Select Health of South Carolina

Healthy Connections

Provider Manual Change Control Record

Date	Section	Page	Change
01/01/20	Podiatry Services	74	**Revised:** Podiatry services are those services medically necessary for the diagnosis and treatment of foot conditions. **Effective January 1, 2020,** 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~~ **covered for all members.**
02/01/20	Services That Require Prior Authorization	21	**Revised:** Transplants ~~– including transplant evaluations~~
02/01/20	Rehabilitative Behavioral Health Services (RBHS)	28	**Revised:** **Prior authorization requirements** The following RBHS services will require prior authorization — **added 2019 Psychological and Neuropsychological testing codes**
02/01/20	Inpatient Admissions/ Outpatient Admissions or Procedures	33 – 34	**New section:** **Readmission Reimbursement Policy** Select Health does not allow separate reimbursement for claims that have been identified as a readmission to the same facility or hospital system for the same or similar diagnosis or procedure within 30 days of the original admission. Requests for authorization for such readmissions will be denied. If the prior discharge was not apparent at the time of the readmission request and the request was approved, we reserve the right to deny the claim and/or recoup any payment for the readmission. **Non-reimbursable readmissions may include but are not limited to:** • An infection or complication arising from the previous admission. • A diagnosis or surgical intervention indicating a complication of a surgical procedure. • Post-discharge decompensation of a comorbid chronic disease. • An unmet need occurring in the post-discharge period that could have been prevented by adhering to acceptable standards of care during the hospitalization or in the post-hospital period. • A condition related to premature discharge. • Lack of medical necessity. **Exceptions to the readmission policy include:** • Readmissions primarily for cancer or chemotherapy. • Planned readmissions such as staged surgical procedures or burns. • Admissions for psychiatric disease and substance abuse. • Admissions for rehabilitation • Patient non-compliance, with adequate documentation. • Transfers for a higher level of care. • Maternity readmissions.

Date	Section	Page	Change
02/01/20	Health Care Professional/ Provider Disputes	37	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 **including, but not limited to, the inadvertent processing of your dispute as a duplicate claim.** For accurate and timely resolution of disputes, providers are to include **with their submissions**: • **A Provider Claim Dispute Form located in the Exhibits section of this manual and/or available on the Select Health website at: http://www.selecthealthofsc.com/provider/resources/forms.aspx.** • **A request/description of the reason for the dispute, using the word dispute in the subject line on the first page of the request.**
02/01/20	Appeal of Utilization Management Decisions	38	**Revised:** If the member or authorized representative does not follow up ~~with written confirmation~~ **in writing** within thirty calendar days of initiating an oral appeal, the appeal ~~may be dismissed~~ **will be closed**. If the written ~~confirmation~~ **appeal** is received after thirty calendar days from the date of ~~filing an~~ oral appeal ~~request but is within the sixty calendar day filing period, the thirty calendar day resolution time frame will begin at the time of receipt of written confirmation.~~ **but still within the time frame for filing an appeal (60 calendar days from the date on the notice of adverse benefit determination), a new appeal will be opened.**
02/01/20	Member Disenrollment	45	**Revised:** The following are considered cause for a member to request disenrollment at any time: • **First Choice or Healthy Connections terminates the contract for First Choice to participate in the managed care organization program.** • **Member uses managed long-term care support services, and would have to change their residential, institutional, or employment supports provider based on that provider's change in status from in-network to an out-of-network provider with First Choice.** • 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. **If the request to change health plans is denied by Healthy Connections, the member has the right to file for a state fair hearing of the decision.** First Choice may be notified of an involuntary disenrollment by the SCDHHS due to any of the following reasons: • ~~Member enrolls in a commercial HMO~~ • Member is placed out of home [i.e., intermediate care facility for the mentally retarded (ICF/MR). ~~psychiatric residential treatment facility (PRTF)~~]
02/01/20	Member Responsibilities	48	**Revised:** **14.** Make every effort to keep any agreed upon appointment **or cancel an appointment in advance of when it is scheduled.**

Date	Section	Page	Change
02/01/20	Co-Payments	52	**Revised:** There will be no co-payment for children less than 19 years of age, pregnant women, and individuals receiving emergency services, **well-child visits from birth through the month of the 21st birthday** or federally recognized Native Americans.
02/01/20	2020 Prior Authorization Information	85	**Revised:** Transplants~~, including transplant evaluations~~
03/01/20	Administrative Days Readmission Reimbursement Policy	34	**Deleted** entire section **Added:** New section
03/01/20	Provider Disputes	37	**Revised:** 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 **including, but not limited to, the inadvertent processing of your dispute as a duplicate claim**. For accurate and timely resolution of disputes, providers ~~should include the following information:~~**are to include with their submissions:** • **A Provider Claim Dispute Form located in the Exhibits section of this manual and/or available on the Select Health website at: http://www.selecthealthofsc.com/provider/resources/forms.aspx.** • **A request/description of the reason for the dispute, using the word dispute in the subject line on the first page of the request.**
03/01/20	Appeal of Utilization Management Decisions	38	**Revised:** If the member or authorized representative does not follow up ~~with written confirmation~~**in writing** within thirty calendar days of initiating an oral appeal, the appeal ~~may be dismissed~~**will be closed**. If the written ~~confirmation~~ **appeal** is received after thirty calendar days from the date of ~~filing an~~ the oral appeal ~~request but is within the thirty calendar day filing period, the thirty calendar resolution time frame will begin at the time of receipt of written confirmation~~ **but still within the time frame for filing an appeal (60 calendar days from the date on the notice of adverse benefit determination), a new appeal will be opened.**

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03/01/20	Member Disenrollment	45	**Added:** • **First Choice or Healthy Connections terminates the contract for First Choice to participate in the managed care organization program.** • **Member uses managed long-term care support services, and would have to change their residential, institutional, or employment supports provider based on that provider's change in status from in-network to an out-of-network provider with First Choice.** • 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. **If the request to change health plans is denied by Healthy Connections, the member has the right to file for a state fair hearing of the decision.** **Revised:** • ~~Member enrolls in a commercial HMO;~~ • Member is placed out of home [i.e. intermediate care facility for the mentally retarded (ICF/MR). ~~psychiatric residential treatment facility (PRTF)]~~
03/01/20	Member Responsibilities	48	**Added:** Make every effort to keep any agreed upon appointment **or cancel an appointment in advance of when it is scheduled.**
03/01/20	New section	69	Prospective Payment Reductions for Multiple Radiology Procedures
03/01/20	Podiatry Services	74	Podiatry services are those services medically necessary for the diagnosis and treatment of foot conditions. **Effective January 1, 2020,** 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.~~ **covered for all members.**
04/01/20	No updates		
05/01/20	No updates		
06/01/20	No updates		
07/01/20	Our Vision	1	**Revised:** ~~Leading America in health care solutions for the underserved and chronically ill.~~ **To be a national leader in empowering those in need, especially the poor and the disabled, across their full life journey, from wellness to resilience, in order to achieve their American Dream.**
07/01/20	Ownership Disclosure	Various	Removed references to Ownership and Control Interest Statement form 1514 — no longer required to be collected by MCO, this information is collected by SCDHHS.

Date	Section	Page	Change
07/01/20	Disclosure of Ownership and Control	12	**Deleted:** ~~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.~~
07/01/20	Behavioral Health Under First Choice	25	**Revised:** Psychological and neuropsychological testing: **96130-96146**
07/01/20	Prior authorization requirements - RBHS	28	**Added:** S5145 Therapeutic Foster Care (TFC) per diem to chart.
07/01/20	New section	29	Therapeutic Foster Care (TFC)
07/01/20	Opioid Treatment Programs (OTP)	31	**Revised:** ~~OTPs are reimbursed for the following all-inclusive procedure and assessment codes according to the SCDHHS fee schedule:~~ • ~~H0047 — Medication-assisted Treatment Initial/ Annual Assessment~~ • ~~H0020 — Methadone Maintenance Treatment~~ • ~~H0016 — Buprenorphine Maintenance Treatment~~ Effective July 1, 2020, Select Health transitioned to the Centers for Medicare & Medicaid Services (CMS) series of HCPCS codes to designate services provided by an OTP. The CMS code set is as follows: Code chart The fee schedule for the services listed above is available at **www.scdhhs.gov**.
07/01/20	New section	49	Reimbursement for Initial Visit for Children in Foster Care
07/01/20	New sections	57	Contraceptive Coverage Hepatitis-C Medications
07/01/20	FQHC Payment Methodology	67	**Added:** Effective July, 2020, long acting injectable medications, indicated for the treatment of Opioid Use Disorder (OUD), including Naltrexone for extended-release injectable suspension and Buprenorphine extended-release will be reimbursed in addition to an E/M encounter for FQHCs. A list of these codes can be found on the Select Health website at: **www.selecthealthofsc.com/provider/member-care/behavioral-health/opioid-treatment-programs.aspx**.

Date	Section	Page	Change
07/01/20	Outpatient Services	74	**Added:** Long-acting Injectable Medications for Outpatient Hospitals Effective July 1, 2020, long-acting injectable medications indicated for the treatment of opioid use disorder, including naltrexone for extended-release injectable suspension and buprenorphine extended-release, are reimbursed as "add-on" services for reimbursement type 1 and reimbursement type 5 claims for outpatient hospital providers.
08/01/20	No Updates		
09/01/20	Services That Require Prior Authorization	22	**Revised:** Chiropractic **~~(all services)~~ under 18 years of age, 6 visits per State fiscal year (July 1 – June 30).** Durable medical equipment, (DME), billed charges $750 and greater, **includes wheelchair accessories, custom cranial, cervical, ankle, foot, knee, hip, elbow, wrist, hand, finger & thoracic-lumbar-sacral orthotics (TLSO).** Enteral nutritional supplements ~~and supplies~~ Home-based services Home health care (physical therapy, occupational therapy, speech therapy), **home health aides** and skilled nursing (after **18** combined visits regardless of modality). Prosthetics ~~and custom orthotics~~
09/01/20	Services That Do Not Require Prior Authorization	23	**Added:** Acupuncture Bronchoscopy – rigid or flexible w/fluoroscopic guidance 1 & 2 or more lobes Circumcisions
09/01/20	Medical Director Availability (Peer-to-Peer)	37	**Revised:** The requesting/ordering provider may request a peer-to-peer review with one of the Select Health medical directors within ~~3~~ **five** business days from verbal notification of the determination that the authorization request does not meet medical necessity criteria. The peer-to-peer option is no longer available to the health care professional/provider after ~~3~~ **five** business days from the verbal notification of the determination. The Medical Director will respond to requests for a peer-to-peer discussion from the requesting/ordering provider within ~~one~~ **three** business days.

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09/01/20	Prenatal Risk Assessment Form and Care Authorization	41-42	**Revised:** Three **obstetrical ultrasounds per pregnancy** 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~~ **Ultrasounds are performed in the first trimester to establish viability, gestational age or to detect malformations. Two additional ultrasounds, performed during the second or third trimester, are performed to establish more detailed anatomy and/or interval growth.** **For Maternal Fetal Medicine (MFM) specialists, there is no limit on the number of ultrasounds that can be submitted for reimbursement. However, all ultrasounds provided by MFM specialists must have documentation to support medical necessity in the patient's medical record.**
09/01/20	Claims and Payments	58	**Added:** Claim filing deadlines All original paper and electronic claims must be submitted to the plan within 365 calendar days from the date services were rendered or compensable items were provided (or the date of discharge for inpatient admissions). Please allow for normal processing time (30 days for clean claims) before resubmitting a claim either through the EDI or paper process. This will reduce the possibility of your claim being rejected as a duplicate claim. Claims are not considered as received under timely filing guidelines if rejected for missing or invalid provider or member data. Resubmit previously denied claims with corrections and requests for adjustments within 365 days from the date services were rendered or compensable items were provided. Deadline exceptions Claims with explanations of benefits (EOBs) from primary insurers, including Medicare, must be submitted within 60 days of the date of the primary insurer's EOB (showing claim adjudication). This exception applies when the claim cannot be submitted within 365 days of the date of service due to the involvement of a primary insurer.
09/01/20	NEW SECTION	63	Health Value Optimization Polices
09/01/20	Prior Authorization Information	86	Revised grid
10/01/20	New Section	66	**Added:** Same Day Reimbursement – Evaluation & Management Services with Modifier 25

10/01/20		69	**Revised:** 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)~~ **(up to nine administrations per date of service.)** 90461 – Each additional vaccine/toxoid component ~~(two units per date of service)~~ **(up to 8 components per date of service.)** **Deleted:** ~~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.~~
11/01/20	No updates		
12/01/20	Anesthesia Deep Sedation for Gastrointestinal Endoscopy	63	**Deleted entire section** – policy retired