Healthy Connections *Visual*

MEDICAID BASICS BOOK

Introduction

An illustrated companion to the interactive courses at: MedicaideLearning.com.

Updated April 2024

SOUTH CAROLINA Healthy Connections MEDICAID

Contents

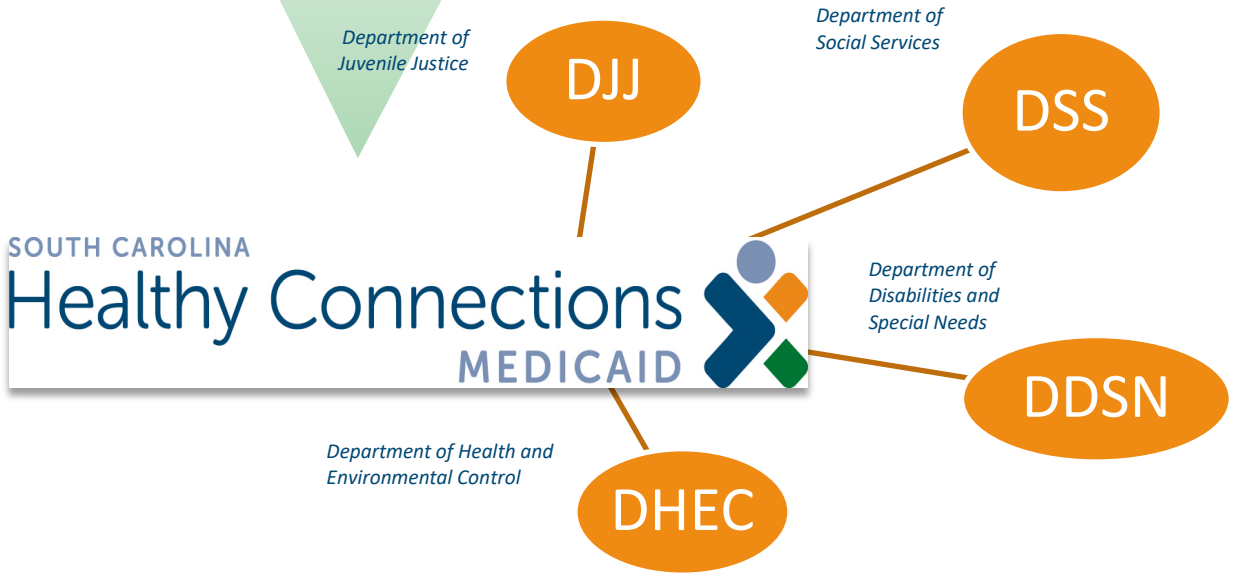
Healthy Connections Medicaid

The new name for South Carolina's Medicaid Program is *Healthy Connections Medicaid*.

Healthy Connections Medicaid has branded itself like other states' programs have done.

- *For example:* California's Medicaid: *Medi-Cal*; Tennessee's: *Tenn-Care*.

Partnerships with other health-related agencies include:



LINK:
Section 1 : **GENERAL INFORMATION AND ADMINISTRATION**

Eligibility

The SC Healthy Connections Program is designed to provide coverage for certain individuals who meet the following criteria:

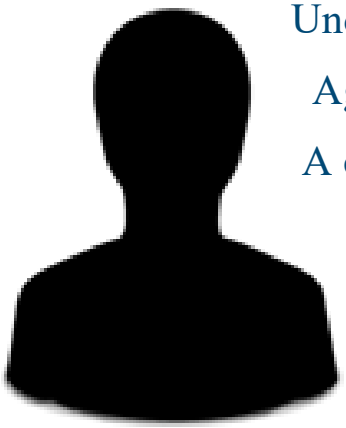
Their income and resources must be at or below certain income limits.

They must meet U.S. citizenship guidelines.

- Non-citizens must also meet certain guidelines, *which will make them eligible for limited benefits such as emergency services*.

The individual must also reside in the state.

In addition, to be eligible for SC Healthy Connections, a person must be one of the following:



Under the age of 19

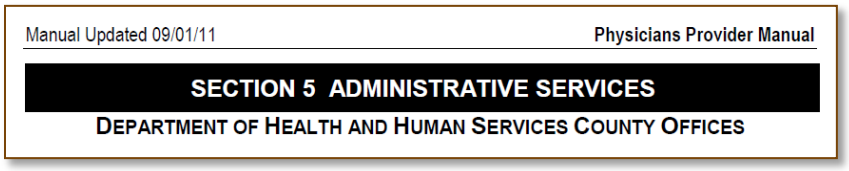
Age 65 or older

A caretaker relative living with a child under age 18

Pregnant

Totally or permanently disabled

For more information on eligibility requirements, you can refer to the Eligibility Manual on the agency's Web site.


Manual Updated 09/01/11 Physicians Provider Manual

SECTION 5 ADMINISTRATIVE SERVICES

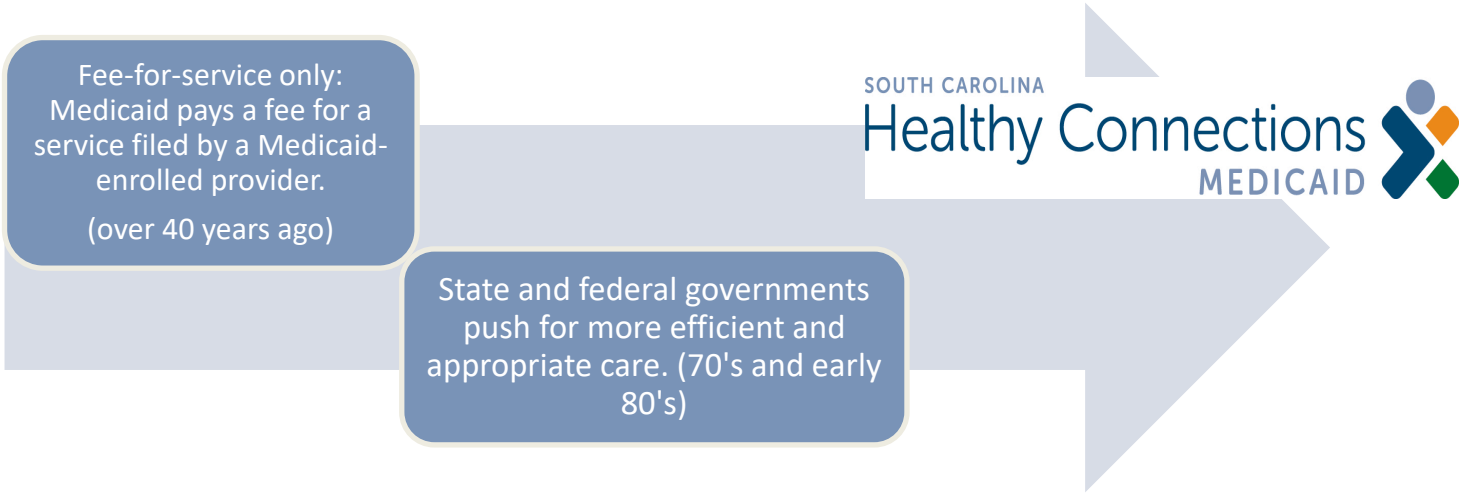
DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

Uninsured patient in your office?
Benefit from the SC Healthy Connections Program?

- Refer to section 5, provider manual, www.scdhhs.org
- Lists all SC counties eligibility offices

Progression

South Carolina began participating in the Medicaid program in July 1968.



South Carolina Department of Health and Human Services (SCDHHS)

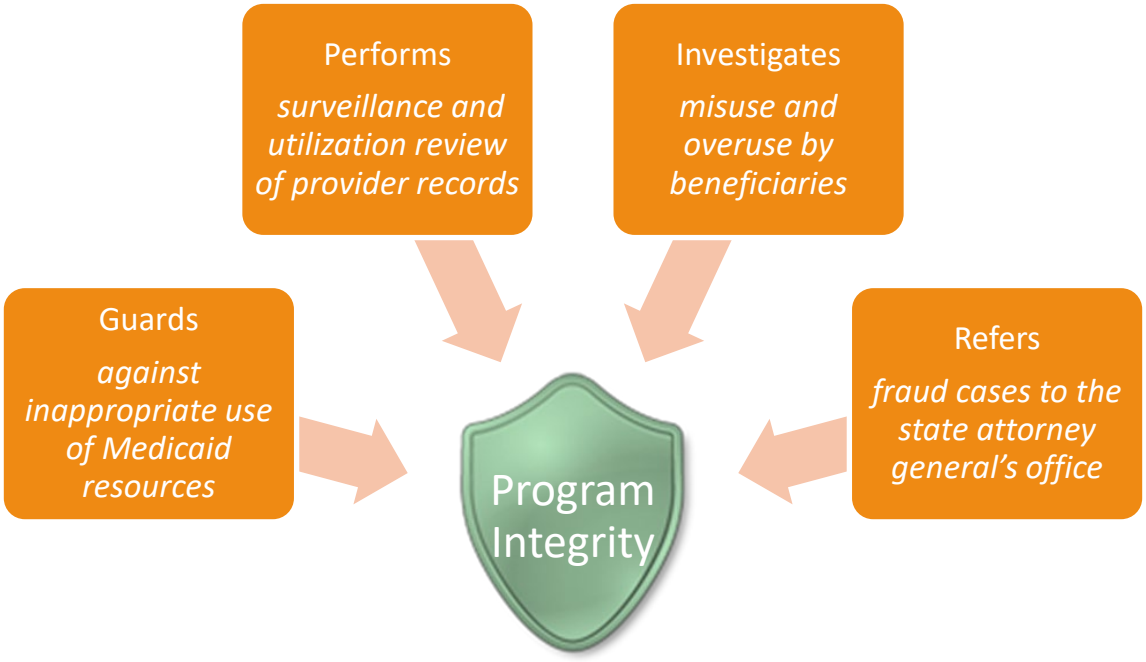
SCDHHS administers SC Healthy Connections.

SCDHHS Policy Program Areas

- Organized by provider specialty
  - Includes Community Long Term Care & Behavioral Health, Medical & Health Services.
  - Physicians, Hospitals, DME, Managed Care fall under the Medical & Health Services area
  - Inquiries? Provider Service Center (888) 289-0709

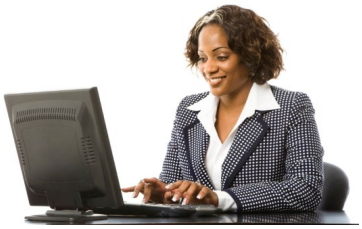
SCDHHS Program Integrity

SCDHHS focuses on program integrity to ensure that resources are used effectively and efficiently.



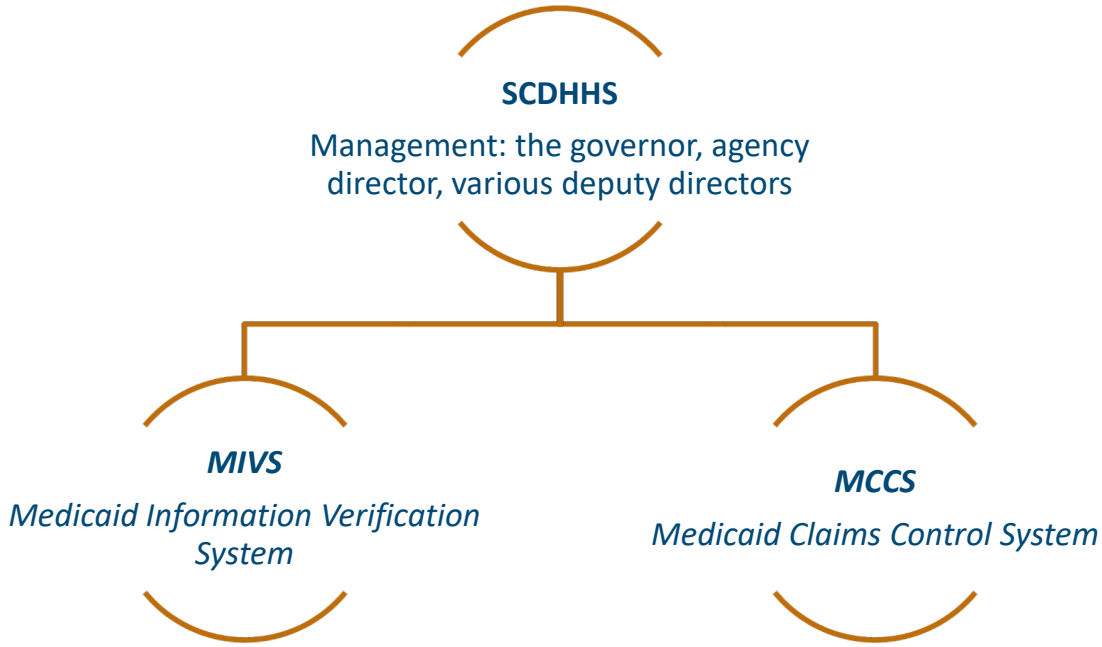
Eligibility Processing

SCDHHS handles eligibility processing. Beneficiaries have several options to apply for benefits:

Apply in	Mail in the	Apply online
		
At each county's eligibility processing office*	To the Division of Central Eligibility Processing*	DHHS Web site: www.SCDHHS.org

*A full list of county offices with addresses is located in Section 5 of your provider manual.

SCDHHS' Structure



Medicaid Information Verification System (MIVS)

MIVS

- maintains third-party liability (TPL) files
- researches recipient's TPL coverage
- assist DHHS in pursuing recovery
- operates the Health Insurance Premium Payment program (HIPP) for SC
  - HIPP pays private insurance premiums for certain SC Medicaid recipients. 803-264-6847

Medicaid Claims Control System (MCCS)

MCCS scans, keys, and processes claims (including adjustment claims).

Provider Support

	Assistance with:
Provider Service Center (PSC) ***1 (888) 289-0709***	• Forms & manual requests, claim inquiries, payment issues, & general billing issues • Filing claims via the Web Tool • Nursing Home, OSS, and Hospice Room and Board questions • Managed Care Services • Qualified Medicare Beneficiary Program
Provider Enrollment ***(Option 4)***	• Enrollment • Status changes
EDI Support Center ***(Option 1)***	• Web Tool questions
	Also assists:
Provider Education	• Provides free training throughout the state • Helps SCDHHS produce provider manuals • Publishes educational materials

New Screening Policies

Effective December 3, 2012, SCDHHS implemented new policies to emphasize stronger requirements for enrollment and screening as established by the Affordable Care Act (ACA).

Reactivation/Revalidation

- Reactivation of Enrollment
- Revalidation of enrolled providers every five years
- DME providers are revalidated every three years

Pre and Post Site Visits

- SCDHHS will conduct pre-enrollment and post-enrollment site visits designated as “moderate” or “high” categorical risks to the Medicaid program. (Example: DME, Home Health)
- The purpose of the site visit is to verify the information submitted to SCDHHS for accuracy and to ensure compliance with State and Federal enrollment requirements.

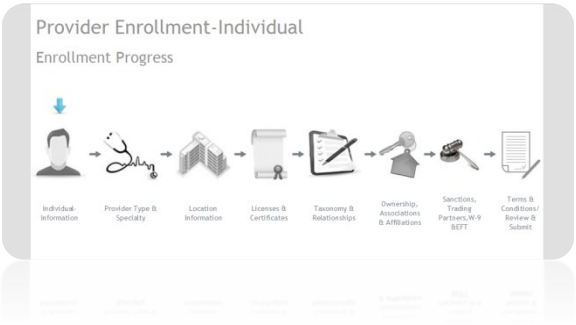
Ordering/Referring Providers

- All ordering/referring providers are required to be enrolled with SC Medicaid if they order and/or refer services for Medicaid beneficiaries.

Interactive Web Application

Visit http://provider.scdhhs.gov to enroll as a new provider, organization or ordering/ referring provider, or to add a new location.

See Video



Medical Necessity

Medicaid will only cover authorized, approved services that are medically necessary for that patient.

med·i·cal ne·ces·si·ty:

- Services to maintain, improve, or protect health, or
- Services to diagnose and treat an illness or disability

SECTION 2

POLICIES AND PROCEDURES

Find: covered & non-covered services, special coverage issues, & prior authorization requirements in Section 2 of your provider manual.

Prior Authorization

Some programs and services require prior authorization (PA) and/or certification of medical necessity. *Some examples:*

Durable Medical Equipment

Dental

Organ transplants

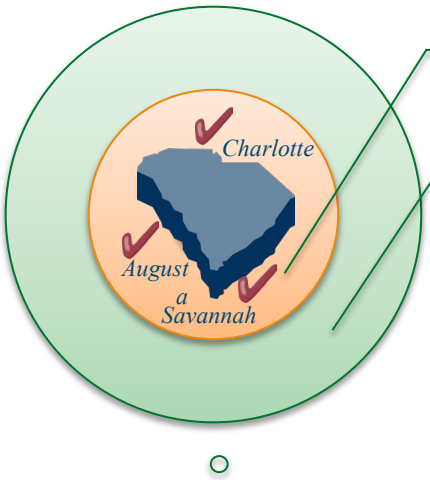
Vision services

Mental health, alcohol & other drug abuse treatment services

Prior authorization must be obtained by the provider, *not* by the beneficiary. Uncertain? Refer to Section 2 of your provider manual for clarification.

Out-of-state referrals and services

Out-of-State Services are services outside the South Carolina Medicaid Service Area.



SCMSA (within 25 mi. of border)

Out of state

Exception:
Emergency medical services (including pregnancy-related services) **do not require** a referral if they are provided outside of the SCMSA. (However, prior authorization may still be required by a particular agency.)

Documentation is key. A physician must complete a referral form certifying that the needed services are not available within the SCMSA. When in doubt, document.

Copayments

Beneficiary's responsibility: contribute to the cost of their care, including copayments.

Your provider responsibility

- Copayment amount is deducted from the provider's Medicaid payment
- Make beneficiaries aware of their copayment responsibility
- *Can't pay at time of service?* Don't withhold services.
- *Which providers generally charge a copyament?*
  - See copayment schedule (provider manual, Appendix 3)

Many beneficiaries may be *exempt* from copayment:

Children under 19
Institutionalized individuals
Individuals receiving hospice care, family planning services, pregnancy-related services, emergency services, End Stage Renal Disease (ESRD) services, or behavioral health services

Appeals

Appeals are the formal process to resolve or settle a dispute and should be the avenue of last resort. It is not a reconsideration or claims review process.

How to request an appeal

- Send a letter requesting a hearing
- Send a copy of the notice of adverse action or a copy of the remittance advice showing the denial
- Requests must be made within 30 days of date of the notice of adverse action or the remittance advice.

Send all documents to:
Division of Appeals and Hearings
Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

Non-claim appeals?
Refer to the manual.