



Health Care Professional and Provider Manual

Select Health of South Carolina Provider Manual

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Provider Services: **1-800-741-6605**

■ 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 (SCDHHS). Headquartered in Charleston, S.C., Select Health is a mission-driven health care organization with more than 25 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 millions of individuals nationwide.

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

OUR VISION

To be a national leader in empowering those in need, especially the underserved and the disabled, across their full life journey, from wellness to resilience, in order to achieve their American Dream.

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 location, additional facility locations, or changes to telephone numbers.
- Changes to tax identification numbers or payee information. (Provide a copy of your W-9.)
- 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 member is enrolled in an MCO, the health care professional/provider must be enrolled with South Carolina Medicaid and contracted with the managed care company or may need to obtain prior authorization in order to be reimbursed.

■ Prohibited payments

In accordance with the SCDHHS MCO contract, Select Health is prohibited from making payments for the following:

- **Nonemergency items or services**
Nonemergency items or services provided by, under the direction of, or under the prescription of an individual excluded from participation under Title V, XVIII, XX, 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act, or when the individual performing such item or service knew or had reason to know of the exclusion.
- **Assisted suicide**
Any amount expended for a purpose for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.
- **Home health**
Any amount expended for home health care services unless the organization provides the appropriate surety bond as required under Section 1861(o)(7) of the Social Security Act.
- **Hospital-acquired condition (HAC) or provider-preventable condition (PPC)**
Any service resulting from an HAC or PPC that meets the following criteria:
 - Is identified in the state plan.
 - Has been found by the state, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines.
 - Has a negative consequence for the member.
 - Is auditable.

- Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient, surgical or other invasive procedure performed on the wrong body part, or surgical or other invasive procedure performed on the wrong patient.

■ Provider enrollment in the South Carolina Medicaid program

Provider participation in the South Carolina Medicaid program is voluntary. To participate in the Medicaid program, a provider must meet SCDHHS and federal requirements and submit certain documentation. For detailed information, please consult the *SCDHHS Provider Administrative and Billing Manual's* Provider Enrollment section, which accompanies each provider manual located on the SCDHHS website, **www.scdhhs.gov**.

■ Ownership disclosure

Federal Medicaid regulations (42 CFR 455.100 – .106) require that all Medicaid providers disclose the name, address, and other identifying information for each person with an ownership or control interest in the provider and any subcontractor in which the provider has a 5% or more interest.

The SCDHHS requires all providers who do not have a South Carolina Medicaid ID to submit ownership and control information, including information on agents or managing employees of the provider.

This form should be filled out and signed by an authorized agent for the provider's organization. The enrolling provider's name **should not** be on this form unless they are an owner or managing employee of the organization. A link to the SCDHHS ownership disclosure form is located on the Select Health website at: **<https://www.selecthealthofsc.com/provider/resources/forms.aspx>** under State of South Carolina Ownership Disclosure form. Failure to submit the Ownership Disclosure form will result in nonpayment of claims.

■ South Carolina Department of Health and Human Services (SCDHHS) Article 1/Appendix D

As a condition of participation in the Medicaid program as a subcontractor of a managed care organization, certain language is required to be included in the provider/subcontractor contract with SCDHHS. In the event that SCDHHS modifies, amends, or otherwise changes the required subcontract language as set forth in the MCO contract, the provider/subcontractor understands and agrees that SCDHHS-required subcontract boilerplate shall be amended to conform to the requirements and standards without the need for a signed, written amendment. Article 1/Appendix D has been updated and is part of your participating agreement with Select Health. It can be found in its entirety in the **Exhibits section** of this manual.

■ Quality Assurance and Performance Improvement Program

In accordance with federal regulations 42 CFR § 438.240 – § 438.242, Select Health of South Carolina'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 services 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 National Committee for Quality Assurance (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/recredentialing process.
- Conducting member and practitioner satisfaction surveys to identify opportunities for improvement.
- Reducing health care disparities by measuring, analyzing, and redesigning 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, 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 (QAPIC)

The QAPIC oversees Select Health's efforts to measure, manage, and improve quality of care and services delivered to Select Health members, and to 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.) and 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 to 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 ensure that services are coordinated and effective. The committee 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 that required prior authorization.

Practitioner involvement

- Every provider in the Select Health provider network is required by contract to cooperate with and participate in Select Health's Quality Management/Quality Assessment and Performance Improvement (QM/QAPI) program. We rely on your cooperation and participation to meet our own state and federal obligations as a Medicaid MCO.
- Select Health's access to the medical records maintained by our providers is a critical component

of our data collection as we seek to ensure appropriate and continued access to care for our member population. Select Health or its designee must receive medical records from you in a timely manner for purposes of HEDIS data collection, NCQA accreditation, medical records documentation audits, and other quality-related activities that comprise our QAPI program. Select Health will reach out from time to time to request records for these purposes; it is essential that you provide requested records within the time frames set forth in those notices.

- As our technological capabilities continue to advance, Select Health will seek to enhance the efficiency of our data collection activities in support of our QAPI and population health programs, including through the use of bidirectional automated data exchange with our providers. These exchange opportunities, as available, are intended to capture data related to gaps in care and to identify social determinants of health that may also be targets for intervention. Select Health will work with our providers to identify and implement the most appropriate format and cadence for data exchange.
- Select Health clinical reviewers fully investigate potential quality of care (QOC) concerns, in accordance with Select Health policy. Providers are expected to comply with QOC review processes, beginning with the timely submission of records in response to requests from Select Health. Your support of and participation in this critical review process helps to ensure the provision of high quality care and service to the First Choice by Select Health of South Carolina member population.

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. Practitioners and providers agree to allow Select Health to use their performance data as needed for the organization's quality improvement activities to improve the quality of care and services and the overall member experience. Ongoing QAPI activities include the following:

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, or health management programs, or to contact the medical director, call or fax during or after normal business hours:

- Behavioral Health Utilization Management, toll-free: **1-866-341-8765**
- Behavioral Health Utilization Management Fax, toll-free: **1-888-796-5521**
- Population Health, toll-free: **1-888-559-1010**
- Population Health, Charleston area: **1-843-764-1988**
- Population Health Fax, toll-free: **1-888-824-7788**
- Population Health Fax, Charleston area: **1-843-863-1297**

- Population Health Right Fax: **1-866-368-4562**
- Provider Contact Center: **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**
- PerformRxSM Pharmacy Services: **1-866-610-2773**

For membership verification, member complaints, requests to transfer members, and Language Services Associates (LSA)/INTERPRETALK interpretation services:

- Member Services, toll-free: **1-888-276-2020**
- Member Services, Charleston area: **1-843-764-1877**
- Member Services Fax, Charleston area: **1-843-569-4875**
- 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: **1-843-569-1759**
- Fax, toll-free: **1-800-316-0093**
- For claims: **1-800-575-0418**
- Website: www.selecthealthofsc.com

■ **Select Health credentialing requirements**

Select Health of South Carolina (Select Health) maintains criteria and processes to credential and recredential health care professionals, including but not limited to physicians, physician assistants, certified nurse midwives/licensed midwives, certified registered nurse anesthetists, nurse practitioners/clinical nurse specialists, podiatrists, chiropractors, audiologists, and private therapists — occupational, physical, and speech and language therapists.

Behavioral health practitioners who are credentialed include but are not limited to psychiatrists, psychologists, licensed clinical social workers, licensed social workers, licensed professional counselors, licensed marriage and family therapists, substance use treatment practitioners, board-certified behavior analysts and board-certified assistant behavior analysts, registered behavioral health technicians, and school-based practitioners.

Select Health will credential resident physicians who are not working as hospital-based practitioners. Hospital-based practitioners who are practicing exclusively in an inpatient setting are not credentialed or recertified by the plan. Examples of hospital-based practitioners are but are not limited to pathologists, anesthesiologists, radiologists, emergency medicine, neonatologists, and hospitalists.

The scope of the credentialing program includes all health care professionals and nonphysician health care professionals who have an independent relationship with the organization and who see members outside the inpatient hospital setting or outside of ambulatory free-standing facilities. Health care professionals who have been credentialed through a plan delegate are not directly credentialed by Select Health.

The criteria verification methodology used by Select Health is designed to credential and recredential in a nondiscriminatory manner, with no attention to practitioners’ race, ethnic/national identity, gender, age, sexual orientation, or specialty and procedures performed. Select Health’s credentialing/recertification criteria and standards are consistent with the SCDHHS contractual and statutory requirements, federal regulations, and the NCQA. Recertification will take place at least every 36 months.

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 the **SCDHHS Provider Administrative and Billing Manual**.

REQUIRED CREDENTIALING DOCUMENTATION

All health care professionals/providers must submit a signed and dated application that includes a signed and dated attestation/release form. Applications must be filled out correctly and completely, be legible, and contain the provider’s attestation of the application’s correctness and completeness. Select Health accepts the SC Uniform Managed Care Credentialing Application or applications submitted through the Council for Affordable Quality Healthcare (CAQH). The initial credentialing file must be completed within 30 calendar days of receipt of the completed credentialing application. The health care professional’s application and attestation/release form must have a signature dated within 305

calendar days prior to Select Health’s Credentialing Committee decision date. (CAQH applications must be in a current, nonexpired status.) Original, faxed, photocopied, and electronic signatures by the health care professional/provider are acceptable. (Stamped signatures are not acceptable.)

In addition, the health care professional/provider must submit supplementary information, including but not limited to licensure; a current, active Drug Enforcement Agency (DEA) license, if applicable; malpractice coverage and professional liability claims history; hospital admitting arrangements; work history; and education. The full list of required supplemental information will be included in the credentialing application packet. 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 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 Board website. The verification page is printed and inserted in the credential file. All nonphysician 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, Medicare/Medicaid sanction activity, restrictions on licensure, or limitations on scope of practice for all health care professionals/providers:

- National Practitioner Data Bank (NPDB)/Health Integrity Protection Data Bank (HIPDB). (HIPDB data was merged and is currently included within the NPDB database.)
- Office of the Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) database.
- General Services Administration (GSA) System for Award Management (SAM).
- South Carolina Department of Health and Human

Services (SCDHHS) SC Excluded Providers List.

- SCDHHS Provider Termination list for both physical health and behavioral health.
- SCDHHS Provider Suspension list.
- The Centers for Medicaid and Medicare Services (CMS) Clinical Laboratory Improvement Amendment (CLIA) website.
- Medicare Opt Out Report.
- National Plan and Provider Enumeration System (NPPES).
- Social Security Death Master file via Provider Trust.

Note: Watchdog or Provider Trust may be used to query OIG and SAM.

If a health care professional/provider is found to be excluded or terminated from any government program, the credentialing process will cease and the health care professional/provider’s file will be discontinued. The SCDHHS referral process for denial for cause will be followed.

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, they will not be allowed to participate in the plan’s network.

All certificates received as verification (i.e., DEA, CDS/CSC, malpractice insurance) must be current at the time of the credentialing/recredentialing decision. If a document will expire within 30 days of receipt, the Credentialing Department will reach out for an updated certificate.

All verifications, with the exceptions of education/training and work history, may not be older than 120 calendar days at the time of the credentialing or recredentialing decision. There is no time limit for verification of education/training. Verification of work history may not be older than 305 calendar days at the time of the credentialing or recredentialing decision.

The application packet must include the following items:

- Current, active, unrestricted 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 Clinical Laboratory Improvement Amendments (CLIA) (if applicable).
- Collaborative Agreement for Physician Assistants (PAs).
- Nurse Protocol: All NPs must provide a copy of their most recent signed written protocol between the nurse and the preceptor physician.

*Note: Suboxone DEA certificate must be loaded in the credentialing database. These licenses have an “X” in front of the license number, which will allow the practitioner to prescribe Suboxone.

This list is not all-inclusive. For questions or a complete list of required documentation, contact your provider network account executive.

Please submit all completed credentialing documents to your account executive.

The following information is requested in order to complete the **recredentialing** 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).
- 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 305 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.

LEAVE OF ABSENCE

If during the recredentialing cycle, Select Health of South Carolina is notified that a practitioner is on a leave of absence that will extend beyond the time the practitioner is due for recredentialing, the practitioner will not be terminated. Practitioners who are unable to recredential within the 36-month time frame due to military assignment, maternity leave, medical leave, or sabbatical during which the contract between Select Health of South Carolina and the practitioner remains in place are recredentialled within 60 calendar days of return from the leave. Documentation of the reason for the delay is clearly recorded in the in the file.

COLLABORATIVE AGREEMENTS (FOR PAs)

1. All PAs must provide a copy of their most recent signed written collaboration agreement between the PA and the preceptor physician filed with the state.
2. The primary physician preceptor must be a participating provider with the plan.
3. The collaboration agreement must include the scope of the PA’s practice and delineate the preceptor arrangement with supervising physician(s).
4. The agreement must be signed by both the PA and preceptor physician(s).
5. All PAs and supervising physicians must review, sign, and date the agreement biennially.

ADVANCED NURSE PRACTITIONERS (NPs), NURSE MIDWIVES, AND CERTIFIED NURSE PRACTITIONERS (CRNPs) PROTOCOLS

All advanced NPs, nurse midwives, and CRNPs 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, which must not be dated over 365 days before the copy is submitted:
 - 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 (not applicable to CRNPs).
 - d. Situations that require direct evaluation by or referral to the physician.

The preceptor must be a contracted and credentialed medical doctor who is qualified to oversee the services provided by an advanced nurse practitioner, nurse midwife, or CRNP with Select Health; be within a 45-mile radius; and have telephone contact with the NP, nurse midwife, or CRNP.

Written protocols will be reviewed for completeness and must be signed by a preceptor. The plan will not enroll advanced NPs who use 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 dietitian (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 and nonorganizational.

Organizational providers include but are not limited to hospitals, home health agencies, skilled nursing facilities, and residential and free-standing ambulatory surgical centers.

Nonorganizational providers include but are not limited to laboratory centers, infusion agencies, radiology centers; audiology, speech, occupational, and 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 recredentialed every 36 months, consistent with the SCDHHS contractual requirements and health plan accreditation standards. The recredentialing process will ensure that organizational/nonorganizational 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 an 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 three 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 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 three years at the time of approval.
- For skilled nursing facilities: Joint Commission, Accreditation Association for Ambulatory Health Care (AAAHC) or 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 three 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 three years at the time of approval.

Behavioral health facilities — Facilities providing mental health and substance use 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 the following services:
 - Substance use and/or behavioral/mental health outpatient.
 - Substance use and/or behavioral/mental health inpatient.
 - Substance use and/or behavioral/mental health residential treatment.
 - Substance use and/or behavioral/mental health partial hospitalization.
 - Substance use 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.

The plan will conduct:

- A Medicare/Medicaid Sanction review via OIG online.
- A Medicare/Medicaid sanction review via the GSA SAM.
- A Medicare/Medicaid Sanction review via online SCDHHS SC Excluded Providers List.
- An Adverse Action review via the NPDB; NPDB is inclusive of HIPDB data.
- A Medicare Opt-Out status checked via the Palmetto GBA Medicare website.

Ancillary providers — nonorganizational

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.

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.

Audiology, Speech, Occupational, and 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.

Laboratories must:

- Be certified by CMS under the 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.

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 nonresident South Carolina Permit issued by the South Carolina 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.
- A Medicare/Medicaid Sanction review via OIG online.
- A Medicare/Medicaid sanction review via the GSA SAM.
- A Medicare/Medicaid Sanction review via online SCDHHS SC Excluded Providers List.
- An Adverse Action review via the NPDB. NPDB is inclusive of HIPDB data.
- A signed application and attestation of correctness of the information supplied must be provided.

Radiology centers must:

- Provide a business license, if applicable.
- Have X-ray equipment periodically and 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, and

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.

Nonaccredited organizational providers

If an organizational provider applicant is nonaccredited 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 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 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.

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 SCDHHS 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 and 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 recredentialing cycles and act on any identified quality or safety issues expeditiously.

Required recredentialing documentation

- Application — SC Uniform Managed Care Health Care Professional Credentials Update Form, OR;
- CAQH Universal Provider Datasource College of American Pathologists health care professional/provider CAQH reference number.
- Credentialing Attestation.
- Office hours/Patient Loads Form/Service addresses.
- Claims Information Form (if applicable).
- 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 recredentialing cycle are sent a recredentialing notification (letter, email, fax) approximately four months prior to the recredentialing 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/rec credentialing can be found on the Select Health website, www.selecthealthofsc.com.

Select Health credentialing/rec credentialing actions

Select Health will:

- Verify state license through appropriate licensing agency.
- Verify board certificate or residency training or medical education.
- Query NPDB.
- 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.
- The plan may conduct surveys of the health care professional/provider as needed.
- The health care professional/provider agrees to submit periodic/annual file audits conducted by the plan regarding the performance of its delegated responsibilities.
- The 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.
- The 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.

Health care professional/provider site visit requirements

Site review evaluates the appearance and accessibility of the facility, record-keeping practices, and safety procedures. A site visit will be conducted when a complaint has been logged against a specific provider for concerns regarding medical record keeping, accessibility, availability, or physical site quality. If areas are identified that require corrective action, the contract management representative will work with the provider over time to improve these areas.

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:

- Debarred, suspended, or excluded from participation in Medicare, Medicaid, the State Children’s Health Insurance Program (SCHIP), or any other federal health care program;
- Convicted of a criminal offense related to the delivery of items or services under the Medicare or Medicaid program; or
- 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 the professional/provider 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 that 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

During the review of the credentialing and recredentialing applications, applicants are entitled to certain rights, as listed below. Every applicant has the right to:

- Review the information submitted to support their credentialing application, with the exception of

recommendations and peer-protected information obtained by Select Health.

- Correct erroneous information. When information is obtained by the Credentialing department that varies substantially from the information the provider provided, the Credentialing department will notify the health care professional/provider to correct the discrepancy. The health care provider/professional must correct erroneous information within 10 calendar days of receipt of the notification of the erroneous information.
- Upon request, to be informed of the status of their credentialing or recredentialing application. The Credentialing department will share all information with the provider with the exception of references, recommendations, or peer-review protected information (i.e., information received from the NPDB). Requests can be made via phone, email, or in writing. The Credentialing department will respond to all requests within 24 business hours of receipt. Responses will be via email or phone call to the provider.
- Be notified within 60 calendar days of the Credentialing Committee or Medical Director review decision.
- Appeal any recredentialing denial within 30 calendar days of receiving written notification of the decision.
- Know that all documentation and other information received for the purpose of credentialing and recredentialing is considered confidential and is stored in a secure location that is only accessed by authorized plan associates.
- Receive notification of these rights.

To request or provide information for any of the above, the provider should contact the **Provider Network Management account executive** for their area of the state or Select Health of South Carolina’s Credentialing department at the following address:

Select Health of South Carolina
Attn: Provider Network Management
P.O. Box 40849
Charleston, SC 29423

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 the Professional Review Committee, a subcommittee of Select Health's Credentialing 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 Professional Review 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 Professional Review 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's Professional Review Committee. At the hearing, the health care professional/provider shall have the right to:
 - Appear in person and present evidence relevant to their case; they may choose to be represented by legal counsel or another person of their choice.
 - Submit a written statement to the Professional Review 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 Professional Review 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 Professional Review Committee is 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 their 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 notification, 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 and 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 their 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 nontreatment.
 - The member's right to participate in decisions regarding their 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 their 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, waste, 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 for knowing and abiding by all applicable state and federal regulations.

Select Health is dedicated to eradicating fraud, waste, and abuse from its programs and cooperates in fraud, waste, 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, wasteful, or 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 that are not medically necessary.
- Misrepresenting the services rendered.
- Submitting a claim for health care professional/provider services on behalf of an individual who 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
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: Division of Program Integrity
P.O. Box 100210
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 — This 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 (a *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.
 - This provision allows rewards between 15% and 25% of the proceeds of the action or settlement if the government intervenes, or 25% to 30% 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.”¹ Therefore, knowingly and improperly failing to return an overpayment could form the basis of an FCA action against a provider. Overpayments must be reported and returned within 60 days of discovery.

The 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.)

1. “False Claims Act Description,” Centers for Medicare and Medicaid Services, <https://downloads.cms.gov/cmsgov/archived-downloads/smdl/downloads/smd032207att2.pdf>

- South Carolina DHHS Administrative Sanctions Against Medicaid Providers Act. (See S.C. Code of Regulations R. 126-400 et seq.)

The 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, a health maintenance organization, or 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, imprisoned for not more than 5 years, OR BOTH.
- A misdemeanor if the amount of the claim is \$2,000 or less.
 - If convicted, the person MUST be fined not more than \$1,000, imprisoned for not more than 30 days, OR BOTH.

(See The South Carolina Presenting False Claims for Payment Statute S.C. Code Ann. n. Ann. § 38-55-170)

South Carolina Medicaid False Claims Statute:

- Provides criminal, civil, and administrative penalties and sanctions related to health care providers who knowingly and willfully make or cause to be made a false statement in an application or request for benefit, payment, reimbursement, or in any report or certificate submitted to the Medicaid program.
- The statute provides that it is unlawful for a provider to knowingly and willfully conceal or fail to disclose any material fact that 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.
- The attorney general may bring civil action to:

- Recover treble damages.
- Seek penalties of up to \$2,000 per false claim.
 - The state agency administering Medicaid program may impose administrative sanctions against a Medicaid provider who has been determined to have abused the Medicaid Program.

Note: Providers are responsible for ensuring all staff are educated on at least the same aspects of fraud, waste, and abuse, and the provisions of the False Claims Act as noted herein.

■ Culturally and Linguistically Appropriate Services (CLAS)

Section 601 of Title VI of the Civil Rights Act of 1964 states no person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied of, or be subjected to discrimination under any program or activity receiving federal financial assistance.

Title III of the Americans with Disabilities Act (ADA) states that public accommodations must comply with basic nondiscrimination requirements that prohibit exclusion, segregation, and unequal treatment of any person with a disability. Public accommodations must specifically comply with, among other things, requirements related to effective communication with people with hearing, vision, or speech disabilities, and other physical access requirements.

To ensure the delivery of culturally and linguistically appropriate services, Select Health, a three-time recipient of the Multicultural Health Care Distinction awarded by the National Committee for Quality Assurance, has adopted the national standards for CLAS as issued by the U.S. Department of Health and Human Services' Office of Minority Health. As part of our commitment to diversity, Select Health has established comprehensive policies and procedures 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 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.

■ **Bariatric surgery centers**

Our bariatric centers share these characteristics:

- Excellent infrastructure.
 - Hospital systems (medical and surgical specialties).
 - Program components (pre- and postsurgery).
- 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.

Programs that are accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP), as listed on the American College of Surgeons website (**American College of Surgeons MBSAQIP Accredited Bariatric Surgery Centers**), are considered to have preferred status with Select Health.

All bariatric surgical procedures require prior authorization. Providers are to submit requests to Select Health Population Health via the NaviNet provider portal (preferred method), by calling **1-888-559-1010**, or by completing the prior authorization request form located on the Select Health website at **Prior authorization request form** and faxing it to **1-888-368-4562**.

Prior authorization requests submitted by bariatric

centers not accredited by the MBSAQIP may be denied as not meeting preferred status based on the standards set forth by the American College of Surgeons MBSAQIP.

Population Health will review requests and authorize those that meet medical necessity requirements.

■ **Population Health 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 health care 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.

In accordance with 42 CFR 438.210 (a)(5), *medically necessary services* are those services utilized in the state Medicaid program, including quantitative and nonquantitative treatment limits, as indicated in state statutes and regulations, the state plan, and other state policy and procedures.

Medical necessity means the need for treatment/ services is necessary to diagnose, treat, cure, or prevent an illness, or participation in services is expected to relieve pain, improve and preserve health, or be essential to life.

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

Adverse benefit 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, their medical expertise, and external resources, determines if the request for payment of services will be approved or denied.

All adverse benefit 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 Population Health 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 NCQA and

the 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% 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. The member’s record contains a page or form that 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’s record will show the date of the first patient exam made through or by the MCO.
4. The 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. The 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 to 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 on the problem list). There should be an inquiry about allergies on the first visit.
9. Past medical history is listed, including 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. The 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. A clinical/physical assessment and/or objective findings are recorded.

- a. The 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. The plan of action/treatment is 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's/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. The consult reports reflect the health care professional's/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's/provider to indicate the health care professional's/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, the reviewer should indicate an 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's/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/provider or another system ensuring health care professional/provider review is in place. Electronic medical records indicate health care professional's/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 use 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, and follow-up.
 - a. Health care professionals/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. 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 that 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 Population Health 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 48 hours of referral or notification of the primary care physician.
- Scheduling of appointments for routine care (nonsymptomatic) within four weeks and a maximum of 12 weeks for unique specialists.

Nonparticipating health care professionals/providers

PCPs and plan participating specialists may refer members to a nonparticipating 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 nonparticipating health care professional/provider must contact Select Health's Population Health department for prior authorization.

Services that require prior authorization

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

- Acute inpatient psychiatric facility services.
- All out-of-network services (except services listed under "Services that **do not** require authorization").

- Advanced outpatient imaging*:
 - 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).
- Air ambulance.
- All unlisted and miscellaneous codes (including but not limited to codes ending in “99”).
- Autism spectrum disorder (ASD) services.
- BabyNet services.
- Behavioral health (psychological and neuropsychological testing, electroconvulsive therapy, environmental intervention, interpretation or explanation of results, unlisted psychiatric services, and inpatient services).
- Behavioral health individual outpatient therapy sessions (CPT codes 90832, 90834, 90837), after 24 visits per state fiscal year. Limitation: six visits per month.
- BRCA 1 and 2 — full sequence & duplication/deletion gene analysis.
- Chiropractic, under 18 years of age, six visits per state fiscal year (July 1 – June 30).
- Cochlear implantation.
- Contact lenses, including dispensing fee.
- Department of Alcohol and Other Drug Abuse Services (DAODAS) offerings (bundled services and some discrete services).
- * Advanced outpatient imaging — Authorizations administered by NIA (see **Advanced Outpatient Imaging Services** in the **First Choice Covered Services section** of this manual for more information).
- Durable medical equipment (DME) leases and rentals.
- Gastric bypass/vertical band gastroplasty.
- 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).
 - Private duty nursing (extended nursing services), covered when medically necessary for under age 21.
 - Home infusions and injections. (See list of medications that require authorization on the Select Health website under Pharmacy Services.)
- Hyperbaric oxygen.
- Hysterectomy (Hysterectomy Consent and Surgical Justification forms are required), oophorectomy and ovarian cystectomy, elective abortions.
- Implants (over \$750.00).
- Inpatient services:
 - All inpatient hospital admissions, including medical, surgical, and rehabilitation.
 - Obstetrical admissions/newborn deliveries exceeding 48 hours after vaginal delivery and 96 hours after caesarean section.
 - Inpatient medical detoxification.
 - Elective transfers for inpatient and/or outpatient services between acute care facilities.
 - Long-term care initial placement, if still enrolled with Select Health.
- Medications: Consult the **Prior Authorization Lookup Tool** to determine authorization requirements.
- Medications not listed on the South Carolina Medicaid Professional Services Fee Schedule are not covered by First Choice.
For questions contact PerformRxSM: **1-866-610-2773**.
- Psychiatric residential treatment facility (PRTF) services.
- Rehabilitative behavioral health services (RBHS) — see the **Behavioral Health Under First Choice section** for specifics.
- Surgical services that may be considered cosmetic, including:
 - Blepharoplasty.
 - Mastectomy for gynecomastia.
 - Mastopexy.
 - Maxillofacial.
 - Panniculectomy.
 - Penile prosthesis.
 - Plastic surgery/cosmetic dermatology.
 - Reduction mammoplasty.
 - Septoplasty.

- Therapy services — Speech therapy requires prior authorization after initial assessment or reassessment. This applies to private and outpatient facility-based services.
- Transplants.

When services requiring prior authorization are necessary for a member, the health care professional/provider should contact Select Health Population Health toll-free at **1-888-559-1010** or **1-843-764-1988** 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/pdf/provider/resources/prior-authorization-grid.pdf.

Providers may not bill members for services that require prior authorization when 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 Population Health 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

- Acupuncture.
- Enteral nutritional supplements.
- Bronchoscopy — rigid or flexible with fluoroscopic guidance (one and two or more lobes).
- Circumcisions.
- Outpatient Psychotherapy codes 90832, 90834, and 90837 (combined), first 24 visits.
- Behavioral health medication management.
- Emergency room services (in-network and out-of-network).
- 48-hour observations (except for maternity — notification required).
- Low-level plain films — X-rays, electrocardiograms (EKGs).
- Family planning services.
- Poststabilization services (in-network and out-of-network).
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

- Women’s health care by in-network providers (OB-GYN services).
- Routine vision services.
- Opioid Treatment Program (OTP) services.

Services that require notification

- All newborn deliveries.
- Maternity obstetrical services (after the first visit) and outpatient care (includes 48-hour observations).
- Continuation of covered services for a new member transitioning to the plan the first 90 calendar days of enrollment.
- Behavioral health — Crisis Intervention: notification required (within two business days) post-service. Medical necessity review required after 80 units per state fiscal year (July 1 – June 30).

CLINICAL GUIDELINES

Select Health of South Carolina and the AmeriHealth Caritas Family of Companies 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 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; 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, 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 on Select Health's website in the form of a **clinical guidelines library**. The clinical guidelines library will contain both plan-specific and national guidelines. Approved guidelines may be used by members, network providers, and Select Health associates in the interpretation of coverage determinations for those services addressed by the CPC.

■ 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 DME, 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 a First Choice member.
2. Request the prior authorization number from First Choice Population Health 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 **1-843-764-1988** (Charleston area) if you need assistance.

CHILDREN'S REHABILITATIVE SERVICES AND BABYNET

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

CRS is responsible for requesting prior authorization from Select Health's Population Health department for the following covered services:

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

BabyNet services are early intervention services offered to build upon and provide support and resources to assist and enhance the learning and development of infants and toddlers with disabilities and special needs. For more information, see the **BabyNet Services** section in this manual.

DURABLE MEDICAL EQUIPMENT

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.

HOME HEALTH CARE/FAMILY SUPPORT SERVICES

Home health care provided to homebound members requires prior authorization from the Select Health Population Health 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 the 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 Population Health 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 Population Health department is required for therapy services after the initial evaluation or re-evaluation. 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 and require prior authorization after the initial evaluation or re-evaluation.

■ 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: 96130-96146.
- Electroconvulsive therapy: 90870.
- Environmental intervention: 90882.
- Interpretation or explanation of results: 90887.
- Unlisted psychiatric service or procedure: 90889.

Individual psychotherapy visits

Medical necessity review is required for individual psychotherapy after 24 visits (combined) for codes: 90832, 90834, and 90837 (effective 05/01/22).

Once the member has reached the 24th visit, providers will be required to submit an authorization request via the NaviNet provider portal including:

- The most recent individual plan of care (IPOC).
- Progress notes.
- Three most recent clinical service notes.

Failure to submit an authorization request will result in an X01-authorization or referral not obtained denial beginning with the 25th visit.

Crisis management services

Crisis management services require notification. Providers are required to complete the Crisis Management Notification Request form located on the Select Health website at www.selecthealthofsc.com/pdf/provider/forms/bh-crisis-form.pdf.

Notification requests must be submitted within two business days post-event.

Provider's forms are also acceptable as long as they contain:

- Member-identifying data (name, date of birth, member ID).
- Provider-identifying data (name, provider ID, NPI).
- What kind of crisis event it was and where it took place.
- What occurred during the crisis event (summary and what the provider did)

For questions, contact Behavioral Health Utilization Management at **1-866-341-8765**.

Parent signature is required (for members under the age of 21):

- Parental signature is necessary post-crisis notification for care management, utilization management, and reporting purposes.
- If parental signature is not on the form, providers must submit a statement on/or attached to the form that an effort was made to obtain parental signature.

Notes:

- For these services, nurse practitioners are included as allowed provider types.
- Behavioral health providers must adhere to the

following access standards, as prescribed by the NCQA for First Choice members:

- Non-life-threatening emergency care: requires immediate attention but absence of care would not result in death; within 6 hours or referred to the emergency room.
- Urgent care: severe enough that care is required to prevent deterioration of member's condition; within 48 hours.
- Routine care, initial visit: nonemergency, nonurgent, and not post-discharge follow-up appointment; within 10 business days.
- Routine care, follow-up care: Member appointments are to be scheduled as indicated for condition management and within 30 calendar days of initial care.

In addition, the following is a HEDIS follow-up health measure:

- Post-discharge follow up: an outpatient visit following hospitalization for a mental health disorder; with a mental health practitioner for adults and children 6 years and older within seven calendar days.

In cases where the DAODAS or the Department of Mental Health (DMH) 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.

Prior authorization

For behavioral health services that require prior authorization, requests may be submitted via the NaviNet provider portal (preferred method), utilizing the Medical Authorizations link.

There are also 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/provider/member-care/behavioral-health/behavioral-health.aspx, or by contacting the Behavioral Health department and requesting they fax the necessary forms. If a form is required to be completed for a particular service, it can be uploaded and submitted with the prior authorization request within the NaviNet provider portal. For questions regarding prior authorization requirements or to obtain authorization, contact Select Health Behavioral Health Utilization Management 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 developmental evaluation centers, intensive family treatment services, adolescent treatment facilities, inpatient psychiatric hospital, private residential treatment facility services, and waiver programs.

REHABILITATIVE BEHAVIORAL HEALTH SERVICES (RBHS)

Select Health is also responsible for the rehabilitative behavioral health service (RBHS) array provided by DMH, private RBHS providers, and school districts. RBHS are medical or remedial services that are recommended by a physician or other licensed practitioner of the healing arts for maximum reduction of physical or mental disability and restoration of a member to their best possible functional level.

RBHS includes the following categories:

- **Assertive Community Treatment (ACT) services** — an intensive nonresidential treatment and rehabilitative mental health service that provides a single, fixed point of responsibility for treatment, rehabilitation, and support needs for members with severe mental illness (SMI) who require a higher level of community care and have not been well supported in lower level-of-care options.
- **Behavior modification** — Used to provide the member with redirection and modeling of appropriate behaviors in order to enhance function in the home and/or community.
- **Psychosocial rehabilitative services** — Intended

as a skill-building service, not a form of psychotherapy or counseling.

- **Family support services** — Utilized to enable the family or caregiver to be an engaged member of the treatment team and/or improve their ability to care for the member.
- **Community integration services** — Targeted treatment service for adults ages 18 years and older with serious and persistent mental illness.
- **Therapeutic child care (TCC)** — Targeted treatment services for children under age 6 who have experienced trauma, neglect, and abuse and are in need of early intervention.
 - **Note:** In accordance with SCDHHS, TCC providers are allowed to fulfill the requirement of parallel work with the primary caregiver by rendering family psychotherapy twice per month in conjunction with the TCC service.
- **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.

The addition of this benefit includes coverage of services rendered by state and other public agencies that previously did not participate in the Select Health provider network. This includes such providers as the Department of Mental Health and the Department of Education.

Services included under the RBHS benefit are:

- Behavioral health screenings.
- Diagnostic assessment services.
- Psychological evaluations and testing.
- Individual psychotherapy.
- Group psychotherapy.

- Family psychotherapy.
- Service plan development.
- Crisis management.
- Medication management.
- Psychosocial rehabilitation services.
- Behavior modification.
- Family support.
- Community integration services.
- Therapeutic child care center services.
- Peer support services (DMH and DAODAS providers only).
- Substance use disorder treatment services (DAODAS providers only).
- Therapeutic foster care services.
- School-based mental health services.
- Assertive Community Treatment (ACT) services.

RBHS provided by licensed or certified clinicians must follow supervision requirements as required by South Carolina State Law. Services provided by master's level clinicians must be supervised by a Licensed Practitioner of Healing Arts (LPHA) licensed to practice at the independent level. Substance use clinicians who are in the process of becoming credentialed must be supervised by a certified substance use clinician or an LPHA.

Services provided by any unlicensed/uncertified clinician must be supervised by a master's level qualified clinician or an LPHA. When services are provided by an unlicensed or uncertified clinician, the state agency or private organization must ensure the supervising master's level clinician:

- Monitors the performance of the unlicensed clinician and at least every 30 days provides documented consultation, guidance, and education with respect to the clinical skills, competencies, and treatment provided.
- Maintains a log documenting supervision of the services provided by the unlicensed or uncertified clinician for each member.

Supervision may take place in either a group or individual setting and must include:

- Opportunities for discussion of the plan of care and the individual member's progress.
- Service notes in the individual's clinical record documenting issues.

Case supervision and consultation does not negate training requirements. The frequency of supervision should be evaluated on a case-by-case basis.

Providers must have a South Carolina Medicaid ID number and be contracted and credentialed by Select Health as an RBHS provider in order to provide these services to First Choice members. Prior authorization of services and claims payment will be received directly from Select Health.

WHO CAN ESTABLISH MEDICAL NECESSITY?

LPHAs must certify that the beneficiary meets the medical necessity criteria for each service. The LPHA must be enrolled in the South Carolina Medicaid Program. The following professionals are considered to be licensed at the independent level in South Carolina and can establish and/or confirm medical necessity:

- Licensed Physician.
- Licensed Psychiatrist.
- Licensed Psychologists.
- Licensed Psycho-Educational Specialist.
- Licensed APRN.
- Licensed Independent Social Worker — Clinical Practice (LISW-CP).
- Licensed Physician’s Assistant.
- Licensed Professional Counselor (LPC).
- Licensed Marriage and Family Therapist (LMFT).
- Licensed Addiction Counselor (LAC)*.

*Effective July 1, 2021, Licensed Addiction Counselors (LACs), master’s degree and above, were added to the list of LPHAs. This change was made to align with the South Carolina Department of Labor, Licensing and Regulation’s (LLR) recognition of LACs.

When medical necessity for services is required to be established and/or confirmed, the professional must be licensed at the independent level in each respective state where the professional renders services to Medicaid members outside of South Carolina, but within the South Carolina Medical Service Area (SCMSA).

An LMSW is considered an LPHA in South Carolina and can establish and/or confirm medical necessity when employed by a state agency. For private providers, an LMSW must have the DA cosigned by an independent LPHA. LPHAs must be licensed in the state where they render services to the member.

Prior authorization requirements

The following RBHS services will require prior authorization:

Procedure code	Procedure code description
96130	Psychological testing evaluation services by physician or other qualified health care professional, first hour
96131	Psychological testing evaluation services by physician or other qualified health care professional, each additional hour. (List separately in addition to code for primary procedure.)
96136	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method, first 30 minutes
96137	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes. (List separately in addition to code for primary procedure.)
96138	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method, first 30 minutes
96139	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method, each additional 30 minutes. (List separately in addition to code for primary procedure.)
96146	Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only
H0010*	Alcohol and/or drug services; sub-acute detox (residential addiction program, inpatient)
H0011*	Alcohol and/or drug services; acute detox (residential addiction program, inpatient)
H0015*	Alcohol and/or drug intensive outpatient
H0018*	Alcohol and other drug (AOD) short-term residential (American Society of Addiction Medicine [ASAM])
H0019*	AOD long-term residential (ASAM)
H0038	Peer support services (PSS)
H2014	Behavior modification
H2017	Psychosocial rehabilitation services (PRS)
H2030	PRS (clubhouse or community integration services [CIS] — adults)

Procedure code	Procedure code description
H2035*	Alcohol and/or drug treatment program, per hour
H2037	Developmental delay preventive, 15 minutes (therapeutic child care [TCC])
S9482	Family support
S5145	Therapeutic foster care (TFC) per diem

*DAODAS only

For prior authorization requests, the start date for RBHS must be the date that the LPHA signs the DA to confirm medical necessity. The start date is not the date that the DA was completed unless the LPHA signed the DA on the completion date.

Remember: Associates/interns (LPC-A, LMFT-A, social work associates, etc.) cannot establish medical necessity.

Medical necessity must be established by the LPHA.

Prior authorization may be obtained by submitting a request through the NaviNet Provider Portal or by contacting the Select Health Behavioral Health Utilization Department at **1-866-341-8765**.

THERAPEUTIC FOSTER CARE (TFC)

The Select Health behavioral health benefit also provides coverage of TFC services for Medicaid-eligible children 0 – 21 years of age.

Psychosocial Rehabilitative Services (PRS code H2017) has been replaced with an inclusive per diem reimbursement (TFC code S5145).

TFC code S5145 — Foster care, therapeutic, child; per diem must be billed with the appropriate modifier:

- Level 1 — No modifier
- Level 2 — TF modifier
- Level 3 — TG modifier

TFC providers providing services to members in TFC placement must not bill PRS (H2017).

TFC is an inclusive community support service that will be reimbursed on a per diem basis. TFC will replace billing for Psychosocial Rehabilitation Services (PRS) for members in TFC placements as noted below:

Members in TFC placement

- Will no longer be allowed to receive PRS outside of this per diem code. Emphasize to patients/parents that PRS is no longer available through a community-based provider (e.g., school, DMH, private RBHS, etc.).
- Will still be allowed to receive Behavior Modification (BMOD), Family Support Services (FSS), and any other appropriate behavioral health services (e.g., psychotherapy) on the same date of service.

Members not in TFC placement

- May still receive PRS from a community-based or a TFC provider.

TFC services must be rendered by licensed, custodial foster parents supervised by qualified, clinical professionals who are employed or contracted with an SCDSS-certified child-placing agency.

AUTISM SPECTRUM DISORDER (ASD)

Select Health also provides ASD coverage for members under 21 years of age. This benefit includes ASD services rendered by Board-Certified Behavior Analysts (BCBA), Board-Certified Assistant Behavior Analysts (BCaBA), and Registered Behavioral Technicians (RBT), as well as by licensed independent practitioners (LIPs) who are approved by South Carolina Department of Disabilities and Special Needs (SCDDSN) to provide evidence-based treatment (an ABA alternative therapy modality).

The following LIPs providers are permitted to render ASD services for Select Health members once approved by South Carolina Department of Disabilities and Special Needs (SCDDSN) and registered with SCDHHS and Select Health:

- LIPs — master’s or doctoral.
- Licensed Psychologist.
- LPES.
- LISW-CP.
- LMFT.
- LPC.
- ASD services may also be rendered by school districts that enroll with SCDHHS as ASD group providers.

ASD service array:

- Behavior Identification Assessment.

- Comprehensive Testing/Assessment Report, which establishes an ASD diagnosis (medical necessity) must be completed and on file.
- Observational Behavior Follow-Up Assessment.
- Exposure Behavior Follow-Up Assessment.
- Adaptive Behavior Treatment by Protocol.
- Adaptive Behavior Treatment With Protocol Modification.
- Family Adaptive Behavior Treatment Guidance.
- Group adaptive behavior treatment by protocol, multiple patients by RBT.
- Group adaptive behavior treatment by protocol, multiple patients by BCBA.

Services must be recommended by a licensed psychologist (Ph.D., Psy.D) developmental pediatrician, or an LPES and may be provided in the member's home, clinical setting, or other settings authorized by SCDHHS.

Prior authorization requirements for ASD services:

- Prior authorization is required for all ASD services, including assessments and treatments.
- Detailed assessment of members with a diagnosis of autism must be provided upon initial request for authorization of services.
- Select Health will adhere to InterQual criteria and medical necessity requirements as outlined for each service in the **SCDHHS Autism Spectrum Disorder Services Manual**, located at: www.scdhhs.gov/provider-manual-list.
- To request prior authorization, providers may submit a request online via the NaviNet provider portal (preferred method) or complete the ASD Treatment Request form, located on the Select Health website, at www.selecthealthofsc.com/pdf/provider/forms/autism-spectrum-disorder-treatment-request-form.pdf and in the **Exhibits section** of this manual.

Fax completed forms to Behavioral Health Utilization Management at **1-888-796-5521**. For questions, contact Behavioral Health UM at **1-866-341-8765**.

For claims filing details, consult the **Claims Filing Instructions**, located on the Select Health website at www.selecthealthofsc.com/pdf/provider/claim-filing-manual.pdf.

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES (PRTF)

Select Health provides coverage for services rendered at a psychiatric residential treatment facility (PRTF) for eligible members. This benefit includes psychiatric care provided to children under age 21. If services are provided immediately before the member reaches age 21, services may continue until the earlier of the date the member no longer requires the services or the date the member reaches age 22.

Members are referred for PRTF services by an LPHA via the completion of the PRTF treatment request form. The PRTF referral form may be completed by the admitting facility, current treatment provider, or referral source. For questions regarding a member who is receiving PRTF services, please contact Behavioral Health Utilization Management at **1-866-341-8765** and ask to speak to a licensed clinician regarding PRTF placements.

Prior authorization of PRTF services:

- All initial admissions and continued stays require prior authorization. Certain documentation is required for completion of the medical necessity review.
- For detailed information regarding the prior authorization process and documentation requirements, see the **Behavioral Health Utilization Management (BH UM) Psychiatric Residential Treatment Facility (PRTF) Quick-Reference Guide**, located on the Select Health website at www.selecthealthofsc.com/pdf/provider/behavioral/prtf-guide.pdf.

Fax completed forms to Behavioral Health Utilization Management at **1-888-796-5521**. For questions, contact Behavioral Health UM at **1-866-341-8765**.

For claims submission details, consult the **Claims Filing Instructions**, located on the Select Health website at www.selecthealthofsc.com/pdf/provider/claim-filing-manual.pdf.

LICENSED INDEPENDENT PRACTITIONERS (LIPs)

The Behavioral Health benefit includes services rendered by LIPs:

- Licensed Psychologist.
- LPES.
- LISW-CP.
- LMFT.
- LPC.

In accordance with SCDHHS policy for LIPS providers, any combination of the following codes may be billed up to six sessions per month: 90832, 90834, and 90837.

Select Health of South Carolina adheres to benefit limits as established by SCDHHS. Providers are to coordinate care when more than one behavioral health provider is providing services to the same member to ensure compliance with the benefit limit.

Children and Adolescents (20 and under):
Select Health realizes that there may be exceptional situations in which six sessions per month may not be sufficient to meet the needs of children and adolescent members (ages 20 and under). In these situations, providers will need to submit a prior authorization request to Select Health's Behavioral Health Utilization Management Department to determine if additional monthly visits are medically necessary.

For questions, contact the Behavioral Health Utilization Management department at **1-866-341-8765**.

LIP providers must adhere to the supervision guidelines as outlined in the **Services Rendered Under Supervision section** of the **SCDHHS Licensed Independent Practitioners (LIPs) Rehabilitative Services manual**.

ACUTE INPATIENT PSYCHIATRIC FACILITIES

The Select Health contract with SCDHHS includes coverage of acute inpatient psychiatric services provided in free-standing psychiatric facilities for members under 21 years of age.

Select Health adheres to the guidelines as outlined in the **SCDHHS Psychiatric Hospital Services Provider Manual**.

Prior authorization is required for all admissions. Requests may be submitted via:

- **Online:** Through NaviNet, at navinet.navimedix.com/sign-in (preferred method). Go to **Medical Authorizations** under **Workflows for this Plan**.
- **Phone:** Contact Behavioral Health Utilization Management at **1-866-341-8765**.
- **Fax:** Complete the Behavioral Health Inpatient fax request form located on the Select Health website at www.selecthealthofsc.com/pdf/provider/behavioral/behavioral-health-fax-form.pdf.

An **SCDHHS Certification of Need (CON) for Psychiatric Hospital Services for Children under 21**

form must be completed for all members under age 21 admitted for acute inpatient treatment services in a free-standing psychiatric hospital. This form can also be found on the behavioral health forms page on the Select Health website at www.selecthealthofsc.com/pdf/provider/behavioral/behavioral-health-cert-need-children-under-21.pdf.

Claims will be submitted on the UB04 claim form and will be reimbursed as follows:

- DMH free-standing psychiatric hospitals will be reimbursed based on the prospective payment system.
- All other free-standing psychiatric hospitals will be reimbursed based on the diagnosis-related group (DRG) reimbursement system.
- The \$25 inpatient admission copay would apply for members over the age of 18 who are not part of a federally recognized Native American tribe and/or pregnant.

OPIOID TREATMENT PROGRAMS (OTP)

Select Health covers programs that provide evidence-based medication-assisted treatment (MAT) for members with opioid use disorder (OUD).

With the exception of continuity of care, coverage must be provided by providers who are contracted with Select Health and enrolled with SCDHHS. For members being treated by an out-of-network provider, Select Health Utilization Management will work with providers and the member to transition to an in-network provider.

Prior authorization is not required for OTP services. However, members must meet certain requirements to qualify for treatment and seek treatment from an in-network provider. Consult the **SCDHHS Clinic Services Provider Manual**, for a list of these requirements.

- Medical necessity must be confirmed at time of admission by either a physician or advanced practice registered nurse (APRN) who is employed by or contracted with the OTP.

Select Health transitioned to the CMS series of HCPCS codes to designate services provided by an OTP.

The CMS code set is as follows:

New Code	Current Code	Description
G2067	H0020	Medication-assisted treatment, methadone, weekly bundle
G2068	H0016	Medication-assisted treatment, buprenorphine (oral), weekly bundle
G2069	N/A	Medication-assisted treatment, buprenorphine (injectable), monthly bundle
G2073	N/A	Medication-assisted treatment, naltrexone, monthly bundle
G2074	N/A	Medication-assisted treatment, weekly bundle not including the drug
G2076	H0047	Intake activities for medication-assisted treatment
G2077	H0047	Periodic assessment for medication-assisted treatment

The fee schedule for the services listed above is available at www.scdhhs.gov/providers/fee-schedules.

Claims will be submitted directly to Select Health on a CMS 1500 claim form. Standard billing and coding guidelines will apply.

For questions, contact Behavioral Health Utilization Management at **1-866-341-8765**.

SCHOOL-BASED MENTAL HEALTH INITIATIVE

In accordance with the SCDHHS School-based Mental Health Initiative, effective July 1, 2022: RBHS are allowed to be delivered in school settings by Select Health of South Carolina master’s level behavioral health providers who are contracted by the school district for members under 21 years of age.

South Carolina school districts are free to choose to:

- Continue to utilize the South Carolina (DMH by contracting with DMH, who will then bill Select Health.
- Hire their own counselors and bill Select Health directly.
- Contract with a private provider who will bill Select Health directly.
- Use a combination of these delivery methods to meet the needs of the children in their district.

Services eligible in the school-based setting

- Diagnostic Assessment — Initial and Follow up:
 - 90791 — Diagnostic evaluation without medical services — 1 per member every 6

months.

- H0031 — Mental health comprehensive assessment follow-up — 12/year.
- Service Plan Development (H0032) — 15 minutes = 1 unit; 10 units/week.
- Crisis Management (H2011) — 15 minutes = 1 unit; 16 units/day; 80 units/year. Notification required. Must be submitted within 2 business days post-event, via the **Crisis Intervention Notification form** located on the Select Health website.
- Individual Psychotherapy (in any combination):
 - 90832 — 30 minutes = 1 unit; 1/day; 6/month.
 - 90834 — 45 minutes = 1 unit; 1/day; 6/month.
 - 90837 — 60 minutes = 1 unit; 1/day; 6/month.
- Family Psychotherapy:
 - 90846 (without patient) — 50 minutes = 1 unit; 1/day; 4/month.
 - 90847 (with patient) — 50 minutes = 1 unit; 1/day; 4/month.
- Group Psychotherapy (90853) — 60 minutes = 1 unit; 8/month.

These services will be reimbursed according to the **LEA School-based Services Alternative Fee Schedule**.

Eligible provider types

The following professionals may be reimbursed for providing RBHS in the school setting:

- LISW.
- LMFT.
- LPC.
- LPES.
- Licensed Master Social Worker (LMSW) (supervision required).
- Mental Health Professional (supervision required).
- Qualified Clinical Professional (DMH only).

Provider enrollment

Existing LIPS and RBHS providers, school districts, and DMH providers will not need to complete a new application. However, submission of a fully executed agreement with a South Carolina School District to **state_contracts@scdhhs.gov** is required prior to rendering services.

Unenrolled RBHS providers will need to complete the Healthy Connections Medicaid provider application, located on the SCDHHS website, and a Select Health credentialing application.

For more information on enrollment requirements, prior authorization for services, and billing requirements visit the **School Based Mental Health Initiative** webpage on the Select Health website, or the Select Health **Claims Filing Instructions manual**.

Providers are advised to review the SCDHHS Local Education Agencies (LEA) Services Provider Manual, the LEA School-based Services Alternative Fee Schedule, and the Frequently Asked Questions (FAQ) document located on the **SCDHHS School-based Mental Health Services webpage** for full details.

Questions or concerns regarding the policy changes should be directed to the SCDHHS Office of Behavioral Health at: behavioralhealth004@scdhhs.gov.

PSYCHOTHERAPY SUPERVISION GUIDELINES

Reimbursement will be made for covered psychiatric and psychotherapy services provided by a physician or an NP or by Licensed Master Social Workers (LMSWs) under the direct supervision of the physician or NP. The LMSW cannot be reimbursed directly under the Medicaid Physician Services program but will be reimbursed under the physician or NP.

The physician or NP must:

- See each member initially unless the member was accepted as a referral from another physician.
- Authorize the treatment services to be provided by the LMSW.
- Participate in patient staffing with the LMSW to document progress summaries.
- If the member is referred by a nonphysician (e.g., Department of Social Services, school counselor, etc.), the referral source must be documented in the chart.

These guidelines pertain to services delivered LMSWs under the supervision and direction of a physician or NP.

- The LMSW 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 LMSW.
- The supervising clinician must be accessible to the

LMSW while services are being delivered and must meet with the LMSW at a minimum of every 90 days to review member progress.

- The service must be furnished in connection with a covered physician/NP service that was billed to Select Health; therefore, the member must have been seen by the physician/NP.
- A psychiatric diagnostic evaluation has to be performed by the supervising clinician. The LMSW providing psychotherapy personally works with the member to develop the Individualized Plan of Care (IPOC), and the supervising clinician meets with the member 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 their continued participation in the management of the course of treatment.
- The supervising clinician assumes professional responsibility and liability for all services provided by the LMSW.
- The supervising clinician must spend as much time as necessary directly supervising the services to ensure that members are receiving services in a safe and efficient manner in accordance with accepted standards of practice.
- The supervising clinician must meet with the LMSW 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.

Services rendered by Licensed Independent Counselor Interns (LPC/I), Licensed Marriage and Family Therapist Interns (LMFT/I), “applicants for LISW licensure” under the supervision of Licensed Psychologists (PhD), Licensed Professional Counselor Supervisors (LPC/S), Marriage and Family Therapist Supervisors (LMFT/S), Licensed Independent Social Work-clinical practice Supervisors (LISW-CP-S), and Licensed Psycho-Education Specialists (LPES) supervisors are subject to the following limits:

- Licensed psychologists may supervise an unlicensed person providing psychological services. No more than three full-time supervisees may be employed by the psychologist supervisor.
- LMFT/S may supervise only those with the LMFT/I designation. LPC/S may supervise only those with the LPC/I designation. No more than six full-time supervisees may be employed by the LMFT/S or

LPC/S.

- LISW-CP-S may supervise only those applicants for LISW licensure. No more than six full-time supervisees may be employed by the LISW-CP-S.
- They all must be licensed to practice in South Carolina.

Supervision must be direct, meaning at the same location as the supervisee. The supervising clinician must be immediately accessible by phone or other device at the time of service provision and cosign all clinical notes. There must also be written protocol for crisis situations in place.

Prior to services being rendered by allied professionals, the names and credentials of the allied professionals being supervised must be submitted to:

**Select Health of South Carolina
Behavioral Health Department
P.O. Box 40849
Charleston, SC 29423**

In addition to the above requirements, the South Carolina Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists, and Psycho-Educational Specialists maintains policies and guidelines for intern supervision.

■ 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 Population Health 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.

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.

Nonelective, medically necessary hysterectomies must meet the following requirements:

1. The individual or their representative must be informed orally and in writing that the hysterectomy will render the individual permanently incapable of reproducing.
2. The individual or their 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 Population Health department. The ordering provider or specialist should contact Population Health prior to the scheduled admission/procedure to confirm eligibility and secure an authorization. It is recommended that hospitals call Population Health when members are presenting for elective/outpatient services that require prior authorization to confirm authorization and/or member eligibility.

Population Health 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. Population Health 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 time frames:

- Nonurgent 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.)
- Concurrent review decisions (initial and continued inpatient stay) are made within one business day from the date the request is received.
- Retrospective review decisions are made within 30 calendar days from the date the request is received.

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 voicemail. Written approval of an authorization is provided only upon request.

Authorization requests may also be submitted via the NaviNet Provider Portal. Approvals, requests for

additional information, and status updates will be communicated within the portal.

Registration is required in order to utilize the provider portal. To register, visit: <https://navinet.navimedix.com/sign-in?ReturnUrl=/Main>.

All emergent/urgent inpatient admissions should be reported to Population Health by the next business day following admission. The Population Health 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 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.

EXTENSION OF AUTHORIZATION TIME FRAMES

Standard prior authorizations:

- Utilization Management (UM) may extend the determination time frame up to 14 additional calendar days if:
 - The member, provider, or authorized representative requests an extension.
 - UM justifies a need for additional information and how the extension is in the member's interest.

Urgent prior authorizations:

- UM may extend the determination time frame up to 14 calendar days, if:
 - The member, provider, or authorized representative requests an extension.
 - UM justifies a need for additional information and how the extension is in the member's interest.

Concurrent reviews (initial and continued inpatient stay):

- UM may extend the determination time frames up to 72 hours from the date of request, if:
 - The member, provider, or authorized representative requests an extension.
 - UM justifies a need for additional information and how the extension is in the member's interest.

Retrospective reviews:

- There is no extension allowed for retrospective reviews.

UM will document the justification to provide to South Carolina Department of Health and Human Services, if requested.

READMISSION REIMBURSEMENT POLICY

With limited exceptions, hospital readmissions occurring within 30 days of a prior discharge (or as otherwise stated by state law, regulation, contract, and/or provider contract) to the same facility or hospital system for the same or similar diagnosis or procedure are not payable.

■ 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 on the Select Health website.

Federal guidelines for sterilization procedures include completing and submitting a **Consent for Sterilization form** for:

- Tubal ligation by a method other than laparoscope following a vaginal delivery.
- Tubal ligation following C-section or other intra-abdominal surgery (tubal ligation as the minor procedure).
- Ligation, transection of fallopian tubes; abdominal or vaginal approach.
- Occlusion of fallopian tubes by device.
- Laparoscopic sterilization by fulguration or cauterization.
- Laparoscopic sterilization by occlusion by device.
- Vasectomy.

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 must be 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 **Consent for Sterilization 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 Telemedicine services includes:

- Office or other outpatient visits (99201 – 99215).
- Inpatient consultation (99251 – 99255).
- Psychotherapy (90832, 90834, and 90837).
- Psychiatric diagnostic interview examination (90791 and 90792).
- Neurobehavioral status examination (96116).
- Electrocardiogram interpretation and report only (93010).
- Echocardiography (93307, 93308, 93320, 93321, and 93325).

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

Noncovered services include:

- Telephone conversations.
- Email messages.
- Video cell phone interactions.
- Facsimile transmissions.
- Services provided by allied health professionals.

Covered referring sites are:

- The office of a physician or practitioner.
- Hospital (Inpatient and Outpatient).
- Rural Health Clinics.
- Federally Qualified Health Centers.
- Community Mental Health Centers.
- Public Schools.
- Act 301 Behavioral Health Centers.

The consulting provider is the provider who evaluates the member via a telemedicine mode of delivery upon the recommendation of the referring provider. Practitioners at the distant site who may furnish and receive payment of covered telemedicine services are:

- Physicians.
- Nurse practitioners.

- Physician assistants.

NOTE: A licensed physician and/or nurse practitioner are the only providers of telepsychiatry services.

■ Therapeutic and nonelective 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 their professional judgment, the pregnancy is a result of rape or incest or the person 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 person 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 O04, O07 (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 pregnant person 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 Population Health department prior to performing the procedure.

NONELECTIVE ABORTIONS

All nonelective 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 nonelective abortions:

1. Spontaneous, inevitable, or missed abortions should be reported with the appropriate other diagnosis codes (e.g., O010, O011, and O019; O0281; O021; O035 and O0387; and O045. This list is not all inclusive; determination of the appropriate ICD-10 code should be based upon clinical interpretation.).
2. Nonelective abortion procedure codes for outpatient hospital are 59812, 59820, 59821, 59830, 59870, and 59200. For inpatient hospital, the appropriate ICD-10-PCS code based upon clinical interpretation for the specific situation will need to be submitted. These procedure codes should be used for spontaneous, incomplete, inevitable, missed, septic, hydatidiform mole, or other nonelective 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 if 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 for 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, and the signed abortion statement form.
4. The following diagnosis codes do not require the submission of supporting documentation: O010, O011, and O019; O0281; O021; O364xx0; O4200, O4290, and O42011; and O4210, O42111, and O42119. This list is not all inclusive; determination

of the appropriate ICD-10 code should be based upon clinical interpretation.

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 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.

A sick visit can be billed on the same date of service as the well-woman exam. If the well-woman exam cannot be completed, bill only the sick visit.

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 noncontracted out-of-network health care professional/provider, the provider dispute system addresses nonpayment, 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 either verbally (telephonically or in person via the provider's designated account executive) or in writing (surface mail). Disputes received after 60 calendar days from 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, noncompliance, nonadherence 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, 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 is also available on the Select Health website at 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.
- Health care professional's/provider's name.

- Health care professional's/provider's plan ID number.
- Health care professional's/provider's NPI number.
- A contact person's name, phone number, and address for further correspondence.
- 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 Contact Center at **1-800-575-0418** or their 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: There is only one level of disputes. Claims payment disputes are not appeals. Appeals are for preservice issues. An appeal is a request for review of an adverse benefit determination. An adverse benefit determination 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 do not have the right to an appeal except on behalf of the affected member, as described in the following section.

If any dispute remains unresolved following the exhaustion of the provider dispute process, the dissatisfied party should notify the other party and the matter should be promptly submitted to arbitration in accordance with the provisions of the Select Health of South Carolina, Inc. provider participation agreement and Title 15 of the South Carolina Code of Laws, as amended.

All matters in controversy will be submitted to a Board of Arbitrators consisting of three members under the rules and regulations of the American Health Lawyers Association. All claims must be submitted in writing to the Board of Arbitrators within 30 days after the dispute or controversy first arises. Any claim not submitted within this time frame will be deemed to have been waived in its entirety. Both parties agree to be bound by the decision of the

arbitrators as the final determination of the matter in dispute. Judgment rendered by the arbitrators may be entered into in any court having jurisdiction thereof.

Any fees or costs of such arbitration shall be shared equally by the parties unless otherwise assessed by the arbitrators. Any administrative fee required shall be advanced by the party initiating the arbitration, subject to final apportionment by the arbitrators in their award.

It is understood by the parties that in the event of any claim of professional liability against PROVIDER and/or PLAN, said claim shall not be submitted to binding arbitration. The Board of Arbitrators does not have the power to amend, delete, or otherwise modify any provision of the provider participation agreement.

For full details on the arbitration process, please review your provider participation agreement.

Select Health encourages providers to contact your provider Account Executive or the Provider Contact Center 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 them 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 benefit determination.

MEDICAL DIRECTOR AVAILABILITY

(PEER-TO-PEER)

Medical directors are available to discuss possible adverse benefit determinations (peer-to-peer) with the requesting or ordering health care professional/provider as a preliminary step *before initiation of an appeal*. This provides the requesting or ordering

health care professional/provider the opportunity to discuss the case and possibly present additional information not included in the initial review.

The requesting/ordering provider may request a peer-to-peer review with one of the Select Health medical directors within **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 **five business days** from the verbal notification of the determination. If the health care professional/provider does not request a peer-to-peer review and prefers to file an appeal; the appeal process is outlined in the **Appeal of Utilization Management Decisions section** of this manual.

The medical director will respond to requests for a peer-to-peer discussion from the requesting/ordering provider within three business days. If the original medical director is not available for a peer-to-peer review, the request will be forwarded to another medical director.

If the requested service is not approved, a letter of denial of coverage will follow. This letter informs the health care professional/provider of their right to appeal on behalf of the member (see Appeal of Utilization Management Decisions) and clearly documents the reason for denial. The denial notification additionally explains how a health care professional/provider can discuss the case with a medical director or obtain the criteria used in making the determination. A copy of the letter of denial is sent to the member, primary care provider, and all other health care professionals/providers as necessary.

APPEAL OF UTILIZATION MANAGEMENT DECISIONS

A member, a member's authorized representative, 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 adverse benefit determination by Select Health based on a medical necessity/appropriateness.

An appeal is a request for review of an adverse benefit determination as "adverse benefit determination" is defined in 42 C.F.R. § 438.400. "Adverse benefit determination" 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) a denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a “clean claim” at § 447.45(b) of the SCDHHS managed care organization (MCO) contract is not an adverse benefit determination; (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 the MCO contract with SCDHHS; (6) for a resident of a rural area with only one MCO, the denial of a Healthy Connections MCO member’s request to exercise their right under 42 C.F.R. § 438.52(b)(2)(ii) to obtain services outside the MCO’s network; (7) the denial of a member’s request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

Appeals must be filed within 60 calendar days from the date on the denial or adverse benefit determination notification. Appeals may be filed orally or in writing. The written request should include 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 must be signed by the member. The request for appeal and the member’s written consent can be combined in one document, or the **Member 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/pdf/provider/forms/member-consent-provider.pdf).

Submit appeals and supporting documentation to:

Select Health of South Carolina
Attn: Member Appeals
P.O. Box 40849
Charleston, SC 29423-0849

The member may initiate the process through Member Services. Members will be informed of all time frames associated with filing an appeal and of the limited time available in the case of an expedited appeal, information will also be provided on the availability of the State Fair Hearing process once the plan appeal process is exhausted.

Assistance is available to members throughout the

appeal process at no cost to the member. Member advocates will provide written acknowledgment of receipt of an appeal, including appeals that are withdrawn, to the member and/or member’s authorized representative within five business days.

Providers, appealing on behalf of the member, may initiate an appeal through the Population Health appeals department. Select Health ensures that no punitive action is taken against a provider, acting on behalf of the member, who requests an expedited resolution or supports a member’s 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:

- An appeal of a denial based on lack of medical necessity.
- A grievance of denial of expedited resolution of an appeal.
- A 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 a standard appeal request via certified mail, return receipt requested, to the member or authorized representative and to the requesting provider.

EXTENSION OF GRIEVANCE AND APPEAL RESOLUTION TIME FRAMES

Select Health may extend the time frames for Grievances, Standard Appeals, and Expedited Appeals resolution for up to 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 time frame, written notice of the reason for the delay will be sent to the member if the extension was not requested by the member. Select Health will:

- Make reasonable efforts to give the member prompt oral notice of the delay.
- Within two calendar days, give the member written notice of the reason for the decision to extend the

time frame and inform the member of the right to file a grievance if they disagree with that decision.

- Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

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 120 calendar days of the denial or action notification. State Fair Hearing appeal requests can be made through the SCDHHS website at <https://msp.scdhhs.gov/appeals> or sent to:

SCDHHS Division of Appeals and Hearings
P.O. Box 8206
Columbia, SC 29202

Members are provided the instructions above 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 them at the State Fair Hearing. Health care 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 will be sent to the member via certified mail with a return receipt request and to the practitioner acting on the member's behalf within 72 hours after receipt of the appeal.

If the request for expedited resolution is denied, the appeal will be transferred to the standard time frame, reasonable effort will be made to give the member prompt oral notice of the denial of expedited resolution, and it will be followed up within two calendar days of oral notice with a written notice. This decision will not constitute an action or require a notice of action. The member may file a grievance in response to this decision.

CONTINUATION OF BENEFITS

Select Health will continue member benefits while the Select Health appeals and the State Fair Hearing is pending if:

- a. The member or authorized representative files the appeal timely.
- b. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
- c. The services were ordered by an authorized provider.
- d. The original period covered by the original authorization has not expired.
- e. The member requests an extension of benefits.

Select Health will continue or reinstate the member's benefits, at the member's request, while the appeal or State Fair Hearing is pending until one of the following occurs:

- a. The member withdraws the appeal or State Fair Hearing request.
- b. Ten calendar days pass after the plan mails the notice of an adverse resolution to the member's appeal, and the member has not requested a State Fair Hearing and continuation of benefits.
- c. A State Fair Hearing Officer issues a hearing decision adverse to the member.
- d. The time period or service limits of previously authorized service has been met.

If the final resolution of the appeal is adverse to the member, the plan may recover the cost of the appealed services furnished to the member while the

appeal was pending.

If Select Health or the State Fair Hearing Officer reverses a decision to deny, limit, or delay services that were not provided while the appeal was pending, Select Health will authorize or provide the services to the member promptly and as fast as the member's health condition requires. This will occur no later than 72 hours from the date that Select Health receives notice of the reversed decision.

Providers or authorized representatives may request an appeal or file a grievance but cannot request continuation of benefits.

■ 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 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 allows 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 comorbidities or may have a single serious diagnosis, like HIV or cancer. Our care managers work one-on-one

with patients to meet their physical and behavioral health care needs. The following are some of the interventions provided by our nurse care 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, and so on).
- **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** — An 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** — A 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 following link: <https://diabetes.org/>
- **Heart First** — A cardiovascular disease 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 Association, accessible by the following link: www.acc.org/guidelines
- **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:

<https://www.nhlbi.nih.gov/health-topics/sickle-cell-disease>

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 health care 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:

- A member discharged from the hospital with short-term home IV therapy.
- A member with recent trauma requiring short-term physical or occupational therapy.
- A member with a dehiscence surgical wound requiring wound VAC therapy.

Our Rapid Response nurses make sure our members get the appropriate care in the appropriate setting and 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, and so on) provided by the OB provider in the OB office setting.

Fetal biophysical profiles, non-stress tests, and amniocentesis are allowed when medically necessary. 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. Ultrasounds are performed in the first trimester to establish viability and 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.

- **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.**

Authorization requests and the prenatal risk assessment may also be submitted online through the NaviNet provider portal.

A Prenatal Outreach representative will fax the provider an authorization number once the risk assessment information is received. If the request is submitted online and all required clinical information is included, the authorization number will be given through NaviNet. **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 Population Health department to secure any additional authorizations for service at **1-888-559-1010**.

Alpha Hydroxyprogesterone Caproate (Makena and 17P) injection authorizations

Effective April 6, 2023, the Food and Drug Administration (FDA) withdrew the approval and use of Makena/17P for those members who are at risk for preterm labor based on preterm delivery with their first pregnancy. Providers will need to discuss alternative therapy with members who are receiving this treatment.

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.

We support all of our pregnant members in making healthy choices and being active participants in their prenatal care.

Pulse oximetry screening

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 mandates 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 SCDHEC guidelines located at www.scdhec.gov/sites/default/files/docs/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 clinicians 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 nonmedically 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.
- Implementing a universal screening and referral tool for physicians. This tool will screen pregnant people for tobacco use, substance use, 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 ten or more visits with the certified provider. For more information on submitting centering pregnancy claims, consult the Claims Instructions located on the Select Health website at <https://www.selecthealthofsc.com/pdf/provider/claim-filing-manual.pdf>.

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 Instructions located on the Select Health website at <https://www.selecthealthofsc.com/pdf/provider/claim-filing-manual.pdf>.

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 nonparticipating pediatric providers

There may be cases where a nonparticipating 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 noncontracted providers within the first 60 days following hospital discharge.

In the interest of continuity of care, Select Health will compensate these nonparticipating 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.

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**.

■ **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 primary care provider offices:

- Routine visits are scheduled within four to six weeks.
- Urgent, nonemergency 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 nonurgent 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 ensure 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:

- 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 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 available on the Select Health website at: **www.selecthealthofsc.com/pdf/member/eng/handbook.pdf**.

ELIGIBILITY VERIFICATION

Each member will have two identification cards.

- Healthy Connections ID cards are mailed by the state to each head of household.
- 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, **<https://navinet.navimedix.com/sign-in?ReturnUrl=/Main>**, 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:

- First Choice or Healthy Connections terminates the contract for First Choice to participate in the managed care organization program.
- The 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.
- The 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:

- 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 Medicare eligible.
- 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.
- Loss of Medicaid MCO participation in the Medicaid managed care organization program or in the member's service area.
- Member becomes age 65 or older.
- Member is placed out of home (i.e. intermediate care facility for those with mental disabilities [ICF/MD]).
- Member's behavior is disruptive, unruly, or uncooperative and prevents First Choice from providing the services to member or other enrolled members.

First Choice can request SCDHHS to disenroll a member from the First Choice plan for the following reasons:

- First Choice no longer participates in the Medicaid managed care organization program or in the member's service area.
- Member dies.
- Member becomes an inmate of a public institution.
- Member moves out of state or the First Choice service area.

- 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 those with mental disabilities [ICF/MD], psychiatric residential treatment facility [PRTF]).

Health care professionals/providers are requested to document nonmedical 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 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 to the 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.

There is a Physician's Request for Transfer of Member form available on the Select Health website at **www.selecthealthofsc.com/pdf/provider/forms/request-member-transfer-form.pdf**.

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. Member rights and responsibilities are communicated via:

- Member handbook. (Members may receive a hard copy upon request.)
- Member newsletters.
- Member Services representatives outreach to member households to discuss plan benefits and member rights and responsibilities.
- Plan website in the **Information for you** section, **<https://www.selecthealthofsc.com/member/english/info-for-you/rights-responsibilities.aspx>**.

Members' and Potential Members' Bill of Rights

1. To be treated with respect and with due consideration for their dignity and privacy.
2. To participate in decisions regarding their health care, 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 their medical records and request that they be amended or corrected.
5. To receive health care services that are accessible and 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 get help from both SCDHHS and First Choice in understanding the requirements and benefits of First Choice'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 member and/or potential member, to receive information about the basic features of managed care, which populations may or may not enroll in the program, and First Choice's responsibilities for coordination of care in a timely manner in order to make an informed choice.
12. To receive information on First Choice's services, including 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 First Choice but available to members and information on how to get those benefits, including how to get a ride.
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 30 calendar days before the intended effective date of the change. Notice of changes can be made by letter or included in the member newsletter. The benefits package includes services, benefits, and providers.
15. To receive information on the grievance, appeal, and fair hearing procedures.
16. To receive detailed information on emergency and after-hours coverage, including 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 First Choice's policy on referrals for specialty care and other benefits not provided by the member's PCP.
18. To have their 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 First Choice, its providers, or SCDHHS treat the members.
20. To have a candid discussion of appropriate or medically necessary treatment options for their 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. To establish them or their children with a primary care provider within 30 days of entering the plan.
2. To not change their PCP without approval from First Choice.
3. To inform First Choice of any loss or theft of their ID card.
4. To present their ID card whenever using health care services.
5. To be familiar with First Choice procedures to the best of their ability.
6. To ask the First Choice Member Services department any questions they have.
7. To get preventive services.
8. To treat their PCP(s) and the PCP's staff with kindness and respect.
9. To provide their PCP(s), practitioners, providers, and First Choice with accurate and complete medical information.
10. To understand their health problems, and help develop mutually agreed-upon treatment goals.
11. To follow the prescribed treatment of care recommended by the provider or to let the provider know the reasons the treatment cannot be followed as soon as possible.
12. To get a referral from their PCP(s) before they go to the hospital their PCP(s) recommended.
13. To go to the emergency room only for emergencies.
14. To call their PCP(s) as soon as they or a family member feels ill. They should not wait. If they feel they have a life-threatening emergency, they should go to their closest hospital.
15. To make every effort to keep any agreed-on visit or cancel a visit before it is scheduled if they will be unable to go.
16. To notify First Choice if their or their child(ren)'s name, address, or phone number changes.
17. To inform First Choice of any change in their legal status regarding their authority to make decisions on behalf of their child(ren).
18. To understand their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.

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 health care 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 health care decisions for them, they have the right to make these desires known to their doctor, hospital, or other health care 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 health care powers of attorney. The South Carolina legislature has approved forms for both a living will and a health care 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 **1-803-734-9900**.

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 **1-843-764-1877** 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 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.

REIMBURSEMENT FOR INITIAL VISIT FOR CHILDREN IN FOSTER CARE

Select Health will reimburse medical providers (physicians, physician assistants, and nurse practitioners) for prolonged evaluation and management (E&M) services before or after directed patient care when initiating a patient-provider relationship with a child in foster care.

Claims for this service should be billed with CPT code 99358 — prolonged evaluation and management service before and/or after direct patient care. The 99358 code must be billed with a modifier of “UA,” which is defined as “initial visit with patient in foster care.” This code should be submitted along with the appropriate evaluation and management or well-visit code for the direct patient care component.

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 PCMH 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. The application level PCMH incentive is no longer recognized for incentive payments.

Practices will not be reimbursed until they have achieved accreditation.

SCDHHS has also deemed that FQHCs who achieved Joint Commission PCMH recognition 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.

Providers may verify eligibility utilizing the NaviNet provider portal, Eligibility and Benefits link under Workflows for this Plan. There will also be a link that enables providers to view a copy of the member's ID card (available 08/01/23).

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, nonemergency visits are to be scheduled within 48 hours.
- Emergency visits should be scheduled 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 nonurgent 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 hours.

BILLING FOR AFTER-HOURS CARE

In accordance with the South Carolina Department of Health and Human Services (SCDHHS), Select Health covers 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, an outpatient hospital setting, or an urgent care facility (place of service codes 20, 21, 22, and 23). CPT code 99050 and 99051 are codes that 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.

LOCUM TENENS ARRANGEMENTS

A locum tenens, or substitute physician, is often employed to take over professional practices when the regular physician is absent for reasons such as illness, pregnancy, vacation, or continuing medical education.

The locum tenens is employed as an independent contractor rather than an employee of the regular physician. The regular physician may submit claims

and receive payment for covered visit services (including emergency visits and related services) of a locum tenens physician whose services for the regular physician's patients are not restricted to the regular physician's office.

According to SCDHHS, the following requirements must be met for both reciprocal billing and locum tenens arrangements:

- The member must have scheduled or tried to schedule a visit with the regular physician.
- The regular physician must be unavailable to provide the visit services.
- The locum tenens must meet the same Medicaid licensing requirements as the regular physician. However, Medicaid enrollment is not required.
- The locum tenens cannot provide continuous services to the member for more than 60 days.
- Claims must be filed using the regular physician's Medicaid provider ID and NPI number.

The regular physician's office must keep a record of each service provided by the locum tenens and make this record available to Select Health or Medicaid upon request. Covered visit services include any services considered usual and customary for a covered physician visit, as well as any other covered items/services furnished by the locum tenens or by others incident to the physician services.

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 copayments may apply. Please refer to the Copayments 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 **1-888-559-1010**. To request an

exception after the services have been rendered, mail the request to:

Select Health of South Carolina
Attn: Appeals Coordinator
P.O. Box 7324
London, KY 40743

Benefits include but are not necessarily limited to the following:

- 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.
- 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.

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 Contact Center at 1-800-575-0418.

COPAYMENTS

Some adult members will need to pay a small amount (copayment) 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 (nonemergent, 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 copayment split evenly among the 10-month rental payment schedule.

There will be no copayment for children younger than 19 years of age, pregnant women, individuals receiving emergency services, well-child visits from birth through the month of the 21st birthday, or federally recognized Native Americans.

For behavioral health: Psychiatric diagnostic assessment with/without medical evaluation, 90791/90792, for adults (ages 19 and over) are subject to the \$3.30 copay when rendered by a medical doctor or nurse practitioner. No other copays or deductibles apply for persons receiving behavioral health services.

A Medicaid member may not be denied services if they are unable to pay the copayment at the time the service is rendered. However, this does not relieve the member of the responsibility for the copayment. It is the provider's responsibility to collect the copayment from the member 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 an adverse benefit determination. 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 an employee or failure to respect the enrollee's rights.

Members or authorized representatives acting on behalf of the member may file grievances at any

time 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. Grievances may also be filed in writing to:

First Choice Member Services
P.O. Box 40849
Charleston, SC 29423-0849

Health care professionals/providers may act as a member's authorized representative and may report a grievance on behalf of the member with member consent. The member advocate will create and mail a member's acknowledgment letter within one business day of receipt of the grievance. The disposition of the grievance, including notice to the affected parties, is required no later than 90 calendar days from the day Select Health receives the grievance.

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). An adverse final resolution regarding the member's grievance does not provide the member with the right to a state fair hearing.

EXTENSION OF GRIEVANCES RESOLUTION TIME FRAMES

Select Health may extend the time frames for Grievances resolution for up 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 time frame, written notice will be sent to the member of the reason for the delay if the extension was not requested by the member.

Select Health will:

- Make reasonable efforts to give the member prompt oral notice of the delay.
- Within two calendar days, give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if they disagree with that decision.

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, and so on.
- 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 within 45 calendar days of the date the grievance was received.

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 Guideline list is available at www.selecthealthofsc.com/provider/resources/shsc-clinical-policies.aspx, or you can 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 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 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](https://www.cdc.gov/vaccines/vpd/vaccines-age.html), 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>.

Adult annual exams

Select Health will reimburse for annual exams for adults using these codes:

- 99385 — Health Screen, age 18 – 39 (one per year).
- 99386 — Health Screen, age 40 – 64 (one per year).

The following adult cancer screenings are also covered:

- Mammography — baseline ages 35 – 39*, one per year ages 50 and over.
- Hemocult — One per year, age 50 and up (low risk). Age 40 to 49 (high risk).
- Sigmoidoscopy — One per five years, ages 50 and up (low risk). Ages 40 to 49 (high risk).
- Screening colonoscopy — One per 10 years, ages 50 and up (low-risk). Ages 40 to 49 (high risk).
- Multi-targeted stool DNA (MT-DNA) (Cologuard) — One per three years, ages 45 – 75 (low risk).

*The age limits on the cancer screening services are the recommended ages to begin screening services. Screening services are reimbursable to younger members, provided the medical documentation supports the screening service.

ADULT VACCINES

Select Health will reimburse providers for the administration of adult vaccines in accordance with the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) Adult Immunization Schedule.

Adult vaccine claims

- Claims should be billed for both the vaccine and the immunization administration codes.
- For administration of the vaccine, providers should bill for the vaccine and the administration codes,

90471 – 90474.

- For the vaccination codes, the following should be billed:

Vaccination	CPT code	Code description
MenB	90620	Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B (MenB), two-dose schedule, for intramuscular use
	90621	Meningococcal recombinant lipoprotein vaccine, serogroup B (MenB), three-dose schedule, for intramuscular use
MMR	90707	Measles, mumps, and rubella virus vaccine (MMR), live, for subcutaneous use
VAR	90716	Varicella virus vaccine (VAR), live, for subcutaneous use
MMRV	90710	Measles, mumps, rubella, and varicella vaccine (MMRV), live for subcutaneous use

- Federally qualified health centers (FQHCs) should not bill for immunization administration but may bill for the vaccination in addition to an encounter code.

The following is the complete listing of vaccines covered for adult members 19 years of age and older:

- Pneumococcal 15-valent conjugate vaccine (PCV15).
- Pneumococcal 20-valent conjugate vaccine (PCV20).
- 13-valent pneumococcal conjugate (PCV13).
- 23-valent pneumococcal conjugate (PPSV23).
- Haemophilus influenzae type b conjugate vaccine (Hib).
- Hepatitis A (HepA).
- Hepatitis B (HepB).
- Hepatitis A and B.
- Human papillomavirus (HPV) 9-valent vaccine (ages 19 – 45).
- Influenza.
- Measles, mumps, and rubella (MMR).
- Measles, mumps, rubella, and varicella (MMRV).
- Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B (MenB), two- and three-dose schedule, for intramuscular use.
- Rabies.

- Meningococcal Serogroups A, C, W, and Y meningococcal conjugate or polysaccharide vaccine (MenACWY or MPSV4).
- Tetanus and diphtheria toxoids (Td).
- Tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine (Tdap).
- Varicella (VAR).

The rabies, influenza, and Tdap vaccines for adults may be billed through the medical benefit or the pharmacy. If the pharmacy is billed, only the administration fee can be billed through the medical benefit.

For guidance related to COVID vaccines, visit: <https://scdhec.gov/covid19/guidance-healthcare-professionals-covid-19/covid-19-vaccine-provider-enrollment>.

TOPICAL FLUORIDE VARNISH

The best practices of the American Academy of Pediatrics recommend that children receive fluoride varnish application in their primary care provider’s office during their EPSDT visit.

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. SCDHHS has expanded coverage for fluoride varnish application to all children, from the eruption of the first tooth to 21 years, during EPSDT or sick visits. The frequency allowed has also increased:

- Ages birth – 6 years may receive a maximum of four applications per year.
- Ages 7 – 21 years may receive one application per year.

Providers are encouraged to integrate oral screening and oral health education during each EPSDT visit and anticipatory guidance.

Primary care staff applying fluoride varnish must successfully complete an approved training before billing for the service.

Trained staff in a primary care setting must bill 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. 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 II Blood Lead Testing System to analyze the blood lead samples internally, your office should bill us directly using CPT code 83655.

IMMUNIZATIONS FOR CHILDREN

Medicaid providers may obtain free vaccines from the SCDHEC through the federally funded Vaccines for Children (VFC) program. Vaccines are delivered free of charge to providers enrolled in the program.

Providers may bill for the administration of vaccines that are obtained through VFC and administered in the doctor's office.

When billing for immunization services for children under the age of 19, both the administration code and the vaccine code for the administered vaccine must be listed on the claim to receive reimbursement. For this code combination, only the administration code will be reimbursable.

For additional information on the VFC Program or to enroll as a provider in the program, contact SCDHEC at: **1-800-277-4687**. Providers may also visit the SCDHEC website at: <http://www.scdhec.gov/Health/Vaccinations/>.

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.

SC State Vaccine Program Overview:

The South Carolina Department of Health and Environmental Control (SC DHEC) offers the SC State Vaccine Program (State Program) as a supplement to the Federal VFC Program. The purpose of the State Vaccine program is to allow non-FQHC/non-RHC

providers to serve the “underinsured” child in their medical home. Participation in the State Vaccine Program also allows all VFC enrolled providers to vaccinate certain insured-hardship children.

Providers must be enrolled in the Federal VFC Program as a prerequisite to enrollment in the State Vaccine Program.

Providers may opt to participate in the VFC Program only or both the VFC and State Vaccine Programs. A separate enrollment agreement is required in the South Carolina Immunization Application (SCIAPPS) system for the VFC and State Vaccine programs to ensure accountability. Enrollment documents for both programs may be submitted to the Immunization Division together for processing.

Providers will utilize the online SCIAPPS system to enroll or re-enroll into the VFC program located at: <https://www.scdhec.gov/Apps/Health/SCIAPPS/>.

Please note the following: The SC State Vaccine Program offers all ACIP-recommended vaccines with the EXCEPTION of the Meningococcal B vaccines, which are ONLY available through the Federal VFC Program.

SYNAGIS

Synagis is reimbursed on a fee-for-service basis. The administration fee is included in the reimbursement. Prior approval is not required for up to six doses as long as they are given at least 30 days apart and meet the guidelines of the American Academy of Pediatrics (AAP) for Synagis administration. Any dose over the limit of six or administered after the RSV season (October – March) will require prior approval.

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 the child's weight. The administrative fee (procedure code 96372) 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 are eligible for unlimited prescriptions or refills.

For pharmacy questions or concerns, 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 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 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 also covered for certain over-the-counter (OTC) drugs with a prescription written by a doctor. 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**.

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**.

HEPATITIS C MEDICATIONS

Select Health is managing the Hepatitis C medication prior authorization review for First Choice members. Select Health's Pharmacy Benefit Manager (PBM), PerformRx, will conduct the prior authorization review. Reviews will no longer be conducted by Medicaid fee-for-service.

Providers can submit the Hep C medication prior authorization request to the PerformRx prior authorization team by:

- Calling **1-866-610-2773** and speaking with a representative or leaving pertinent information on the confidential voicemail.
- Faxing the completed Hep C prior authorization form, located on the Select Health website, to: **1-866-610-2775**.
OR
- Submitting through the Select Health **online pharmacy prior authorization tool**.

COPAYMENTS

Members who are 19 years of age or older are subject to a \$3.40 copayment per prescription. The following members are exempt from the copayment:

- Members 18 years of age or younger.
- Members who are pregnant and the medicine is related to pregnancy.
- Members who live in a nursing home or group home.
- Members receiving hospice, emergency, or family planning services.
- Members receiving home- and community-based waiver services.
- Federally recognized Native Americans.

SMOKING CESSATION

The tobacco cessation benefit provides all FDA-approved tobacco cessation medications and individual and group tobacco cessation counseling for all members. Medications for tobacco cessation treatment will not require prior authorization or be subject to copays.

The following combination therapies will also be covered:

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

- Nicotine patch + Bupropion SR.

Smoking/tobacco cessation counseling in individual and group settings will be covered (under the medical benefit) using the following CPT codes:

CPT code	Code description
99406	SMOKING/TOBACCO CESSATION COUNSELING, 3 – 10 MIN
99407	SMOKING/TOBACCO CESSATION, INTENSIVE <10 MIN

The benefit for counseling is limited to four sessions per quit attempt for up to two quit attempts annually. SCDHHS policy requires that all tobacco cessation treatment must be ordered by a qualified practitioner, defined as a physician, an NP, a CNM, or a PA.

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. The list of medications that require prior authorization is available on the Select Health website. Requests for PA medications should be directed to Select Health/PerformRx 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 of this manual or go to the Select Health website at www.selecthealthofsc.com/pdf/provider/resources/pharmacy-prior-auth-form.pdf.

Pharmacy authorization requests may also be submitted online for certain medications via the online PerformRx prior authorization form.

Temporary supply

Some medicines need prior approval. Members may get an emergency supply of medicine that will cover them for 72 hours while a prior authorization request is pending. A member is permitted one temporary supply per prescription number. Inhalers, diabetic test strips and supplies, and creams or lotions are exceptions to the supply limit because of how they are packaged. For those medicines, the member may receive the smallest package size available.

Transition supply

Select Health will allow new members who are at the time of enrollment to Select Health receiving nonpreferred or prior authorized medications to continue receiving those medications for up to 90 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 nonpreferred 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 for medications should be directed to Select Health/PerformRx 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.

■ Claims 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 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 electronic data interchange (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.

CLAIM FORMAT

Hospitals use the UB-04 claim form.

All other health care professionals/providers use the CMS 1500 claim form. (See "Claims Filing Instructions" 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's/provider's individual (not group) Select Health health care professional/provider ID number and NPI number Box 76 (UB-04).

- If there is an NPI number entered in box 56, enter the taxonomy code for the facility in Box 81 (UB-04).
- The treating health care professional's/provider's individual (not group) Select Health health care professional/provider ID number and NPI number (Box 24J 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). The requirement for a physical address to be listed in box 33, not a P.O. Box, has been lifted.
- The P.O. Box may be listed in box 33 on paper claims only. The physical address must still be submitted on electronic 1500 claim submissions in compliance with HIPAA X12 standards, version 5010 claims filing format requirements.
- 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 the 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 ensure 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 and by reporting ICD-10-CM diagnoses category P05.01-P05.18 and P07.01-P07.18. If the birth weight is not provided via value code 54 and through ICD-10-CM diagnosis codes, the APR-DRG grouper will assume the patient's weight is that of a normal newborn.

For detailed information regarding APR-DRG billing, consult the "Claims Filing Instructions" located on the Select Health website, www.selecthealthofsc.com.

[com/pdf/provider/claim-filing-manual.pdf](http://www.selecthealthofsc.com/pdf/provider/claim-filing-manual.pdf).

Provider Preventable Conditions Policy

The Centers for Medicare & 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: (1) health care acquired conditions (HCACs) and (2) 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, and so on).

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

OPPCs:

- Post-operative death in a 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.

Nonpayment 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 www.cms.gov/medicare/medicare-fee-for-service-payment/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 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 Instructions” located on the Select Health website, www.selecthealthofsc.com/pdf/provider/claim-filing-manual.pdf.

PRIMARY CARE PROVIDER ENCOUNTER DATA AND BILLING

Primary care providers 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.

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, pending, 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 Change Healthcare’s (formerly Emdeon) 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 payer) as payment in full. The member or member’s representative may not be balance billed for any Medicaid-covered services provided. Providers are not allowed to seek or receive payments from Medicaid members while payment from Medicaid is pending, except if a copay is applicable.

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.

PROSPECTIVE CLAIMS EDITING POLICY

Select Health’s claim payment policies and the resulting edits are based on guidelines from established industry sources such as the Centers for Medicare & Medicaid Services (CMS), the American Medical Association (AMA), state regulatory agencies, and medical specialty professional societies. In making claim payment determinations, the health plan also uses coding terminology and methodologies that are based on accepted industry standards, including the *Healthcare Common Procedure Coding System (HCPCS) Manual*, the *Current Procedural Terminology (CPT)*

Codebook, the *International Statistical Classification of Diseases and Related Health Problems (ICD) Manual*, and the *National Uniform Billing Code (NUBC)*.

Other factors affecting reimbursement may supplement, modify, or in some cases, supersede medical/claim payment policy. These factors may include but are not limited to legislative or regulatory mandates, a provider's contract, and/or a member's eligibility to receive covered health care services.

CLAIMS PAYMENT POLICES/GUIDELINES

Select Health has enhanced clinical editing processes to promote correct coding and to put into practice outpatient payment polices 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.
- OPSS 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, they may submit a request for reconsideration via the NaviNet provider portal under Claim Status Inquiry. Requests submitted through NaviNet are sent directly to the Claims Department for review. The Claims Department will correspond with the health care professional/provider through NaviNet regarding the inquiry. A training video is available within the NaviNet provider portal to assist with the submission process.

Or the health care professional/provider may call the Provider Contact Center 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).

Corrected claims are:

- 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**.
- To include the applicable resubmission/frequency code in box 22:
 - "7" — Replacement of prior claim.
 - "8" — Void prior claim.
- Corrected claims must include the original claim number (in box 22) after the resubmission code. Failure to supply this information will result in rejections.
- Do not write corrected or resubmission on the claim.
- 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. The additional information should be attached.

Corrected and resubmitted claims are scanned during reprocessing. Please remember to use blue or black 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 the section entitled "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 repayment research unit:

Select Health of South Carolina
Attn: Claims Repayment Research Unit
P.O. 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 noncustodial 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 to 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, copay, 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 Instructions, 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 that 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 time frame for the health care 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 time frame 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.

HEALTH VALUE OPTIMIZATION POLICIES

At Select Health of South Carolina (SHSC), our aim is to work in partnership with our network providers to help ensure high-quality, cost-effective care, and value for the Medicaid dollars entrusted to us. To that end, the following policies have been implemented to align with industry standards and to achieve optimal management of our health care plan.

Pharmacy J Codes — Place of Service

The drugs listed below can be safely administered in an in-network infusion center, network provider office, or in a home setting. Providers must receive prior authorization for the administration of these drugs:

- | | |
|-------------------------|---------------|
| • Actemra | • Carimune NF |
| • Alemtuzumab injection | • Cinqair |
| • Avsola | • Crysvita |
| • Benlysta | • Cutaquig |
| • Bivigam | • Cuvitru |

- Elelyso
- Evenity
- Fabrazyme
- Filgrastim g-csf biosimilar injection
- Flebogamma
- GamaSTAN S/D
- Gamifant
- Gammagard Liquid
- Gammagard S/D
- Gammaked
- Gammaplex
- Gamunex-C
- Givlaari
- Glassia
- Glassia/Aralast NP
- Hizentra
- HyQvia
- Idursulfase injection
- Ilaris
- Ilumya
- Imiglucerase injection
- Immune globulin, powder
- Inflectra
- Infliximab (not biosimilar)
- IVIG injection
- Ixifi
- Lanreotide injection
- Leuprolide acetate
- Leuprolide acetate for depot suspension
- Mepolizumab injection
- Naglazyme
- Natalizumab injection
- Ocrelizumab injection
- Octagam injection
- Octreotide injection, depot
- Omalizumab injection
- Onpattro
- Orenzia
- Panzyga
- Pegfilgrastim injection
- Pegloticase injection
- Prolastin
- Prolia
- Radicava
- Reblozyl
- Renflexis
- Respiratory syncytial virus immune globulin injection
- Romiplostim injection
- Simponi Aria
- Soliris
- Stelara
- Tocilizumab injection
- Trogarzo
- Ultomiris
- Vedolizumab injection
- Vimizim
- VPRIV
- Vyepti
- Xembify
- Zemaira

Note: Specific medications used in pediatric population are excluded from this policy requirement.

When these drugs are administered at an outpatient hospital facility instead of the home, an in-network infusion center or an in-network office, authorization for reimbursement will only be provided if one of the following criteria are met:

- Documented history of severe adverse reaction occurred during or immediately following an

infusion and/or the adverse reaction did not respond to conventional interventions.

- Documentation that the member is medically unstable for the safe and effective administration of prescribed medication outside of the outpatient hospital facility setting as a result of one of the following:
 - Complex medical condition, status, or therapy requires services beyond the capabilities of an office, infusion center, or home infusion setting.
 - Documented history of medical instability, significant comorbidity, or concerns regarding fluid status inhibits treatment at a less intensive site of care.
 - Clinically significant physical or cognitive impairment that precludes safe and effective treatment outside of the outpatient hospital facility setting.
 - Difficulty establishing and maintaining reliable vascular access.

The requirement for drug administration in a particular setting depends on availability.

Prior authorization requests can be submitted via the online prior authorization tool or via fax. For further details visit: www.selecthealthofsc.com/provider/resources/pharmacy-prior-auth.aspx.

Emergency Services Level of Care Review

Emergency Department (ED) **professional/physician** claims with billing Level 4 (CPT 99284; HCPCS G0383) or Level 5 (CPT 99285; HCPCS G0384) services will be evaluated after reimbursement to confirm the consistency between diagnosis complexity/severity and reimbursement level. All of the following will be evaluated using the NYU Emergency Room Algorithm (NYU Wager, 2000):

- Presenting problem (ICD-10 CM diagnosis documented on the claim).
- Documented complexity and comorbidities (defined by primary and all other ICD-10 CM diagnoses documented on the claim).
- Diagnostics and services identified in the member's claim history, occurring within three days of the ED visit (see exceptions).

The emergency services claim is not being evaluated for lack of emergency criteria and can be rebilled with a more appropriate level of care.

Exceptions:

- Hospital facility ED claims are excluded.

- Professional ED claims will be exempt from recovery when any one of the following scenarios exist in the member's claim history within three days of the ED visit date of service:
 - Any room board revenue code (0100-0219).
 - Any Operating Room revenue code (0360-0369).
 - Any cardiology revenue code (0480-0489).
 - Any trauma revenue code (0681-0689).
 - Any observation revenue code (0760-0769).

Reimbursement guidelines

Professional claims that meet defined requirements for claim submission, and that are appropriately coded based on all other applicable ICD-10, CPT, or CMS standards, will be reimbursed to the provider. After reimbursement, professional ED claims billing Level 4 or Level 5 services will be reviewed against the "NYU Emergency Room Algorithm" diagnosis list for severity of diagnosis. If diagnosis severity is not consistent with the level of service billed, Select Health will pursue recovery of the claim payment. The provider will receive a standard recovery letter and may:

- Resubmit the claim for the services using a corrected claim, according to plan-defined corrected claim process, coding the appropriate level of care.
- Dispute the recovery utilizing the plan-defined provider dispute process.

If neither of the above actions occur, previously reimbursed funds will be recovered, according to the existing Select Health Program Integrity recovery process.

Outpatient surgical procedures

Select Health reimburses only those services that are furnished in the most appropriate and cost-effective setting for the member's medical needs and condition. This determination is based on the member's medical condition at the time the services are delivered and any required monitoring or additional services that may coincide with the delivery of this service.

The outpatient surgical center is the most appropriate and cost-effective setting for the average-risk patient undergoing the following procedures:

- Anterior cervical fusion, one level.
- Hip joint replacement.
- Knee joint replacement.
- Lumbar fusion, one level.

These procedures require prior authorization, regardless of the setting in which they are performed.

Circumstances that will support performance of any of the above procedures in an inpatient setting:

- Age > 70.
- Decreased functional status requiring inpatient rehab.
- Medical comorbidities requiring inpatient management.

Circumstances that will support performance of spinal fusion in an inpatient setting:

- Multilevel fusions.

Historical findings that will support performance of joint replacement in an inpatient setting:

- Chronic obstructive pulmonary disease.
- Heart failure.
- Coronary artery disease.
- Cirrhosis.
- End-stage renal disease.
- Thromboembolic events.
- Diabetes and HbA1c > 7%.
- Opioid use disorder.
- BMI > 40.

The circumstances and historical findings listed above are not necessarily all-inclusive, and there may be other patient-specific circumstances or historical findings that will support performance of the procedure in an inpatient setting.

For questions, please contact Population Health Management at **1-888-559-1010**.

Performant retrospective claim payment audits

In a continuing effort to manage health care costs and enhance the quality of services provided to our members, First Choice by Select Health of South Carolina has engaged Performant Recovery Inc. (“Performant”) to perform retrospective claim payment audits.

Performant will identify outpatient claims (i.e., Ambulatory Payment Classification [APC]; non-APC payment structures, such as percent of charge or case rate; and Ambulatory Surgical Centers [ASCs]) potentially paid in error, request medical records, and conduct a clinical audit on the selected claims in accordance with recovery look-back time frames as set forth in the

provider contract that exists between a provider and Select Health, as well as pursuant to Select Health’s obligation to its South Carolina contracting partners.

The purpose of these audits is to help determine the accuracy of both the information submitted for reimbursement and the amount paid based on the claim. Performant’s audit work has been customized in accordance with Select Health provider contracts and payment policies.

Providers may receive a letter from Performant requesting information as part of the audit process. It is important that providers respond in a timely manner to the instructions provided in Performant’s audit request.

For questions, please contact Performant at **1-844-308-3781** or the Select Health Provider Contact Center at **1-800-575-0418**.

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.

Reimbursement guidelines for sexually transmitted infection tests

Effective August 1, 2021, Select Health began reimbursing providers using a more comprehensive code when all three individual tests used to detect sexually transmitted infections (STIs) in men and women are billed together by the same provider on the same date of service.

The plan reimburses for the following single tests for STIs in men and women:

- **87491** — Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, amplified probe technique.
- **87591** — Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoea, amplified probe technique.
- **87661** — Infectious agent detection by nucleic acid (DNA or RNA); Trichomonas vaginalis, amplified probe technique.

However, when all three single test codes (87491, 87591, and 87661) are billed together by the same provider on the same date of service, the reimbursement will be based on the rate for the comprehensive test (**87801**). Procedure code 87801 is a more comprehensive, multiple organism code.

- **87801** — Infectious agent detection by nucleic acid (DNA or RNA, multiple organisms).

These reimbursement guidelines are not intended to change provider billing/coding behavior. Providers should continue to bill for the underlying tests performed during the patient's visit in accordance with appropriate CPT coding guidelines. This only applies when the three individual tests are billed on the same date of service by the same provider.

Reimbursement Policy: Molecular Diagnostic Infectious Disease Testing (including seasonal influenza testing).

The Centers for Disease Control and Prevention (CDC) recognizes the Infectious Diseases Society of America (IDSA) guidelines, which indicate the use of the multiplex RT-PCR assays, targeting respiratory viral panel testing, including influenza viruses, should only be used for

hospitalized patients.

Respiratory viral panel testing using reverse-transcription polymerase chain reaction assay targets, including influenza virus (CPT codes 87632 and 87633), are medically necessary for testing performed in an inpatient facility, observation, or emergency setting only. The following limitations apply to seasonal influenza testing:

- Outpatient:
 - Providers should use rapid molecular assays (nucleic acid amplification tests) rather than rapid influenza diagnostic tests (antigen detection tests) to improve detection of influenza virus infection, preferably within four days of symptom onset (IDSA, 2018).
 - To increase influenza virus detection, nasopharyngeal specimens are preferred over other specimens (IDSA, 2018). Testing of specimens for influenza from nonrespiratory sites such as blood, plasma, serum, cerebrospinal fluid, urine, and stool is not medically necessary, except when ordered by an infectious disease specialist.
- Inpatient:
 - In hospitalized patients (IDSA, 2018): Providers should use reverse-transcription polymerase chain reaction or other molecular assays to improve detection of influenza virus infection.
 - In immunocompromised patients, providers should use multiplex reverse-transcription polymerase chain reaction assays to target a panel of respiratory pathogens, including influenza viruses.
 - In inpatients who are not immunocompromised, providers can consider

using multiplex reverse-transcription polymerase chain reaction assays to target a panel of respiratory pathogens, including influenza viruses, if it might influence care.

- Clinicians should not use immunofluorescence assays for influenza virus antigen detection, except when more sensitive molecular assays are not available. Follow-up testing with reverse-transcription polymerase chain reaction or other molecular assays should be performed to confirm negative immunofluorescence test results.
- Clinicians should not use rapid influenza diagnostic tests in hospitalized patients except when more sensitive molecular assays are not available. Follow-up testing with reverse-transcription polymerase chain reaction or other molecular assays should be performed to confirm negative rapid influenza diagnostic test results.
- Clinicians should not use viral culture for initial or primary diagnosis of influenza, but viral culture can be considered to confirm negative test results from rapid influenza diagnostic tests and immunofluorescence assays, such as during an institutional outbreak, and to provide isolates for further characterization.
- Clinicians should not use serologic testing for diagnosis of influenza because results from a single serum specimen cannot be reliably interpreted, and collection of paired (acute/convalescent) sera two to three weeks apart are needed for serological testing.

Alternative covered services:

- In-network routine and preventive health services by a primary care or specialty provider.
- Infectious disease consultation.

For questions about this payment policy, contact Utilization Management at **1-888-559-1010** or your Provider Network Management Account Executive

Reimbursement policy: Presumptive and definitive drug testing.

Select Health allows reimbursement of medically necessary presumptive and definitive drug testing when applicable codes are submitted.

Effective September 23, 2021, when the definitive drug testing code (G0480) and a presumptive drug testing code by instrumented chemistry analyzers

(80307) are reported on the same date of service for the same member by the same independent clinical laboratory, the plan will not allow separate reimbursement for the definitive drug testing code.

The codes applicable to and reimbursable by this policy are listed below:

80305	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; capable of being read by direct optical observation only, includes sample validation when performed, per date of service.	Reimbursable with G0480
80307	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; by instrument chemistry analyzers (e.g., utilizing immunoassay [e.g., EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (e.g., GC, HPLC), and mass spectrometry either with or without chromatography, (e.g., DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service.	Not reimbursable with G0480
G0480	Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays, (2) stable isotope or other universally recognized internal standards in all samples, and (3) method or drug-specific calibration and matrix-matched quality control material; qualitative or quantitative, all sources, includes specimen validity testing, per day; 1 – 7 drug class(es), including metabolite(s) if performed.	Not reimbursable with 80307

Endovascular treatment for intermittent claudication policy

Certain requests for endovascular revascularization for treatment of intermittent claudication are considered medically necessary and require prior authorization

(PA), to ensure certain criteria are met.

Endovascular revascularization for treatment of intermittent claudication is clinically proven and, therefore, medically necessary for members with peripheral artery disease when all of the following criteria are met (Conte, 2015; Gerhard-Herman, 2017):

- Significant functional or life-style-limiting disability.
- Hemodynamically significant aortoiliac occlusive disease, femoropopliteal disease, or multivessel tibial disease with a stenosis of at least 50%.
- Failure of at least 12 weeks of guideline-directed pharmacotherapy, exercise therapy, or both to control symptoms.
- Documented discontinuation of smoking and other tobacco use.
- There is a reasonable likelihood of symptomatic improvement with endovascular treatment.
- The benefits of treatment outweigh the potential risks.

PA must be obtained before performing endovascular revascularization when the above criteria are present.

For any determinations of medical necessity for medications, refer to the applicable state-approved pharmacy policy.

Limitations

All other uses for endovascular revascularization for members with intermittent claudication are investigational/not clinically proven and, therefore, not medically necessary, as their effectiveness has not been established. These include but are not limited to (Conte, 2015; Gerhard-Herman, 2017):

- Treatment of asymptomatic disease, regardless of hemodynamic measures or imaging findings demonstrating presence of disease.
- Treatment of isolated infrapopliteal artery disease.
- Treatment done solely to prevent progression to chronic limb ischemia.

Alternative covered services

- Guideline-directed risk reduction measures (e.g., diet and smoking cessation).
- Pharmacotherapy (antiplatelet drugs, statins, or medications to lower blood pressure).
- Supervised exercise therapy.
- Home-based exercise therapy.

- Open surgical revascularization.

In-office laboratory testing policy

Effective February 15, 2022, when supported by documentation of medical necessity, the lab tests listed below are reimbursable in an office setting. All other lab testing must be performed by a participating laboratory. Please note: The inclusion of a code does not guarantee claims payment and the code list is subject to change. Other policies may apply.

CPT-HCPCS code reimbursable with POS 11

Please note: Codes are subject to change.

Providers conducting these in-office lab tests must meet applicable CLIA certification requirements (or hold a CLIA Certificate of Waiver for CLIA-waived testing).

80047-80048	82570	85025, 85027	87210	87811
80051, 80053	82731	85049	87220	87880
80061	82947-82948	85610	87270	87905
80305-80307	82950-82952	85651	87301	88720
81000	82962	86308	87400	89220
81001-81003	83036-83037	86318	87426	0202U
81005	83655	86328	87428	0240U-0241U
81015	83986	86580	87430	C9803
81025	84132	86756	87490-87492	G0480
82043-82044	84295	86769	87502	G2023-G2024
82247-82248	84703	87070-87071	87650-87652	P9612
82270-82272	84830	87168-87169	87634-87637	P9615
82465	85013-85014	87172	87801-87804	Q0111-Q0115
82565	85018	87205	87806-87808	U0001-U0004

PROGRAM INTEGRITY

The Program Integrity Department utilizes internal and external resources to ensure the accuracy of claims payments and the prevention of claims

payments associated with fraud, waste, and abuse. As a result of these claims accuracy efforts, you may receive letters from Select Health or on behalf of Select Health regarding payment or recovery of potential overpayments. You may be asked to provide supporting documentation, including the medical record or itemized bill to support the review of the claim. In addition, you may be informed that your claim submission patterns vary from industry standards when reviewed and compared to your peer's submission of similar claims; if this were to occur, you would be notified and additional action may be required on your behalf. Should you have any questions regarding the communication received relating to these requests, please use the contact information provided in the communication to expedite a response to your question or concerns.

Examples of these Program Integrity initiatives include:

- **Prospective (preclaims payment):**
 - Claims editing — Policy edits (based on established industry guidelines/standards such as Centers for Medicare & Medicaid Services (“CMS”), the American Medical Association (“AMA”), state regulatory agencies, or Select Health medical/claim payment policy) are applied to prepaid claims.
 - Medical Record/Itemized Bill review — A medical record and/or itemized bill may be requested in some instances prior to claims payment to substantiate the accuracy of the claim.
 - *Please note: Claims requiring itemized bills or medical records will be denied if the supporting documentation is not received within the requested time frame.*
 - Coordination of Benefits (COB) — A process to verify third-party liability to ensure that Select Health is only paying claims for members where Select Health is responsible, i.e., where there is no other health insurance coverage.
 - Within the clearinghouse environment, a review of claim submission patterns will be performed to identify variances from industry standards and peer group norms. If such variations are identified, you may be requested to take additional actions, such as verifying the accuracy of your claim submissions prior to the claim advancing to claims processing.
- **Retrospective (Post-claims payment):**
 - Third-Party Liability (TPL)/Coordination of

Benefits (COB)/Subrogation — As a Medicaid plan, Select Health is the payor of last resort. The effect of this rule is that if Select Health determines a member has other health insurance coverage, payments made by Select Health may be recovered.

- Please also see the section in this manual entitled **Cost Avoidance/Third-Party Liability (TPL/COB) Recovery** for more information.
- Data Mining — Using paid claims data, Select Health identifies trends and patterns to determine invalid claim payments or claim overpayments for recovery.
- Medical Records Review/Itemized Bill review — A Medical record and/or itemized bill may be requested to validate the accuracy of a claim submitted as it relates to the itemized bill. Validation of procedures, diagnosis, or diagnosis-related group (DRG) billed by the provider. Other medical record reviews include but are not limited to place of service validation, readmission review, and pharmacy utilization review.
 - *Please note, if medical records are not received within the requested time frame, Select Health will recoup funds from the provider. Your failure to provide medical records creates a presumption that the claim as submitted is not supported by the records.*
- **Credit balance issues:**
 - Credit balance review service conducted in-house at the provider's facility to assist with the identification and resolution of credit balances at the request of the provider.
 - Overpayment collections — Credit balances that have not been resolved in a timely manner will be subject to offset from future claims payments and/or referred to an external collections vendor to pursue recovery.

Prior authorization is not a guarantee of payment for the service authorized, and Select Health reserves the right to adjust any payment made following the review of the medical record or other documentation and/or determination of the medical necessity of the services provided. Additionally, payment may also be adjusted if the member's eligibility changes between when the authorization was issued and the service was provided.

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 Program.
- 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 HIV/AIDS 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 rework (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 the Change Healthcare, Select Health claims clearinghouse.
- Health care professional/providers should confirm with vendor the accurate location of Select Health’s health care professional/provider ID number.
- Submit with **Payer 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 Change Healthcare 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 “7” for replacement of a prior claim or “8” for void/cancel 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 7 or 8.
- 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 up front).
- 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 (<https://navinet.navimedix.com/sign-in>) can view corrected claims faster than with paper submission processing.

If you do not currently have the capability to submit claims electronically but are interested in doing so, contact the Change Healthcare 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 Change Healthcare and HDX as clearinghouses for the 835 electronic remittance advice transactions. Change Healthcare 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 Change Healthcare.

HDX Contact Information:

1-610-219-3331

HDX Electronic Remittance Service
ERSPayers@HDX.com

Change Healthcare Contact Information:

1-800-845-6592

(Health care professional/provider Help Desk)

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.
- Address.
- Tax ID.
- Payee ID.

South Carolina Encounter Companion guides are available at: <https://msp.scdhhs.gov/managedcare>.

Additional assistance may be obtained by contacting Provider Services at **1-800-741-6605**.

■ Electronic funds transfer (EFT)

Select Health and Change Healthcare Business Services have partnered to offer you direct deposit for your claims payment. Change Healthcare has recently partnered with ECHO Health, Inc. (ECHO), a leading innovator in electronic payment solutions, to offer more electronic payment options and to allow health care providers to process electronic payments more efficiently.

Health care professionals/providers interested in receiving electronic payments through Change Healthcare/ECHO may get additional information by contacting ECHO Health at **1-888-834-3511** or by contacting Select Health Provider Services at **1-800-741-6605**.

Change Healthcare/ECHO ePayment can simplify the payment process by:

- Providing fast, easy, and 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.
- Enabling you to view multiple payers in one easy-to-use application.

When you enroll in EFT, you will automatically receive electronic remittance advices (ERAs) for those payments. All generated ERAs and a detailed Explanation of Payment/Remittance Advice (EOP/RA) for each transaction will also be accessible to download from the **ECHO provider portal (www.providerpayments.com)**.

For assistance with using the provider payments portal, see the **ECHO Provider Payment Portal Quick Reference Guide** located on the Select Health website.

If you are new to EFT, you will need to enroll with ECHO Health for EFT from Select Health.

To sign up to receive EFT from Select Health, visit <https://enrollments.echohealthinc.com/efteradirect/enroll>. **There is no fee for this service.**

To sign up to receive EFT from all of your payers processing payments on the Settlement Advocate platform, visit <https://enrollments.echohealthinc.com>. **A fee for this service may be required.**

If you have questions regarding how to enroll in EFT, please see the **EFT Enrollment Guide** located on the Select Health website.

Claim payment options

The partnership between Change Healthcare and ECHO Health, Inc. enables Select Health to offer more payment options to our health care providers so you can select the payment method that best suits your accounts receivable workflow. In addition to EFT as described above, additional payment options are:

Virtual Credit Card (VCC)

ECHO Health offers Virtual Credit Card as an optional payment method. VCCs are randomly generated, temporary credit card numbers that are either faxed or mailed to providers for claims reimbursement. Major advantages to VCC are that providers do not have to enroll or fill out multiple forms in order to receive VCC, and personal information, like practice bank account information, will never be requested. Providers will also be able to access their payment the day the VCC is received.

Select Health providers who are not currently registered to receive payments electronically will receive VCC payments as their default payment method instead of paper checks. Your office will receive either faxed or mailed VCC payments, each containing a VCC with a number unique to that payment transaction with an instruction page for processing and a detailed Explanation of Payment/Remittance Advice (EOP/RA).

Normal transaction fees apply based on your merchant acquirer relationship. If you do not wish to receive your claim payments through VCC, you can opt out by contacting ECHO Health directly at **1-888-492-5579**.

Medical Payment Exchange (MPX)

If you're enrolled for Medical Payment Exchange (MPX) with another payer, you are not enrolled with us to receive payments via EFT, and you opt-out of Virtual

Credit Card, you will continue to receive your payments in your MPX portal account. Otherwise, you will receive a paper check via print and mail.

Paper check: You may also continue to receive paper checks if that is your preference. To receive paper checks and paper EOPs, you must opt out of VCC services by contacting ECHO Health at **1-888-492-5579** after your initial virtual card payment is received.

■ 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 from birth through the month of their 21st birthday 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 developmental levels. A general screen is recommended, with follow-up screens as indicated. This code is limited to a frequency of two 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 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, including blood pressure measurement.
- Appropriate immunizations according to age and health history.
- Health education, including anticipatory guidance.
- Vision, hearing, and dental screenings.
- BMI percentile.
- Appropriate laboratory tests, including but not limited to lead and anemia screenings 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, ages 1 – 4
99383	Preventive visit, ages 5 – 11
99384	Preventive visit, ages 12 – 17
99385	Preventive visit, ages 18 – 21

Established patients:

99391	Preventive visit, 12 months or younger
99392	Preventive visit, ages 1 – 4
99393	Preventive visit, ages 5 – 11
99394	Preventive visit, ages 12 – 17
99395	Preventive visit, ages 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 (up to nine administrations 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.

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 EPSDT examination 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 Clinics (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, and 90474 intranasal or oral route.
- A sick visit can be billed on the same date of service as the EPSDT visit.
Billable sick child visit codes:
 - New Patient: 99201-99205
 - Established Patient: 99211-99215If the EPSDT exam cannot be completed, bill only the sick visit.

- Select Health will reimburse for sports physicals **if** all the components of a well visit are completed and the claim is coded using DX codes: Z00121, Z00129, Z0000, Z0001, Z020-Z026, Z0282, Z0289, Z021, Z023, Z008, Z0070, Z0071, or Z008 and with EPSDT E/M codes. Do **not** bill another E/M code on the same date of service. Do **not** bill the 97005 (athletic training evaluation) and 97006 (athletic training sports, school, or camp re-evaluation) codes. Sports physicals are reimbursable even if a well-child exam was done earlier in the year.

UNLISTED PROCEDURE CODES

Unlisted procedure codes are services performed by a physician that are not specifically defined in the CPT

book. For these codes:

- Prior authorization is required.
- A special report including a 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 the 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, and so on.

RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER ENCOUNTERS

SCDHHS requires that Select Health submit encounter data to the state using standard ICD-10 and CPT coding. Select Health is not permitted to submit encounter data that consists of the Rural Health Clinic 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 for RHCs.

FQHC PAYMENT METHODOLOGY

The South Carolina (SC) Title XIX State Plan was amended by the SCDHHS to change the Medicaid reimbursement methodology for Federally Qualified Health Centers (FQHCs) from the current payment

methodology to a prospective payment methodology, which means FQHCs are to be reimbursed at their established encounter rate.

As a result, the following guidelines apply to FQHC claims:

- Claims are to be submitted with place of service 50 for FQHC services.
- Standard CPT procedure codes should be billed. Select Health does not reimburse for the T1015 code.
- Diabetic education services are included in the encounter rate.
- FQHC services must be submitted with the appropriate evaluation and management (E/M) code.
- National Correct Coding Initiative (NCCI) appropriate modifiers must be utilized and submitted on codes as necessary.
- Any services that are included in the FQHC encounter must also be submitted on the claim. This includes submission of NDC codes for immunizations.
- Submit claims for services outside of the FQHC encounter rate using place the Community-Based Provider (CBP) ID and NPI numbers, with POS 21, 22, or 23.
- Behavioral Health services are payable in addition to an E/M encounter code.
- Supplies, lab work, injections, etc., are not billable services. These services and supply costs are included in the encounter rate when provided in the course of treatment by a physician, physician assistant, nurse practitioner, certified nurse midwife, chiropractor, clinical psychologist, and/or clinical social worker visit.
- Coordination of benefits will apply for members with other insurance. Claims will be coordinated up to the FQHC encounter rate.

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.

For more detailed information, such as specific codes, consult the **SCDHHS Physicians Provider Manual's** Wrap-Around Payment Methodology section.

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.

LONG-ACTING REVERSIBLE CONTRACEPTIVE (LARC) METHODS

Select Health covers long-acting reversible contraception methods, or LARCs, including intrauterine devices and Nexplanon implants, for our First Choice members. In accordance with South Carolina Department of Health and Human Services' requirements, we reimburse providers for devices and insertion of devices when performed in a private practice, clinic, or during delivery inpatient stay.

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 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 username 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, **https://www1.radmd.com/**. 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 they are the best source for clinical information.***

PROSPECTIVE PAYMENT REDUCTIONS FOR MULTIPLE RADIOLOGY PROCEDURES

In accordance with CMS Multiple Procedure Reduction payment policy and criteria, as it applies to radiology procedures, Select Health applies prospective edits to radiology claims containing procedure codes with the multiple procedure indicator "4" on the Medicare Physician Fee Schedule (e.g., MRI, MRA, CT, CTA and ultrasounds). Reductions apply to claims containing multiple imaging services from the same code family when billed with the same date of service.

Reduction on the **professional component** applies to services rendered by a single provider, under one NPI. The procedure with the highest relative value unit (RVU) price for the professional component is reimbursed at 100%, and the professional component for all secondary procedures is reduced by 25%.

The imaging procedure with the highest technical component is paid at 100%, and technical components for additional, less technical services in the same code family are reduced by 50%.

NONOBSTETRICAL PELVIC ULTRASOUNDS

Select Health adheres to the Centers for Medicare & Medicaid Services (CMS) Multiple Procedure Payment Reduction guidelines to determine reimbursement for eligible multiple diagnostic services.

When a nonobstetrical transabdominal pelvic ultrasound and transvaginal ultrasound are furnished to the same member by the same provider on the same day and during the same session, Select Health will reimburse for the transvaginal ultrasound procedure at 100% of the allowed amount and for the transabdominal pelvic ultrasound examination at 50% of the allowed amount.

The rationale for a reduction in the multiple-procedure payment is that clinical labor activities and supplies are provided only once — for example, preparing and cleaning the exam room, escorting and positioning the patient, and providing education and obtaining consent.

AUTISM SPECTRUM DISORDER (ASD)

Services to treat Autism Spectrum Disorder (ASD), as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, are provided to eligible Select Health members ages 0 to 21.

ASD services must be recommended by a Licensed Psychologist, Developmental Pediatrician, or a Licensed Psycho-Educational Specialist (LPES) within their scope of practice under the South Carolina State law to prevent the progression of ASD, prolong life, and promote the physical and mental health and efficacy of the individual.

For more detailed information, refer to the section on “Autism Spectrum Disorder (ASD)” in the **Behavioral Health Under First Choice** section of this manual.

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:

92552	6 every 12 months
92557	1 every 12 months
92557/52	6 every 12 months
92567	6 every 12 months
92568	2 every 12 months
92584	1 per implant
92585	No limit
92585/52	No limit
92587	No limit
92588	No limit
92590	6 every 12 months
92592	6 every 12 months
92592/52	6 every 12 months
92626	10 per year
V5011	6 every 12 months

BABYNET SERVICES

Select Health adopted the guidelines as outlined by South Carolina’s Individuals with Disabilities Education Act (IDEA), Part C program, known as BabyNet to provide services for First Choice members.

Early intervention services offered in this program build upon and provide support and resources to assist and enhance the learning and development of infants and

toddlers with disabilities and special needs up to 3 years of age. Eligibility ends the day before the 3rd birthday.

Covered services include:

- Audiology.
- Autism.
- Physical, occupational, and speech therapies.
- Vision — ophthalmological services.

Referrals are processed by the BabyNet Central Referral Team. Families and professionals can make online referrals at <https://babynet.scdhhs.gov/prebabynet/> or by calling **1-866-512-8881**.

Authorization requirements

Providers will be required to submit the **MCO Universal BabyNet prior authorization form** and the Individual Family Service Plan (IFSP) indicating the services and frequencies approved for the member, to Select Health Utilization Management prior to rendering services. Documentation should be submitted via fax to **1-866-368-4562**.

For questions regarding prior authorization, contact Select Health Population Health Management at **1-888-559-1010**.

Claims are submitted directly to Select Health for BabyNet services on a CMS 1500 claim form. Standard billing and coding guidelines apply.

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.

BREAST CANCER SUSCEPTIBILITY GENE TESTING (BRCA1 AND BRCA2)

Select Health adopted the guidelines as set forth by SCDHHS to cover BRCA genetic testing for eligible members who meet medical necessity criteria. For SCDHHS guidelines, consult the **SCDHHS Physician Services Provider Manual**.

Medical necessity criteria are based on the current National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology-Genetic/Familial High-Risk Assessment: Breast and Ovarian SCDHHS policy guidelines. To review the current NCCN guidelines visit www.nccn.org/professionals/physician_gls/default.aspx.

Recipients of BRCA genetic testing must be 18 years of age or older. Genetic counseling must be received before and after genetic testing for BRCA1, BRCA2, and BRCA large cell rearrangement. For prior authorization requirements, contact Population Health at **1-888-559-1010**.

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 six visits per state fiscal year.

CIRCUMCISION

Newborn circumcision will be covered for members ages 0 – 6 months in outpatient or inpatient settings. Prior authorization is not required for participating providers.

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, 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 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 nonparticipating health care professionals/providers, Medicaid fee-for-service will cover these services.

DENTAL SERVICES

Select Health is responsible for the reimbursement of charges from the facility operating room or ambulatory surgery center and anesthesia associated with dental procedures for our members. Prior authorization is not required for covered codes. However, if the anesthesia code is unlisted, noncovered or miscellaneous medical necessity review will be required.

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** for a facility locator and information on alcohol and drug use 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 AND NONEMERGENCY 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 nonroutine transports to a Medicaid-covered service. Types of services include ambulance, nonemergency medical vehicles, and air ambulances.

All advanced life support (ALS), basic life support

(BLS), and 911-based emergency transportation services provided via ambulance, air ambulance, and/or medivac are covered by Select Health. This benefit also covers an ambulance that is called to a location but not used for transport (member is not taken to a medical services provider).

Note: In order for ambulance mileage claims to process, providers must bill a minimum of one mile and with whole numbers. Fractions of a mile do not register in our claims adjudication system (e.g., 1.6 miles would be billed as 2 miles; 1.4 miles would be billed as 1 mile).

Nonemergent transportation not performed in an ambulance is covered as a carve-out benefit by SC Healthy Connections/Medicaid FFS.

- Coverage of this benefit is provided by the Medicaid Transportation Broker.
- Members must call their county transportation broker to arrange transportation.
- Calls should be made at least three days in advance for routine medical services. Calls received with less than three days' notice may be denied. However, **urgent** requests made with less than three days' notice will be covered when possible.

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). 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. Nonparticipating providers should notify Population Health at **1-888-559-1010** when providing services to First Choice members. Refer to the Billing Requirements for Certain Services section for billing details.

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

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; a 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 six 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 participating 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 must refer to Select Health participating laboratories and free-standing facilities. Any service rendered by a nonparticipating laboratory provider requires the ordering provider to obtain prior authorization for the service. If prior authorization is not obtained for services provided by a noncontracted laboratory, the claim will be denied.

Members cannot be billed for services provided by a nonparticipating lab that are denied due to an authorization not being obtained.

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 nonemergency 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 a 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, and postpartum services and nursery charges for a normal pregnancy or complications related to the pregnancy.

Providers may bill an initial visit for each pregnancy using the Current Procedural Terminology (CPT) evaluation and management (E/M) code. Under this option, a provider would bill for a new patient E/M code even if the Medicaid member is a patient of record at that practice. The claim must contain a pregnancy diagnosis code. OR providers may bill the appropriate E/M code that meets the CPT description for level of complexity when billing for initial or antepartum visits. The level of complexity must be documented in the patient's medical record. The claim must contain a pregnancy diagnosis code.

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).

NONPAYMENT 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 nonmedically indicated deliveries prior to 39 weeks. This is a result of an extensive effort to reduce nonmedically 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.

OBESITY MANAGEMENT/INTERVENTION PROGRAM

An obesity management/intervention program is available for Select Health members 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 BMI greater than or equal to the 95th percentile for age and sex.

The program will exclude the following member categories:

- 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 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.

The provider must also emphasize the importance of exercise, developing a realistic exercise plan with goals. The obesity intervention plan must be documented in the patient's medical health record. The provider will arrange for an individual nutritional assessment to be provided by a licensed and Medicaid-enrolled dietitian.

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

may bill for all medically necessary diagnostic testing.

Dietitian 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.

NUTRITIONAL COUNSELING 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).

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 table below when billing for nutritional counseling services. These codes should be used for services rendered to both adults and children.

Procedure code	Description	Benefit criteria and limitation
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15-minute units	Allowed for up to four units of service per same provider, provider location, or billing entity. Allowed to be performed via telehealth. These units count toward the 12 hours of combined medical nutrition therapy services allowed per patient per state fiscal year.
97803	Medical nutrition therapy; reassessment and intervention, individual, face-to-face with the patient, each 15-minute units	Allowed up to 12 units of service per month, per patient, up to four units per date of service/visit, with at least seven calendar days between visits. Allowed to be performed via telehealth. These units count toward the 12 hours of combined medical nutrition therapy services per patient per state fiscal year.

Procedure code	Description	Benefit criteria and limitation
97804	Medical nutrition therapy; group (two or more individuals), each 30-minute units	Allowed for one unit of service per date of service. Up to four units per month per patient, with at least seven calendar days between visits. Group size allowed is two – eight patients. Allowed to be performed via telehealth. These units count toward the 12 hours of combined medical nutrition therapy services per patient per state fiscal year.

OBSERVATION SERVICES

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

Continued hospitalization past 48 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 and the assessment and plan of the treating physician will guide medical necessity determination for continued hospitalization at the requested level of care.

In order to ensure proper payment for each 24-hour observation period, Select Health will require revenue codes 762 and 769 to be submitted with the following additional information:

- HCPCS code G0378 — Hospital observation service, per hour:
 - Units will equal the number of hours under observation care during the date of service billed.
- HCPCS code G0379 — Direct admission of patient for hospital observation care, initial:
 - Units will equal 1.

In the case where a patient is admitted directly to observation from outside the hospital system, an additional line of 762 or 769 should be submitted. For example, a direct admit to observation for 24 hours would be submitted as:

- 762: G0378: 24 units.

- 762: G0379: 1 unit.

The G0379 code indicates that the patient arrived as a direct admit, but it does not count as the first hour. The G0378 code indicates how long the patient stayed in observation. G0378 is the time-based code. Whenever G0379 is reported, a line item for G0378 should also be reported, no matter the amount of time the patient remained in observation.

While observation services usually do not exceed 24 hours, they may exceed 24 hours in some cases and are not explicitly limited in duration. Each 24 hours of observation can be filed on one claim, even if the 24 hours spans multiple dates of service.

In cases where the observation stay must span two calendar days, to equal 24 hours, the claim should not be split. Observation should not be billed for two separate dates of service.

For questions, please contact Population Health 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.

LONG-ACTING INJECTABLE MEDICATIONS FOR OUTPATIENT HOSPITALS

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.

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. These services are covered for all members.

PRESCRIPTION DRUGS

Covered pharmaceutical services include most legend (prescription) and certain nonlegend (over-the-counter) products. Select Health sponsors reimbursement for unlimited prescriptions or refills for First Choice members. Where appropriate, medications are prescribed to cover a maximum of 31 days.

A \$3.40 per prescription copay applies, with the exception of the following members:

- Children.
- Federally recognized Native Americans.
- People 18 years of age or younger.
- Pregnant people.
- 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 not required if the medication is on the Select Health Preferred Drug List (PDL)/formulary. The searchable **online PDL** is available on the Select Health website. Providers may also check to see if a medication requires prior authorization by entering the HCPCS code into our **Prior Authorization Lookup Tool**.

Prior authorization is required for nonformulary medications.

Prior authorization requests may be submitted via the **PerformRx online prior authorization form** (preferred method) or by faxing the **printable prior authorization form** to **1-866-610-2775**.

For questions, contact PerformRX Pharmacy Services at **1-866-610-2773**.

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES (PRTF)

Services rendered at a psychiatric residential treatment facility (PRTF) are covered for eligible members. This benefit includes psychiatric care provided to children under age 21. If services are provided immediately before the member reaches age 21, services may continue until the earlier of the date the member no longer requires the services or the date the member reaches age 22.

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 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 are covered on an annual basis by Select Health of South Carolina. Vision coverage is based on the State Fiscal Year (SFY) and includes:

- Routine vision exams, including refractions.
- Initial and replacement eyeglasses.*
- Contacts (when medically necessary, prior authorization required.)
- 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 1 to June 30.)

Effective July 1, 2021, routine vision services are covered for adult members, age 21 and older.

This benefit includes the following services every 2 years (based on the SFY):

- One comprehensive eye exam with no copay.
- One pair of eyeglass lenses including frames.
- One eyeglass fitting.

Authorization requirements: Prior authorization is not required for routine services rendered by participating vision providers.

- Prior authorization is not required for eyeglasses.
- Prior authorization is required for contact lenses.
- Nonparticipating vision providers are required to obtain authorization for all services.

Vision services with a medical diagnosis (disease of the eye — glaucoma, conjunctivitis, and cataracts) are covered for members of all ages. The office visit copay applies for members ages 19 and over.

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.

For diabetic members, the exam, including the refraction component, is covered annually. However, diagnosis codes in the H52 – H53 range are excluded from coverage. Using these diagnoses will cause denials. Claims must be submitted with a diabetic diagnosis code as primary and applicable vision-related diagnosis codes secondary.

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. Robertson's Optical utilizes an online portal for ordering eyeglasses. For

information on order submissions, providers should visit the Robertson's Optical website at: <http://www.robertsonoptical.com/ordering/>. 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 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 Population Health 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): two types that cause 70% of cervical cancer cases and two more types that cause 90% of genital warts cases. Medicaid fee-for-service will cover the Gardasil vaccine for members ages 9 – 18 years. Select Health will cover the vaccine for members ages 19 – 45 years and the administration fee for both age groups.
- **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 older adults or disabled.
 - Persons with mental 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% of federal poverty level for Family Planning Services only.
- **Nursing home:** After the first 90 to 120 days.
- **Mental health and alcohol/drug services:** Some mental health, alcohol, and other drug use treatment services will be reimbursed by Medicaid fee-for-service. SCDHHS reimburses the following mental health, alcohol, and other drug use treatment services:
 - Services provided or referred by targeted case management.
 - Developmental evaluation centers (DEC).
 - Adolescent treatment facilities (ATF).
 - Waiver programs.
- **Nonemergency medical transportation:** Coordinated with the transportation broker in the member's county of residence.

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 Coordinators:
MUHA (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.

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

- Corneal transplants.
- Post-transplant follow-up services up to 90 days from the date of discharge.
- Post-transplant pharmaceutical services.
- **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.
- **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 individuals with issues relating to alcohol and substance use, children in foster care, chronically mentally ill adults, emotionally disturbed children,

children in the juvenile justice system, sensory impaired individuals, individuals with mental disabilities, 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 disabilities, 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 an older adult or disabled.
 - Persons with mental 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. South Carolina Healthy Connections ID Card
3. New First Choice Member ID Card
4. Chart, First Choice Prior Authorization Information
5. Chart, Obstetrical Care Guidelines
6. Chart, Periodic Health Guidelines for Adults
7. Chart, Periodic Health Guidelines for Children
8. Form, 17-P Authorization
9. Form, Abortion Statement
10. Form, Behavioral Health Crisis Intervention
11. Form, Behavioral Health Outpatient Treatment
12. Form, Certification of Need (CON) for Children Under 21
13. Form, Consent for Sterilization (DHHS 687)
14. Form: Hearing Aid Battery Request
15. Form, Neuropsychological/Psychological Testing Request
16. Form, Member Consent to Provider 104
17. Form, Physician Certification of Incontinence 168IS
18. Form, Pregnancy Risk Assessment Information
19. Form, Prior Authorization, Inpatient Substance Use Disorders
20. Form, Prior Authorization Request Form: Medications
21. Form, Provider Refund Claim form
22. Form, Prior Authorization, DME
23. Form, Prior Authorization, General
24. Form, Prior Authorization
25. Form, SBIRT Screening Tool
26. Form, Surgical Justification Review for Hysterectomy
27. Form, Universal Newborn Prior Authorization
28. Form, Universal Prior Authorization – BabyNet
29. Provider Claim Dispute Form
30. Sample First Choice Autism Spectrum Disorder (ASD) Treatment Request Form
31. Sample First Choice Psychiatric Residential Treatment Facility (PRTF) Request Form
32. Sample Provider/Member Roster
33. Sample Select Health Physician’s Request for Transfer of Member
34. Sample Select Health Remittance Advice
35. Sample WIC Referral Form
36. SCDHHS Subcontractor Requirements

DEFINITIONS

Adverse benefit determination: (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 their right, under 42 C.F.R. § 438.52(b)(2)(ii), to obtain services outside the MCO's network; (7) the denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

Appeal: Request for review of an adverse benefit determination.

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 plan 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.

Facility: Hospitals, birthing centers, home health agencies, rehabilitative therapy or behavioral health centers, and any other health care institution that is licensed, practices under an institutional license or is certified to practice under other authority consistent with the laws of South Carolina and has been approved by plan or with whom the plan has contracted to provide health services to plan members.

Medical Director: A physician designated by plan to monitor and review covered services to members provided or requested by a 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, their participating physician, hospital, or other 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.

Nonparticipating Health Care Professional/Provider: Any health care professional/provider who has not contracted with Select Health to provide covered services to members.

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

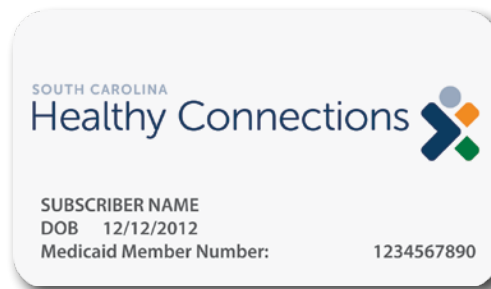
Physician: A doctor of medicine or osteopathy, podiatrist, chiropractor, psychologist, or mental health professional duly licensed to practice in the state of South Carolina. The following physician designations are used within the context of participation with Select Health: participating physician, 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, nonparticipating health care professionals/providers. Except as otherwise permitted by Select Health, each member shall select or have selected on their 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.

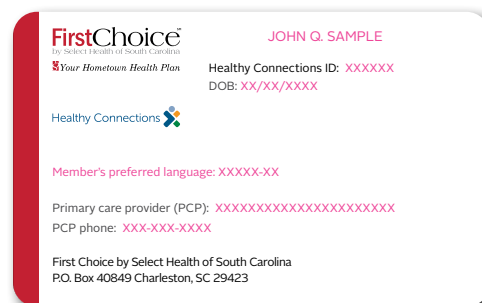
South Carolina Department of Health and Human Services (SCDHHS): The state agency responsible for administering South Carolina's Medicaid program.

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** or online through Medifax, or you may visit the Select Health website at www.selecthealthofsc.com. On the IVRS system 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.

FIRST CHOICE MEMBER ID CARD



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

Eligibility may also be verified through the NaviNet provider portal at: <https://navinet.navimedix.com>.

CHART, FIRST CHOICE PRIOR AUTHORIZATION INFORMATION (PAGE 1)



2024 Prior Authorization Information

Services requiring prior authorization (Note: Prior authorization requirements are applicable to secondary claims.)

Services

- Air ambulance.
- All out-of-network services (with exceptions noted under “Does Not Require Authorization”).
- All unlisted miscellaneous and manually priced codes (including but not limited to codes ending in “99”).
- Autism spectrum disorder (ASD) services.
- BabyNet services.
- Behavioral health (psychological and neuropsychological testing, electroconvulsive therapy, environmental intervention, interpretation or explanation of results, unlisted psychiatric services).
- Behavioral health individual outpatient therapy sessions (CPT codes 90832, 90834, and 90837 combined), after 24 visits, per state fiscal year. Limitation: 6 visits per month.
- Chiropractic care authorization required under 18 years of age (six visits per fiscal year, July 1 through June 30).
- Cochlear implantation.
- Contact lenses (including dispensing fees).
- DAODAS services (bundled services and some discrete services).
- Gastric bypass/vertical band gastroplasty.
- Hyperbaric oxygen
- Hysterectomy (Hysterectomy Consent and Surgical Justification form required) — elective abortions.
- Implants (over \$750).
- Rehabilitative behavioral health services (RBHS) — see “Behavioral Health Services under First Choice” in the Select Health Provider Manual for specifics.
- Transplants.

Therapy (speech, occupational, and physical)

Consult the Prior Authorization Lookup tool to determine authorization requirements. Available at: www.selecthealthofsc.com/provider/resources/prior-authorization-lookup

Plastic surgery

- Surgical services that may be considered cosmetic, including but not limited to:
- Blepharoplasty.
 - Mastectomy for gynecomastia.
 - Mastopexy.
 - Maxillofacial (all codes applicable).
 - Panniculectomy.
 - Penile prosthesis.
 - Plastic surgery/cosmetic dermatology.
 - Reduction mammoplasty.
 - Septoplasty.

Inpatient

- All inpatient hospital admissions, including medical, surgical, and rehabilitation.
- Acute inpatient psychiatric facility services.
- Behavioral health.
- Psychiatric residential treatment facility (PRTF) services.
- Obstetrical admissions, newborn deliveries exceeding 48 hours after vaginal delivery and 96 hours after cesarean section.
- Medical detoxification.
- Elective transfers for inpatient and/or outpatient services between acute care facilities.
- Long-term care initial placement (if still enrolled with the plan).

Home-based services

- Home health care: Speech, physical, and occupational therapy; home health aides; and skilled nursing visits (after 18 combined visits, regardless of modality). Consult the Prior Authorization Lookup tool to determine authorization requirements. Available at: www.selecthealthofsc.com/provider/resources/prior-authorization-lookup
- Home infusion services and injections. Consult the Prior Authorization Lookup tool to determine authorization requirements.
- Private duty nursing (extended nursing services), covered when medically necessary for under age 21.

Pharmacy and medications

- Consult the Prior Authorization Lookup tool to determine authorization requirements. Available at: www.selecthealthofsc.com/provider/resources/prior-authorization-lookup
- Medications not listed on the South Carolina Medicaid Professional Services Fee Schedule are not covered by First Choice.
 - For questions contact PerformRxSM: **1-866-610-2773**

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 Evolent Specialty Services, Inc. (Evolent): www.1radmd.com or call **1-800-424-4895**.

Durable medical equipment (DME)

- Consult the Prior Authorization Lookup tool to determine authorization requirements. Available at: www.selecthealthofsc.com/provider/resources/prior-authorization-lookup

CHART, FIRST CHOICE PRIOR AUTHORIZATION INFORMATION (PAGE 2)

2024 Prior Authorization Information

Services requiring notification

- All newborn deliveries.
- Maternity obstetrical services (after first visit) and outpatient care (includes 48-hour observation).
- Behavioral health — crisis intervention: notification required (within 2 business days) post-service. Medical necessity review required after 80 units per state fiscal year (July 1 – June 30).
- Continuation of covered services for a new member transitioning to the plan the first 90 calendar days of enrollment.

Services that do not require prior authorization

- Acupuncture.
- Bronchoscopy — rigid or flexible with fluoroscopic guidance (one and two or more lobes).
- Circumcisions.
- Emergency room services (in-network and out-of-network).
- 48-hour observations (except for maternity — notification required).
- Low-level plain films — X-rays, electrocardiograms (EKGs).
- Family planning services.
- Post-stabilization services (in-network and out-of-network).
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.
- Women's health care by in-network providers (OB-GYN services).
- Routine vision services.
- Outpatient Psychotherapy codes 90832, 90834, and 90837 (combined) first 24 visits.
- Behavioral health medication management.
- Opioid treatment program services.
- Enteral nutritional supplements.

Contacts

Medical Services

Phone: **1-888-559-1010**
Fax: **1-866-368-4562**

Evolut Specialty Services, Inc. (Evolut)

Website: www1.radmd.com
Phone: **1-800-424-4895**

PerformRxSM

Phone: **1-866-610-2773**
Fax: **1-866-610-2775**

Behavioral Health

Phone: **1-866-341-8765**
Fax: **1-888-796-5521**

Claims

Phone: **1-800-575-0418** or **1-800-741-6605**

Claims Address

Claims Processing Dept.
P.O. Box 7120
London, KY 40742

Select Health

P.O. Box 40849
Charleston, SC 29423
www.selecthealthofsc.com

NaviNet website

Visit **NaviNet** to verify member eligibility and claim status.
<https://navinet.navimedix.com>

NOTE: Prior authorization requirements are applicable to secondary claims.

Disclaimer: Telephone or written approval is not a guarantee of reimbursement. All services are subject to retrospective review to validate the request. **This list is not all-inclusive.**

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www.selecthealthofsc.com

Revised April 2024

CHART, OBSTETRICAL CARE GUIDELINES



Obstetrical care guidelines comprise services normally provided in uncomplicated obstetric care. **Women with medical or obstetric problems may require closer surveillance; the appropriate intervals between visits are determined by the nature and severity of the problems.**

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.

Recommended intervals for routine tests and tests indicated as medically necessary for individual patients during pregnancy:			
Time (in weeks)	Assessments		
Initial visit, as early as possible	<ul style="list-style-type: none"> + History and risk assessment; obtain obstetric database that contains information regarding the patient's: <ul style="list-style-type: none"> * 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 	<ul style="list-style-type: none"> + 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 	
Subsequent prenatal visits	<ul style="list-style-type: none"> + Blood pressure management + Urinalysis for glucose/albumin + Weight measurement and cumulative weight gain + Fetal movement 	<ul style="list-style-type: none"> + Evaluation of edema + Measurement of fundal height + Evaluation of fetal heart tones and rate 	
8–18	<ul style="list-style-type: none"> + Amniocentesis, if indicated + Offer genetic counseling to patients above age 35 or carrying twins above age 33 or with abnormal aneuploidy screening 	<ul style="list-style-type: none"> + Chronic villus sampling, if indicated + Offer nuchal translucency screening (between 10–13 wks) 	
16–18	<ul style="list-style-type: none"> + Maternal serum alpha-fetoprotein after 1st trimester nuchal translucency 	<ul style="list-style-type: none"> + Offer quad screening (if 1st trimester screening was not performed) 	
18–22	<ul style="list-style-type: none"> + Anatomy screening 		
24–28	<ul style="list-style-type: none"> + Diabetes screening 	<ul style="list-style-type: none"> + Repeat hemoglobin or hematocrit measurement 	
28	<ul style="list-style-type: none"> + Prophylactic administration of Rho(D) immune globulin for Rh Neg patients 	<ul style="list-style-type: none"> + Fetal movement counting instruction 	
32–36	<ul style="list-style-type: none"> + Testing for sexually transmitted disease for patients with STD in pregnancy or significant history 		
35-37	<ul style="list-style-type: none"> + Group B strep screening 		
Patient education and information (ongoing)	<ul style="list-style-type: none"> + 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: <ul style="list-style-type: none"> * 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 	<ul style="list-style-type: none"> * 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	<ul style="list-style-type: none"> + Weight + Blood pressure + Breasts 	<ul style="list-style-type: none"> + Abdomen + Pelvic examination 	<ul style="list-style-type: none"> + Patient concerns + Family spacing + Signs of depression + Pap smear, if indicated

Source: American College of Obstetricians and Gynecologists

Adopted: 9/98 Approved: 4/99, 4/01, 7/03, 3/05, 3/07, 3/09, 10/11, 5/12, 5/13

CHART, PERIODIC HEALTH GUIDELINES FOR ADULTS



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.

Sources: Report of the U.S. Preventive Services Task Force, American Academy of Family Practice, American College of Obstetrics and Gynecologists, U.S. Department of Health and Human Services Public Health Service, Center for Disease Control and Prevention, American Cancer Society, and National Cancer Institute.

Adult Preventive Health Guidelines	Age 21-29	Age 30-39	Age 40-49	Age 50-59
Physical examination	Every 2-3 years Consider age, sex and risk factors.	Every 2-3 years Consider age, sex and risk factors.	Every 2-3 years Consider age, sex and risk factors.	Every 1-3 years Consider age, sex and risk factors.
Blood pressure	At least every 1-2 years	At least every 1-2 years	At least every 1-2 years	At least every 1-2 years
Body Mass Index (BMI)	Every year or as suggested by your doctor.	Every year or as suggested by your doctor.	Every year or as suggested by your doctor.	Every year or as suggested by your doctor.
Cholesterol	Every 4-5 years Patients with positive risk factors should be monitored more frequently.	Every 4-5 years Patients with positive risk factors should be monitored more frequently.	Every 4-5 years Patients with positive risk factors should be monitored more frequently.	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.	Every 3-5 years For cervical cytology screening or as suggested by your doctor.	Every 3-5 years For cervical cytology screening or as suggested by your doctor.	Every 3-5 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.	Every year or 5 years with co-testing.	Every year or 5 years with co-testing.	Every year or 5 years with co-testing.
Chlamydial infection screening	All sexually active non-pregnant young women age 24 and younger.	All older non-pregnant women who are at increased risk.		
Mammogram		Baseline at age 35-40 or as suggested by your doctor. Every year for high-risk women beginning at the age of 35.	Every 1-2 years or as suggested by your doctor.	Every year
Clinical breast exam	Every year	Every year	Every year	Every year
Self breast exam	Monthly	Monthly	Monthly	Monthly
Physician testicular exam	Every year	Every year	Every year	Every year
Prostate-specific antigen (PSA)			Every year	Every year
Self testicular exam	Monthly	Monthly	Monthly	Monthly
Skin exam	Every 3 years	Every 3 years	Every year	Every year
Tuberculin skin test	All high risk individuals	All high-risk individuals	All high-risk individuals	All high-risk individuals
Routine lab (UA, CBC, blood chemistry, STD screening)	Yearly as appropriate	Yearly as appropriate	Yearly as appropriate	Yearly as appropriate
Fecal occult blood			Yearly for patients with a family history of colorectal cancer.	Yearly
Colonoscopy			Every 5-10 years depending on family history and findings.	Initial screening at age 50, every 5-10 years depending on family history and findings.
Preventive Counseling				
<i>Tobacco cessation</i>	Hazards of tobacco use. Seek counseling to stop smoking and/or chewing tobacco.			
<i>Alcohol/drug treatment</i>	Hazards of alcohol and/or drug use. Avoid excessive alcohol use, and do not drive while under the influence of alcohol.			
<i>Diet and exercise</i>	Limit fat and cholesterol, maintain caloric balance and emphasize grains, fruits, vegetables and adequate calcium intake for women.			
<i>Injury prevention</i>	Lap and shoulder belts, smoke detectors, safe storage and removal of firearms and back injury prevention.			
<i>Skin cancer</i>	Avoid excess sun exposure and use a sunscreen when in the sun.			
<i>Dental health</i>	Regular visits to the dentist, floss and brush.			
<i>Folic acid</i>	All women who are planning or capable of pregnancy should take a daily multivitamin containing the recommended amount of folic acid.			
<i>Self-examination</i>	Breast, skin and testes.			
<i>Depression</i>	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			

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

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.

Child Preventive Health Guidelines	Birth	3 to 5 days	1 month	2 months	4 months	6 months	9 months	12 months	15 months	18 months	24 months	30 months	3 years	4 years	5 years	6 years	7 to 21 years		
History	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	Every year	
Nutrition screening	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	Every year	
Measurements																			
<i>Height or length and weight</i>	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	Every year	
<i>Head circumference</i>	★	★	★	★	★	★	★	★	★	★	★								
<i>Body mass index (BMI)</i>											★	★	★	★	★	★	★	Every year	
<i>Blood pressure</i>													★	★	★	★	★	Every year	
Sensory screening																			
<i>Vision exam</i>	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	Every year
<i>Hearing exam</i>	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	Every year
Developmental & behavioral assessment						★		★			★	★	★	★	★			Every year	
Physical exam	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	Every year
Dental assessment	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	Every year
Dental referral								★											
Immunization assessment	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	Every year
Procedures—general																			
<i>Hematocrit or hemoglobin</i>								★											At age 13
<i>Urinalysis</i>																★			At age 16
<i>Lead screening</i>								★			★								
Procedures—patients at risk																			
<i>Pap smear</i>	Every three years, starting at age 21.																		
<i>Pelvic exam</i>	Each year for all sexually active young women, or starting at age 21.																		
<i>Chlamydial infection screening</i>	Each year for all sexually active, non-pregnant young women from 16 to 24 years of age.																		
<i>Sickle cell screening</i>	Indicated by family or medical history or in the presence of anemia.																		
<i>Tuberculin testing</i>	Upon recognition of high-risk factors.																		
<i>Parasite testing</i>	When indicated by medical history, physical exam or a positive result of previous test.																		
Preventive counseling and anticipatory guidance																			
<i>Nutrition—2 years and younger</i>	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.																		
<i>Nutrition—2 years and older</i>	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.																		
<i>Injury and violence prevention</i>	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.																		
<i>Dental health</i>	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.																		
<i>Skin cancer</i>	Avoid excess sun exposure, especially those at high risk (fair hair, light skin, easy to burn, freckles). Use sunscreen when in the sun.																		
<i>Parental concerns</i>	Encourage parents to discuss any concerns regarding their child's health, safety and behavior.																		
Immunization schedules																			
<i>Childhood and adolescent catch-up for children 4 mo. to 18 yrs.</i>	www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-schedule.pdf																		
	www.cdc.gov/vaccines/schedules/downloads/child/catchup-schedule-pr.pdf																		

Source: Report of the US Preventive Services Task Force, American Academy of Family Practice, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, US Department of Health and Human Services, Centers for Disease Control and Prevention.

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

FORM, 17-P AUTHORIZATION

MCO Universal 17P/Makena Authorization Form

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

Absolute Total Care
P: 866-433-6041
F: 855-865-9469

First Choice by Select Health
P: 888-559-1010
F: 866-533-5493

Healthy Blue by BlueChoice of SC
P: 866-902-1689
F: 800-823-5520

Molina
P: 855-237-6178
F: 855-571-3011

Humana of SC
P: 800-555-2546
F: 877-486-2621

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 PPRM 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: _____

Provider Information

Ordering Provider Name _____
(Please Print)

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: _____

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, ABORTION STATEMENT



Abortion Statement

This certification meets FFP requirements and must include all of the aforementioned criteria.

Healthy Connections

MEMBER INFORMATION

Member name _____ First Choice ID # _____ SSN _____ Date of birth _____
Member address _____ City, State ZIP _____ Phone _____

TREATING PROVIDER INFORMATION

Name (include credentials) _____ NPI # _____ Phone _____
Address _____ City, State ZIP _____ Fax _____
Contact person name _____ Contact email _____ Contact phone _____

PHYSICIAN CERTIFICATION STATEMENT

I, _____, certify that it was necessary to terminate the pregnancy
of _____ for the following reason:

- a. Physical disorder, injury, or illness (including a life-endangering condition caused or arising from pregnancy) placed the patient in danger of death unless abortion was performed. Name of condition: _____
- b. The patient has certified to me the pregnancy was a result of rape or incest and the police report is attached.
- c. The patient has certified to me the pregnancy was a result of rape or incest and the patient is unable for physiological or psychological reasons to comply with the reporting requirements.

Provider signature _____ Date _____



PATIENT CERTIFICATION STATEMENT

I, _____, certify that my pregnancy was the result of an act of rape or incest.

Member signature _____ Date _____

FORM, BEHAVIORAL HEALTH CRISIS INTERVENTION (PAGE 2)

Crisis Intervention Notification Request Form

Service information (continued)

Outcome of the session:

- Member stabilized and returned home with supports
- Member taken to emergency room (ER) for possible inpatient admission
- Other:

Patient status at end of services:

Planned follow-up of crisis intervention:

Member acknowledgement

"I certify that I am actively involved in receiving Crisis Intervention Services. I understand that payment and satisfaction of claims will be from public funds (federal, state, and local) and that false claims, statements, or documents, or concealment of material facts, may be prosecuted under applicable laws."

Member signature

Date

Member and/or legal guardian declined/
unable to sign the encounter form

Provider signature _____ Date _____

FORM, BEHAVIORAL HEALTH OUTPATIENT TREATMENT



Healthy Connections

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 (90882), 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

FORM, CERTIFICATION OF NEED (CON) FOR CHILDREN UNDER 21



South Carolina Department of Health and Human Services

Certification of Need



Client's name:
Date of birth:
Social Security number:
NPI or Medicaid provider ID:

A review team has evaluated all of the information submitted by the physical and other professionals to justify the client's admission to _____ and certifies that:

- Documentation of comprehensive diagnostic assessment conducted within one week by the LPHA has been reviewed and includes information pertaining, but not limited to, prior treatment history, diagnostic history, mental status examination, current symptoms, risk assessment; and
- Ambulatory services available in the community do not meet the current treatment needs of the client; and
- Prior treatment addressing presenting concern/problem has not been successful; and
- Proper treatment of the client's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
- The inpatient services can reasonable be expected to improve the client's condition or prevent further regression so that the inpatient services will no longer be needed.

OR

- According to current criteria, the client does not meet the requirements for Medicaid-sponsored inpatient psychiatric care.

This certification is not an approval for Medicaid to pay. Medicaid eligibility or continued eligibility must be established by the appropriate SCDHHS Eligibility Office.

Team physician's print name:	
Team physician's signature:	Date:
Physician's NPI:	
Effective date:	Check one: <input type="checkbox"/> Interdisciplinary team <input type="checkbox"/> Independent team

Other team members' signatures, titles, and date signed: (A minimum of one signature must be present.)

Date	Print name	Signature

SHSC_19555832

FORM, CONSENT FOR STERILIZATION

Form Approved: OMB No. 0937-0166
Expiration date: 7/31/2025

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 _____ . When I first asked _____
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 these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____ . The discomforts, risks

Specify Type of Operation and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 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 withholding 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 _____ . My
Specify Type of Operation

consent expires 180 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 if Federal laws were observed.

I have received a copy of this form.

Signature _____
Date

You are requested to supply the following information, but it is not required: (*Ethnicity and Race Designation*) (*please check*)

- | | |
|---|--|
| <i>Ethnicity:</i> | <i>Race (mark one or more):</i> |
| <input type="checkbox"/> Hispanic or Latino | <input type="checkbox"/> American Indian or Alaska Native |
| <input type="checkbox"/> Not Hispanic or Latino | <input type="checkbox"/> Asian |
| | <input type="checkbox"/> Black or African American |
| | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander |
| | <input type="checkbox"/> White |

■ 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 him/her 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

HHS-687 (07/2025)

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ signed the
Name of Individual
consent form, I explained to him/her the nature of sterilization operation _____, the fact that it is

Specify Type of Operation intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled 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 any 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 of Person Obtaining Consent _____
Date

Facility

Address

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon

_____ on _____
Name of Individual _____
Date of Sterilization

I explained to him/her the nature of the sterilization operation

_____, the fact that it is

Specify Type of Operation intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled 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 appeared to understand the nature and consequences of the procedure.

(**Instructions for use of alternative final paragraph:** Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- Premature delivery
Individual's expected date of delivery: _____
- Emergency abdominal surgery (*describe circumstances*): _____

Physician's Signature _____
Date

FORM: HEARING AID BATTERY REQUEST



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

Patient name: Last	First	MI (required)
CRS #	Date of birth	SSN
Medicaid # (if eligible)	Authorization # if new aids ordered (required)	

Home address			
City	South Carolina	Zip	Phone

HEARING AID INFORMATION

How many hearing aids does the patient use? 1 2

	MANUFACTURER	MODEL NUMBER	SERIAL NUMBER	BATTERY SIZE
HEARING AID 1				
HEARING AID 2				

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 _____

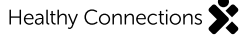
Last updated on 11/15/13

[Click to clear form.](#)

FORM, NEUROPSYCHOLOGICAL/PSYCHOLOGICAL TESTING REQUEST



Psychological/Neuropsychological Testing Request



SUBMIT TO: Behavioral Health Utilization Management Fax: **888-796-5521**.
For assistance please call **866-341-8765**.

Treatment requests must be documented in whole hours and assessments must justify the clinical need for all tests requested.

Testing will not be authorized under any of the following conditions:

1. The referral question can be answered through a comprehensive diagnostic interview and/or routine screening or assessment measure (e.g. self-report inventories, rating scales).
2. Testing is not directly relevant or necessary for proper diagnosis and/or development of a treatment plan for a behavioral health disorder or associated medical condition.
3. Testing is primarily for educational, vocational or legal purposes.
4. Testing is routine for entrance into a treatment program.
5. The tests requested are experimental or have no documented validity.
6. The time requested to administer the testing exceeds established time parameters.

Demographic information		
Patient name:	DOB:	Age:
Referral source:	Medicaid ID/SS #/Patient ID:	
Provider information		
Provider name:	Agency name:	
Professional credential: <input type="checkbox"/> MD <input type="checkbox"/> PhD <input type="checkbox"/> Other:	Address:	
Phone:	Fax:	Medicaid/NPI/Tax ID:
Date of diagnostic interview/intake:		
Please attach a summary of the diagnostic interview, including scores from screening tools used.		
Behavioral and medical diagnoses:		
Specific referral reason/question:		
State how the anticipated results of the testing will affect the patient's treatment plan:		
Was a substance abuse assessment completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Results (or attach the results to this request):	
Has previous psychological or neuropsychological testing been conducted? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please give details to include tests that have been conducted, when they were completed, and reason for testing:		

FORM, MEMBER CONSENT TO PROVIDER



Member Consent for Provider to File an Appeal

(Note: The member or their authorized representative must sign this document.)

Provider information		
Provider name:	NPI:	
Group name:	Phone:	
Address:		
City:	State:	ZIP code:
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 SM . 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:	Date of birth:
Address:	Phone:
Member signature:*	Date:**
* Must be signed by the member. **Consent cannot be dated before the date(s) of the service(s) in question.	

Consent from a designated representative		
<input type="checkbox"/> 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:	Relationship to member:	
Representative signature:	Date:	
Witness name:	Signature:	Date:

First Choice | P.O. Box 40849, Charleston, SC 29423 | www.selecthealthofsc.com

Appeals Department: 1-866-615-5186 | Fax: 1-866-369-6046

FORM, PHYSICIAN CERTIFICATION OF INCONTINENCE 168IS



Physician Certification of Incontinence

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

To _____ **From** _____
Physician name _____
Address _____
City, State Zip _____

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 time frame 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, PREGNANCY RISK ASSESSMENT INFORMATION



Healthy Connections

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**.



BRIGHTSTART

Provider Information

Provider name _____ Tax ID # _____
 Address _____
 Phone _____ Fax _____

Member Information

Member Name _____ Medicaid ID # _____
 Address _____ Email _____
 Date of birth _____ Language preferred _____ 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 Hx of DVT/PE
 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 Poor weight gain
 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) _____

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.

Maternity Authorization # _____
Covering dates of service _____ **to** _____

Select Health Bright Start | PO Box 40849 | Charleston, SC 29423 | Toll free: 1.888.559.1010 | Fax: 1.866.533.5493 | www.selecthealthofsc.com

Revised July 15, 2015

FORM, PRIOR AUTHORIZATION REQUEST FORM: MEDICATIONS



Prior Authorization Request Form: Medications

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

I. PROVIDER INFORMATION

Prescriber name	NPI #
Prescriber specialty	Phone
Prescriber address	
Office contact name	Fax
Pharmacy name	Pharmacy phone

II. MEMBER INFORMATION

Member name	Today's date
Member plan ID #	Date of birth
Drug allergies	
Plan name and fax for form submission First Choice by Select Health 1.866.610.2775	

III. DRUG INFORMATION (ONE DRUG PER REQUEST FORM)

Drug name	Drug strength	Dosage form	Dosage interval	Quantity per day
Diagnosis relevant to this request				ICD-9 code
Expected length of therapy				Number of refills

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.

DRUG NAME	STRENGTH	DIRECTIONS	DATES OF THERAPY	REASON FOR FAILURE OR DISCONTINUATION

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	Date
--	------

PLAN FAX NUMBERS

Absolute Total Care	1.866.399.0929	First Choice by Select Health	1.866.610.2775
Advicare	1.866.255.7569	Molina HealthCare of SC	1.855.571.3011
BlueChoice HealthPlan Medicaid	1.866.807.6241	WellCare of SC	1.866.354.8709
FFS Medicaid	1.888.603.7696		

FORM, PROVIDER REFUND CLAIM FORM (PAGE 1)



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: _____	TIN: _____
Provider Address: _____	
Office Contact: _____	Phone Number: _____

Member Information:				
Member Name	ID Number	Date of Service	Claim Number	Refund Amount
				\$
<i>Please note: if your refund contains more than one claim, please use the attached form (page 2) or attach your own file.</i>				

Type of Refund:	
<input type="checkbox"/> Medical Overpayment	<input type="checkbox"/> Capitation
Other: _____	

Reason for Refund:	
<input type="checkbox"/> Other Insurance (Attach Primary EOB)	<input type="checkbox"/> Subrogation
<input type="checkbox"/> Duplicate payment	<input type="checkbox"/> Claim was processed under the incorrect provider
<input type="checkbox"/> Incorrect provider cashed check	<input type="checkbox"/> Not our check
<input type="checkbox"/> Billing error	<input type="checkbox"/> Contract change/Fee schedule update
<input type="checkbox"/> Eligibility	<input type="checkbox"/> Recovery project (Please include project letter)
<input type="checkbox"/> Bonus payment	<input type="checkbox"/> Return Supplies (Durable Medical Equipment)
Other (Please provide details "overpayment" is not a valid reason) _____	

To save form changes

FORM, PRIOR AUTHORIZATION, UNIVERSAL



Prior Authorization Request Form

Please type this document to ensure accuracy and to expedite processing.
 All fields must be completed for the request to be processed.
 Please make a selection where applicable throughout the document.

DATE			
TYPE OF REQUEST	<input type="checkbox"/> URGENT	<input type="checkbox"/> STANDARD	<input type="checkbox"/> RETROSPECTIVE
TREATMENT SETTING	<input type="checkbox"/> INPATIENT	<input type="checkbox"/> OUTPATIENT	
REQUEST TYPE	<input type="checkbox"/> EXTENSION	<input type="checkbox"/> INITIAL	<input type="checkbox"/> CANCEL
	<input type="checkbox"/> ADDITIONAL CLINICAL	<input type="checkbox"/> DISCHARGE PLANNING	<input type="checkbox"/> OTHER
PREVIOUS AUTHORIZATION NUMBER			
CONTACT NAME			
CONTACT PHONE		CONTACT FAX	

MEMBER INFORMATION

LAST NAME		
FIRST NAME		
MEMBER ID (MEDICAID ID OR HEALTH PLAN ID)		
MEMBER PHONE NUMBER		DATE OF BIRTH
MEMBER STREET ADDRESS		
CITY	STATE	ZIP

FORM, SBIRT SCREENING TOOL



SBIRT INTEGRATED SCREENING TOOL



*** Fax the COMPLETED form to the patient's plan and referral site and keep a copy in patient file**

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Absolute Total Care
Fax: 877-285-3226 | <input type="checkbox"/> Blue by BlueChoice of SC
3-580-2810 | <input type="checkbox"/> Molina Healthcare of SC
Fax: 866-423-3889 | <input type="checkbox"/> BlueCross BlueShield of South Carolina & BlueChoice HealthPlan
Fax: 803-870-9884 |
| <input type="checkbox"/> First Choice by Select Health
Fax: 866-533-5493 | <input type="checkbox"/> Humana Healthy Horizons in SC
Fax: 877-533-3690 | <input type="checkbox"/> SCDHHS (Fee-For-Service)
Fax: 803-255-8247 | |

PATIENT INFORMATION						
Patient's last name:	First:	Middle:	Language:	Race:	Ethnicity:	Expected due date:
Phone no: ()	Street address:		Member ID 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 drunk 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?			YES	NO
Smoking Have you smoked any cigarettes in the past three months?			YES	NO
Please provide additional details for any "yes" responses:				
	Review risk	Review domestic violence resources	Review substance use, set healthy goals	Consider mental evaluation

ADVICE FOR BRIEF INTERVENTION			
	Y	N	N/A
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	
Non-Pregnant	Pregnant/Planning Pregnancy
7+ drinks/week 3+ drinks/day	Any Use is Risky Drinking

CONFIDENTIAL SBIRT REFERRAL INFORMATION					
Patient referred to: (Check all that apply)	<input type="checkbox"/> DMH	<input type="checkbox"/> DAODAS	<input type="checkbox"/> DHEC Quitline Fax: 800-483-3114	<input type="checkbox"/> Private provider (Name & NPI)	<input type="checkbox"/> Domestic violence 803-256-2900
Date of referral appointment (DD/MM/YY):	Date screened:	<input type="checkbox"/> Patient refused referral	<input type="checkbox"/> Referral not warranted:	<input type="checkbox"/> 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.

Physician's Signature: _____

**Adapted from Institute for Health & Recovery, (2015)*

FORM, UNIVERSAL NEWBORN PRIOR AUTHORIZATION

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.**

- | | | | | | |
|--|--|---|---|---|--|
| <input type="checkbox"/> Absolute Total Care
P: 1.866.433.6041
F: 1.866.918.4451
www.absolutetotalcare.com | <input type="checkbox"/> Advicare
P: 1.888.781.4371
F: 1.888.781.4316
www.advicarehealth.com | <input type="checkbox"/> BlueChoice HealthPlan Medicaid
P: 1.866.902.1689
F: 1.800.823.5520
www.bluechoicesmedicaid.com | <input type="checkbox"/> First Choice by Select Health
P: 1.888.559.1010
F: 1.866.368.4562
www.selecthealthofsc.com | <input type="checkbox"/> Molina HealthCare of SC
P: 1.855.237.6178
F: 1.855.571.3011
www.molinahealthcare.com | <input type="checkbox"/> WellCare of SC
P: 1.888.588.9842
F: 1.877.431.8859
www.wellcare.com |
|--|--|---|---|---|--|

Patient's name (first, middle, last)			DOB		
Street address, apt. number			City, State, Zip		
Home phone		Mobile phone		Medicaid number	
				MCO ID number	
Mom's name (first, middle, last)			Mom's Medicaid number		Mom's SSN

SECONDARY COVERAGE

Plan		ID number		Group number	
Policy holder		DOB		Relationship to patient	
				Employer	

<input type="checkbox"/> EPSDT and Immunization					
<input type="checkbox"/> 99381 (EPSDT new)		<input type="checkbox"/> 99391 (EPSDT established)		<input type="checkbox"/> 1 visit <input type="checkbox"/> 2 visits	
<input type="checkbox"/> 90471	DOS	Immunization administered			
<input type="checkbox"/> 90472	DOS	Immunization administered			
<input type="checkbox"/> 90473	DOS	Immunization administered			

<input type="checkbox"/> E/M Non-EPSDT					
<input type="checkbox"/> CPT	Dx	DOS	<input type="checkbox"/> CPT	Dx	DOS

<input type="checkbox"/> Labs CLIA Certificate Number:					
<input type="checkbox"/> CPT	DOS	<input type="checkbox"/> CPT	DOS	<input type="checkbox"/> CPT	DOS
<input type="checkbox"/> CPT	DOS	<input type="checkbox"/> CPT	DOS	<input type="checkbox"/> CPT	DOS

<input type="checkbox"/> Other					
<input type="checkbox"/> 17250	DOS	<input type="checkbox"/> 54160	DOS	<input type="checkbox"/> 96150	DOS
<input type="checkbox"/> 51701	DOS	<input type="checkbox"/> 94640	DOS	<input type="checkbox"/> 96152	DOS
<input type="checkbox"/> 54150	DOS	<input type="checkbox"/> 94760	DOS	<input type="checkbox"/> 97802	DOS
<input type="checkbox"/> CPT	DOS	<input type="checkbox"/> CPT	DOS	<input type="checkbox"/> CPT	DOS

Practice name			Practice NPI number		
Attending physician (last name, first name)			Physician NPI number		
Contact person		Phone		Fax	
Plan point of contact		Date plan called		Time of call	
				Plan reference/confirmation number	

For MCO use only.					
<input type="checkbox"/> Approved <input type="checkbox"/> Denied		Authorization number		Date of notification to pediatric office	
Reviewer name		Reviewer 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.	

Universal Newborn Authorization Form 1.2014

FORM, UNIVERSAL PRIOR AUTHORIZATION – BABYNET

MCO Universal Prior Authorization Form – BabyNet

A copy of the IFSP must be attached to the PA request. For questions, contact the plan at the associated phone number.

*Fax the COMPLETED form and the IFSP

- | | | | | |
|---|---|--|--|---|
| <input type="checkbox"/> Absolute Total Care P:
1.866.433.6041
F: 1.866.912.3606
www.absolutetotalcare.com | <input type="checkbox"/> First Choice by Select Health
P: 1.888.559.1010
F: 1.866.368.4562
www.selecthealthofsc.com | <input type="checkbox"/> Healthy Blue by BlueChoice of SC
P: 1.866.902.1689
F: 1.800.823.5520
www.healthybluesc.com | <input type="checkbox"/> HUMANA
P: 1.833.432.0001
F: 1.833-441-0950
www.humana.com | <input type="checkbox"/> Molina HealthCare of SC
P: 1.855.237.6178
F: 1.866.423.3889
www.molinahealthcare.com |
|---|---|--|--|---|

Patient's name (first, middle, last)			DOB		
Street address, apt. number			City, State, Zip		
Home phone		Mobile phone		Medicaid number	
MCO ID number		Start Date		Stop Date	
ICD-10 Diagnosis Code					

Secondary Coverage

Plan		ID number		Group number	
Policy holder		DOB		Relationship to patient	
Employer					

AUDIOLOGY EVALUATION

PROCEDURE CODE	UNITS REQUESTED	TIME SPAN			
		Daily	Weekly	Monthly	Annually

AUDIOLOGY SERVICES

PROCEDURE CODE	UNITS REQUESTED	TIME SPAN			
		Daily	Weekly	Monthly	Annually

AUTISM ASSESSMENT

PROCEDURE CODE	UNITS REQUESTED	TIME SPAN			
		Daily	Weekly	Monthly	Annually

AUTISM SERVICES

PROCEDURE CODE	UNITS REQUESTED	TIME SPAN			
		Daily	Weekly	Monthly	Annually

PROVIDER CLAIM DISPUTE FORM



Provider Claim Dispute Form

A **dispute** is defined as a request from a health care provider to change a decision made by Select Health of South Carolina related to claim payment or denial for services already provided. A provider dispute is not a pre-service appeal of a denied or reduced authorization for services or an administrative complaint.

Submitter/Contact information		
Name (Last, First)	Submission date	Phone

Provider information		
Provider name (Last, First)	NPI #	Tax ID #
Phone	<input type="checkbox"/> I am a participating provider <input type="checkbox"/> I am not a participating provider.	

Member information		
Member name (Last, First)	Date of birth	Member ID#

Claim information		
Claim number	Billed amount	Date(s) of service(s)
Claim number	Billed amount	Date(s) of service(s)
Claim number	Billed amount	Date(s) of service(s)
Claim number	Billed amount	Date(s) of service(s)

Attach additional sheets if necessary.

Payment Dispute Section	
To ensure timely and accurate processing of your request, please check the applicable reason below for your dispute.	
<input type="checkbox"/> Inaccurate payment	<input type="checkbox"/> Denied for no primary payer EOB (EOB attached)
<input type="checkbox"/> Post-service authorization denial	<input type="checkbox"/> Denied for no authorization (service does not require authorization)
<input type="checkbox"/> Denied as a duplicate	<input type="checkbox"/> Denied for no authorization (auth. # on file)
<input type="checkbox"/> Clinical edit limitation or denial	<input type="checkbox"/> Untimely filing (proof of timely filing attached)
<input type="checkbox"/> Other:	
Additional information:	

Please mail this completed form and any supporting documentation to:

Select Health of South Carolina
Provider Claims Disputes
P.O. Box 7310
London, KY 40742-7310

SHSC_20756453

SAMPLE FIRST CHOICE AUTISM SPECTRUM DISORDER (ASD) TREATMENT REQUEST FORM



Autism Spectrum Disorder (ASD) Treatment Request Form



Please print clearly — incomplete or illegible forms will delay processing. Please fax to: First Choice by Select Health of South Carolina's (Select Health) Behavioral Health Utilization Management (BHUM) department at **1-888-796-5521**. For assistance contact: **1-866-341-8765**.

Member information		
Patient name:	Legal guardian:	Member date of birth:
Medicaid/Health plan #:	Last authorization # (if applicable):	
Provider information (board-certified behavior analyst [BCBA]/licensed provider)		
Group/agency name:	<input type="checkbox"/> In network <input type="checkbox"/> Out of network <input type="checkbox"/> In credentialing process	
Provider name:	Provider credential: <input type="checkbox"/> MD <input type="checkbox"/> PhD <input type="checkbox"/> LIP <input type="checkbox"/> BCBA <input type="checkbox"/> BCaBA <input type="checkbox"/> RBT I <input type="checkbox"/> RBT II	
Provider name:	Provider credential: <input type="checkbox"/> MD <input type="checkbox"/> PhD <input type="checkbox"/> LIP <input type="checkbox"/> BCBA <input type="checkbox"/> BCaBA <input type="checkbox"/> RBT I <input type="checkbox"/> RBT II	
Provider name:	Provider credential: <input type="checkbox"/> MD <input type="checkbox"/> PhD <input type="checkbox"/> LIP <input type="checkbox"/> BCBA <input type="checkbox"/> BCaBA <input type="checkbox"/> RBT I <input type="checkbox"/> RBT II	
Physical address:	Phone number:	Fax number:
Medicaid/Provider/NPI #:	Contact name:	

Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis		
Primary DX:	Secondary DX:	Medical DX:
Is the member diagnosed with an ASD?		

Assessment and clinical documentation requirements:

All required clinical information is the responsibility of the referring and/or requesting provider to obtain and provide to Select Health's BHUM department for a medical necessity determination. A failure to submit all clinical documentation may delay processing this request.

1. Diagnostic evaluation/report (initial requests).
2. Full behavior support plan/treatment plan (including symptoms/behaviors requiring treatment, specific treatment interventions, and that these were indicated by the assessment tool).
3. Applied behavior analysis (ABA) therapy progress summary, including cumulative graphs of progress/standard celeration charts.
4. Sample schedule of treatment.
5. Documentation of caregiver goals, involvement in treatment, and progress in skill development.

Additional information: _____

SAMPLE FIRST CHOICE AUTISM SPECTRUM DISORDER (ASD) TREATMENT REQUEST FORM

Autism Spectrum Disorder (ASD) Treatment Request Form

DOCUMENTATION OF CARE COORDINATION IS A SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES AUTISM SPECTRUM DISORDER (SCDHHS ASD) SERVICE MANUAL REQUIREMENT. Providers **MUST** complete this section of this form or may attach a separate document providing this information. List of any other services the member is receiving, including service names/therapy; number of hours per week of each treatment and the targets of those treatments; and evidence of coordination with school, preschool, or early intervention program and other therapy providers (coordination that is more than a phone call or notification of enrollment).

School/preschool/early intervention program **(Required)**:

Type of service	Number of hours/week	Behaviors/deficits targeted

Other therapies provided **(Required)**:

Type of service	Number of hours/week	Behaviors/deficits targeted

Summary of contact with other providers **(Required)**:

Treatment request:

Treatment start date:				
ASD treatment	Units	CPT code	Time frame (weekly/monthly)	Limitation reminders
Behavior identification assessment (ABA)		97151		32 units per assessment BCBA/BCaBA required
Group adaptive behavior treatment by protocol, multiple patients by RBT		97154		24 units per day RBT required
Adaptive behavior treatment with protocol modification		97155		64 units per month BCBA/BCaBA required
Adaptive behavior treatment by protocol		97153		160 units units per week RBT required
Family adaptive behavior treatment guidance		97156		96 units per year BCBA/BCaBA required
Group adaptive behavior treatment by protocol, multiple patients by BCBA		97158		24 units per day BCBA/BCaBA required
Therapeutic behavioral service		H2019		Four units per week PhD, MD, LISW, LMFT, LPC, LPES required

Provider signature with credentials and date:

My signature confirms that any paraprofessional under my supervision has the appropriate education, training, and certifications as applicable.

SAMPLE FIRST CHOICE PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF) REQUEST FORM



Psychiatric Residential Treatment Facility (PRTF) Authorization Request Form



The purpose of this form is to request authorization for admission to a psychiatric residential treatment facility (PRTF). This form should be sent to the Behavioral Health Utilization Management (BHUM) department only. Fax to **1-888-796-5521**. For any questions, please contact BHUM at **1-866-341-8765**.

Steps to request a PRTF authorization:

All PRTF authorizations are based on medical necessity of services. All PRTF authorizations require supporting clinical documentation to be submitted with the PRTF Authorization Request Form. All required clinical information is the responsibility of the referring or requesting provider to obtain and provide to Select Health of South Carolina (Select Health) BHUM for a medical necessity determination. Failure to submit all clinical documentation will delay processing this request.

1. The request must include the following documentation to be reviewed for medical necessity:
 - a. Most recent psychosocial and/or diagnostic assessment by a licensed practitioner of the healing arts (LPHA) within the previous week.
 - b. Court order for placement (if applicable).
 - c. Most recent IEP/504 plan (if applicable).
 - d. Psychological and/or neuropsychological testing (if applicable).
 - e. Certificate of Need per 42 CFR 441.152.
2. Upon receiving all clinical information, Select Health BHUM will schedule a telephonic review to determine medical necessity. The telephonic review is required to include the member's LPHA who has completed a face-to-face assessment with the member.

Referral information		
Date of referral:	Referral contact:	
Referring facility/agency/provider:	Phone:	Fax:
Demographic information		
Child's name:	Date of birth:	Medicaid ID:
Ethnicity:	Language:	Diagnosis:
Home address:	Phone number:	
City:	State:	ZIP code:
Custody (parents, DSS, other family, juvenile court, other agency):		
Name of custodian:	Relationship:	Phone number:
LPHA recommending a PRTF level of care		
Provider name:	Phone:	
Contact person:	Phone:	

SAMPLE FIRST CHOICE PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF) REQUEST FORM

Psychiatric Residential Treatment Facility (PRTF) Authorization Request Form

NPI/Tax ID number:	Fax:
Date the LPHA completed a face-to-face assessment/session with the member (required to be within seven calendar days of the Certificate of Need)?	
What is the member's current status or placement?	

Reason for referral

Current MH/SUD symptoms (frequency, dates, consequence that lead to a referral for PRTF):		
What are the contributing factors to the main clinical need/problem?		
What are the goals for the PRTF admission and recommended interventions to the contributing factors indicated above?		
Current living situation:		
Family's role in treatment:		
DSS, DJJ, legal, or other involvement? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate type:	If so, contact name:	Phone number:
Child's current grade level:	Current school:	Special education classification? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, type:

All medication	Dose	Schedule	Prescribing provider	Target symptoms

A medical necessity determination will be made after a review of all required clinical information and a telephonic review. A medical necessity determination will be made within seven calendar days of Select Health BHUM receiving all required clinical documentation. After it is determined that the PRTF admission is medically necessary, finding a PRTF facility or placement will be the responsibility of the referral source.

SAMPLE PROVIDER/MEMBER ROSTER

20000856
Montgomery Family Services
 1856 North Creek Road
 Middlebrook, SC
 853-945-3267

FIRST CHOICE
SELECT HEALTH OF SOUTH CAROLINA,
PROVIDER ROSTER FOR:


Member #	Name	Address	City, State, Zip	Phone	Sex	DOB	Age	Member PCP Eff Date	Date
111111111	DOE, JANE	2435 WHITEHALL RD, APT 5	CHARLESTON, SC 29407	756-8510	F	1/10/1993	10Y	11/1/2001	11/1/2001
222222222	DOE, JOHN	3456 LANTERN RD	HOLLYWOOD, SC 29449	987-7151	M	2/28/1986	17Y	1/1/2002	1/1/2002
333333333	DOE, JANE	3456 LANTERN RD	HOLLYWOOD, SC 29449	987-7151	F	5/23/1989	13Y	1/1/2002	1/1/2002
444444444	DOE, JOHN	21 OAK BROOK RD	HOLLYWOOD, SC 29449	985-7903	M	09/23/1992	10Y	1/1/2002	1/1/2002
555555555	DOE, JANE	P O BOX 76	WADMY, SC 29487	595-3476	F	3/8/1993	10Y	11/1/1998	8/22/2001
666666666	DOE, JOHN	2390 THRUSH LANE	HOLLYWOOD, SC 29449	876-0934	M	3/31/1987	15Y	1/1/2002	1/1/2002
777777777	DOE, JANE	32 CROSS KEYS ROAD	CHARLESTON, SC 29407	756-9032	F	10/31/1986	16Y	12/1/2001	12/1/2001
888888888	DOE, JOHN	29 BLACK ROCK RD	CHARLESTON, SC 29406	786-4562	M	6/03/1988	14Y	11/1/1998	7/25/2001
999999999	DOE, JANE	4730 RAINEY BLVD	N CHARLESTON, SC 29418	347-0920	F	01/20/2002	1Y	6/1/2002	5/1/2002
101010101	DOE, JOHN	4730 RAINEY BLVD	N CHARLESTON, SC 29418	347-0920	F	11/14/1988	14Y	6/1/2002	5/1/2002
121212121	DOE, JANE	23 ORCHARD ROAD	CHARLESTON, SC 29407	735-2013	F	10/28/1996	6Y	8/1/2002	11/20/2002
131313131	DOE, JOHN	33 LEMON STREET	JOHNS ISLAND, SC 29455	578-3450	F	8/13/1989	13Y	5/1/2002	4/1/2002
141414141	DOE, JANE	33 LEMON STREET	JOHNS ISLAND, SC 29455	578-3450	M	12/18/1987	15Y	5/1/2002	4/1/2002
151515151	DOE, JOHN	44 CHAINEY AVE.	JOHNS ISLAND, SC 29455	578-5698	F	11/8/1991	11Y	5/1/2002	4/1/2002
161616161	DOE, JANE	22 RIVER ROAD	JOHNS ISLAND, SC 29455	578-9874	F	9/24/1968	34Y	5/1/2002	4/1/2002
171717171	DOE, JOHN	22 RIVER ROAD	JOHNS ISLAND, SC 29455	578-9874	F	10/22/1992	10Y	5/1/2002	4/1/2002
181818181	DOE, JANE	892 JOHNS HIGHWAY	JOHNS ISLAND, SC 29455	598-2345	F	10/22/1995	7Y	6/1/2000	3/5/2002

Total Membership for Provider/Group Service Address

17
Tax ID Number: 853670143

SAMPLE SELECT HEALTH PHYSICIAN'S REQUEST FOR TRANSFER OF MEMBER



Healthy Connections 

Physician's Request for Transfer of Member

Please fax this form to Select Health of South Carolina at **1-800-575-0419**

If you have questions, please call Member Services at **1-888-276-2020** or **1-843-764-1877** (Charleston)

Provider information

Provider name:		Tax ID number:
Address:		
Phone:	Fax:	Date of request:

Member information

Member name:	Member ID number:
Address:	
Date of birth:	Phone:

Reason for transfer request

Reason for termination of this member from your practice:

If more room is needed, please continue on the other side.

Transfer member to new primary care provider (PCP):

New PCP information

Provider name:		Tax ID number:
Address:		
Phone:	Fax:	Date of request:

Member's signature: _____

Date: _____

Physician's signature: _____

Date: _____

The PCP change will take effect the first day of the month following completion of this form. The member will be sent an updated ID card reflecting the new PCP's information. A copy of the member's medical records should be forwarded to the new provider.

SH-17540

SAMPLE SELECT HEALTH REMITTANCE ADVICE



SAMPLE ONLY

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

Forwarding Service Requested
 JOHN DOE, MD
 123 MAIN STREET
 ANYWHERE, SC 55555

Payee ID: 1234567
Tax ID: 123-45-6789
NPI #: 1011011011
Check #: 50000676
Check Ref: 20011002101019
Payment: 0.00
Date: 07/01/08

Remittance Advice

Provider ID	123456		Member ID	987654321		Patient ID	27930108089		*COB*		
Provider Name	Doe, John		Member Name	Smith, Jane		Claim ID	01227B042500				
Date of Service	Proc/Rev/DRG Code	Mod	Description	Qty	Charged Amount	Allowed Amount	OIC	Coins	COB	Amount Paid	Adj/Den
12/1/03 - 12/1/03	99213		Office or other out-patient visit	001	65.00	32.00	0.00	0.00	0.00	0.00	R36
Interest Paid										0.00	
Prior Payment										0.00	
Claim Total					65.00	32.00	0.00	0.00	0.00	0.00	0.00

Statement Total

Please note that these sections are located at the end of the remit, after the Statement Totals.

Charged Amount	Allowed Amount	OIC	COB	Coins	Interest Payment	Deductible	Amount Paid	Claim Count
65.00	32.00	0.00	0.00	0.00	0.00	0.00	0.00	001
Claims Reversed							0.00	000
Net General Claims Total							0.00	001
Less Other Transactions							0.00	
Total Paid to Payee							0.00	

Coordination of Benefits

Member Name	Claim Number	Other Insurance	Address	Group No.	Policy No.
-------------	--------------	-----------------	---------	-----------	------------

Payment Reduction Summary

Patient ID	Explanation	Date of Service (#13)	Check Date (#14)	Check Number (#15)	Claim ID
Date of Original Reduction	Original Amount of Reduction	Provider Receipts	Applied to Current Claims	Claim Reduction Amount Recovered to Date	Provider Receipts to Date

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.

SAMPLE WIC REFERRAL FORM

Sample WIC Referral 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

SCDHHS SUBCONTRACTOR REQUIREMENTS

ARTICLE 1 SCDHHS MEDICAID REQUIREMENTS

1.1 SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES REQUIRED SUBCONTRACT BOILERPLATE

The following language is required by the South Carolina Department of Health and Human Services (SCDHHS, *heretofore referred to as the Department*) as a condition of participation in the Medicaid program as a subcontractor of a Managed Care Organization. To the extent that any provision of this subcontract conflicts with any provision or requirement set forth within this Section, the Department required language shall be controlling. Any other provision in this agreement notwithstanding, in the event that the Department shall modify, amend, or otherwise change the required subcontract language, as set forth in the MCO Contract, Subcontractor understands and agrees that the Department required subcontract boilerplate shall be amended to conform to the Department's requirements and standards, without the need for a signed, written amendment.

A. **DEFINITIONS**

1. **Action** – As related to Grievance, either (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 the Department; (5) the failure of the CONTRACTOR to act within the timeframes provided in §9.7.1 of the MCO Contract; or (6) for a resident of a rural area with only one CONTRACTOR, the denial of a Medicaid Managed Care Member's request to exercise his or her right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the CONTRACTOR's network.
2. **Additional Services** – A service(s) provided by the CONTRACTOR that is a non-covered service(s) by the South Carolina State Plan for Medical Assistance and is offered to Medicaid Managed Care Members in accordance with the standards and other requirements set forth in the Department's Medicaid Managed Care Contract that are outlined in another section of this Contract.
3. **Administrative Services Contracts or Administrative Services Subcontracts** – Are Subcontracts or agreement that include but are not limited to: 1) any function related to the management of the Medicaid Managed Care Contract with the Department; 2) Claims processing including pharmacy claims; 3) credentialing including those for only primary source verification; 4) all Management Service Agreements; and 5) all Service Level Agreements (SLAs) with any Division of Subsidiary of a corporate parent owner.
4. **Clean Claim** – A claim that can be processed without obtaining additional information from the Provider of the service or from a third party.
5. **Continuity of Care** – The continuous treatment for a condition (such as pregnancy) or duration of illness from the time of first contact with a healthcare Provider through the point of release or long-term maintenance.
6. **Emergency Medical Condition** – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: placing the health of the

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individual (or, with respect to a pregnant woman, the health of the woman and/or her unborn child) in serious jeopardy; serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

7. **Emergency Services** – Covered inpatient and outpatient services that are as follows: (1) furnished by a provider that is qualified to furnish these services under this title; and (2) needed to evaluate or stabilize an Emergency Medical Condition.
8. **Federal Qualified Health Center (FOHC)** – A South Carolina licensed health center certified by the Centers for Medicare and Medicaid Services that receives Public Health Services grants. An FQHC provides a wide range of primary care and enhanced services in a medically under-served area.
9. **Grievance** – An expression of dissatisfaction about any matter other than an Action. The term is also used to refer to the overall system that includes Grievances and appeals handled at the CONTRACTOR level. (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 Medicaid Managed Care Member's rights.)
10. **Managed Care Organization (MCO)** – An entity that has, or is seeking to qualify for, a comprehensive risk contract that is (1) a Federally qualified HMO that meets the advance directive requirements of subpart I of 42 CFR Part 489; or (2) any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions: (a) makes the services it provides to its Medicaid Managed Care Members as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid recipients within the area serviced by the entity; and (b) meets the solvency standards of 42 CFR §438.116. This includes any of the entity's employees, affiliated Providers, agents, or CONTRACTORS.
11. **Management Service Agreements** – A type of Subcontract with an entity in which the owner of the CONTRACTOR delegates some or all of the comprehensive management and administrative services necessary for the operation of the CONTRACTOR.
12. **Medically Necessary Service** – Those medical services which: (a) are essential to prevent, diagnose, prevent the worsening of, alleviate, correct or cure medical conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in illness or infirmity of a Medicaid Managed Care Member; (b) are provided at an appropriate facility and at the appropriate level of care for the treatment of the Medicaid Managed Care Member's medical condition; and, (c) are provided in accordance with generally accepted standards of medical practice.
13. **Medicaid Managed Care Member** – An eligible person(s) who is enrolled with a Department approved Medicaid Managed Care Organization (MCO, a.k.a. CONTRACTOR). For purpose of this Subcontract, Medicaid Managed Care Member shall include the patient, parent(s), guardian, spouse or any other person legally responsible for the Medicaid Managed Care Member being served.
14. **Minimum Subcontract Provision (MSP)** – Minimum Service Provisions are detailed in subsection 1.2 below.

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15. **Primary Care Provider (PCP)** – The Provider serving as the entry point into the health care system, for the Medicaid Managed Care Member, responsible for providing primary care, coordinating and monitoring referrals to specialist care, authorizing hospital services, and maintaining Continuity of Care.
16. **Rural Health Clinic (RHC)** – A South Carolina licensed Rural Health Clinic is certified by the Centers for Medicare and Medicaid Services and receiving Public Health Services grants. An RHC is eligible for state defined cost based reimbursement from the Medicaid fee-for-service program. An RHC provides a wide range of primary care and enhanced services in a medically underserved area.
17. **Provider** – In accordance with 42 CFR § 400.203 Definitions specific to Medicaid, any individual or entity furnishing Medicaid services under a Provider agreement with the CONTRACTOR. or the Medicaid agency. These may include the following
 - Any individual, group, Physicians (such as but not limited includes Primary Care Providers and Specialists) or entity (such as but not limited to Hospitals, Ancillary Providers, Outpatient Center (free standing or owned) Clinics and Laboratories) furnishing Medicaid services under an agreement with the Medicaid agency; or
 - For the Medicaid Managed Care Program, any individual, group, Physicians (including, but not limited to, Primary Care Providers and Specialists) or entity (such as but not limited to Hospitals, Ancillary Providers, Clinics, Outpatient Centers (free standing or owned) and Laboratories) that is engaged in the delivery of health care services and is legally authorized to do so by the state in which it delivers services.
18. **South Carolina Medicaid Network Provider** – A Provider of healthcare services or products which includes but is not limited to an institution, facility, agency, person, corporation, partnership, practitioner, specialty physician, group or association approved and enrolled by the South Carolina Department of Health and Human Services, licensed and/or credentialed which accepts as payment in full for providing benefits to Medicaid Managed Care Members amounts pursuant to the CONTRACTOR’s reimbursement provisions, business requirements and schedules.
19. **Service Level Agreement (SLA)** – A type of Subcontract with a corporate owner or any of its Divisions or Subsidiaries that requires specific levels of service for administrative functions or services for the CONTRACTOR specifically related to fulfilling the CONTRACTOR’s obligations to the Department under the terms of this Contract.
20. **Subcontract**– A written agreement between the CONTRACTOR and a third party to perform a part of the CONTRACTOR's obligations as specified under the terms of this Contract.
21. **Subcontractor** – Any organization or person who provides any functions or service for

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the CONTRACTOR specifically related to securing or fulfilling the CONTRACTOR's obligations to Department under the terms of this Contract.

B. ADMINISTRATIVE REQUIREMENTS

1. The Department retains the right to review any and all Subcontracts entered into for the provision of any services under this Contract
2. The Department does not require the Subcontractor to participate in any other line of business (i.e. Medicare Advantage or commercial) offered by the CONTRACTOR in order to enter into a business relationship with the CONTRACTOR.
3. The Department does not require the Subcontractor to participate in the Network of any other Managed Care Organization as a condition of doing business with CONTRACTOR.
4. The CONTRACTOR and the Subcontractor shall be responsible for resolving any disputes that may arise between the two (2) parties, and no dispute shall disrupt or interfere with the Continuity of Care of a Medicaid Managed Care Member. Subcontractor recognizes and agrees that it does not have a right to a State Fair Hearing before the Department's Division of Appeals and Hearings.
5. The Subcontractor represents and covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services hereunder. The Subcontractor further covenants that, in the performance of this Contract, no person having any such known interests shall be employed.
6. The Subcontractor recognizes that in the event of termination of the Department's Medicaid Managed Care Contract between the CONTRACTOR and Department, the CONTRACTOR is required to make available to the Department or its designated representative, in a usable form, any and all records, whether medical or financial, related to the CONTRACTORS and Subcontractor's activities undertaken pursuant to this Contract. The Provider agrees to furnish any records to the CONTRACTOR that the CONTRACTOR would need in order to comply with this provision. The provision of such records shall be at no expense to the Department.
7. In the event of termination of this Subcontract, the Department must be notified of the intent to terminate this Contract one hundred and twenty (120) calendar days prior to the effective date of termination. The date of termination will be at midnight on the last day of the month of termination.
8. If the termination of this Contract is as a result of a condition or situation that would have an adverse impact on the health and safety of Medicaid Managed Care Members, the termination shall be effective immediately and the Department will be immediately notified of the termination and provided any information requested by Department.
9. The Contractor and Subcontractor shall develop, maintain and use a system for Prior Authorization and Utilization Management that is consistent with this Subcontract.

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C. HOLD HARMLESS

1. At all times during the term of this Contract, the Subcontractor shall, except as otherwise prohibited or limited by law, indemnify, defend, protect, and hold harmless the Department and any of its officers, agents, and employees from:
 - a. Any claims for damages or losses arising from services rendered by any Subcontractor, person, or firm performing or supplying services, materials, or supplies for the Subcontractor in connection with the performance of this Contract.
 - b. Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of state or federal Medicaid regulations or legal statutes, by the Subcontractor, its agents, officers, employees, or Subcontractors in the performance of this Contract;
 - c. Any claims for damages or losses resulting to any person or firm injured or damaged by Subcontractor, its agents, officers, employees, or Subcontractors by the publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under this Contract in a manner not authorized by the Contract or by federal or state regulations or statutes;
 - d. Any failure of the Subcontractor, its agents, officers, employees, or Subcontractors to observe the federal or state laws, including, but not limited to, labor laws and minimum wage laws;
 - e. Any claims for damages, losses, or costs associated with legal expenses, including, but not limited to, those incurred by or on behalf of the Department in connection with the defense of claims for such injuries, losses, claims, or damages specified above;
 - f. Any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against the Department or their agents, officers or employees, through the intentional conduct, negligence or omission of the Subcontractor, its agents, officers, employees or Subcontractors.
2. As required by the South Carolina Attorney General (SCAG), in circumstances where the Subcontractor is a political subdivision of the State of South Carolina, or an affiliate organization, except as otherwise prohibited by law, neither Subcontractor nor the Department shall be liable for any claims, demands, expenses, liabilities and losses (including reasonable attorney's fees) which may arise out of any acts or failures to act by the other party, its employees or agents, in connection with the performance of services pursuant to this Contract.
3. It is expressly agreed that the CONTRACTOR, Subcontractor and agents, officers, and employees of the CONTRACTOR or Subcontractor in the performance of this Contract shall act in an independent capacity and not as officers and employees of the Department or the State of South Carolina. It is further expressly agreed that this Contract shall not be construed as a partnership or joint venture between the CONTRACTOR or

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Subcontractor and the Department and the State of South Carolina.

D. LAWS

1. The Subcontractor shall recognize and abide by all state and federal laws, regulations and the Department's guidelines applicable to the provision of services under the Medicaid Managed Care Program.
2. The Subcontractor must comply with all applicable statutory and regulatory requirements of the Medicaid program and be eligible to participate in the Medicaid program.
3. This Subcontract shall be subject to and hereby incorporates by reference all applicable federal and state laws, regulations, policies, and revisions of such laws or regulations shall automatically be incorporated into the Subcontract as they become effective.
4. The Subcontractor represents and warrants that it has not been excluded from participation in the Medicare and/or Medicaid program pursuant to §§ 1128 (42 U.S.C. 1320a-7) (2001, as amended) or 1156 (42 U.S.C. 1320 c-5) (2001, as amended) of the Social Security Act or is not otherwise barred from participation in the Medicaid and/or Medicare program.
5. The Subcontractor also represents and warrants that it has not been debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders.
6. The Subcontractor shall not have a Medicaid contract with the Department that was terminated, suspended, denied, or not renewed as a result of any action of Center for Medicare and Medicaid Services (CMS), United States Department of Health and Human Services (HHS), or the Medicaid Fraud Unit of the Office of the South Carolina Attorney General. Subcontractors who have been sanctioned by any state or federal controlling agency for Medicaid and/or Medicare fraud and abuse and are currently under suspension shall not be allowed to participate in the Medicaid Managed Care Program. In the event the Subcontractor is suspended, sanctioned or otherwise excluded during the term of this Contract, the Subcontractor shall immediately notify the CONTRACTOR in writing.
7. The Subcontractor ensures that it does not employ individuals who are debarred, suspended, or otherwise excluded from participating in federal procurement activities and/or have an employment, consulting, or other Contract with debarred individuals for the provision of items and services that are significant to the CONTRACTOR's contractual obligation.
8. The Subcontractor shall check the Excluded Parties List Service administered by the General Services Administration, when it hires any employee or contracts with any Subcontractor, to ensure that it does not employ individuals or use Subcontractors who are debarred, suspended, or otherwise excluded from participating in federal procurement activities and/or have an employment, consulting, or other contract with debarred individuals for the provision of items and services that are significant to

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Subcontract's contractual obligation. The Subcontractor shall also report to the CONTRACTOR any employees or Subcontractors that have been debarred, suspended, and/or excluded from participation in Medicaid, Medicare, or any other federal program.

9. In accordance with 42 CFR §455.104 (2010, as amended), the Subcontractor agrees to provide full and complete ownership and disclosure information with the execution of this Contract if not enrolled with the South Carolina Department of Health and Human Services as a South Carolina Medicaid Network Provider and to report any ownership changes within thirty-five (35) calendar days to the CONTRACTOR. Provider must download the appropriate form from the CONTRACTOR's website or request a printed copy be sent. Failure by the Provider to disclose this information may result in termination of this Contract.
10. It is mutually understood and agreed that all contract language specifically required by the Department shall be governed by the laws and regulations of the State of South Carolina both as to interpretation and performance by Subcontractor. Any action at law, suit in equity, or judicial proceeding for the enforcement of the Department required language shall be instituted only in the courts of the State of South Carolina.

E. AUDIT, RECORDS AND OVERSIGHT

1. The Subcontractor shall maintain an adequate record system for recording services, service Providers, charges, dates and all other commonly accepted information elements for services rendered to Medicaid Managed Care Members pursuant to this Contract (including, but not limited to, such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed). Medicaid Managed Care Members and their representatives shall be given access to and can request copies of the Medicaid Managed Care Members' health records, to the extent and in the manner provided by S.C. Code Ann. §44-115-10 et. seq., (Supp. 2000, as amended).
2. The Department (SCDHHS), HHS, CMS, the HHS Office of Inspector General, the State Comptroller, the State Auditor's Office, and the South Carolina Attorney General's (SCAG) Office, or any of their designees, shall have the right to evaluate, through audit, inspection, or other means, whether announced or unannounced, any books, contracts, computer or other electronic systems of Subcontractor (or any subcontractor of Subcontractor) that pertain to any aspects of services and activities performed, or determination of amounts payable, under CONTRACTOR's contract with the Subcontractor, including those pertaining to quality, appropriateness and timeliness of services and the timeliness and accuracy of encounter data and claims submitted to the CONTRACTOR.
 - a. The Subcontractor shall cooperate with these evaluations and inspections. The Subcontractor will make office workspace available for any of the above-mentioned entities or their designees when the entities are inspecting or reviewing any records related to the provision of services under this Contract. Subcontractor will make available, for purposes of an audit, evaluation or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid enrollees.
 - b. The right to audit Subcontractor will exist through ten (10) years from the final

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date of the contract period or from the date of completion of any audit, whichever is later. If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the Subcontractor at any time.

3. The Subcontractor will allow the Department and the U.S. Department of Health and Human Services, HHS or their designee, to inspect and audit any financial records and/or books pertaining to: 1) the ability of the Subcontractor to bear the risk of financial loss; and 2) services performed or payable amounts under the contract.
4. Whether announced or unannounced, the Subcontractor shall participate and cooperate in any internal and external quality assessment review, utilization management, and Grievance procedures established by the CONTRACTOR or its designee.
5. The Subcontractor shall comply with any plan of correction initiated by the CONTRACTOR and/or required by the Department.
6. All records originated or prepared in connection with the Subcontractor's performance of its obligations under this Contract, including, but not limited to, working papers related to the preparation of fiscal reports, health records, progress notes, charges, journals, ledgers, and electronic media, will be retained and safeguarded by the Subcontractor in accordance with the terms and conditions of this Contract. The Subcontractor agrees to retain all financial and programmatic records, supporting documents, statistical records and other records of Medicaid Managed Care Members relating to the delivery of care or service under this Contract, and as further required by the Department, for a period of five (5) years from the expiration date of the Contract, including any Contract extension(s). If any litigation, claim, or other actions involving the records have been initiated prior to the expiration of the five (5) 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 (5) year period, whichever is later. If Subcontractor stores records on microfilm or microfiche, the Subcontractor must produce, at its expense, legible hard copy records upon the request of state or federal authorities, within fifteen (15) calendar days of the request.
7. The Department and/or any designee will also have the right to:
 - a. Inspect and evaluate the qualifications and certification or licensure of Subcontractors;
 - b. Evaluate, through inspection of Subcontractor's facilities or otherwise, the appropriateness and adequacy of equipment and facilities for the provision of quality health care to Medicaid Managed Care Members;
 - c. Audit and inspect any of Subcontractor's records that pertain to health care or other services performed under this Contract, determine amounts payable under this Contract;
 - d. Audit and verify the sources of encounter data and any other information furnished by Subcontractor or CONTRACTOR in response to reporting requirements of this Contract or the Department's Medicaid Managed Care Contract, including data and information furnished by Subcontractors.

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8. Subcontractor shall release health records of Medicaid Managed Care Members, as may be authorized by the Medicaid Managed Care Member or as may be directed by authorized personnel of the Department, appropriate agencies of the State of South Carolina, or the United States Government. Release of health records shall be consistent with the provisions of confidentiality as expressed in this Contract.
9. Subcontractor shall maintain up-to-date health records at the site where medical services are provided for each Medicaid Managed Care Member for whom services are provided under this Contract. Each Medicaid Managed Care Member's record must be legible and maintained in detail consistent with good medical and professional practice that permits effective internal and external quality review and/or medical audit and facilitates an adequate system of follow-up treatment. The Department's representatives or designees shall have immediate and complete access to all records pertaining to the health care services provided to the Medicaid Managed Care Member.

F. SAFEGUARDING INFORMATION

1. The Subcontractor shall safeguard information about Medicaid Managed Care Members according to applicable state and federal laws and regulations including but not limited to 42 CFR 431, Subpart F, and Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164.
2. The Subcontractor shall assure that all material and information, in particular information relating to Medicaid Managed Care Members, which is provided to or obtained by or through the Subcontractor's performance under this Contract, whether verbal, written, electronic file, or otherwise, shall be protected as confidential information to the extent confidential treatment is protected under state and federal laws. Subcontractor shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securement of its rights under this Contract.
3. All information as to personal facts and circumstances concerning Medicaid Managed Care Members obtained by the Subcontractor shall be treated as privileged communications, shall be held confidential, and shall not be divulged to third parties without the written consent of the Department or the Medicaid Managed Care Member, provided that nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning Medicaid Managed Care Members shall be limited to purposes directly connected with the administration of this Contract.
4. All records originated or prepared in connection with the Subcontractor's performance of its obligations under this Contract, including but not limited to, working papers related to the preparation of fiscal reports, health records, progress notes, charges,

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journals, ledgers, and electronic media, will be retained and safeguarded by the Subcontractor in accordance with the terms and conditions of this Contract.

G. BILLING A MEDICAID MANAGED CARE MEMBER

1. The Subcontractor may bill a Medicaid Managed Care Member only under the following circumstances:
 - a. Subcontractor is a Provider of services and is seeking to render services that are non-covered services and are not Additional Services, as long as the Subcontractor provides to the Medicaid Managed Care Member a written statement of the services prior to rendering said services. This written statement must include: (1) the cost of each service, (2) an acknowledgement of the Medicaid Managed Care Member's responsibility for payment, and (3) the Medicaid Managed Care Member's signature; or
 - b. Subcontractor is a Provider of services and the service provided has a co-payment, as allowed by the CONTRACTOR, the Subcontractor may charge the Medicaid Managed Care Member only the amount of the allowed co-payment, which cannot exceed the co-payment amount allowed by the Department.
2. In accordance with the requirements of S.C. Code Ann. § 38-33-130(b) (Supp. 2001, as amended), and as a condition of participation as a South Carolina Medicaid Provider, the Subcontractor hereby agrees not to bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have recourse against, Medicaid Managed Care Members, or persons acting on their behalf, for health care services which are rendered to such Medicaid Managed Care Members by the Subcontractor, and which are covered benefits under the Medicaid Managed Care Member's evidence of coverage. This provision applies to all covered health care services furnished to the Medicaid Managed Care Member for which the Department does not pay the CONTRACTOR or the CONTRACTOR does not pay the Subcontractor. Provider agrees that this provision is applicable in all circumstances including, but not limited to, non-payment by the CONTRACTOR and insolvency of the CONTRACTOR. The Subcontractor further agrees that this provision shall be construed to be for the benefit of Medicaid Managed Care Members and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the Subcontractor and such Medicaid Managed Care Members.

1.2 PROVIDER SUBCONTRACTOR BOILERPLATE

A. HEALTHCARE SERVICES

1. The Subcontractor shall ensure adequate access to the services provided under this Contract in accordance with the prevailing medical community standards.
2. The services covered by this Contract must be in accordance with the South Carolina State Plan for Medical Assistance under Title XIX of the Social Security Act, and the Subcontractor shall provide these services to Medicaid Managed Care Members through the last day that this Contract is in effect. All final Medicaid benefit determinations are within the sole and exclusive authority of the Department or its designee.

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3. The Subcontractor may not refuse to provide Medically Necessary Services or covered preventive services to Medicaid Managed Care Members for non-medical reasons.
4. The Subcontractor shall render Emergency Services without the requirement of prior authorization of any kind.
5. The Subcontractor shall not be prohibited or otherwise restricted from advising a Medicaid Managed Care Member about the health status of the Medicaid Managed Care Member or medical care or treatment for the Medicaid Managed Care Member's condition or disease, regardless of whether benefits for such care or treatment are provided under the Department's Medicaid Managed Care Contract, if Provider is acting within the lawful scope of practice.
6. The CONTRACTOR shall not include covenant-not-to-compete requirements or exclusive Provider clauses in its Provider agreements. Specifically, the CONTRACTOR is precluded from requiring that the Provider not provide services for any other South Carolina Medicaid Managed Care CONTRACTOR. In addition, the CONTRACTOR shall not enter into Subcontracts that contain compensation terms that discourage Providers from serving any specific eligibility category. No provision in this Subcontract shall create a covenant-not-to-compete agreement or exclusive Provider clause.
7. The Subcontractor must take adequate steps to ensure that Medicaid Managed Care Members with limited English skills receive, free of charge, the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this Contract in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.) (2001, as amended) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended).
8. The Subcontractor shall provide effective Continuity of Care activities, if applicable, that seek to ensure that the appropriate personnel, including the PCP are kept informed of the Medicaid Managed Care Member's treatment needs, changes, progress or problems.
9. The Subcontractor must adhere to the Quality Assessment Performance Improvement and Utilization Management (UM) requirements consistent with this Contract. The CONTRACTOR is responsible for informing the Subcontractor of such requirements and procedures, including any reporting requirements.
10. The Subcontractor shall have an appointment system for Medically Necessary Services that is in accordance with the standards in this Contract and prevailing medical community standards.
11. The Subcontractor shall not use discriminatory practices with regard to Medicaid Managed Care Members such as separate waiting rooms, separate appointment days, or preference to private pay patients.
12. The Subcontractor must identify Medicaid Managed Care Members in a manner that will not result in discrimination against the Medicaid Managed Care Member in order to provide or coordinate the provision of all core benefits and/or Additional Services and out of plan services.

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13. The Subcontractor agrees that no person, on the grounds of handicap, age, race, color, religion, sex, or national origin, shall be excluded from participation in, or be denied benefits of the CONTRACTOR's program or be otherwise subjected to discrimination in the performance of this Contract or in the employment practices of Provider. The Subcontractor shall show proof of such non-discrimination, upon request, and shall post in conspicuous places, available to all employees and applicants, notices of non-discrimination.
14. If the Subcontractor performs laboratory services, the Subcontractor must meet all applicable state and federal requirements related thereto. All laboratory-testing sites providing services shall have either a CLIA certificate or waiver of a certificate of registration along with a CLIA identification number.
15. If the Subcontractor is a hospital, Provider shall notify the CONTRACTOR and the Department of the Births when the mother is a Medicaid Managed Care Member. The Subcontractor shall also complete a Department request for Medicaid ID Number (Form 1716 ME), including indicating whether the mother is a Medicaid Managed Care Member, and submit the form to the local/state Department office.
16. If the Subcontractor is an FQHC/RHC, Provider shall adhere to federal requirements for reimbursement for FQHC/RHC services. This Contract shall specify the agreed upon payment from the CONTRACTOR to the FQHC/RHC. Any bonus or incentive arrangements made to the FQHCs/RHCs associated with Medicaid Managed Care Members must also be specified and included in this Contract.
17. If the Subcontractor is a PCP, Provider shall have an appointment system for covered core benefits and/or Additional Services that is in accordance with prevailing medical community standards but shall not exceed the following requirements:
 - a. Routine visits scheduled within four (4) to six (6) weeks.
 - b. Urgent, non-emergency visits within forty-eight (48) hours.
 - c. Emergent or emergency visits immediately upon presentation at a service delivery site.
 - d. Waiting times that do not exceed forty-five (45) minutes for a scheduled appointment of a routine nature.
 - e. Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures.
 - f. Walk-in patients with urgent needs should be seen within forty-eight (48) hours.
18. As a PCP Provider must also provide twenty-four (24) hour coverage but may elect to provide twenty-four (24) hour coverage by direct access or through arrangement with a triage system. The triage system arrangement must be prior approved by the CONTRACTOR.
19. The Subcontractor shall submit all reports and clinical information required by the CONTRACTOR, including Early Periodic Screening, Diagnosis, and Treatment

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(EPSDT), if applicable.

B. PAYMENT

1. CONTRACTOR, or its designee, shall be responsible for payment of services rendered to Medicaid Managed Care Members in accordance with this Subcontract and shall pay ninety percent (90%) of all Clean Claims from practitioners, either in individual or group practice or who practice in shared health facilities, within thirty (30) days of the date of receipt. The CONTRACTOR shall pay ninety-nine percent (99%) of all Clean Claims from practitioners, either in individual or group practice or who practice in shared health facilities, within ninety (90) days of the date of receipt. The date of receipt is the date the CONTRACTOR receives the claim, as indicated by its data stamp on the claim. The date of payment is the date of the check or other form of payment.
2. The Subcontractor and Provider may, by mutual written agreement, establish an alternative payment schedule to the one presented.
3. The Subcontractor shall accept payment made by the CONTRACTOR as payment-in-full for covered services and Additional Services provided and shall not solicit or accept any surety or guarantee of payment from the Medicaid Managed Care Member, except as specifically allowed by 1.1.G, Billing of Medicaid Managed Care Members.
4. No Subcontract shall contain any provision that provides incentives monetary or otherwise, for the withholding of Medically Necessary Services.
5. Any incentive plans for Providers shall be in compliance with 42 CFR Part 434 (2009, as amended), 42 CFR § 417.479 (2008, as amended), 42 CFR §422.208 and 42 CFR §422.210 (2008, as amended).



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