Select Health of South Carolina

Healthy Connections

Provider Manual Change Control Record

Date	Section	Page	Change
01/01/24	RBHS	28	**Added:** Under Therapeutic child care (TCC) • Multisystemic therapy (MST) — An intensive, evidence-based, family-based, and community-based treatment that addresses the externalizing behaviors of youth who have significant clinical impairment in behavior (such as disruptive behavior) and mood, and/or have substance use disorder. • For youth ages 11 – 18 years old who are at high risk of out-of-home placement or may be returning home from a higher level of care. • Procedure code for MST: H2033, with 48 encounters over a period of 120 days; one encounter may be billed per member, per day. For full details of the MST benefit, consult the SCDHHS Rehabilitative Behavioral Health Services (RBHS) Provider manual, **Appendix B**.
01/01/24	Benefits include but are not necessarily limited to the following	55 – 56	**Added:** • Acute inpatient psychiatric facility services. • Alcohol, drug, and substance use treatment services through the Department of Alcohol and Other Drug Abuse Services. • Ambulance transportation. • Ancillary medical services. • Audiological services. • Autism spectrum disorder (ASD) services. • BabyNet services. • Chiropractic services. • Circumcisions. • 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, and abortions (according to federal and state regulations). • Independent laboratory and X-ray services. • Inpatient hospital services. • Institutional long-term care facilities/nursing homes.

Date	Section	Page	Change
01/01/24	Benefits include but are not necessarily limited to the following	55 – 56	*Continued from previous* • Interprofessional Consultation services. • Maternity services. • Newborn hearing screenings. • Nutritional counseling. • Opioid treatment program (OTP) services. • Outpatient pediatric aids clinic services (OPAC). • Outpatient services. • Physician services. • Prescription drugs. • Preventive and rehabilitative services for primary care enhancement (PSPCE/RSPCE). • Psychiatric outpatient services. • Psychiatric residential treatment facility (PRTF) services. • Rehabilitative behavioral health services. • Rehabilitative therapies. • Transplant and transplant-related services. • Vision care services.

Date	Section	Page	Change
01/01/24	EPSDT and adult health screenings	58	**Added: EPSDT and adult health screenings** PCPs who provide care to members from birth through the month of the 21st birthday will provide EPSDT 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. Providers must follow the United States Preventive Services Task Force (USPSTF) grade A and B recommendations available on the USPSTF's website at A and B Recommendations | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org) when providing preventive screenings to full-benefit Healthy Connections Medicaid members. **Immunizations** Providers must follow the Advisory Committee on Immunization Practices (ACIP) recommendations on vaccines for both children and adults available at ACIP Vaccine Recommendations | CDC, when administering vaccines to full-benefit Healthy Connections Medicaid Members. For an age-appropriate immunization schedule, the provider must reference the CDC at **https://www.cdc.gov/vaccines/vpd/vaccines-age.html**.

Date	Section	Page	Change
01/01/24	Family planning services	79	**Added: Family planning services** Family planning services should be billed using the appropriate CPT/HCPCS code with a family planning (FP) modifier and an appropriate family planning diagnosis code. The FP modifier 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 (e.g., hysterectomy in cases of cervical, uterine, or ovarian cancer) would not be billed with the FP modifier. Referrals are not required nor are copays applied to family planning services, including prescriptions. **Interprofessional consultation services** Interprofessional consultation is an interaction in which the patient's treating physician or other qualified health care practitioner requests the opinion and/or treatment advice of a physician or other qualified health care practitioner with specific specialty expertise (consulting practitioner) to assist with the patient's care. Interprofessional consultation is intended to expand access to specialty care and foster interdisciplinary input on patient care. It is not intended to be a replacement for direct specialty care when such care is clinically indicated. In accordance with SCDHHS guidelines, effective for dates of service on or after January 1, 2024, Select Health will reimburse providers for Interprofessional Consultation services as distinct services using procedure codes: 99446, 99447, 99448, 99449,99451 and 99452. Reimbursement of interprofessional consultation is permissible, even when the Medicaid member is not present, as long as the consultation is for the direct benefit of the member. SCDHHS will reimburse for interprofessional consultation services delivered via telehealth.

Date	Section	Page	Change
01/01/24	Nutritional counseling services	86	**Obesity management/intervention program** ~~**Nutritional counseling program**~~ An obesity management/intervention program ~~nutritional counseling program was implemented~~ is available for Select Health members ~~with a body mass index (BMI) of 30 and greater~~ who are not seeking gastric bypass surgery or related services. Members eligible for the obesity management/intervention program are: • Adults age 21 or older with a body mass index (BMI) of 30 or greater. • Children age 12 to 21 years with a BMI greater than or equal to the 95th percentile for age and sex. The ~~Nutritional Counseling~~ program will exclude the following member categories: ~~Dual eligible:~~ • Pregnant women. • Members who have had or are scheduled to have bariatric surgery, gastric banding, or other related procedures. • Members receiving active treatment with gastric bypass surgery/ vertical-banded gastroplasty. The ~~nutritional counseling~~ obesity management/intervention 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. • Therapeutic treatment to support weight loss, in conjunction with intensive lifestyle therapy. Providers must follow the SCDHHS Preferred Drug List (PDL) when prescribing therapeutic treatment. • ~~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, and initial dietitian visit for nutritional clounseling, and five follow- up visits. Obesity management related treatment for children will continue to be covered as a part of the Medicaid EPSDT Program.~~ The provider must also emphasize the importance of exercise, developing a realistic exercise plan with goals. The obesity intervention plan must be documented in the patient's medical health record. The provider will arrange for an individual nutritional assessment to be provided by a licensed and Medicaid-enrolled dietitian.

Date	Section	Page	Change
01/01/24	Nutritional counseling services	86	*Continued from previous* A follow-up exam must be completed by the provider to evaluate the progress the patient has made, reviewing compliance with the exercise and nutritional plan of the patient. Documentation of each service must include the patient's BMI, progress toward weight management goals, activities, and compliance with the treatment plan. The provider must record the patient's BMI in the chart. Providers may bill for all medically necessary diagnostic testing. **Dietitian 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. An 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 **www.selecthealthofsc.com/provider/resources/credentialing**. *New Section* **Nutritional Counseling ~~Benefits~~ Services** Nutritional counseling will be covered for Select Health members who have a diagnosis of obesity or eating disorders when there is a chronic, episodic, or acute condition for which nutrition therapy is a critical component of medical management. These may include inappropriate growth, metabolic disorders, genetic conditions that affect growth and feeding, metabolic syndrome, or acute burns. For a list of medical conditions covered under the nutritional counseling benefit, visit the SCDHHS Physicians Services Provider Manual. Dietary evaluation and counseling services will be covered in hospital outpatient clinics; public agencies such as health departments, federally qualified health centers, and rural health clinics; private agencies; physician offices and residential facilities (when billed by qualified health care professionals).

Date	Section	Page	Change
01/01/24	Nutritional counseling services	86	*Continued from previous* Nutritional counseling services may be billed when rendered by physicians, physician assistants, nurse practitioners, and registered dietitians. Services performed by dietitians must be prescribed or referred by a physician. **Service limits** A total of 12 hours of combined initial, reassessment, and group medical nutrition therapy may be reimbursed per state fiscal year, (July 1 – June 30) per Medicaid member. **Telehealth** Nutritional counseling services may be provided in person or via telehealth. Telehealth encounters must be billed with a GT modifier and count toward the 12-hour service limit. Services delivered in person or via telehealth by the same provider type will be reimbursed at the same rate. **Procedure code consolidation** All provider types must use the procedure codes included in the following table when billing for nutritional counseling services. These codes should be used for services rendered to both adults and children. [Procedure Code table]

Date	Section	Page	Change
02/01/24	Chronic kidney disease (CDK) or end stage kidney disease (ESKD) management program	47	**Added: Chronic kidney disease (CKD) or end stage kidney disease (ESKD) management program** Select Health of South Carolina is working with Somatus, a value-based kidney care organization to offer an integrated care delivery program to support eligible members with or at risk of developing CKD or ESKD. This program is designed to help improve our members' quality measures and clinical outcomes. The Somatus program provides our members with a personal support team of health professionals (e.g., doctors, nurses, clinical pharmacists) to help manage their kidney disease and actively follow their treatment plan. The program is part of all eligible members' coverage and is available at no extra cost. The Somatus team supports patients through: • One-on-one care to help manage their kidney disease and comorbidities and address social determinants of health. • Personal health coaching that is based on their condition, treatment options, and diet. • Assistance to transition safely from hospital to home. • Guidance exploring transplant options, if appropriate. • A 24/7 Somatus Care Hotline: **1-855-851-8354**, ext. 9 A Somatus representative will contact providers to schedule an onsite visit to review the program. The representative can also share the patient list during the onsite visit. For questions, please contact Somatus directly at **1-855-851-8354**, Monday through Friday, from 8 a.m. to 8 p.m. ET, or email **provider@somatus.com.**
02/01/24	Contraceptive coverage	61	**Added: Contraceptive coverage** Select Health extended coverage of contraceptive prescriptions written for a one-month supply up to a six-month supply. The six-month supply applies to systemic contraceptives, including oral, vaginal rings, and transdermal patches. Prescriptions may be written for a one-month supply or up to a six-month supply after the prescribing physician determines the member has established stability on a particular contraceptive. Licensed Pharmacists are allowed to provide evaluation and management services for new and established patients when delivering contraceptives or performing urine pregnancy tests to members of childbearing age enrolled in the Healthy Connections full benefit program or the Family Planning Limited benefit. For questions or concerns, contact PerformRx Pharmacy Services at **1-866-610-2773**.
02/01/24	Durable medical equipment	83	**Added: 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.

Date	Section	Page	Change
02/01/24	Hearing aids and hearing accessories	83 – 84	**Hearing aids and hearing aid accessories** Select Health is responsible for providing the following for all members: 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
02/01/24	First Choice covered services	90	**First Choice Covered Services** • **Organ transplants:** Includes pretransplant 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)~~ ~~**1-843-792-2123**~~ Transplant Coordinators: Medical University Hospital Authority (MUHA) **1-843-792-2123** Prisma Health Transplant Center **1-864-455-1770** Select Health is responsible for all transplant-related services for First Choice members, effective February 1, 2024. • **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.
02/13/24	Services that require prior authorization	23	**Deleted:** ~~Managed by eviCore healthcare. Check the online Prior Authorization Lookup Tool on the Select Health website. If prior authorization is required, submit requests through eviCore healthcare at www. evicore.com/pages/ProviderLogin.aspx or call **1-877-506-5193**.~~ Added: Durable medical equipment (DME) leases and rentals.

Provider Manual Change Control Record

Date	Section	Page	Change
02/13/24	Services managed by eviCore healthcare	24	**Deleted:** • ~~Services managed by eviCore healthcare:~~ • ~~Diagnostic sleep testing.~~ • ~~DME.~~ • ~~Genetic testing.~~ • ~~Joint and spine surgery.~~ • ~~Medical oncology.~~ • ~~Occupational therapy (private, outpatient facility, and home).~~ • ~~Pain management.~~ • ~~Physical therapy (private, outpatient facility, and home).~~ • ~~Radiation oncology.~~ ~~Submit a request through eviCore healthcare at **www.evicore.com/pages/providerlogin.aspx** or by calling **1-877-506-5193**.~~
02/13/24	Durable medical equipment	25	**Deleted:** ~~eviCore healthcare provides utilization management for most DME. Providers are advised to consult the online Prior Authorization Lookup Tool to determine if eviCore healthcare is managing the review of a particular code or if it is still being managed by Select Health. Providers should follow the prior authorization guidelines provided by the look- up tool. 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.~~ **Added:** Effective October 1, 2023, DME coverage includes bath safety items that were previously covered under the SCDHHS Community Long Term Care (CLTC) waiver. Durable medical equipment includes medical products; surgical supplies; 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.
02/13/24	2024 Prior Authorization Information	95	**Replaced: 2023 Prior Authorization Information with 2024 Prior Authorization Information**

Provider Manual Change Control Record

Date	Section	Page	Change
03/01/24	Services provided by Medicaid fee-for-service	90	~~**Deleted: 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.~~ **Added: Under First Choice Covered Services** **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 University School of Medicine, USC in Columbia, or the Medical University of South Carolina at Charleston.
03/01/24	Services provided by Medicaid fee-for-service	90	**Added:** • **Oncotype DX breast cancer coverage:** Oncotype 81519 DX breast cancer assay is a genetic test used for gene expression profiling real-time RT-PCR of 21 genes, utilizing formalin-fixed paraffin embedded tissue. One test per lifetime is covered.
03/01/24	Services provided by Medicaid fee-for-service	90	**Added:** • **Neuropharmacogenomic testing:** Defined as a pharmacogenetic test (PGx) that allows providers to see how patients would interact with different medications for a mental health diagnosis without going through a trial-and-error process to determine optimal medication and dosage. The test is available to adult Select Health members with prior authorization and must meet state criteria.
04/01/24	Services provided by Medicaid fee-for-service	90	**Added:** • **Nucleic acid amplification test (NAAT):** NAAT is covered for the diagnosis of bacterial vaginosis when performed by qualified lab providers.
04/01/24	Entire manual	Entire manual	January 1, 2024. NIA changed names to Evolent. Revisions reflecting the name change have been made throughout the manual.
04/01/24	Speech, Physical, and Occupational Therapies	26	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 ~~and require prior authorization after the initial evaluation or re-evaluation.~~ **Replace sentence with:** No authorization is required for members ages 20 and under for the first 72 visits, nor is it required for members ages 21 and over, for the first 27 visits per year. Prior authorization is required following the 72nd visit for members aged 20 and under, and it is required following the 27th visit for members aged 21 and over.

Date	Section	Page	Change
04/01/24	Same day reimbursement-Evaluation & management services with modifier 25	70	**Delete Section:** ~~Same-day reimbursement — Evaluation & management services with modifier 25 Modifier 25 is used to describe a significant and separately identifiable evaluation and management (E/M) service performed by the same physician or other qualified health care professional on the same day of a procedure or service.~~ ~~Office or outpatient E/M procedures (CPT codes: 92002, 92004, 92012, 92014, and 99201 – 99215) appended with modifier 25, when the service date occurs on the same day as a Class S or T code, will be reimbursed as follows:~~ ~~If an E/M service is billed with a modifier 25 by the same physician or other qualified health care professional on the same day as a Class S or T code, the E/M service will be reimbursed at 50% of the allowable amount.~~ ~~Reimbursement of certain preoperative and postoperative services is included in the Global Surgical Package and, therefore, such services are not separately reimbursable. These preoperative and post-operative services are specified in the Surgical Package Code list found in the SCDHHS Physicians Services Provider Manual.~~ ~~Exceptions~~ ~~E/M procedures from other CPT categories such as Hospital Inpatient; Observation; Emergency Room; or Preventive Medicine will be reimbursed at the nonreduced allowable amount, as defined by the provider's contract and state and federal guidelines~~
04/01/24	Services provided by Medicaid fee-for-service	90	**Add:** ***Mild Obstructive Sleep Apnea (OSA Treatment)** Effective April 1, 2024, SCDHHS expanded their coverage for the treatment of OSA to include treatment for mild OSA, with an FDA-approved prescriptive device eXciteOSA, which is covered under the SCDHHS DME benefit. No prior authorization for members aged 18 or older. Eligible members must have a diagnosis of mild OSA, indicated by a sleep study, with a score of apnea-hypopnea index of more than five and less than 15.
05/01/24			No updates.
06/01/24	Submitting Corrected claims electronically	75	**Update email address:** From edi.sh@hmhp.com to edi@selecthealthofsc.com

Date	Section	Page	Change
06/01/24	Coding considerations	77 – 78	**Delete:** • ~~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 EPSDT examination code to receive reimbursement.~~ **ADD bullet:** • When billing for an immunization administration and an EPSDT examination code on the same day, the provider must use modifier XU in order to receive additional reimbursement. **Replace 25 with XU** • The appropriate vaccination administration code with a 25 XU modifier.
06/01/24	FQHC payment methodology	78	**Replace** • ~~Claims are to be submitted with place of service 50 for FQHC services.~~ **New bullet:** • Claims are to be submitted with place of service 50 for FQHC services or place of service 15 for an FQHC mobile unit.
06/01/24	Audiological services	81	**Update chart:** 92552 ~~6 every 12 months~~ 1 per day and up to 2 per 24 months per patient 92557 ~~1 every 12 months~~ 1 per day and up to 2 per 24 months per patient 92557/52 ~~6 every 12 months~~ 1 per day and up to 2 per 24 months per patient 92567 ~~6 every 12 months~~ 1 per day and up to 4 per 12 months per patient 92568 ~~2 every 12 months~~ 1 per day and up to 2 per 24 months per patient 92584 ~~1 per implant~~ 1 per 12 months per patient ~~92585 No limit~~ ~~92585/52 No limit~~ 92587 ~~No limit~~ 1 per day per patient 92588 ~~No limit~~ 1 per day per patient 92590 ~~6 every 12 months~~ 1 per 12 months per patient 92592 ~~6 every 12 months~~ 1 per day and up to 4 per 12 months per patient 92592/52 ~~6 every 12 months~~ 1 per day and up to 4 per 12 months per patient 92626 ~~10 per year~~ 1 per day and up to 4 per 12 months per patient V5011 1 per day and up to 2 per 12 months per patient

Provider Manual Change Control Record

Date	Section	Page	Change
06/01/24	Maternity care	84	**Add bolded sentence to end of paragraph** Maternity services include high levels of quality care for pregnant members. Maternity care service benefits include prenatal, delivery, and postpartum services and nursery charges for a normal pregnancy or complications related to the pregnancy. **Additionally, there is no visit limit in place for pregnancy or postpartum care.**
06/01/24	First Choice covered services	90	**Transplant Coordinators:** **Add:** **Augusta University Transplant Program** **1-706-721-2888**
06/01/24	Entire manual		Effective July 1, 2024, the copay responsibility for all recipients of South Carolina's Medicaid program ("Healthy Connections") has been reduced to zero per the South Carolina Department of Health and Human Services. Revisions reflecting the copay have been made throughout the manual.
06/01/24	Entire manual		Effective July 1, 2024, the state of SC has gone from a Preferred Drug List (PDL) to a Consolidated Drug List. Revisions reflecting the change have been made throughout the manual.