

# SCDHHS – Healthy Connections 2010

## Enrollment/Disenrollment

1. Why would someone not be eligible for managed care enrollment: have to enroll in FFS instead? For information concerning eligibility to participate in managed care, refer to the Managed Care Supplement located in each provider manual and under MC information on the agency's website – [www.scdhhs.gov](http://www.scdhhs.gov).
2. Why do approved providers (SCDHHS approved) have to go through credentialing with each individual MCO? All health plans are required to credential each provider as outlined in 42 CFR 438.214, and the MCO contract and policies & procedures.
3. Who and what phone number would a patient call to change health plans when allowed? South Carolina Healthy Connections Choices (SCHCC) at 877-552-4642.
4. Is there a way a provider can find out when the anniversary date of a patient is – the purpose being to remind them to complete the necessary process for renewing Medicaid? We hope to be able to provide the managed care anniversary date to providers in the near future via the eligibility verification process. At this time, providers may only confirm this information by contacting the MCO or SCDHHS health plan program manager. Concerning renewal of Medicaid eligibility, all beneficiaries receive information weeks prior to the established renewal date.
5. Do providers need to check eligibility multiple times? Yes, as eligibility may change between the time of a scheduled appointment and when it actually occurs.
6. Is there any way to find out how long a beneficiary has been enrolled in a plan? No.
7. Do beneficiaries have to choose a plan or can they stay in FFS? Beneficiaries may stay in FFS, but must proactively choose to do so. If an enrollment packet is sent and the beneficiary does not respond in a timely manner, the beneficiary will be enrolled in a health plan by SC Healthy Connections Choices (SCHCC). SCHCC will not leave the beneficiary in FFS.

## Authorizations/Referrals

1. If an MCO does not authorize a covered service (i.e. individual speech therapy but not group speech therapy as well), would FFS pay for the unauthorized MCO service? Not if the service is included in the MCO core benefits & rate.
2. As an out of network provider, can I get a prior authorization from an MCO to treat their member (both Healthy Connections and Healthy Connections Kids)? It is possible, but not guaranteed. Providers must contact the MCO for additional information and assistance.
3. Does Medicaid monitor authorization codes provided by a PCP in a MHN? How do they know if one is valid? Medicaid does not monitor MHN authorization numbers – they are assigned by the MHN and/or PCP. DHHS provides the MHN with monthly referral reporting for use in verifying the accuracy of authorization codes which have been submitted on claims for MHN members.
4. Where can I find documentation on the services provided by Medicaid Fee for Service and the MCO? Medicaid prior authorization information is published in Medicaid provider manual(s). In addition information is available on the Qualis, the SCDHHS contracted Quality Improvement Organization, website at [www.qualishealth.org](http://www.qualishealth.org). Each MCO has their own prior authorization requirements, which must be obtained from the MCO(s).

5. Do contracted providers have to get prior authorization from the MCOs? **Yes, if it is required by the MCO. Refer to your contract with the health plan for additional information.**
6. What should we do if ER claims are being denied for no authorization?  
**Services rendered to MCO members in the emergency room do not require prior authorization. For assistance, contact the SCDHHS program manager assigned to the MCO. You can reach the Medicaid health plan program managers by calling the Division of Care Management at 803-898-4614.**
7. Where on the claim do you put the authorization? **Claims submitted for reimbursement on services rendered to MHN members must include the PCP's 6-digit referral number in the appropriate box on the appropriate claim form:**
  - a. **CMS-1500 Claim Form, the referral number must be entered in block 19.**
  - b. **UB-04 Claim Form, the referral number must be in block 63.**
8. How are specialty-care services handled under an MHN? **The MHN does not contract with specialists. The MHN enrolled PCP may refer his/her patients to any Medicaid enrolled provider, and must provide the specialist with a 6-digit referral number. The specialist's claim, including the 6-digit referral number, is billed to Medicaid.**
9. Are they required to have some type of relationship (referral) with specialists in the area to assure that beneficiaries have access (i.e. the specialists accepting Medicaid patients) to services? **Yes, the MCOs contract with a variety of provider types and are required to meet network adequacy guidelines based on Medicaid FFS practice patterns. Medicaid staff initially review & approve the networks on a county by county basis and review them monthly on an on-going basis. PCPs enrolled in the MHN may refer to any Medicaid enrolled specialist.**
10. Do Private Rehab Therapy Providers have to get a referral number from the PCP if the beneficiary is in the MHN program? **Yes, you should contact the beneficiary's primary care provider for the 6-digit referral number.**
11. Is a Private Rehab Facility who is in network with an MCO required to get authorization for therapies? **Yes, if it is required under the authorization policy of the MCO.**
12. Does our Medicaid pre-authorization protocol and phone number for utilization review (Level 2, 1 treatment) remain the same? **Certain procedures require Prior Authorization that must be given by our QIO Qualis Health. They can be reached by phone at (877) 717-8592 and by fax: (877) 717-8594 for general information: (803) 739-2755. Website: [www.qualishealth.org](http://www.qualishealth.org).**

## Healthy Connections Kids

1. HCKIDS – What do I do? – Where do I bill? **Healthy Connections Kids (HCK) is a non-Medicaid managed care program for children up to age 19, who do not have other insurance coverage & whose family income is less than 200% of the federal poverty limit. HCK benefits are based on the state health plan benefits. Children covered under this program must be enrolled in one of the MCOs who provide HCK coverage. Dental care is billed to Medicaid, but claims for all other HCK services must be filed with the MCO.**
2. It is my understanding that there is a law that precludes certain groups such as state employees to participate in Healthy Connections Kids (HCK). That being said, what is the rationale behind this? **HCK benefits are based on the state health plan. State employees have the ability to purchase this coverage for their children. HCK enrolled beneficiaries may not have, or have access to, private insurance.**

3. Explain carved out services (contract with DAODAS) Healthy Connections Kids (HCK) who to bill and how? The term “carved out” refers to those services which are not included in the MCO rate setting process. As such, claims for these services are adjudicated by the SCDHHS on a fee-for-service basis. Claims for services rendered to HCK beneficiaries are filed to the MCO with the exception of dental. Claims for dental services are submitted to the SCDHHS as dental services are considered a “carve out” for the HCK population.
4. Were Psychiatric Residential Treatment Facility (PRTF) services for HCK members added as a carve-out? Yes, effective with dates of service on or after July 1, 2009, services provided by a PRTF are considered “carved out”.
5. What is the difference between SC Healthy Connections and SC Healthy Connections Kids (HCK)? SC Healthy Connections is the name of the SC Medicaid program. SC Healthy Connections Kids is **not** Medicaid, but is the stand-alone State Children’s Health Insurance Program (SCHIP) for children (under age 19) based on the State Employee’s Health Insurance Program. See the Managed Care Supplement for more information concerning both.
6. I need assistance getting payment for HCK clients. Providers should contact the health plan directly. Should the health plan be unable to provide assistance to the provider’s satisfaction, the provider should contact the SCDHHS program manager assigned to the health plan. You can reach the Medicaid health plan program managers by calling the Division of Care Management at 803-898-4614.
7. Will HCK patients who are removed from home and placed in foster care automatically become FFS Medicaid? When an HCK child is placed in foster care, HCK eligibility will be terminated and a Medicaid eligibility determination must be completed.
8. What about HCK Kids removed from home, placed in foster care and then referred to Intensive In-Home Services? We can’t treat them because HIS is for Medicaid clients only. How can the client get out of that 12-month lock in with HCK? HCK is an eligibility category for children who exceed Medicaid guidelines – they are in HCK because they don’t qualify for Medicaid. There is no FFS coverage under the HCK program. If a child’s circumstances have changed and they enter foster care, they should qualify and receive Medicaid coverage.
9. Do migrant children qualify for HCK? Yes, if they meet the program criteria – including citizenship requirements.
10. HCK is supposed to follow SC State health plan; however, First Choice Kids will not cover therapy services for a diagnosis of developmental delay whereas the state health plan will. Is this their prerogative? Benefits for the HCK population are driven from the State Employees Health Plan. Therapy services are not covered under the State Employees Health Plan when the services are being rendered as a result of developmental delay or disability.

## Web Tool

1. How or can we use/have more than one password for Web Tool – or is that needed? Each user id has a unique password which corresponds to unique data. A provider may have more than one Web Tool ID assigned to them; however, they will not share any data. You can request additional Login Ids and passwords from the EDI Support Center.
2. Is there anyway to access the Web tool to check to see if a particular procedure code has been utilized within a year. Blue Cross EDI
  - a. For example: 92004  
No, there is no way to run a report on the Web Tool to search for information filed on previous claims.

3. We applied for Web tool but haven't heard anything? **Contact the EDI Support line at 888-289-0709**
4. File claims online and receive ECF other insurance this was keyed on original claim what action needs to be taken? **If you received an ECF with an edit code stating there is another insurance primary to Medicaid, please review the, "INSURANCE POLICY INFORMATION" section at the bottom of the ECF and file to them as primary or file out the Health Insurance Information Referral Form if that information is incorrect.**
5. Is there a max on psych visits? **All recipients are limited to 12 Psychiatric and counseling visits per State Fiscal Year (June 30<sup>th</sup>-July 1<sup>st</sup>).**
6. Web tool – Display number of visits allowed – Is it current? **Yes, the visit count number that is displayed on the Eligibility Verification screen updates nightly. Therefore, if a claim processes today and it "uses" a visit count, the count will update tonight.**
7. How to identify an MHN patient? **There is no MHN-specific payment category. MHN enrollment will be identified through Medicaid eligibility verification. Upon checking eligibility, providers will be able to determine managed care participation. The Web Tool will list the name and phone number of the MCO, or the name and phone number of the primary care physician for beneficiaries enrolled in an MHN. The IVRS will provide the same information, however it is not shared until the end of the message.**

## Reimbursement

1. 989 edit codes started in September, prior to October 1 effective date for Rehab Services to be included. These should not have occurred until incorrect billing after October 1. Will these be corrected automatically or should we resubmit our claims?  
**This issue has been resolved. All claims receiving the edit in error have been recycled for payment. These claims have been recycled. If you have not received payment, please resubmit the claim(s).**
2. How to get a Family Planning visit paid? Note: **Family planning services are not covered for HCK members. Family planning services for Medicaid beneficiaries enrolled in a Medicaid MCO should be billed to the MCO except for members of First Choice by Select Health of SC. Family planning services provided to First Choice members should be billed to Medicaid. Family planning services provided to MHN members should be billed to Medicaid.**
3. If an insured has a private HMO or 3<sup>rd</sup> party insurance and the claim is rejected, can we re-file to the Medicaid MCO for payment? **Beneficiaries cannot have commercial HMO/MCO coverage and also be enrolled in a Medicaid MCO. However, if non-HMO private coverage denies payment for a service provided to a Medicaid MCO member, the claim for that service can be billed to the MCO for payment consideration. Please contact the MCO for billing assistance.**
4. Loop 2300/REF02 for 837 (EDI claims) When billing MCO carved-out charges to the agency, is there a particular modifier that is required? **Carved-out services are those services paid on a fee-for-service basis. For assistance with billing questions, contact the specific area (i.e. Physician Services, Hospital Services).**
5. Are there any other codes other than 99 that we should be aware of that may affect payment? **Payment Category 99 is a non-Medicaid category which means the child is covered by Healthy Connection Kids (HCK). There are other Payment Categories which indicate limited benefits – e.g., Payment Category 55 = Family Planning Waiver and covers family planning services only.**
6. If patient has Medicaid and Medicare, if we file Medicare and they reject will Medicaid reimburse for those services if they are usually covered under Medicaid, such as eye exams or glasses. **If the primary insurance (including Medicare) rejects or does not cover**

- a Medicaid covered service, the provider must file the claim indicating that the primary denied (“0” payment) and Medicaid will reimburse up to our allowable.
7. If you are unable to get an MCO to pay claims after a year, can you file the response from the MCO to SCDHHS? No, each MCO has a documented appeals process that should be followed when a provider disagrees with a denial. The provider may also contact the plan’s assigned SCDHHS program manager for assistance after exhausting the appeals process. The SCDHHS does not serve as a “safety net”, paying denied claims for services rendered to MCO members.
  8. Injection 96372 code not covered under Family Planning, rejected with an FP modifier; will it pay without it, if patient is getting Depo? This has been paid in the past, but in the most recent months J1055 MOP FP paid, 99211 MOP FP – paid – 96372 Denied with 990 FP edit. Was paid previously without a problem – This is a FFS plan and patient’s with Family Planning Waiver. The CPT code 96372 is for the administration of an injection. This code can be billed with a ‘FP’ modifier.
  9. When patients have Medicaid as secondary and the primary insurer fails to pay, how do we show/prove that the private insurance was actually filed and denied payment? Information concerning third-party insurance (TPL) should be included on all claims submissions to both MCOs and Medicaid fee-for-service (FFS). For assistance with billing issues, contact the health plan or your Medicaid FFS program manager.
  10. If an MCO is not paying for therapy visits should we then bill Medicaid? No – contact the Medicaid program manager for the health plan. You can reach the Medicaid health plan program managers by calling the Division of Care Management at 803-898-4614.
  11. We have been told by our billing service that we cannot provide vision exam services to MCO beneficiaries. Is this true? Is it regulated by age? All Medicaid beneficiaries are entitled to one comprehensive eye exam annually regardless of age. The annual eye exam has been paid by FFS Medicaid; however, effective April 1, 2010 the service will no longer be paid by FFS for MCO enrolled members for assistance with MCO enrolled patients, please contact the MCO. For assistance with FFS beneficiaries, please contact Physician Services at 803-898-2660.
  12. If a patient is out of visits and chooses to be seen – do they need to sign a waiver stating they understand they are responsible? We recommend the provider have the recipient sign a form to ensure they understand these services will be non-covered and that they are responsible.
  13. Botox claims aren’t getting paid – who do I talk to? The Physician Services manual outlines SC Medicaid Botox policy and coverage guidelines. Hospital Services handles the authorizing of the claims.
  14. Our office needs help with getting Ultrasounds and NST paid. When we get the denial (713) additional information. We send information, but claim still gets denied. HELP. Three ultrasounds are allowed per pregnancy. Additional ultrasounds are payable if medically necessary. When additional documentation is sent, coding must be accurate and it must show that additional ultrasounds, outside of the three were necessary. Sending documentation does not guarantee payment and necessity.
  15. If patient visits ED or Urgent Care on same day they visit PCP will both claims be paid? Both claims are payable. Medical documentation may be necessary to show that both services were rendered and medically necessary.
  16. Will Medicaid pay for 2 WCRs in a year if for instance they come in late for a 3-year WCR late then a few months later come in for their actual 4 year WCR –Physician Services question? EPSDT beneficiaries are eligible to receive 20 screenings in 21 years of life. Periodic Screenings are determined according to the age of the child and, in some instances, when last screened. When the child passes age 2, another screening

- isn't due until age 3. During ages 3 through 6 four screenings are allowed one year apart.
17. According to bright futures and AAP recommendations we can now see patients for a 30 month WCR. Is this going to be paid by Medicaid? EPSDT screenings are outlined in the manual and are not currently being revised. The Screening Age Guidelines chart at the end of the "Pediatrics and Neonatology" heading will detail all services that are reimbursable for SC Medicaid.
  18. Can you charge a Medicaid patient if you are out of state flu shots and the patient is willing? The patient must be informed that they will be self-pay and agree to that designation prior to receiving the service.
  19. Why doesn't Medicaid cover the A and B for the flu test? If the provider purchases the vaccine for a beneficiary over 19 years of age, the procedure 90658 should be billed. Procedure code 96372 should be billed for the administration of the vaccine.
  20. 99050, 99051 – Why doesn't FFS pay for after hour charges. We are open 365 days and this keeps patient's from going to the ER. If your office is open 365 days then, those are your regular hours. After hour codes are for services outside of your regular posted business hours. The agency decided to discontinue coverage of those codes.

## Miscellaneous

1. What is the difference between MHN and MCO? See the Managed Care Supplement located in all provider manuals and under 'MC Information' on the agency's website – [www.scdhhs.gov](http://www.scdhhs.gov).
2. Status of Health Savings Accounts/Health Opportunity Accounts component of Healthy Connections? The program is not going as well as expected. We have three people enrolled.
3. Will DAODAS continue to be carved out of MHN option? DAODAS services are not carved out of the MHN – all MHN services are billed to Medicaid. A referral from the MHN PCP is not required for DAODAS services.
4. School-based OT, PT, and ST are covered by fee-for-service. If the child receiving services has an MCO, how is their school-based therapy going to affect their eligibility for private therapy? Will there be a combined 75-visit limitation? I have not encountered any problems, but a speech pathologist at this session stated that her office has. The 75-visit limit is specific only to private therapy services.
5. If a recipient is in an MCO/MHN do you need something in writing to treat as non-Medicaid? All beneficiaries must be informed and agree to being treated as a non-Medicaid/self-pay patient prior to receiving the medical service in question. A written acknowledgement is not required, but it is strongly recommended providers use a written form and keep the documentation in the patient's medical record for future reference.
6. Are the MCO's also like Medicaid, based on federal and state funding? Indirectly, the managed care health plans receive per member per month (PMPM) premiums from SCDHHS. Medicaid premiums are a combination of state and federal funds.
7. Could one authorized representative form be automatically included in the Medicaid application packet so that parents can ensure that both parents are authorized to make changes to plans? For Medicaid eligibility purposes, a parent listed on the application who is living in the home is authorized to take actions for the child(ren) in the Budget Group. MEDS allows only 1 authorized representative in the system. The parent should be referred to the toll free number (1-888-549-0820) to request plan changes. As long as they are listed in the household as a parent, they are able to request the change.

8. What is the difference between “Outpatient Rehab Therapy” and “Private Rehab Therapy Services?” Outpatient services are rendered in an outpatient hospital setting, whereas private rehabilitation services are rendered in one of the following places of service: clinic, office, or home.
9. Can local clinic be PCP for MHN? Yes
10. Is there a separate contract needed for Family Planning? First Choice by Select Health of SC operates under an ethical contract that does not include family planning services. Family planning claims for their members are filed to Medicaid. The other MCOs operate under a standard contract that includes family planning services. Regardless of plan enrollment, federal regulations mandate freedom of choice for family planning services and beneficiaries may receive family planning services from any Medicaid enrolled provider.
11. May I have access to this booklet in mass quantity? We do not produce our booklets in mass quantity for distribution purposes. We provide these training booklets to providers who attend training. Please note that our trainings are offered on a monthly basis and are free of charge.
12. Lots of news stories in the past 4 days re: horrifying dollars spent by Medicaid of Fraudulent claims. How did SC do, as a percentage of total payments? Last state fiscal year 2009, the South Carolina Department of Health and Human Services, collected more than \$22 million in repayments due to waste, fraud and abuse. The department investigated 1,166 complaints about Medicaid fraud and abuse, opened 580 Program Integrity cases, and referred 8 providers and 263 beneficiaries to the SC Attorney General's Office for criminal fraud investigation.
13. How do we address migrant patients that have Medicaid from another state?  
A migrant worker can choose to:
  - Establish residence in the state where he is employed or seeking employment, or
  - Claim one state as his domicile or State of Residence.How the situation is handled will depend on the choice of the migrant worker. If he/she opts to establish residence in South Carolina, and then the regular process will be completed to determine Medicaid eligibility in South Carolina. If the individual has selected another state as his state of residence, whether he is Medicaid eligible is determined by his home state, and the medical provider giving care will have to contact that state for instructions concerning how to bill.
14. What’s your best guess re: the effect on Medicaid that the likely form of the upcoming health reform legislation will have? SCDHHS continues to monitor federal legislation and all information coming to the states from CMS; however, there are no specific guidelines available at this time. For this reason, it would be virtually impossible to speculate changes for the SC Healthy Connections program.