include project letter)

☐ Bonus payment  ☐ Return Supplies (Durable Medical Equipment)

☐ Other (Please provide details. "overpayment" is not a valid reason)

Print Form  Save As
### Additional Claim Form

If your refund contains more than one claim, please complete the attached form or attach your own file.

<table>
<thead>
<tr>
<th>Member Name</th>
<th>ID Number</th>
<th>Date of Service</th>
<th>Claim Number</th>
<th>Refund Amount</th>
<th>Reason for Claim</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

To save form changes:

- [+ ] Add Form
- [△ ] Move Form
- [Save As]
- [(-) Delete Form]
- [▲ Move Form]
- [Print Form]
PL103 448, §204(e) requires States using managed care arrangements to serve their Medicaid beneficiaries to coordinate their WIC and Medicaid Programs. This coordination should include the referral of potentially eligible women, infants, and children and the provision of medical information to the WIC Program. To help facilitate the information exchange process, please complete this form and send it to the address listed below. Thank you for your cooperation.

Name of Person Being Referred

Address

Telephone Number

The following classifications describe the populations served by the WIC program. Please check the category that most appropriately describes the person being referred:

- Pregnant woman
- Woman who is breast-feeding her infant(s) up to one year postpartum
- Woman who is non breast feeding up to six months postpartum
- Infant (age 0-1)
- Child under age 5

States may consider using this space to either include specific medical information or to indicate that such information can be provided if requested by the WIC Program.

Provider’s Name

Provider’s Phone

I, the undersigned, give permission for my provider to give the WIC Program any required medical information.

(Signature of the patient being referred or, in the case of children and infants, signature and printed name of the parent/guardian)

Send completed form to:

WIC Program Contact
Address
Phone Number
<table>
<thead>
<tr>
<th>Member #</th>
<th>Name</th>
<th>Address</th>
<th>City, State, Zip</th>
<th>Phone</th>
<th>Sex</th>
<th>DOB</th>
<th>Age</th>
<th>PCP Eff Date</th>
<th>Date</th>
</tr>
</thead>
</table>

Total Membership for Provider/Group Service Address: 17
Tax ID Number: 853670143
### Remittance Advice

For further inquiries on this remittance advice contact:
Select Health of SC, Inc.
Airport Business Center
200 Stevens Drive
Philadelphia, PA 19113
or call 800.575.0418

**Payee ID:** 1234567  
**Tax ID:** 123-45-6789  
**NPI #:** 1011101101  
**Check #:** 50000676  
**Check Ref:** 20011002101019  
**Payment:** 0.00  
**Date:** 07/01/08  

**Payee ID:** 123456  
**Tax ID:** 123-45-6789  
**NPI #:** 1011101101  
**Check #:** 50000676  
**Check Ref:** 20011002101019  
**Payment:** 0.00  
**Date:** 07/01/08

---

**Sample ONLY**

Up-to-date information can be found at [Select Health Professional Provider Manual](http://www.selecthealthsc.org/hcp/)

**For further inquiries on this remittance advice contact:**  
**Select Health of SC, Inc.**  
**Airport Business Center**  
**200 Stevens Drive**  
**Philadelphia, PA 19113**  
**or call 800.575.0418**

**Provider ID:** 123456  
**Member ID:** 987654321  
**Patient ID:** 27930108089  

**Forwarding Service Requested**

**JOHN DOE, MD**

**123 MAIN STREET**

**ANYWHERE, SC 55555**

---

### Provider Information

<table>
<thead>
<tr>
<th>Provider ID</th>
<th>Member ID</th>
<th>Patient ID</th>
<th>&quot;COB&quot;</th>
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</thead>
<tbody>
<tr>
<td>123456</td>
<td>987654321</td>
<td>27930108089</td>
<td>&quot;COB&quot;</td>
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</tbody>
</table>

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### Claim Information

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Proc/Rev/ DRG Code</th>
<th>Mod</th>
<th>Description</th>
<th>Qty</th>
<th>Charged Amount</th>
<th>Allowed Amount</th>
<th>OIC</th>
<th>Coins</th>
<th>COB</th>
<th>Amount Paid</th>
<th>Adj/Den</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/1/03 - 12/1/03</td>
<td>99213</td>
<td>001</td>
<td>Office or other out-patient visit</td>
<td>65.00</td>
<td>32.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>R36</td>
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</table>

**Claim Total**

<table>
<thead>
<tr>
<th>Charged Amount</th>
<th>Allowed Amount</th>
<th>OIC</th>
<th>COB</th>
<th>Coins</th>
<th>Interest Payment</th>
<th>Deductible Amount</th>
<th>Amount Paid</th>
<th>Claim Count</th>
</tr>
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<tbody>
<tr>
<td>65.00</td>
<td>32.00</td>
<td>0.00</td>
<td>0.00</td>
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</tbody>
</table>

**Payment Reduction Summary**

- **Original Amount of Reduction**
- **Date of Original Reduction**
- **Provider Receipts**
- **Applied to Current Claims**
- **Claim Reduction Amount Recovered to Date**
- **Remaining Balance**
- **Provider Receipts to Date**
- **Source**

**Messages**

- **R36 Capitated Service**

**The Payment Reduction Summary will now include the original Date of Service, Check Date and Check Number.**

**Less Other Transactions captures payment retractions and other reductions, which are detailed in the Payment Reduction Section.**

---

**Coordination of Benefits**

<table>
<thead>
<tr>
<th>Member Name</th>
<th>Claim Number</th>
<th>Other Insurance</th>
<th>Address</th>
<th>Group No.</th>
<th>Policy No.</th>
</tr>
</thead>
</table>

---

**Please note that these sections are located at the end of the remit, after the Statement Totals.**

---

**Please note that these sections are located at the end of the remit, after the Statement Totals.**